Health Subcommittee of the
Health and Human Services Committee

Public Hearing on

Mental Health Care and Substance Abuse Treatment: Planning for the Future

Allegheny County Human Services Building
Homestead Grays Room
1 Smithfield Street
Pittsburgh, Pennsylvania 15222-2221

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Subcommittee on Health
19th Legislative District, Democrat
Allegheny County (part)

Douglas G. Reichley, Chairperson
Subcommittee Chairperson
134th Legislative District, Republican
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ALSO PRESENT:

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to Representative Jack Wheatley, Jr.

Sandra L. Bennett, Executive Director
Health & Human Services Committee, Democrat

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P R O C E E D I N G S

(5:30 p.m.)

REPRESENTATIVE JAKE WHEATLEY: Good evening, everybody. I am State Representative Jake Wheatley, for those who may not know me. I am a Representative from Allegheny County, the City of Pittsburgh, 19th Legislative District.

I have with me my Co-Chair for the Subcommittee on Health, Representative Doug Reichley, and we would like to convene the Subcommittee Hearing.

I want to call up several of our testifiers. And on your agenda, if I can, I'm going to make one small change based on the fact that one of our presenters, who is in a later panel, has to leave a little early.

So I want to call up Dr. Christine A. Martone, who is the President of the Pittsburgh Psychiatric Society, Pennsylvania -- yeah, Pittsburgh Psychiatric Society. I want to bring you up. But I also want to bring up Joan Erney, Deputy Secretary for the Office of Mental Health and Substance Abuse Services, Department of Public Welfare; Richard Ellers, Director of the Bureau of

Health Care Services, Kathleen...

MS. KATHLEEN GNALL: Gnall.

REPRESENTATIVE JAKE WHEATLEY: Gnall, thank you. Deputy Secretary of Re-Entry and Specialized Programs. Dr. Jack Walmer, Chief of Psychological Services for the Pennsylvania Department of Corrections; and Patricia Valentine, Deputy Director. I do have Amy Kroll. Is she here? If she can come right there.

I believe Dr. Martone will make her presentation, and then she would be leaving.

I also want to recognize Stan Mitchell and Sandy. They are staff members for the Health and Human Service Committee and Representative Oliver who, of course, is our Chairman, who has allowed for us to go around the state and hold these subcommittee meetings. So I am really appreciative of their traveling here to Pittsburgh from Harrisburg today.

I want to make sure that our panelists have had an opportunity to really go to the heart of their testimony. And what we're trying to encourage, we do have your written, many of your written testimonies before us.

Because of the time and because we are

competing -- many of you will probably be leaving this hearing and going to the Mayview hearing, closing hearing, so we don't want to keep you any longer than we need to.

So, really, if you can get to your major points without reading your full testimony that would be very good for us and for those who are coming behind you.

So with that being said, Dr. Martone, I would turn this over to you.

DR. CHRISTINE A. MARTONE: Good evening, Chairman Oliver, Keeney, Wheatley and esteemed -- good evening, Chairman and esteemed members of the House Health and Human Services Subcommittee. My name is Christine Martone. I'm a physician specializing in the field of psychiatry. I'm the Chief Psychiatrist at the Allegheny County Behavioral Assessment Unit, which is a court agency for the criminal court. I am also the Program Director for the Forensic Psychiatry Fellowship at the University of Pittsburgh Medical Center, and as an Associate Professor of Psychiatry at UPMC.

I have board certification in the American Board of Psychiatry with a subspeciality in

forensic psychiatry. I'm currently the President of the Pittsburgh Psychiatric Society, a chapter of the Pennsylvania Psychiatric Society. The society is a district branch of the American Psychiatric Association and represents over 1700 physicians in the Commonwealth of Pennsylvania.

Since Representative Wheatley asked me not to read everything, I'm going to sort of try to summarize.

The society's mission is to assist individuals in the community who have mental illness. The mission is to help them gain access to treatment. Most of the people that have mental illness also have co-morbidities of substance abuse and major physical problems.

What I'm to talk about is the stigma of mental illness, the barriers to treatment of individuals with mental illness in the correctional system, the Mental Health Courts and the difficulties around transferring patients to Forensic Units.

Regarding the stigma, I think you can read the study done by the World Health Organization. I won't go into that, but it should be noted that mental illness is an equal opportunity disease.

It affects everyone of all social, economic, racial, gender and creeds. It affects people and people are often reluctant to seek treatment because of the label and the stigma, and this is something we are seeking to overcome.

Barriers to care for individuals in the correctional system, I think that it is worth mentioning this: That across the United States approximately 1.1 million people or 16 percent of the individuals incarcerated in correctional facilities suffer from severe, serious and persistent mental illness.

There are other people that suffer from substance abuse. Many individuals suffering from substance abuse also have mental health disorders such as depression and bipolar disease. Often these illnesses have contributed to the reason that these people are incarcerated in the first place.

I'm not going to go into the studies since Senator Wheatley -- I mean Representative Wheatley asked me not to go into everything in such detail. I would like to, however, highlight this.

That contrary to public opinion there's a low incidence of violence perpetrated by people

with mental illness. I would want to paraphrase that for you. Most violent crimes are not committed by people with mental illness. Most people with mental illness do not commit violent crimes. There is a subset of people that are mentally ill and do become violent, and they often find their way into the prison systems and into our courts.

We sometimes experience problems with providing treatment to our patients who are incarcerated in local jails, based on poor access to medications and services that could enhance their recovery while they're serving sentences.

We look forward -- the society looks forward to working with you on legislation that would ensure that individuals seek treatment prior to having adverse outcomes that lead to arrest and incarceration.

That brings me to Mental Health Courts. As you know, Allegheny County created the first state -- the state's first mental health court in 2001, followed closely behind by Erie County. The premise behind the Mental Health Court is that incarceration will not help these individuals who are diagnosed with severe and persistent mental

illness.

Although I work for the court, I spend much time in jails. I've also worked in penitentiaries, and I can tell you that certain individuals who have serious and severe mental illness that have the misfortune of being arrested end up serving their maximum sentences. They often serve them in DHU, a Disciplinary Housing Unit, because they can't abide by the rules in prisons. And it becomes a very sad situation. If I could put a face on this, if you would allow me --

REPRESENTATIVE JAKE WHEATLEY: Sure.

DR. CHRISTINE A. MARTONE: -- to put a face on this? I saw one man, he was 40 when I saw him. He was an African-American man, very large built, muscular, and one of the most hostile men we've ever seen. He was incarcerated on a four to eight-year sentence. I think he served, in the end, ten years because of other infractions, most of the time in the Disciplinary Housing Unit.

He was about to be discharged. He had maxed out, so they found another charge to keep him in the Allegheny County Jail to hopefully get him some treatment before he hit the community.

This man had not been treated. Most people just thought he was bad, not mad. And one of the doctors at the jail insisted that I try to send him to Mayview. At Mayview he was treated with Geodon.

He came back quite a different individual. He's a success story. The charges were dropped. He was discharged. He was rearrested on another charge, and he said to me, finally after the age of 40 -- I would add that while he was in prison he was gang-raped, he developed HIV.

While he was in prison -- when he came back after his rearrest -- he said to me, you know, I was stupid. I stopped my medication. I stopped -- I started taking drugs. I burglarized someplace. Please send me back. Please get me treated. I'm sick of ending up in DHU. I'm sick of being in prison. I want a good life. I just want to put a face on what these people are like.

And the Mental Health Courts have been really instrumental. They try to fast-track the mentally ill. They want to help those people by having them evaluated and diverting them from correctional facilities into treatment.

For those persons who refuse to comply,

sometimes they have to -- and comply means a treatment plan and other court-mandated stipulations. Sometimes they have to be detained in jails and treated by psychiatrists and monitored by psychiatrists.

It is our opinion that individuals with nonviolent crimes, including substance abuse, theft, other misdemeanors, are appropriate candidates for Mental Health Courts. Often people think psychiatrists that work in the forensic system are getting, quote, murderers off. I can tell you that most of my people have charges such as defiant trespassing, criminal trespassing, aggressive panhandling, obstructing traffic, retail theft. They're often incarcerated for other reasons.

We do, however, remain sensitive to the concern that the use of Mental Health Courts can perpetuate the stigma related to mental illness, can erode confidentiality of those patients already under care, and sometimes lead to more restrictive treatment in-service than is necessary.

It is our belief and our opinion, however, that the court-ordered treatment, comprehensive

mental health evaluation should be performed by psychiatrists and other mental health providers that act within the scope of their practice. And we look forward to working with your committee to allocate additional funds to create some additional Mental Health Courts throughout the state, preserve and enhance activities of current county Mental Health Courts, and to provide training for court and law enforcement personnel in crisis intervention, general mental health and substance abuse issues.

With the closure of various state hospitals and mental health facilities across the Commonwealth over the past ten years -- and this is across the nation. This isn't just us. And it's even more than ten years -- coupled with the barriers to treatment I've mentioned previously, there have been an increase in individuals with mental illness being charged with crimes or engaging in violent crimes.

Here in Allegheny County, we are in the midst of a closure of Mayview State Hospital, Forensic Unit, and the transfer of patients in need of additional treatment and services to Torrance State Hospital in a completely intact

Forensic Unit. I mean, it's going to have the same number of people, the same doctors, everything.

However, what we are concerned about is that there would be no interruption for admissions or services because of the wait time.

Let me explain to you a little bit of what it's like in the Allegheny County Jail. We have -- and I just got these numbers. We have an Acute Mental Health Unit, which has 25 beds; a less acute, which has 26. These are for the males only.

And these are the only places where people are not double-celled where they have people watching them 24-7 and they are getting medication. They are not inpatient units. They are not even outpatient units. In the Acute Unit people are kept in their cell 23 out of 24 hours a day because of a security risk, not wanting them to hurt themselves, et cetera.

All the other places in the jail are double-tiered and double-celled. By that, I mean, there's two to a cell. There are two tiers. So, obviously, we don't want mentally ill people on those pods. Females have only 26 beds.

In February, 500 people at the jail were using major psychotropic medication. Now, it's over 800. That's out of 2600 people.

So if we have an interruption -- right now the wait time is between two and three weeks, between the time that I say this individual is a commitment and we have the commitment hearing and when they actually get transferred. It's a long time, but it's an acceptable time. We can deal with this.

If there's an interruption -- here's our concern -- is that the areas where there are some safeguards, in other words, where there's single-celled and single-tiered, that these place -- there's only so many cells that are made that way, and they will get filled up. And there will be people that either will be in the general population needing transferred to the Mental Health Unit, which cannot get transferred because they're filled up with people that are waiting for transfer to Mayview -- I mean to Torrance or people that are on the Mental Health Unit will get transferred off before they're really ready because somebody is worse out in the general population.

So we really ask that this be looked at very carefully, that we don't have an interruption in services because the jail is really in a state of dire need right now, and we don't want people who need treatment to fall through the cracks. We don't want an increase in suicides or violent behavior because mentally ill people are in the general population.

We're extremely interested in working with OMHSAS on this and other interested stakeholders to find ways that we can assist these individuals.

We applaud Representative Wheatley and members of your subcommittee for trying to address our concerns about providing access to adequate treatment for those suffering from mental illness and substance abuse issues and challenges our patients face daily.

I extend our willingness to work with all of you, the committee, the House and Senate leadership, the Departments of Corrections, Departments of Welfare, OMHSAS to develop policies and procedures that state and local municipalities can use better to serve our patients and their families so that they won't end up in jail, and to help those that are in jail and prisons to get the

treatment that they need and, hopefully, recover and get back into society.

I'm open for any questions.

REPRESENTATIVE JAKE WHEATLEY: Thank you, thank you. And just to take a step back for your purposes, give you some background, we had kicked off this set of hearings in Harrisburg I want to say about a month or so ago, and our goal is to have a very thorough set of hearings around the state. We've had one in Scranton. We were in Philadelphia last week. This week we're here in Pittsburgh. We'll be going tomorrow to Erie, and we'll have one more that has not been set up in Harrisburg, which is kind of a closeout evaluation program/conversation.

But the hopes that we are trying to get to is a complete picture of what is happening out there in relation to those individuals who have mental illness or substance abuse, and what we have as a Commonwealth to provide a safety net, and also to provide some treatment and access to them becoming healthy and productive citizens, and all of those facets that are associated with that.

So although all of the committee members may not be here today, we have the testimony, and

we will be gathering more testimony, and we will be collecting information and having conversations in Harrisburg from that information. So we hope to, at some point in time, come back to you and either through legislation policy or as we go through our budget cycle next year and really try to put all of this into some prospective for us as we move forward. So I wanted to say that first.

Secondly, I wanted to, some of the things you were talking about, if you could just help me understand from your prospective where you see what we may be doing right and what you think we should be doing more of and what we may be struggling or having some challenges from a state prospective, what you think we should be doing more of.

DR. CHRISTINE A. MARTONE: Okay. I think the Mental Health Courts have been very successful. I think that Amy Kroll's group -- and I hope I have the name straight now because they've changed their name -- it's correctional -- no, Justice Related Services. They do a terrific job for diversion. That's where people are seen at their arraignment. She'll probably tell you about it, and even before they get into the

criminal system, they're diverted into the mental health system if their crimes are minor enough.

And I think that they do a very good job, but it's one that's overwhelming for the people that don't qualify for diversion or Mental Health Court. You have to have a nonviolent crime for Mental Health Court. There are people, just like the man I used as my poster child, who now was actually given renewal and a probation with a lot of stipulations for his second crime that he had the burglary.

There are people that have mental illness, and they get probation with stipulations for mental health treatment. And this is where Amy and her group does a very good job of setting up the treatment plan, and then they go out into the community. The problem is there's not a good way of tracking these people after the time that Amy -- I mean, she can't keep tracking people that are on probation for four or ten years.

In my opinion it would be great if we could -- and I think this is like my wish list. I don't know that this can be done. If we could have some kind of a clinic that would work strictly with these individuals and the Probation

Officers. They have such a clinic at Cuyahoga County. The danger of this, as Amy will tell you, is you're stigmatizing the person even more. Now, they have -- this is the person that has mental illness and a crime, that's where they're going.

But, on the other hand, they could be tracked, and we could make sure that the stipulations are really being carried out. Sometimes they're carried out. Sometimes the only way that the Probation Office tells me that they know about somebody who has fallen through the cracks and is not getting their treatment is if a family member calls up and says, hey, he's not taking his medication. He's not going to treatment.

How about the people that don't have family members or are estranged from their families, which many of these people are by then. There's no way we can track them, and they fall through the system and either become victims or commit another crime because they are mentally ill. Sometimes it's a serious crime.

We've had several incidents in Allegheny County recently, and I don't think that's because of the closure of Mayview. I just want to go on

record with that. These are just people that have been on probation, and they were being seen by their outpatient doctor who didn't even know they were on probation. Originally, somebody did, but now they're on probation maybe five, ten years, and they get lost in the system.

And I would think that some kind of general -- maybe help with the probation officers where they could track these people better or some kind of clinic where people would be all going and there would be the expectation that there would be a certain amount of liaison with the Probation Office, not where the confidential information they're giving the doctor, but merely to say yes, they are coming, yes they are complying with medication and treatment.

REPRESENTATIVE JAKE WHEATLEY: I was just wondering, are probations officers or correctional officers, are they trained also to identify those who may have mental disorders or substance abuse?

DR. CHRISTINE A. MARTONE: I can't speak for those two people. They have their own representatives. But I know that in the Probation Office there's at least three probation officers in the Probation Office of Allegheny County that

carry most of the mental health load, so I would assume that they have some sort of training. I know one of them, and he does a really good job.

I mean, sometimes people that do a really good and are crusaders are not well liked by everyone else, and I could tell you that happens with him, because he's always there really advocating for his individuals.

The correctional officers have some training, particularly the ones that are on the mental health pods, and my hat's off to them. They do a really good job. I'm not sure everywhere they have the same even training, but often, you know, somebody's acting up on the pod, and it's the correctional officer who says, hey, doc, somebody's got to look at this guy. I don't think he's just being -- in fact, the man that I talked about was on DHU, and Dr. Mebane went and saw him and started treating him. And the people in DHU said, boy, he's different. He's really different.

So some of them do have training. I can't speak to what kind because I don't work for those two departments.

REPRESENTATIVE JAKE WHEATLEY: And you

don't necessarily have to answer today, but you spoke briefly in your testimony about pieces of legislation that you would like to see promoted in Harrisburg. One was to promote reducing the stigma of mental illness on individuals who seek treatment. So I don't know if you have some model legislation that has been introduced or other states have passed that you want to pass along to this committee to take look at?

DR. CHRISTINE A. MARTONE: I think that the society could get back to you with that. I mean, they have a whole department that takes care of that, and I think they could do it better than I could.

REPRESENTATIVE JAKE WHEATLEY: Okay. And you also mentioned, I think, the support of more Mental Health Courts, that you thought additional funds needed to go into. How much does it cost a county to institute a Mental Health Court, and are they getting support currently from the state for those courts?

DR. CHRISTINE A. MARTONE: Well, that I'd have to -- I think probably Amy and Pat Valentine know a little bit more about that, but I know that there are many counties that don't have them, the

smaller counties.

And there's also situations -- and I think this probably goes a little afield, but I happen to know because they send people to me. For example, in some of the smaller counties, the correction -- if somebody's in jail and they need medication, they require them, the individual, to pay for part of that medication.

And while that sounds really good on paper, it's saying, well, this individual has to appreciate how -- it's a small amount. They don't make them pay like the full amount. It makes them appreciate what they have.

I just saw a young lady the other day who didn't have the money or the sense to pay for it. I said, well, are you back on your Zoloft? Are you taking your Depakote? She said, no, because they want me to pay $5 for each prescription, and I won't have enough money when I get out, so I'm just going without. So I'm not sure that's a really good idea either.

REPRESENTATIVE JAKE WHEATLEY: Sure. Thank you. Representative Reichley.

REPRESENTATIVE REICHLEY: Thank you. I have a couple of very pointed questions because I

know you need to get going. I think we'd like to hear generally from the rest of the panel, the presenters, just what kind of legislation you think promotes reducing the stigma of mental illness. I'm not sure that's a legislative enactment that we can do. It's more of an overall educational endeavor.

But on, I guess on Page 3, you supported a court ordered treatment being made after a comprehensive mental health evaluation performed by a psychiatrist or mental health provider acting within the scope of their practice. Do you have a concern that's not happening right now? Are there people outside?

DR. CHRISTINE A. MARTONE: I think it happens here in Allegheny County, you know, pretty much. I don't think it happens elsewhere, and I think we're talking statewide. I don't think it happens elsewhere. We do it here.

If anybody needs a diagnosis -- I mean, Amy's people who are the people that get involved with this refer them back to -- I work for the court and the court agency called the Behavior Assessment Unit. We do the evaluations, give them the diagnosis, make some generalized

recommendations, and they make the treatment plan. They do a great job.

I don't think that happens in other counties. I don't think there are enough Mental Health Courts. I think our Mental Health Court is probably pretty burdened and they can only take certain people.

And here's the problem -- and I understand why it's done this way -- but they will take people with nonviolent crimes, so these people get a lot of supervision and the best of monitoring, and they do very well. And I think that we should spend money on saving those people because they can be saved.

But there are other people, like my poster child, but there's tons of people like that who would never qualify for Mental Health Court because their crimes have been violent. They've been a recidivist.

And they are processed -- so we don't -- we have less monitoring of people with more serious crime. And I'd like to see more funds go to organizations like either Amy's or with some kind of clinic that could do more monitoring and following of these individuals who are the

difficult patient. I mean, they're the ones with the serious, persistent mental illness. They're the ones that end up in prison. They particularly end up if they're male and they're large because people are afraid of them, and rightly or wrongly sometimes.

And, in fact, the man that I told you, he never, ever -- he was angry with me all the time. He never, you know, assaulted me or threatened me in any way or Dr. Mebane or anything. He would say a lot of mean things, but he never did anything.

But these are the people that need further monitoring, whether you're going to do it through a clinic or maybe giving Amy's group more money so they can follow more of these people. That's the people that slip through.

REPRESENTATIVE REICHLEY: Why is the need for money to ensure continued monitoring through a Probation Office?

DR. CHRISTINE A. MARTONE: Because I think that Amy's group -- and she'll tell you more about that -- don't have enough people to follow these people long enough. So you either have to set up another kind of a clinic or help the Probation

Officers or something that they can follow them long enough.

I see people that repeatedly reenter the jail, that are mentally ill. Obviously they don't see me if they're not mentally ill. And I see people that repeatedly -- a sad little note was one person said, whatever happened to so and so, we haven't seen him in a while. Then he came back and we found out because he was serving a prison sentence.

REPRESENTATIVE REICHLEY: My last two questions: You mentioned those who are in the Acute Unit. What are the charges for those people?

DR. CHRISTINE A. MARTONE: It doesn't matter. It doesn't matter. We have them from homicide down to defiant trespassing, but if they are severely mentally ill, they're in the Acute Unit, then the Step-Down Unit.

And when I say severely, these people are so ill that some of them can't put a sentence together, some of them are smearing feces on the walls. I mean, this is severe, persistent and very primitive mental illness.

REPRESENTATIVE REICHLEY: There's been a --

I don't want to call it a diversionary impetus, but some kind of an assessment, once the person goes to a preliminary arraignment or for a preliminary hearing?

DR. CHRISTINE A. MARTONE: Oh, the diversion -- and Amy's going to tell you more. We got taken out of order. The diversion is done at the arraignment, and that's minor changes, mentally ill individuals that can be diverted right into the mental health system. They're usually summary charges or charges that can be made a summary, and she'll tell you more. If I'm giving you any misinformation, she'll correct it because that's her job.

The people I see is at least misdemeanor -- it's usually at least misdemeanors, and defiant trespassing can go either way, disorderly conduct can go either way. But it can be a minor charge. I mean. There are people with homicide and the illness is very severe on the Acute Unit. Either they're a danger to themselves, others or they can't take care of themselves, and they're locked in 23 out of 24 hours because it's not a treatment facility. They are getting their medication if they will accept it. If they don't accept it, you

have to have reason to force it, such as violent behavior towards self or others or unless they're committed.

Once we have the commitment in place the doctors are a little more comfortable about pushing the meds. The Step-Down Unit is for people who are ill, so very ill, but they're not as acute. And there's no Step-Down Unit for females. It's only for males.

And then we have another unit, 5F -- I just made sure I got these numbers right -- with 56 cells, which can be double-cells, so that can increase the number. These people are all on medication, but they're not acute.

The problem with F5 is that it's double-celled, it's double-tiered. You know what I mean by double-tiered? That people can jump over the side, you know, push people over. It's not as secure.

REPRESENTATIVE REICHLEY: These are a county facility, not a state hospital, is that right?

DR. CHRISTINE A. MARTONE: Yeah, these are all at the jail. I'm talking to you about the jail.

REPRESENTATIVE JAKE WHEATLEY: Thank you. I know you have to leave, so I appreciate your testimony.

DR. CHRISTINE A. MARTONE: Thank you, everyone.

REPRESENTATIVE JAKE WHEATLEY: And this portion of it is the government panel, although we have a provider coming in as part of the government panel. What we will do is let you all make your remarks in full before we will ask you any questions, so with that, Madam Secretary.

DEPUTY SECRETARY JOAN ERNEY: It's nice to see you again. Thank you for giving us a chance to highlight, I think, both our strengths and some of our challenges related to the behavioral health system.

I really want to recognize Representative Wheatley's leadership and Representative Reichley and certainly the committee members and the staff.

We are really going to focus today, and I will try to summarize my comments as well. They are fairly brief. We wanted to give you an update on the closure of Mayview State Hospital. We wanted to talk a little bit about justice-related services, including Mental Health Courts, and we

wanted to focus a bit on the stigma and the impact of stigma, which continues to be, unfortunately, alive and well in our world.

I wanted to do a little briefing, having not had the opportunity necessarily to do this previously about just the baseline of our service system.

We are, in fact, a system that serves almost 300,000 individuals annually, and that is through an array of different services. And we have enabling legislation which dates back to 1966. At the time it was considered very landmarked, but it allows not only for the state to engage in the delivery of services, but really focuses our work on county government.

In the behavioral health system, really the counties are the key to the success of programs and the program development. We currently, of the 67 counties, have 48 county joinders, so we do have some neighboring counties that have come together to administer the system.

And I only wanted to speak briefly about HealthChoices. The Behavioral Health Program in Pennsylvania is really fairly unique across the country. We have a carve-out, which means that we

separate out behavioral health, mental health and substance abuse from overall healthcare in Medicaid. And we gave counties the right of first opportunity over 11 years ago in order for them to manage Medicaid dollars.

And of the counties who have agreed to do that, including Allegheny and many of our western partners, we have -- of the 67, we have 43 counties that either individually or together manage the benefit themselves, the HealthChoices benefit.

The others are in a contract directly with the Commonwealth, but this has allowed counties to pull together resources in a very different way. So they have Medicaid, they have county-based funds that are dollars that we distribute through grants. They also have access to their own match funding. They have federal block grant dollars that they have available.

But it has allowed the county to really use those resources strategically, and we have seen great benefit. And we wanted to highlight the fact that HealthChoices has been really something very special, and I think very positive for the program.

We had three major objectives in HealthChoices: One was to increase access to behavioral health services, improve the quality and stabilize the funding. And we believe we've really made great progress in all those areas.

Each year we can see we serve more people. We are actually able to document that we have more people coming into the Medicaid program in order to access services. We have expanded the provider network, so people have a greater choice. And most importantly, we've stabilized the Medicaid funding.

We are clearly below the trends that were aggressively moving upward at the time we started HealthChoices, and we've been able, over the course of time, to really stabilize that Medicaid funding for the behavioral health side.

So we feel very positive about the access and about the fact that we've created a lot of different kinds of services which are cost effective alternatives.

So, for example, in fee for service, you had inpatient, psychiatric hospital, or you had outpatient or you had partial. You had a fairly limited opportunity.

Now we have alternatives, like community treatment teams which serve the individual where they are. We have certified peer specialists as you heard about at the last hearing that allows people to really be diverted from the high use of psychiatric inpatient or crisis services.

So we've seen that we have been able to decrease some of those higher costs and some of those more traditional medical services by enabling other things to be made more available.

That's actually true as well in the drug and alcohol side by the advent of mobile medications and the access of more outpatient, intensive outpatient through the Medicaid program. So we've been able to offset some of the non-hospital rehab or inpatient detox services. And so we see that as a great benefit.

Having said that, I want to talk a little bit about Mayview, if I could. We announced the closure of Mayview State Hospital in August of 2007. This is the second state hospital that we targeted for closing. We closed Harrisburg State Hospital two years ago, and we really believe very strongly that people have a right to be in the community, that they are served better in the

community, that they have an opportunity and need to have an opportunity to live in our communities.

We have what's called a service area planning process which brought together stakeholders that had some major objectives. One is that we would really look at every individual who was in our state facilities over two years, because what we know now is that most people that come into our state hospitals, they actually stay less than nine months. The days of people coming in and staying forever really doesn't happen much anymore.

So the folks who are there over two years, which right how is about 900 individuals across the state, they really have been there because folks have not done the kind of planning that needs to happen in order for them to be in the community. So we made one objective around really looking at that group.

The second objective was to look at recycling. As you heard from the doctor, what we are concerned about is folks getting out into the community and not having a positive experience, not having the ability to stay grounded in the community. So we looked at readmission rates, and

then we also looked at their interaction with the criminal justice system. That's three things we wanted to target.

But as a result of that service area planning, what we learned is that we clearly could move people into the community through the closure, and so we moved forward with the closure of Mayview. And we have worked diligently, which you'll hear from Pat, I think, and others, with a very broad stakeholder group who actively participated in that service area planning. And that plan itself really became the blueprint for the closure.

Just to give you some idea of where we're at, we now have three units operating with 83 persons remaining at Mayview. That's down from 251 at the time of the announcement. In addition to the closing of the civil side, which you heard, were also transferring Mayview Forensic Unit to Torrance State Hospital, and we will do that prior to December 31st of 2008. It will move in total. We're not changing the amount of beds. We'll move the entire operation over to Torrance.

We have, as I mentioned, the three units open. And if placements are not made or people

are not able to move into the community safely we've really built some flexibility into the plan because we're not going to have folks move out, unless they have really a strong community support plan.

We have grounded this process ensuring that families and consumers themselves and their peers and the physicians at Mayview, as well as the community, are all actively engaged in the planning process. And it can take months for us to really plan appropriately how they will be supported in the community.

We have created quite an infrastructure to try to make sure that the Mayview closing goes smoothly. We have created a team out here that includes the CEO and folks who have had a lot of experience with Mayview.

We also, as Secretary Richman has pointed out I think on several occasions, she's very actively involved and continues to really review every discharge prior to that person leaving.

We've also really worked and made some -- a lot of emphasis -- placed emphasis on making sure that our staff are going to have employment opportunities. At Harrisburg State Hospital, out

of the 500 individuals who were employed there, no one was furloughed. We found positions for everyone. We intend to do the same here.

We currently have about 84 individuals who do not have a placement yet, but we're working on that, and we obviously still have a couple of months to do that.

And we had over 500 employees at Mayview as well, so we've had some great success in finding some very, very sound options for people. And then also associated with Mayview obviously, as you mentioned, is the Land Use Task Force. We really appreciated the General Assembly's support in helping us with the leadership of that.

As I mentioned or as the Secretary mentioned, we continue to support Representative Frankel's House Bill 1448 really looking at when we sell properties, when we have properties that are state operated or state owned, that those funds really be utilized to support a housing trust or something of that nature so that we can work with you in order to make sure that folks have a good housing and good place to go.

Justice-related services, we have obviously been incredibly interested and have been working

on this issue quite diligently. I think you'll find that we've been working with the Council of State Governments, we've also been working with our partners at the Department of Corrections, we've been working with the Supreme Court who identified a mental health initiative, and really has that as a priority in their upcoming year.

And so to that end, we've done a number of things. One is that we ground our justice-related services in something that's really referred to as the intercept model, which means there are different places along the way that you can have an impact with someone who has mental illness who's involved in the criminal justice system, and you can change the direction of the outcome.

And so one is really around police training, and police training has really, as we know, is that first level of interaction. And we have a number of places across the state who have done some really interesting and, I think, very positive, including here in Allegheny County, Cambria County, a number of places where police are trained. And they are specially trained on how do you interact with someone who has mental illness. If you come across them and they're

acting differently or they're acting strangely, here's a way you can interact, so that you don't have a result of, one, something bad happening to either person or necessarily an arrest.

The second place where something can change at an intercept is during the district justice. Lehigh Valley, quite frankly, has a great program where they really, at the time that a person is being arraigned in front of the district justice, they actually combine information.

They find out information, they put together a case management team, and if they identify this is someone who has mental illness, they actually really work with the district justice to engage that person in treatment, get them involved in treatment. And if, in fact, the person is successful, they have been successful in dropping charges when they have, again, not been of the violent nature.

Also the Mental Health Courts, as you heard about, we work with the Pennsylvania Commission on Crime and Delinquency. We were each able to commit $500,000, so we had a total of a million in a grant program to nine counties to create or enhance Mental Health Courts.

So, as you can see, although it's a million dollars -- and in this environment that's tough to come by -- in partnership with PCCD. We do have some groundwork done for these nine Mental Health Courts.

There also were five additional ones that have developed on their own, and there are eight that are also coming up. So we really do believe that will become the state of the art as each county really looks forward to getting a Mental Health Court where you can divert from the jail.

And then another initiative that we're working on with our Department of Corrections is really around the reentry, so you have the front end where you're trying to really prevent folks from landing in jail or into the correctional system.

And then clearly what we want to focus on is when someone is leaving jail, what are the things we could do to really make sure they aren't reoffending, they're not really landing back into the correctional setting.

And so to that end we have been working on trying to work on case planning for those who are the most seriously ill. What we know about people

with mental illness is they often are the ones that max out. They have the longest sentences, they have a very difficult time because of the planning that really needs to happen. So we've been working with our Department of Corrections in doing that.

Then I would say that one of the things we've talked about, but not been able to really get off the ground as well as we would like, is really a consolidated kind of case management that has specialized probation and parole with us, similar to what you here at the county level have, at the state level, so that we could help more with the state correctional issues so that we could help more with really networking with state parole agents in order to have them and us be in partnership to help folks from reoffending.

So I've given you a list in my testimony around the different things that we're working on, but I would say we're making steps. We're not there yet, but we really can see some, I think some really fundamental changes in the way we're addressing the issues. And it absolutely requires a partnership, not only at the local level, the District Attorney's Office, the Public Defender's

office, the local jail, the psychiatric community, the stakeholder community with peers, et cetera. It does require us all to work together in order to make it happen for folks with mental illness.

Then I'm going to end, and as I said, keep my comments brief around stigma just because it is so relevant to us. We still know that stigma is still one of the number one issues for folks in their experience in the community, and it really strikes people in a number of ways.

One is that there still is misinformation and misunderstanding about what mental illness is, and then what co-occurring with mental illness and substance abuse, what's different, what is not. And it really does affect how folks are viewed in their community, how they're treated in their community.

One of the things that has become really very challenging for us is the not in my backyard phenomenon. And we have really appreciated, quite frankly, the legislators in this community when we went to close Mayview said to us, you know what, people should have a right to live throughout our communities, not only limited to one area or another. And we took you at your word, so we have

been looking at places in all across the counties that report to or who refer to Mayview in order to assure that people have access to different communities. And what we are finding is that we're not always wanted.

And so we still have folks who really don't understand, and they are concerned and they are worried. They are worried about violence. They're worried about property values. And what we know is that when we come into a community, we're good neighbors. The providers are good neighbors. They keep the property up.

They are, in fact, folks who ensure that the values stay constant. And we have not seen that the property values are diminished as a result of people being in the community.

We also know that we do not have folks with serious mental illness -- I think as you heard testify -- who are the folks who are engaging in violent acts. Oftentimes, folks with mental illness are the victims, not the perpetrators. And so we recognize that folks are concerned, but we want to engage that every community in welcoming and being a welcoming partner for us, and we're still struggling from time to time.

What we do have on our side is a Federal Fair Housing Act, which really talks about discrimination and the fact you can't discriminate against people with mental illness. But we really don't want to come in and always be in a litigation mode. We really want to engage the community and really help with making sure it's a welcoming place for people to be.

But it does continue to be something that's really a struggle. I think you'll hear -- you heard from a peer, I understand, in Philadelphia. And you may have an opportunity to hear from others today across the system. It really is the individual with mental illness that makes the biggest difference in really describing their own successes.

We know that folks are able to recover, they're able to be well, they're able to work, they're able to be great partners with us in their own recovery and in the community, and clearly are the greatest advocate for themselves when they are trying to fight stigma.

We do have a program called Open Minds, Open Doors that we support through the Mental Health Association of Pennsylvania. It has been a

great resource. They have worked with both, I think, with legislatures, with employers and others to try to break down those barriers. They've got videos, et cetera. But I still believe the personal touch, having someone who is a family member, yourself or whomever, having an opportunity to speak with someone who has mental illness changes more minds than any way.

So thank you very much, and I'm open for questions when you're ready.

REPRESENTATIVE JAKE WHEATLEY: Thank you. Mr. Ellers.

DEPUTY SECRETARY JOAN ERNEY: Down the line?

MR. RICHARD ELLERS: If I may, I'd like to go over, and I will move through this as quickly as possible. Sorry, no popcorn tonight.

We appreciate the opportunity to be here this evening to address you. As public servants and as taxpayers, we would like to explain to you some of the services that are being provided for inmates while they're in the Department of Corrections and the scope of the same.

Obviously, the Department of Corrections is responsible for public safety. The confinement of

inmates does result in the deprivation of liberty. We are responsible for the safety of the community, staff and inmates. Our custodial care is the health and safety of the inmates. We also have an Eighth Amendment obligation, which I'm going to briefly touch.

We have institutions throughout the entire Commonwealth. We currently have 27 correctional institutions, 24 of which house male inmates, two, female inmates. Of the approximately 46,000 inmates, 95 percent are male, 5 percent are female.

Our department budget for all of the services we provide for this fiscal year is -- last fiscal year was $1.6 billion. And we currently spend $32,000 a year per inmate or $87.76 per day. 4200 of that is medical, which includes the mental health services, which is $11.50 a day of that.

As most of you are well aware, our population continues to increase. In the last three years we've increased in excess of 4 percent per year to our current population of 46, in excess of 46,000 inmates throughout the Commonwealth.

The average age of our inmates is 36 years old. Half of our offenders are of ages between 25 and 39. 56 percent of our inmates are African-American, 95 percent are male, and 46 percent of our inmates come from Philadelphia and Allegheny Counties.

Across the nation, about 16 percent of prisoners suffer from mental illness, and my colleague, Dr. Walmer will be giving you some more specific details on the Pennsylvania breakdown. In Pennsylvania, it comes out to about 18 percent. 16 percent are in jails, 7 percent in federal prisons. And the IQ average is about 83, that's the mean.

Once again you can see the difference male to female. There's a higher percentage of individuals in prisons who are female who have mental illness. There's a higher percent of whites than blacks who suffer from mental illness.

I did indicate -- and I don't want to belabor this point -- but inmates enjoy, because of their loss of liberty, have one right that none of us in this room have fortunately, and that is they have a constitutional right for healthcare because they cannot choose their healthcare

providers when they're in our custody. We are responsible for their services. That responsibility is ours. We have an obligation to provide care for them because they cannot provide care for themselves.

We must take care of what are called deliberate medical needs. We must be aware of the needs, and we must have a physician or qualified person diagnose them and have the treatment plan to address those needs.

And this involves access to care, both regular, emergency and routine care. Care that is ordered and professional medical judgments by licensed professionals.

The services that we do not provide, such as radial keratotomy and transsexual surgery. You can see the rest of those listed.

In Pennsylvania we contract with three separate providers to provide services. Tonight we're talking about Mental Health Services. We also contract for our medical services, also our laboratory services. We do this so we have the ability to coordinate the care, and we have specialists that we can contract with who have expertise.

Currently our mental health contract is with a company called Mental Health Management, and for this fiscal year -- excuse me, last fiscal year the budget was $14.49 million, and that is for the services we pay for a private contractor to help us provide the mental health services.

Dr. Walmer's going to go through a more detailed or a description of the type of services that we're paying for. I think this is pretty self-explanatory in your handout.

Currently, MHM employs 30 psychiatrists. They have mental health workers and certified mental health units. They also provide the nursing staff for those services as well.

In Pennsylvania we have 15,750 employees in the Department of Corrections. 961 of those medical personnel are state employees and another 333 are vendor staff, as indicated. The only other thing I wanted to bring up, there was a question about the copay services, and Pennsylvania does have a copay charge for inmates receiving medical services as well as prescriptions.

However, if an inmate requests mental health services, they are not charged that copay

fee. If they do not have money, they're still provided with those examinations, and they're also provided with those medications.

The other thing that's a little bit different for us, we do have the ability, since they are in our custody and control, we can monitor compliance of medications fairly easily. And there are many medications, due to their cost and severe side effects, we have inmates -- it's called direct observation therapy, where they must come to a window and be administered that medication, and it has to be observed they're taking that medication. So that's one distinct advantage we might have over some community services. Thank you.

MS. KATHLEEN GNALL: We actually have about three sections for the Department of Corrections.

REPRESENTATIVE JAKE WHEATLEY: Oh, okay.

MS. KATHLEEN GNALL: We're just kind enough to give you the overview.

I'm going to provide a little bit more information about the specifics of the treatment that we provide to those inmates who have mental illness within the department.

At present, over 18 percent of the total

inmate population in the Department of Corrections is listed on our mental health, mental retardation roster. The MH/MR roster identifies those offenders that require psychological or psychiatric services due to a substantial disorder of thought or mood, which significantly impairs judgment, behavior, the capacity to recognize reality, or the ability to cope with the ordinary demands of life.

Likewise, over 2.5 percent of our current population is on the psychiatric review team roster. The PRT roster includes the most seriously mentally ill inmates, usually with multiple psychiatric and medical disorders.

This subset of offenders demonstrate the severe difficulty in adjusting to institutional life and requires close regular monitoring by a multi-disciplinary team. There's no doubt that the mentally ill subpopulation requires a variety of services to appropriately address each offender's individual needs.

In response, the department offers a broad range of mental health treatment services to each offender from the moment of their arrival at our Diagnostic and Classification Center at Camp Hill

and Muncy. The availability of mental health services continues throughout their entire incarceration at all of our 26 state correctional institutions and our boot camp.

Embracing the philosophy of early and appropriate detection of mental illness, the Department of Corrections ensures that every Diagnostic and Classification Center staff, regardless of job title, is specially trained in recognizing the signs and symptoms of mental illness, mental retardation and suicide.

Furthermore, SCI-Camp Hill is the location of a special observation unit, which is a 20-bed housing unit for newly committed inmates who are experiencing stress and are suspected of having mental health problems.

We employ approximately 170 psychology staff across our institutions and also utilize vendor-based psychiatry staff at each facility. Offenders can access psychology or psychiatric services via the Inmate Request System or correctional staff can make a direct telephone referral during crisis situations.

A full range of mental disorders can be treated, including serious mental illness, such as

major thought and mood disorders, along with adjustment disorders. Individual and group outpatient services are available along with specialized housing for offenders with specialized needs.

These Special Needs Units, or what we refer to the SNU's, are non-licensed living areas established to provide a safe, secure and specialized housing for those inmates as being unable to function on a general population unit. Special Needs Units are present in 22 of our state correctional institutions and house approximately 1600 inmates with medical and mental handicaps.

At least 35 hours of specialized programming is offered per week on each SNU. The ultimate goal of the specialized programming, be it mandatory medication compliance groups or vocational in training, is to integrate the mentally ill offender onto a general population housing unit for the duration of their incarceration.

Some offenders, however, are not prepared or able to care for themselves on the SNU's. The licensed intermediate care unit was established for those offenders with an extensive history of

serious mental illness requiring frequent psychiatric hospitalizations who need interim housing to prepare them for living on an SNU.

The same difficulties that plague our communities are often parallelled within the walls of the institution. As reflected in society, many persons with mental illness have difficulty adapting to the established rules and regulations.

For those inmates who, because of a mental illness, have demonstrated patterns of poor behavior resulting in long-term disciplinary custody placement, the department has developed a special assessment unit.

This five-bed psychiatric unit on SCI-Waymart's restricted housing unit is designed to provide an independent assessment using a multi-disciplinary approach to evaluate the offender and develop a treatment plan to address his future mental health needs.

I do want to mention that we are very cognizant of the fact that, in the past, some inmates with mental health issues have lived in our restricted housing unit or disciplinary custody units. We believe that offenders are better served on units like the special assessment

unit or Special Needs Unit, and have made, I think, pretty heroic efforts to try to keep inmates with severe mental illness out of our restricted housing units, something that Secretary Beard is certainly cognizant of and something that we're constantly monitoring as we look at our restricted housing population making sure they don't have long-term mental health issues that would really put them in that unit inappropriately and we need to place them in other places.

Special Needs Units were established for the safe and secure housing of inmates unable to function in the general population. Mentally ill offenders who have demonstrated an inability to function on a regular Special Needs Unit by accumulating substantial amounts of disciplinary custody time can be transferred to the secure Special Needs Unit. We have lots and lot of acronyms in the Department of Corrections: SNU, ICU, SSNU.

The SSNU Program was established at five institutions, four male and one female, as a specialized treatment program, that will afford the offender the opportunity to return to a Special Needs Unit following a demonstrated period

of improvement in their behavior.

As you can see, our ultimate goal is really to keep offenders in the least secure setting that they can within a prison environment where they can safely be housed, whether that be in the general population, a Special Needs Unit, a secure Special Needs Unit or the ICU. We attempt to integrate all of them that are possible back into the general population. And then if that isn't possible we go up the scale until we go to psychiatric inpatient treatment, which I'll get to in a minute.

To address the needs of offenders, serious mental illness disorders, the Department of Corrections has opened five small inpatient psychiatric units licensed through the Department of Public Welfare's office of Mental Health and Substance Abuse Services. These Mental Health Units, operated by contracted vendors, provide short-term emergency care and voluntary mental health commitments for both male and female offenders. Specific treatment programs, such as medication compliance, problem solving and interpersonal skills are offered to offenders while housed on mental health units.

Similarly the Forensic Treatment Center, a 90-bed licensed secure psychiatric hospital located at SCI-Waymart, provides long-term inpatient care for the Department of Corrections inmates and short-term emergency psychiatric treatment to inmates from Lackawanna, Susquehanna and Wayne County prisons. A multi-disciplinary mental health team clinically assesses each inmate to develop an individualized comprehensive treatment plan. Offenders also have the opportunity to participate in specialized treatment groups, therapeutic shop programs and educational classes.

Internal Department of Corrections data shows that approximately 55 percent of the offenders listed on the mental health, mental retardation roster can be considered dually diagnosed. A dually diagnosed offender is defined as an individual with co-occurring mental health and substance abuse issue.

To address the needs of this subpopulation, the Department of Corrections has established an inpatient dually diagnosed therapeutic community. Overall, therapeutic communities are the most intensive AOD treatment the department offers to

all offenders requiring these services.

There's currently one six-month dual diagnosis therapeutic community in the department, which is located SCI-Retreat. Forty-seven offenders have completed that program in this year and another 33 are presently enrolled. The department also plans to open another dually diagnosis therapeutic community at SCI-Muncy, which is one of our female facilities.

For mentally ill offenders, whose substance abuse issues do not necessitate a program as intensive as the therapeutic community, the dual diagnosis outpatient program offered at 25 of our institutions is the recommended course of treatment. This program, which follows the principles of effective correctional intervention, utilizes motivational enhancement therapy techniques in lieu of the cognitive behavioral approach.

Not forgetting the specialized needs of our female offender population, the department offers the Seeking Safety Program at both of our women's facilities. This evidence-based cognitive behavioral program, incorporated into the curriculum of the house of therapeutic abuse

community, is designed to provide trauma treatment for survivors of domestic violence and sexual assault.

The Seeking Safety Program, in conjunction with the therapeutic community or outpatient program, helps offenders obtain safety from trauma and substance abuse by learning safe coping skills relevant to those disorders.

An ongoing dilemma at federal, state and county levels is the reentry of offenders into the community. These offenders suffering from mental illness present their own unique challenges for placement treatment at community supervision. A recent study conducted by the Pennsylvania Board of Probation and Parole found that the parole rate for offenders on the Department of Corrections Psychiatric Review Team roster -- those are the most seriously mentally ill offenders in our system -- was 40 percent lower than those offenders not having a mental illness.

Consequently, offenders on the MH/MR and PRT rosters spend less time under parole supervision than an offender without a history of mental illness. To address this disparity, the department and the Board of Probation and Parole

have worked on a Mental Health Reentry Improvement Initiative. The purpose of this proposal is to establish protocols for the continuity of care for mentally ill offenders for release to the community, either under parole supervision or completing their maximum sentence. Specialized parole agents, increased interagency cooperation and the expansion of mental health services in community correction centers are just some of those strategies under the development.

At present, the Bureau of Community Corrections provides contractual outpatient, mental health and dual diagnosis residential services to offenders upon their release to a community correction center.

The community correction system is what's commonly referred to as the Halfway House System in Pennsylvania, which is supervised by the Department of Corrections. We currently have about 50 community correction centers. Thirteen of those are state owned, the remainder are contracted providers.

As of September 1st, the department contracts with community vendors to provide outpatient mental health treatment services for

279 individuals in seven community corrections facilities across the state. Additionally, the department has two community corrections facilities that contract for dual diagnosis treatment services for both male and female offenders.

Over the past year, the Bureau of Community Corrections, through pre-released parole or halfway back, has admitted 501 offenders who appear on the active mental health, mental retardation roster. Forty-two of those offenders are also simultaneously listed on the Psychiatric Review Team roster. As of August of this year, the Department of Corrections had over 200 mentally ill offenders approved for release through the parole or pre-release process, still awaiting placement at a community corrections facility.

Although the department makes every effort to assist the mentally ill offender in obtaining viable housing and mental health services in the community, individual county resources and funding is limited. In an attempt to combat the increasing prison population across Pennsylvania and the nation as a whole, many jurisdictions have

established cost effective diversionary programs such as Mental Health Treatment Courts.

I know that Amy's going to speak to Mental Health Courts, and certainly she can do it a lot more eloquently and with first-hand experience than I could. But one of the things I do want to say is that the department does support the creation of Mental Health Courts and supports diversion for those offenders who can safely be managed in the community. We believe that they should be safely managed in the community and that prisons should be a last resort for those folks. And there are some who cannot be safely managed at other levels of deterrents in the criminal justice system.

So that's pretty much what I wanted to cover, and I wanted to turn it over to Dr. Walmer, who's going talk a little more about our mentally ill population.

REPRESENTATIVE JAKE WHEATLEY: Tell me your name again.

MS. KATHLEEN GNALL: Kathy Gnall.

DR. JACK WALMER: Jack Walmer, Chief of Psychological Services.

Representative Wheatley, thank you for the

opportunity to talk about our services. I'll do my best to not duplicate any information, but as Dr. Martone said, I would like to, in some way, put a face on the tremendous challenges we have.

We get great support for mental health services within the Pennsylvania Department of Corrections, and my Director, Andrea Priori-Meintel, and Deputy Secretary Gnall, have given tremendous support to psychology and psychiatry services, and Mr. Ellers with medical services and the psychiatry vendor.

And I'll take the liberty of saying it's always a honor of being in any presentation with Amy Kroll. She is a legend in Pennsylvania forensics and community services and just a tremendous resource when our folks are returning to Allegheny County and to the western part of the state. And as Dr. Martone mentioned, if I say anything wrong, Amy will point that out. I've been in many meetings with Amy, and she's terrific. Thank you.

Staffing, to flush things out, every institution has a chief psychologist, a licensed psychologist. I'm a Pennsylvania licensed psychologist since 1983. I did 12 years of work

at the State Correctional Institution at Rockview, and then assumed the role last January as chief for the State Department of Corrections.

We have 29 LPM's, LP, licensed psychologists, these are individuals who are licensed psychologists, but may not be a chief psychologist, but they are on our staff, seven of those individuals. And then a great many of our folks are Psychological Services Specialists, Psychological Services Associates, 168 individuals. These are Department of Corrections employees who work in our 27 facilities.

As Mr. Ellers has already went over, psychiatry is provided via contract providers. And every institution has psychiatric services available. And Mr. Ellers talked about inmates access to services.

We especially are able to bring crisis response for psychiatry services very rapidly. It is in our best interest and the inmates' best interest to have these services delivered as quickly as possible. And many times we do quite well with that, and we're proud of that.

Our key is the mental health roster. Dr. Martone was talking and relevant to the kinds

of folks that work with Amy. The community has a tremendously difficult task of monitoring. We have an easier task. We know where our people are and we know who they are, and I say that with no sense of arrogance or control or that sort of thing.

State correctional institutions do require significant controls, but we have a tremendous benefit in that we do know where individuals are, and we can do a lot of monitoring from our correctional officers on up.

Our mental health roster is individuals who have reception, or as disease entities might emerge during their incarceration, have been identified as having mental illness, 8,564 individuals. And that is the face of mental illness in the Pennsylvania Department of Corrections. It's a very significant number. The vast majority of inmates are males and the vast majority of individuals on the roster are males.

The topic of stigma did come up. I think women are perhaps more accepting of and more willing to self-identify as needing or wanting mental health services, so the actual percentages, this is true at both of our female institutions,

Muncy and Cambridge Springs. The actual percentage amount is significantly higher, but obviously the vast majority of individuals that we are treating and tracking with our roster are males.

The Psychiatric Review Team is a subset of individuals with the most serious mental illness. And I'll go to those definitions I think we have coming up. We have an A, B, C, D system. Every inmate who's on mental health roster is one of these categories. And A is we're on arrival at our classification center. There's no history and no psychiatric treatment in the past five years. It wouldn't be unusual if a child had a conduct disorder that they might have seen a psychiatrist, and that's why we have that clarification as part of public school course. And that may differ from the concept of psychiatric treatment. So an individual with an A has no mental illness or identified mental health illness and might be very offended if you tried to claim that they did. Sort of the other side of stigma. Sometimes individuals are very resistant to being identified as such.

B, an individual with a past history of

mental health treatment may be doing all right at this point, but that alerts us, it's a different roster category, and that alerts us to be aware these difficulties could emerge from this person.

C is an individual receiving mental health treatment, probably housed, might be on the Special Needs Unit or might be in the general population.

D -- and there's our full definition -- substantial disturbance, thought or mood significantly impairs judgment. They have the capacity to recognize reality or cope with ordinary demands of life. And treatment history is very significant, and current treatment need is very significant.

And we use our medication compliance groups because, unlike many other diseases, of course, part and parcel of mental illness can be that if the disease comes to the fore, part of that may be resistance to treatment, so to speak, and that the individual -- then we're up against two problems: The manifestations of the disease or disorder, as well as the increased likelihood to not be willing to take part in treatment. So we really like to keep people involved in treatment.

Those who use diagnostic codes, but even more so than the numbers, are certainly familiar, again, with the face of mental illness. Overall, we have just about 1300 individuals with thought disorders, disorders of information processing, as you may want to conceptualize them. Life is difficult enough with accurate information. It's tremendously difficult with inaccurate information, and these individuals suffer with diseases that alter information tragically, and can create tremendous disruption for themselves and others.

As is typical in mental health work, the mood disorders, alterations in mood and outlook thought to be driven by the disease process, 3,036. But getting to some specific categories -- and, again, names of disorders that you're very familiar with -- 571 individuals with paranoid schizophrenia. These are figures based on our latest mental health roster that we put together a few weeks ago.

Schizoaffective disorder, which spans both thought disorder as well as a mood disregulation component, 544. You can see the numbers. The overall mood disorders, again, come into higher

number.

And of the personality disorders, disorders we think of as more related to learned behavior, a borderline personality disorder can tremendously afflict the person's life and their behavioral presentation and propensity to self-harm, a very significant group also.

Individuals, especially the ones with the thought disorders, the ones with the 295 coding, as well as individuals with borderline personality disorder who may be having a lot of difficulty maintaining stability, they have a high propensity for self-harm, very likely to be housed on our Special Needs Unit.

We also have a system of Mental Health Units that was mentioned. Again, there's our bed totals. This is adequate for the Pennsylvania Department of Corrections. We run typically about 75 percent capacity. If we have to run 100 percent I guarantee you we will run 100 percent. If we're on a given week running 50 percent, then that's what we'll run.

We utilize mental health commitments with community delegates and/or delegate representatives that that county has approved, and

we utilize the Mental Health Act Commitments just like any individual in the community. We cannot put people in the Mental Health Units without action under the Mental Health Act in Pennsylvania.

Our Forensic Treatment Center, likewise, these individuals must be under a force of commitment, and it has 90 beds. And all of this has been developed since the early 1990's. We used to liaison with the Civil Hospital System, which had tremendous strains already on its capabilities. We were able to set this up in coordination with the Department of Public Welfare, and this has been a tremendous resource for us.

SCI-Muncy is a women's institution. There are four mental health units at the male institution, and then the Forensic Treatment Center is for males.

Special Needs Units, we've talked about them, supportive programming. The development of them began in the mid 1980's. It's hard to imagine running a State Correctional Institution without Special Needs Units. They are a tremendous resource. They provide a safe and

secure environment for our individuals who are plagued by and very vulnerable because of serious mental illness, as well as some of our individuals who may have some propensity to acting out, but can receive a lot of supervision and a lot of prevention of more serious consequences that can be done with correctional staff.

Correctional staff on the Special Needs Unit are specially selected, specially trained and are very good at intervening with inmates and trying to take care of a problem on the block before it would get to a restricted housing unit. Kind of placement disciplinary custody. Total population about 1600 around the system on the Special Needs Unit.

I will not again describe every unit. My message is more, these are our resources within the system, and I will want to talk specifically about the SSNU's, and I think we have something coming up on that.

This is a development of the last couple of years. It is an absolutely necessary development. Dr. Martone talked about the man who can languish in disciplinary custody. Disciplinary custody is 23 hours a day, locked down in a disciplinary

cell. The situations can be very intractable. They needed to be addressed, and we're proud of our response.

We have set up secure Special Needs Units where individuals still maintain, at the beginning, what's call L5 custody in our state system, the highest level of custody. But it's a treatment milieu, including provision of treatment within this milieu even with custody considerations, and the individual can progress to population.

If an individual does not succeed at one secure Special Needs Unit, then after a good try at it they go to another secure Special Needs Unit. We are going to be building more.

There's our capacity right now, and the Department of Corrections has been very clear to the individual State Correctional Institutions: Identify your individuals who have significant amounts of disciplinary custody time who have very serious mental illness. We're not just going to let them be in place month after month in L5 custody where it is just very difficult to really bring good help for their mental disorders.

We make, we feel, tremendous efforts at

suicide prevention, just to acquaint you with this difficult phenomenon. There are statistics since 1993, if you just look down, and my point with that is not so much the individual numbers per se. One suicide is too many, and we do make good efforts, but as you can see, it varies. No one year is the same per se necessarily. We have had years that were higher. And by the way the total number of inmates has increased very significantly over that span of years from roughly 26,000 to about 46,000 at this point. It's 2008, it's October, we've had seven completed suicides. I hope we don't have anymore. We will make good efforts.

Suicide prevention screenings over arriving inmates, both the classification as well as every juncture in the Department of Corrections, each state correctional institution, they go through a lot of inmates at our multiple State Correctional Institutions over the course of a sentence.

We have a brochure we give out. We show videos with a suicide prevention message, and they're worked into the inmate channel. They are presented every week at multiple times. They are presented in English and Spanish.

Psychiatric observation, every State Correctional Institution has psychiatric observation cells. Here we do have a significant advantage over the community. We can, through creation of what's called Administrative Custody Status, sequester an individual in a we think very safe essentially suicide-proof cell simply based on concern, presenting dangerous behavior, this sort of thing. They're admitted by a psychiatrist. They are under a psychiatrist's care. They cannot leave that cell without a discharge from the psychiatrist. Every institution has them in their medical area.

I already talked about mental health commitments. If we do have a suicide and very serious suicide attempts, we do what's called a clinical review, get all the principals together, discuss the event, try to learn from it, and issue a report about that event.

Critical Incident Stress Management, CISM, that's where we deal with the fact that suicide attempts and completed suicides can be very difficult for all involved, and very heroic measures are often done by line correctional officers to try to preserve life. There's a

tremendous strain involved in this, and we provide debriefing and defusing services for the staff that are involved whenever there are these kind of events.

And reentry -- and here are, of course, we have a tremendous partner for Allegheny County with Amy Kroll. First job, track these individuals. Again, we have some advantages in terms of knowing where people are, and yet it's still a tremendous challenge. We've tried to enhance the lists that we've been able to use so our partners from the outside can all us up and say, Isn't this individual coming out in a year? And on housing kinds of situations -- and that's why that's No. 2 on the list -- tremendous demand. You really have to start planning a year out to give the community a sufficient chance to try to have housing.

Coordination with county-based mental health services, try to arrange people appointments. Benefits pre-application -- we are trying to go as fast as we can on this. We're trying to interact with agencies, just something like a non-driver's photo ID can make a tremendous difference, having a birth certificate, having

Social Security kinds of things in place before the person leaves. Not an easy task. And State Correctional Institutions are very demanding kinds of entities to run, but we're trying to get more and more proactive on those.

Psychiatric medications, individuals leave with a 30-day supply of psychiatric medications. That behooves us to have a psychiatric appointment in the community waiting for them within 30 days or obviously that will not work out.

And transportation, either in coordination with folks like Amy's forensic folks, or if the situation warrants, we will transport an individual. The state, on the last day of their sentence, we are able to transport them to a destination. Contact information, thank you. And I think we all are available for questions.

REPRESENTATIVE JAKE WHEATLEY: Thank you.

MS. PATRICIA VALENTINE: Good evening. In the interest of time and trying to be sensitive to time, I'm going to significantly abbreviate my oral testimony, but you do have my written testimony, and I am confident you'll refer to that.

I would like to thank you, as everybody

else has. I would also like to say that I also do not question for a moment that Amy will tell me if I'm wrong in anything that I say, and I'm also a member of the Amy Kroll fan club.

Before I talk about what we were talking about today, I would like to tell you just a little bit about the Allegheny County Department of Human Services because the office of Behavioral Health and Justice Related Services Division of the office of Behavioral Health does function within an integrated Department of Human Services.

The DHS has five program offices: It's the Area Agency on Aging, the Office of Mental Retardation and Developmental Disabilities, the Office of Community Services, the Office of Children, Youth and Families, and the Office of Behavioral Health, for which I'm responsible.

In 2007, the Department of Human Services provided service to 210,000 Allegheny County residents, and most of those residents received multiple services from multiple program offices.

The office of Behavioral Health plans for and administers publicly funded mental health and drug and alcohol services. In 2007, through our contracted providers, OBH provided services to

65,834 people. Of those there were about 57,000 adults and children who participated in mental health services, and almost 16,000 who participated in drug and alcohol services.

One of the populations that is both challenging and rewarding to serve is the population of people with serious mental illness and involvement with the criminal justice system. We find that involvement with the criminal justice system both compounds and in some ways seems to, in quotes, justify the uncertainty and fear with which some people who do not have the knowledge that they should have and that they need to have to make such a judgment have of people with serious mental illness.

I noted a moment ago that people with mental illness who are involved with criminal justice are both challenging and rewarding for us to serve and all of the multiple systems with which individuals may be involved.

And it's only fair to note that our systems, they may be challenging for us, our systems are challenging for them to negotiate and, unfortunately, they don't get as many rewards as we do out of working with our systems.

In the community prevalence rates of mental illness are estimated at about 20 percent per year. Within the criminal justice system, prevalence rates are much higher. And as was noted earlier, female inmates have higher rates of mental health problems, at least acknowledged, than male inmates do. In state prisons, 73 percent of females and 55 percent of males; in federal prison 61 percent of females and 44 percent of males; and local jails, 75 percent of females and 63 percent of males.

It's not a simple matter, and it's not just a matter of so people with serious mental illness cannot negotiate the systems as well, so they wind up being incarcerated at a higher rate. They are also, as has been noted, likely to have a higher prevalence of co-occurring substance use disorders, which also drastically compounds things. Substance use disorders are nearly four times greater for jail detainees than for the population as a whole.

And because of that, along with other factors, people with serious mental illness tend to be re-incarcerated at a higher rate than anybody else. It's also more expensive to house

people with mental illness in jails and prisons than in the community and supported by treatment.

This is dated information, but according to a 2004 report from Miami, Dade County taxpayers spent $18 per day to house inmates from the general population, and $125 per day to house inmates with mental illness in the county jail. A particular issue that we have for individuals in the county jail is that their benefits, whether it's Medical Assistance, SSI or whatever, are terminated when they are in the jail more than 30 days.

This presents particular difficulties in terms of being able to get them hooked up to treatment immediately upon release, and very often can result in somebody decompensating and winding up back in the jail.

We do work very hard, including using base funds to provide prescriptions for people until they are able to get back on Medical Assistance or onto Medical Assistance, providing housing for two to three months, providing clothing. We work very hard to prevent people from falling through that hole in the safety net.

However, it's important for you to know

that is a hole in the safety net. We've chosen to dedicate funds to that, but many counties either can't or don't; and, therefore, would not have the patch I guess on the hole in the safety net that we have.

Also, for law enforcement officials who are trying to fulfill their primary task of public safety, responding to certain incidents involving people with mental illness or co-occurring substance use disorders, can sometimes clearly require arrest and detention. However, many times that is not needed at all. Many times -- and we have found this through our CIT, police based Crisis Intervention Team, what is needed is some respite, some assessment, some triage, so that individuals can get into the treatment that they need as opposed to being incarcerated, which really just starts a downhill slide.

Again, these units, these triage assessment and basic stabilization units are very expensive, and we are utilizing, in Allegheny County, funds that would otherwise be utilized for treatment or case management services to purchase these services because we believe that they are so important. But funds that could be dedicated to

that kind of a service would be extremely, extremely helpful.

We have been working for years with the courts and the Allegheny County Jail to divert people. And Amy will tell you more about that, so I'm not -- I'm just going to skip that whole section, except to tell you that it is very important that people who get out of jail, get out of prison have assistance not only in terms of medication and treatment, but in terms of their ability to organize their lives because something as simple as a missed court date can wind up with a warrant, being arrested for somebody.

And somebody can miss a court date for a number of reasons, including not having a calendar, including not having a telephone. I mean, it's not all related to people's mental illness, although much of it may be. But there are very practical things because people come out, they are poor, they are disorganized, and they do not have a tremendous amount of support, unless they are involved in certain services. And it is so easy because of a lack of calendar or lack of a watch to wind up back in jail. And I think that frankly is unconscionable.

So what do we need? We need rational, knowledgeable examination of facts related to what works with regard to health and public safety, without the fear of prejudice and myth that often substitutes for fact when it comes to mental illness and people with mental illness.

We have tons of statistics. We've got tons of facts. We know what works. However, it is still often not accepted as good practice. We also need a mechanism for investing in services and supports that work, using resources from systems that are saving or will save money in order to provide those services. It is very frustrating and very difficult.

And, again, in Allegheny County, we have made a tremendous commitment. However, many counties can't make that kind of commitment. And if they were able to be assured that savings from wherever, county jails, SCI's, court processes, whatever, could pay for the services that they need to provide, I believe that we would see more of those counties being able to do this, and we would see more of an overall savings. Thank you.

REPRESENTATIVE JAKE WHEATLEY: Thank you.

MS. AMY KROLL: Hi, I'm Amy Kroll. My name

is Amy Kroll, and I am with Allegheny County Office of Behavioral Health. I actually run the Justice Related Services Program, and basically I'm here to tell you where the rubber meets the road. I have 27 staff. They are in every part of Allegheny County every day. We are in the trenches 24 hours a day, seven days a week because we are on call 24 hours a day, seven days a week. Any given day, any given time you can find us in the hill, in the north side, McKees Rocks, McKeesport, all over pretty much the lower socioeconomic level of Allegheny County.

What our jobs are to do is basically we have seven different programs underneath Justice Related Services. They're all to divert the person from penetrating further into the criminal justice system or helping them reenter and stabilize their lives.

So basically from the very beginning the first intercept that Ms. Erney described was basically we try to train the City of Pittsburgh police officers. We actually have a grant currently to train them. It's a small grant to try to make a big dent in a huge system.

There are 900 City of Pittsburgh police

officers. We are trying to help a small team of those officers to understand that when they encounter a person with mental illness to go in all gangbuster is just going to escalate the situation, not deescalate the situation. We're helping the officers understand the signs and symptoms for mental illness.

No, we don't want them to be touchy-feely or social workers. We want them to realize that this person has some other type of disorder going on besides them thinking it's just a drug and alcohol problem.

Secondly, our second program is our Prebooking Diversion Program. That if the officers do make it an arrest and they bring them to the jail, they could ask for our staff to say, you know what, there's something wrong with this guy. I want you to take a look at him.

At that point, we have the ability to divert. If it's a nonviolent crime, we can divert them at their initial arraignment, working with the judges and the police to divert them to what is known as one of our Triage Centers that Pat explained, which is our essential recovery center, where they can go for 72 hours to get a full

workup of what's going on. We guarantee that person will show up at their preliminary hearing.

From there, at the preliminary hearing, our Postbooking Diversion Program are there with service plans saying to the victim, saying to the Magisterial Judge, and saying to the police officer, in lieu of incarceration, which is going to cost this county a heck of a lot of money, let's keep this person in the community, in treatment, and help this person to return back to the courts to make sure that they go through the whole process.

But if the individual does follow the service plan and does well in treatment, would you consider either reducing the charge and/or dismissing the charge, which helps us not to criminalize the mentally ill because somebody was in a neighborhood yelling at a mailbox because they believed the mailbox was possessed is no reason to lock the individual up? So we are trying to give the courts another idea or another road to go down than placing them in jail.

Our third and fourth programs are involved in the court system, both our Mental Health Court and our Drug Court. These judges have been asking

and asking, help us deal with this community problem. Give us different avenues. Locking people up is not going to solve the problem. Does disorderly conduct, sleeping in abandoned buildings and are some of the other minor charges that we work with.

But our Mental Health Court also works with felonies. So correcting Dr. Martone, we work with a lot of felonies. There are people that try to kill themselves by very violent means. We have become involved with those individuals.

There are individuals, because sometimes if you go to a psychiatrist, the crack dealer on the corner looks a lot better and is quicker to get into. We find individuals self-medicate with drugs and alcohol becoming involved in the law.

Everybody knows by your fourth retail theft you're looking at a felony charge. Those are accepted in our Mental Health Court. Our Mental Health Court -- and everybody that is trained on that Mental Health Court team, which means the District Attorney's Office, the Public Defender's Office and the Judge have a clear understanding of mental illness.

What their job is to do is to look at how

can we keep public safety most important, but not waste important tax county dollars on housing somebody in the jail when we can use Medical Assistance and other funding to keep them in the community and save our important county dollars for other services.

So in that program where we're dealt everything from aggravated assaults with the police officers, and everything from minor arson charges, it's on a case-by-case basis. But each time the Judge has looked at it saying, Because this person was psychotic in the community, this was the end result. Yes, a crime was committed, but is there a better way to handle it?

The other thing, anybody that doesn't get Mental Health Court, they don't fall through the cracks. We follow them in our Community Support Program, so that no matter where you're at in that criminal justice system, somebody's going to be in court advocating in lieu of incarceration, treatment in the community, and then our job is to reenter you.

And we're like Enterprise. We pick you up at the jail. We put you in our cars. We take you out in the community because we're not going to

lose you on the corner to the crack dealer because they're always there ten times quicker than everybody else.

So we try to help these individuals get their basic needs. Before I'm going to take a pill or see somebody for my treatment, I need to know where I'm going to sleep, what clothes I'm going to wear, and what I'm going to eat. That's our job.

But two of the most important things that I really would like to talk to you about is: It's hard enough to overcome the stigma. I'm mentally ill; I have a drug and alcohol problem; and also I'm involved in the criminal justice system.

That isn't one strike. That's three strikes against these individuals. And you want them to recover their lives in the community and act like a normal citizen when they've already got three black eyes looking at them.

So the most important thing that we try to do with these individuals is to try to get them jobs. We have a third of our clients, 805 clients that are working in the community that are trying to find jobs with a daily wage that will support them, plus pay their court costs, plus keep up all

their bills, plus pay for any medication that they have a copay or anything else.

The most important thing is that we can get jobs in Allegheny County, whether it's support, peer support, coaching jobs that help individuals get into the community. But we have individuals that have mental illness that have been struck down with mental illness that have masters levels, Ph.D's.

We actually have a lawyer in Mental Health Court that has schizophrenia. To get back and get his career back, he has to overcome a tremendous stigma. So we are looking to try to get these individuals back. There's no way that you belong to your community until you get a job, until you're involved in the community. That's how you stay away from the crack dealer and the crack house two doors down from you.

We're asking individuals that choose to go back to the communities that they love, that they grew up in, but they're fighting a tremendous problem because it's so much easier than to fight all the problems that are in our system because you have to see your Probation Office, you have to report to your mental health specialist, you have

to fight the pharmacy to get the meds that you need. And believe me if any of you have sat in a Medical Assistance office just to try to get a person's Medical Assistance card, I'd jump over the counter and pummel the guy behind there because they make you feel like, one, you're begging for your money. But second of all, as soon as they see these individuals have a criminal record, they automatically put them on this wait list.

So we have finally worked out with Medical Assistance that we're not going away, that you have to deal with these clients, and that these clients deserve all the other benefits that anybody else deserves.

But it's really hard at $205 a month to survive, to get a bus pass that costs $60 to get to your treatment, to pay your court costs, because you have to pay your court costs, and that's at least $10 to $15 a month, to pay copays on your medical stuff, plus be able to go to all the different trips that you have to negotiate.

One of our programs is to be out there fighting for the client, to say, You know what, who gives a damn about your past? This is the

future. This is the first day of the rest of your life, and you are somebody. You are somebody to us.

Our clients are put -- we put them in our own cars and drive them there because if we drove them in a taxi or a bus, what would we be saying? They're not real people, and these are real people. They've made a lot of damn mistakes in their lives, but I don't think anybody in this room could walk away and say we haven't made some goofy mistakes in our lives.

And a lot of them, because of the felony convictions, whether it's been drug and alcohol, that have masters levels and bachelors levels and high school, because of that, they can't get jobs in child care, in any type of public health field because of this criminal justice stigma.

And our biggest thing -- we're looking at other states. They're doing the same thing. They're repealing a lot of that saying certain criminal justice crimes can be allowed for certain employment, not across the board, if you've ever been arrested for a felony, you don't get a job. And we know there's other individuals who are very law-abiding that are also in the same dire

straights of needing employment, but these individuals deserve just as much.

The other two programs we have are our reentry programs. We actually work with people maxing out of the state prison system. And yes, we are like Enterprise, we will drive to a state prison and pick you up there because we don't want you getting lost on your way back because the fear of re-entering society is tremendous for most of these individuals because they've been out of the system for a while.

And so to go through all of the different bureaucratic obstacles you have to to just go with your probation of what's needed for that and/or if you're maxing out. It is tremendous to gain back your life, what you lost.

They know they did something wrong. They served their time. We have a right to give them the same rights as everybody else: To pick up their lives and go on. A lot of them come out with tremendous attitudes in the right place, saying I am going to recover my life. But they get beat down day after day after day with roadblocks right and left.

I have had guys sit in my office that have

put in 27 applications. They have a good education and still can't get a job. And that crack dealer looks better and better. So yes, Dr. Martone says we do lose some, but in our diversion program our recidivism rate is 15 percent. In our Mental Health Court it's 14.7 percent. That's 500 plus graduates.

In our state support program, which works with the higher level offenders, that's around 17 to 18 percent. In our max-out program, these people don't need to give squat. They've done their time, they don't need to work with us, there's no hold on them. They have served their entire sentence in the state prison system. That's around 18 percent.

These individuals, if given the chance, can really turn their lives around, and these individuals have more mountains to climb than any person I've ever known, and we've seen people recover their lives. I want to leave you with this story.

We had an individual that came out of the State Corrections Institution 22 years, and he was a large African-American guy, but I called him Gentle Ben. His name was actually Ben because he

had the most low, quiet voice you would ever know. He was a schizophrenic. When he would become psychotic, yeah, he would get loud and scare the heck out of all of us.

But several years ago he maxed out from the state corrections institution in 1999, and about five years ago all of a sudden people came running into my office and said, Ben's downstairs screaming your name. Get down there, Amy. We think he's psychotic.

So I come down in the elevator, and I hear, where's Ms. Kroll? And he's coming, booming down the hall. And all of sudden, I thought, oh, Ben. He's going to squish me like a bug. And he came up to me and he said, Ms. Kroll, Ms. Kroll, look at this. And it was a pay stub. And he said to me, How am I supposed to live with all this coming out of here? How am I supposed to live?

And I said, You know, Ben, when we first started up that long, long road five years ago I told you some day -- all you talked about was entering my world. I want to be like you, Ms. Kroll. I want to help others. I want to get back in society. I said, Well, Ben, welcome to my world. That's called paying taxes.

So we have watched people do it. So if you asked me what I would like you to do, like all your other constituents, we need jobs. We need jobs. But we do know other counties that are struggling to reenter those individuals.

If there could be some bill or allocation that they get one support specialist in every county that works both with the state and with their county jail because some of the counties are very rural, so you're not going to need 27 people like Philadelphia and us to do the job, but one person that Kathy Gnall can call or Jack Walmer can call or their warden from their prison to say, I have a guy coming out. I need you to help him reenter society. I need you to be the support. He needs to walk past the crack dealer on the corner so that he can reenter society and do well because we've watched hundreds in Allegheny County do it.

(Audience clapping)

REPRESENTATIVE JAKE WHEATLEY: Thank you. You're the first person to receive clapping, but I know we're a little past the time, so I'm going to try to limit my questioning.

This is something that's been kind of on my

mind from the previous two and now that you're here I'm going to ask it.

It seems like from the testimony that I've heard so far we catch people once they have already entered into the system at some form or fashion, be it they got in trouble in school for the youth or they're entering into the law enforcement because of something that's happened.

What do we do -- how do we assess or how do we identify people with needs before they actually have entered into the system? Do we have a process in place, or is this more of a reactive system that we have and that's the best that we can do?

DEPUTY SECRETARY JOAN ERNEY: I can comment and certainly Pat could as well. I think there's a couple of things, but one of our challenges is one of our strengths. I think Pat made a comment about opportunities and challenges.

You know, we have 67 different counties. We have 47 different county joinders of which they actually bring great strength because they can target their work to their population, they can really do things that are very unique.

One of challenges, though, is we have lot

of diversity among those counties, so what I'm telling you is available in some counties, but not necessary in all because there are some programs that NAMI, the National Alliance for Mentally Ill, supports, and other initiatives around first signs, so that individuals who are having their first signs or symptoms of mental illness do have support services for their families, the psychiatric community starts to try to link folks up.

But I would say that in the public system your point about it defaulting, parity should help us. One of the issues has been that there's not been private -- you have the first sign and your private insurance will get used.

And quite frankly the benefits in private insurance have been very limited, but folks don't start to default into the public sector, which actually provides a lot more service and a lot better array, but you also don't get access to public services often until you've totally gone through your private sector of resources, and then you're defaulting in, and by that time you already are experiencing some challenges.

So one parity will help us on the financial

side in the sense that we'll have more access to the third party payer, and if we can connect the first signs where family members and others know that we need to link the public and private sector in a more comprehensive manner, I think is promising.

College campuses, there are also some really targeted initiatives on college campuses for first signs of serious mental illness, so again, folks can get connected up to their local systems of care.

And then I would offer that in many areas, the school districts, and what we know is that some younger students, although mental illness or serious mental illness might not emerge until a later teenage or early adulthood, certainly there are a number of individuals who get identified in their youth and through the school system that we then start to default into our public sector again. And the schools are getting better at identifying and then allowing us to intervene earlier.

So there are some. I think that there are a lot of strengthening that we could do around prevention, which is really -- it's always a

challenge because it's sometimes the funding issues around prevention. Oftentimes your dollars are in treatment, but not in prevention.

But I think Pat, in a human services model, where systems locally integrate and look at how they bring their resources together, you can then start to reinvest into prevention to try to do some of these earlier activities.

And then the final, relative to the corrections, the police training has been one of the keys. A number of the counties with the Crisis Intervention Training that comes out of a another state. Georgia? I forget which state it is.

MS. AMY KROLL: Tennessee.

DEPUTY SECRETARY JOAN ERNEY: One of those southern states. They came in and did the training in a number of areas, in Cambria County, Allegheny, Philadelphia, et cetera, and that really has been I think a real opportunity to, at the first sign, someone's interacting, a police officer is interacting with someone with mental illness, you're getting a different outcome because you have trained professionals who are saying, I don't even have to take this a step

further. I really can just take them over -- call Amy, and she'll come in and help this individual.

So there are some initiatives. It's not statewide. It's not as -- it's not available in every county, but there certainly are some efforts in them.

REPRESENTATIVE JAKE WHEATLEY: Is that state supported, that police training, or is that county supported?

DEPUTY SECRETARY JOAN ERNEY: It's both. We've provided grants in a number of instances. Some counties have chosen to purchase it themselves. It's really not overwhelmingly expensive, but you have to make the commitment to do it, and there have been some federal grants I think as well.

MS. AMY KROLL: Right, because ours is on a federal grant, but we are actually seeing, we've got a small handful of police trained, but we're seeing them where they could have made the arrest. They actually diverted the individual into a CRC and said, You know what, help this guy. I'm not putting him in the jail. The guy needs your help.

MS. PATRICIA VALENTINE: Just one other answer to your question, in Allegheny County of

the approximately 57,000 people who were served in 2007, 15,000 of those have a serious and persistent mental illness. And what you will see is that between their natural support systems, their families and others in our provider system, the vast majority of them are not involved with the criminal justice system.

So that we are not just reactive. There are a number of people, a few hundred, a thousand with whom we have to be reactive. But despite tremendous odds, about 14,000 people with serious and persistent mental illness out there don't see law enforcement personnel or become negatively involved with the system. And I would say that really is a success.

REPRESENTATIVE JAKE WHEATLEY: And they are accessing the care that they need?

MS. PATRICIA VALENTINE: Yes.

REPRESENTATIVE REICHLEY: I just have a couple quick questions. We want to get to the next panel.

Really the thrust of my questions are twofold: From the local level -- maybe Ms. Erney, you can comment upon this as well or Ms. Kroll -- Lehigh County, where I live, they do not embrace

this concept at all.

Some of the older Judges, particularly the President Judge says that's not judgment, that's not being judged. I don't know if it's a generational thing or they think real judges have trials and stuff like that, so they have a certain attitude.

What's your budget on an annual basis?

DEPUTY SECRETARY JOAN ERNEY: For Justice Related Services?

REPRESENTATIVE REICHLEY: Right.

MS. PATRICIA VALENTINE: That's hard to answer because, as Amy said, she's got 27 staff. However, each of our Service Coordination Units, or what used to be called Base Service Units, also has forensic liaisons or justice-related liaisons.

When Amy's staff, as people are coming out, will help to get them stabilized, serve them for two months, three months, sometimes a little bit longer. But then they need to be served by the system, otherwise we would have a tremendous backup in the jail.

I would, rather than guessing, I would really rather get that information to you in terms of -- because I could pretty much tell you what

our budget is. What I can't tell you is what the whole budget is, and it's very important that you understand the totality. So can I get that to you?

REPRESENTATIVE REICHLEY: Oh, yeah, please. I guess you may not be aware of where I'm going with this, but if the counties aren't willing to support that, by the county expenditure, is that a situation where the state should be stepping in -- and we're going to be very tight budgeted here next year -- so if we had to rank this in the priority of services we could try to provide.

And I can see where overall it's a state issue. It would help in reducing overall expenditures. Maybe there's a 50/50 match to go into it with the state on having this kind of a program.

DEPUTY SECRETARY JOAN ERNEY: One, I only want to comment that the Lehigh Valley, although your Judges are tough, your assistant D.A., who works at the DJ level, who has created a very excellent program where they really are doing something very similar to a Mental Health Court, and it really is quite stellar, and they're having some great success. So, he's helping to --

REPRESENTATIVE REICHLEY: Right here in Lehigh?

DEPUTY SECRETARY JOAN ERNEY: Yeah, Lehigh Valley. And he's actually trying to influence your Judges.

REPRESENTATIVE JAKE WHEATLEY: Who is it?

MS. AMY KROLL: He's doing it more in a magisterial level. So it's kind of more of a diversion court than the Court of Common Pleas.

DEPUTY SECRETARY JOAN ERNEY: I can't think of his name either, but he's really a dynamo out of the D.A.'s Office, and very invested, so a promising practice. He's very good.

But so I would say yes, we have funded Mental Health Courts. PCCD and OMHSAS, this current year are funding the nine Mental Health Courts. We also have provided some grant money when, you know, we're really picking and trying to offer some grant money as well.

And I think part of your point is, one, we're in a tough economic time. It requires partnership, so things that we can do, we try to use grant money as much as possible. We look to the feds for some grant money. We have partnered with counties.

Today there was a Mental Health Court training, so one of the things is we used Amy, and she goes around, and, quite frankly, the Judges here have been great, have been able to influence other Judges.

So, one, it's getting the investment. Often it is not the financial investment, although that obviously helps to get it seeded, and that's what we were doing with our grant money. It really is the collaboration that has to happen between the parties.

You need to have a strong Judge who's onboard. You need to have the Public Defender's Office, the District Attorney's Office, the Behavioral Health System, and the partnership convened. And most of the counties do that through the CJAB, that Criminal Justice Advisory Board, at the local level, but it's creating the partnership and having folks work together, and then having the resources to dedicate staff.

The smaller counties have a hard time dedicating staff to this because there's so many competing priorities, and that's where the resources are necessary. Some kind of partnership among all of us to say it is a priority. It is

something that is really important to us to try to keep folks out of the courts. It has a savings associated to it down the road, which is what some states are doing. They're using a reinvestment theory, but putting it on the front end and saying but we'll expect you to see those savings in the future.

So it's a good investment, but I think it requires all of us to kind of ante up a bit and say we'll target some resource for the case management or that dedicated staff person like in Amy and even regionalize some of the smaller rural counties.

MS. AMY KROLL: And we offer free training that we'll go there or they can come here. And the smaller counties, we're not asking for a huge Mental Health Court. They can't pay for it. We're asking for one case manager to be mainly their forensic person, that we can call Jack and say, Jack, in this small county, that's who you call now if one of your guys are coming out.

We train them here to say, it's a different county, but this is what you're going to face in Medical Assistance, this is what the person's going to need, this is what they're going to do.

And some of our services are billable to our Managed Care, so it's not like we're drawing down all this county dollars or state dollars. We're actually billing Medical Assistance for some of the, just the intensive case management services.

So we're trying to not have them reinvent the wheel. You know, come see what we do to scale it way back, and that one person is just the contact for the jail. But, again, it takes the jail opening the doors that I can go in and see my person there.

And I'll admit, the state has been wonderful, and I beat them up all the time, but they have opened their doors, that we go into all 27 prisons. We see our people there before they come out. They have a name to a face. They know what services they'll get when they get back here. They know we're there for them, which lowers that anxiety, causes the mental illness to be stable, and they know who they're coming home to. And so sometimes it just takes one person.

REPRESENTATIVE REICHLEY: Two more questions really fast. What's the degree of training or background your people have? Are they college graduates, masters?

MS. AMY KROLL: Most of them are college graduates. A lot of them, while they're with us, go on to get their masters. Everybody has some type of background in either corrections and/or psychology, but the predominant amount are individuals that have high energy and are young.

REPRESENTATIVE REICHLEY: And the employers, who do you get these people employed by? Is there a general category, or is it just anybody, when you say you get them jobs?

MS. AMY KROLL: Basically -- well, here's what we have to do first: Everybody, we get up at five o'clock in the morning, we take them to labor ready, which is like a day labor center because first you have to know can the person concentrate on the job? Is the individual willing to go through just the basics: Getting up, getting there? And a lot of times we're hauling them out of bed going, hurry up, get dressed. But if we see that, we see a commitment to the job, and then just in our county jail we have what is known as Job Days where we have employers come in.

Mainly it's what they can get a job, and because of all the barriers, it's nursery and grass cutting. We have other jobs, lots of

construction jobs. We have warehouses in our strip district that employ a lot of our guys, unloading trucks. We have women even down there unloading trucks.

And any inroads we can we try to make for anybody. If you need a job and you have a decent education and the willingness to work, we'll find you something. It may take us a month, but we'll beat down every door we can to get you a job because we know that's one step further you'll never go back to the criminal justice system.

REPRESENTATIVE REICHLEY: Can I get your contact information because I'd like to try to promote this in Lehigh County? And for the sake of time, I'm not going to ask you to respond now, but I'm also on the Sentencing Commission, and I've been curious about whether we shouldn't be utilizing the SIP Program to a greater degree for those state inmates who have either mental health or dual diagnosis issues to assist them before they come out. Because it's an underutilized program right now. And I've been talking to my fellow commissioners about redoing the guidelines, so that SIP could be utilized by Common Pleas Judges more often for these kinds of people.

MS. KATHLEEN GNALL: I'll be real quick. Yes, we should.

REPRESENTATIVE JAKE WHEATLEY: Thank you everyone. I really appreciate your testimony, and look forward to working with you as we go forward with this issue. Thank you.

Since we are closing in at the 7:34 hour, we were supposed to be finishing up with the second panel at 7:45. I still want to keep on our schedule to be out of here by 8:15. I know our sound man has to be gone, so I don't want to belabor this, so I'm going to call up Sarah Rosso, Director of Public Education for Mental Health America, Allegheny County; Richard Jevon, with the Allegheny Department of Human Services, Mental Health/Mental Retardation Advisory Board member. I don't see Curtis Boyd here. Dr. Emma Lucas-Darby, Professor of Department of Social Work and Interim Chairperson for the Department of Political Science at Carlow University.

I'm also going to combine the panel with an advocate panel, so I'm going to call up Stephen Christian-Michaels, Chief Operating Officer of Family Services of Western Pennsylvania, and I'm going to call up Dr. Paul L. West, past President

and Treasurer of the Pennsylvania Counseling Association.

And, again, I'm just going to ask -- I believe most of you have your testimony before us. I'm going to ask if you could abbreviate some of your testimony and go about the heart of your presentation. That would be great. So we'll start with Sarah.

MS. SARAH ROSSO: Hello, thank you for having us here tonight. I'm going to keep this really brief. And I apologize, I will not be able to stay for questions. I have to run to Mayview right after this to give testimony there.

The majority of what I was asked to speak about tonight was stigma and how stigma impacts people who have a mental illness. And a lot of people have already spoken about that, and you can certainly read my testimony, and I'm just going to focus in on the programs that we're involved with at Mental Health America, Allegheny County.

Stigma harms people who are publicly labeled as mentally ill in several ways. People with mental illnesses are frequently unable to obtain good jobs or find suitable housing because of prejudice.

Finding jobs is obviously key to overcoming a lot of barriers. Stigma also influences the interface between mental illness and the criminal justice system. And, again, a lot of this was said from the previous panel, so I will not belabor that point. There are a number of things that you can do to curb stigma.

And the programs that we're working on at Allegheny County, at Mental Health America, are basically to work on stigma reduction. I am working on a project that came about because of the Mayview closure where we're going into different communities and we're giving people information at PTA meetings, at church groups, at those local organizations where they can ask questions.

We have a group called Let Our Voices Be Heard, and that's a group of consumers, and people in that group come with us. So we're just basically trying to answer people's questions, respond to Letters to the Editor that reiterate the not-in-my-backyard sentiment for the closure of Mayview and those sorts of things.

So if there are community groups that are interested in learning more about that, we'd

certainly be willing to go and speak to them about that.

The other program we're working on is at local college campuses. We are currently working to build relationships with students and faculty and staff. This is the point in life where most people discover if they have some sort of mental health issue. We're working on a program called Active Minds. It's based out of D.C. It's a national organization for college campuses. We're helping college campuses set up those chapters, create programs. We do presentations on those campuses.

The other program that we talked about was mentioned briefly. It's called OpenMindsOpen Doors, and it's funded by the Department of Public Welfare, Office of Mental Health and Substance Abuse Services.

And just quickly some information about it, it's aimed at ending discrimination against people with mental illnesses. Approximately one in five people in this country live with a mental illness. People who have needs just like everyone else and demand basic needs just like everybody else.

As a result of the 1999 Surgeon General's

report on mental health, which focused heavily on the stigmatization of people with mental illnesses, and illuminated the barriers that people with mental health issues face.

OMOD was launched in 2002 with mental health stakeholders. Now, the initiative is supported by more than 50 partners representing thousands of members across the Commonwealth.

OpenMindsOpenDoors develops programs to educate people about mental illnesses, to foster understanding and acceptance among peers, educators, communities and families, and to advocate for the legal rights of people living would psychiatric diagnoses.

The campaign has reached 200 mental health service providers and provided guidelines on eliminating stigma. Twenty-four providers representing 30,000 employees stated they were making changes in hiring and training as a result of our efforts.

The campaign organized leader forums are similar to town hall meetings. 100 percent of those that attended stated they were more aware of mental health issues as a result. To date, OpenMindsOpenDoors has been a successful

collaboration with a crucial message that recovery from even the most serious of mental illnesses is a realistic hope.

The ultimate goal of our campaign is for people with mental illnesses to participate fully in their communities. We encourage legislators to visit our website at OpenMindsOpenDoors dot com to sign the statement of support, adding your name to the growing list of people and organizations that oppose the discrimination and stigma of people who have mental illnesses. Thank you.

REPRESENTATIVE JAKE WHEATLEY: Richard Jevon. I'm sorry, if you Sarah, I don't know --

REPRESENTATIVE REICHLEY: No.

REPRESENTATIVE JAKE WHEATLEY: -- if you need to leave.

MR. RICHARD JEVON: I'm Dick Jevon, and I'm not going to read my testimony. First of all, I think Amy Kroll said it all. I don't know what's left, but maybe there are one or two things that Amy did not mention.

My testimony does talk about the many ways in which stigma affects people with mental illness and their families, and it's terrible. But earlier I think there was a little bit of

discussion -- IT might have been the Doctor talked about the cost. And there is a study, Stephen -- a year ago, A year and a half ago, Rand Corporation did a study on the cost effectiveness of Mental Health Courts, and it showed that Mental Health Courts are cost effective. And so I'm wondering if that might be helpful to you in Lehigh.

And I'll also say from my activity with Amy and involvement as a teacher in the CIT, I find that the judges here in Allegheny County are the strongest advocates for the Mental Health Court system. Incredible.

So I would think the Rand study would be very helpful as you look around the state. And I wish, if we could get -- Stephen, can you get some more specifics and send that to them?

And one other item of interest to you maybe, I believe Beaver County is in the process of cranking up a forensic community treatment team. And Beaver County, being a smaller county, but I think that's really remarkable and a big plus. We hope it's a very successful effort. And it will probably bear many similarities to what Amy does.

One last quick comment on the subject of stigma: I am an active volunteer with NAMI, Southwestern Pennsylvania, and we -- on October 5th, we had our second Walk for the Mind of America. It was at a the South Side Works, which is a new commercial development along with residential.

And I'll tell you, it brought tears to my eyes because just under 2,000 people showed up for the walk. Balloons, music, food. It was a celebration. A celebration on the subject of mental illness. It was an incredible event.

And so activities such as that, whatever support you can give to enable anything that makes mental illness part of everyday life, which it certainly is, is a step in the right direction. Thank you.

REPRESENTATIVE JAKE WHEATLEY: Thank you.

Dr. Emma Lucas-Darvon.

DR. EMMA LUCAS-DARBY: Good evening. And it's a pleasure for me to be able to share some of my thoughts, mostly from the educational prospective, but also as a social worker. But one of the problems we face in terms of mental illness today is that we see it as taboo, but at the same

time we use words every day to describe people who have mental illnesses. And some of those words are crazy, insane and freaked out. And these are embedded in the youth, in the language we use often.

We speak so often of these words until it's at a point where we don't want to understand mental illness, and we don't offer the empathy that some of the people need who do have mental illness. We see mental illness as a disgrace in our society, and one that we must educate people to look at much differently. I want to point out some of the myths around mental illness that lead to us not taking it as seriously as we should.

First of all, we see mental illness and mental retardation as being the same. We look at people who have mental illness as being erratic and violent, and we also look at it as being something that cannot be cured because it's a character weakness.

We see people with mental illness as not being able to work, only being able to do secondhand work. And we also look at children who misbehave for attention as not experiencing mental illness, and those are myths we really do need to

address in our society.

Stigma, itself, refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illness. The stigma of mental illness can lead to prejudice, oppression and discrimination and to such phrases as avoid living with them, not wanting to socialize or work with them, not wanting to rent to them and not wanting to employ them. And those are attitudes we do have to change.

One of the points I want to make is that none of us are untouched by mental illness. All of us know someone, maybe even in our own families who are experiencing or have experienced mental illness.

And NAMI has been spoken of previously, and they are doing a wonderful job in terms of educating the pubic. And the fact of the matter is more money needs to be advocated for educational programs in general around mental illness.

As of Friday, October 6th, 2008, as part of the Economic Rescue Bill signing, President Bush

increased the minimum health insurance coverage for more than one-third of Americans. The bill requires equal healthcare coverage, including copayments, deductibles and limits on treatment for physical illness and for mental illnesses and addiction disorders. This plan would not go into effect until 2010, unfortunately. So during that period from now until 2010 we do need some additional programs to be addressed.

Another point I want to make is that too many people see mental illness as being crippling, both physically and intellectually. And all of us know of individuals who have experienced this, including Ernest Hemingway, Edgar Allan Poe. Michael J. Fox has come out, Muhammad Ali. Even First Lady Barbara Bush talked about her depression, and political advisor George Stephanopoulos. A lot of attention was given to Mike Wallace when he also indicated he was experiencing depression.

But the fact remains just because you do have a mental illness does not mean you're incapable of functioning within society. Again, I want to just comment on the OpenMindsOpenDoors project campaign, I should say, that Sarah

mentioned earlier, which has done a lot to address the whole area of educating the public about mental illness and the rights of people with mental illness. And Pennsylvania is a state that should be commended for the efforts it's made in that arena.

Just a couple other points include the fact that there is so many people who develop mental illness, but they are not at a crisis point. And some of those individuals within our society experience it simply because of their jobs and some of these people include First Responders, healthcare providers, mental health providers.

And it's a secondary stress in compassion and fatigue that many of these individuals are experiencing. We don't often think of mental illness that's associated with childbirth because some mothers have experienced postpartum depression, and studies have indicated the fathers are even vulnerable to postpartum depression.

Children and teens need to be supported with mental health services because of situations they face, including name calling, bullying, peer pressure. The whole notion around sexual identity can be a problem for some teens as well.

We also know that crisis intervention funding is needed to provide more mental health services for individuals who may be experiencing death, family members issues in the workplace, violence, sexual harassment and natural disasters.

Cultural dynamics feed into some of the stigma around mental health illness. Subgroups within our population may be leery or suspicious, at best, regarding mental health services, and we need to address that. Personal biases of professionals towards these subgroups can lead to misdiagnosis and mislabeling.

There is also a lack of culturally competent service providers, and we need to work on making them much more competent so that they can recognize the cultural dynamics that feed into mental health situations that so many people are facing.

So discussions around mental health education programs, prevention, delivery systems, early intervention and cultural competent providers must continue, and funding must be provided for more programs.

Public policies must continue to address how complicated and overburdened the mental health

system is to the every day system who wants to receive services. And we need to continue to address the whole area of mental health parity and the provision of Behavioral Health Services.

I do believe we can reach a state-of-the-art as far as mental health services are concerned, but adequate funding is necessary for that. Thank you.

REPRESENTATIVE JAKE WHEATLEY: Thank you. And I'm losing my Chairman for I'm combining both panels, so if that's not a problem, Stephen.

MR. CHRISTIAN-MICHAELS: Good evening. My name is Steve Christian-Michaels, and I'm the Chief Operating Officer at Family Services of Western Pennsylvania.

Family Services are a comprehensive human service agency providing mental health, mental retardation, drug and alcohol, foster care, and an array of community building programs in our most disadvantaged neighborhoods. We actually provide transportation to 22 of the prisons in this state to help keep families together.

In addition to representing Family Services, I'm also representing Pennsylvania Community Providers Association, PCPA, and the

Conference of Allegheny Providers. I'm the immediate past President of the PCPA and the past President of the Conference of Allegheny Providers.

I'd like to thank Representative Jake Wheatley and the members of the House Health and Human Services Committee for your leadership on holding these hearings. The future of human services depends on your leadership and accurate information from the field.

I will speak on the following topics: Stigma, new services and consistent funding.

Stigma in this county we have seen with the upcoming closure of Mayview considerable fear about people with mental illness returning to the community. Some communities are trying to pass ordinances to limit and/or control people choosing to live in neighborhoods.

The single most difficult challenge we experience is the reluctance of people to seek help when they're struggling and for communities to support people with emotional difficulties, mental retardation or physical challenges.

It is all about fear. Fear runs rampant when people are uninformed. Fear escalates as

organized efforts play on these fears. The reality is people can and do recover from mental illness.

People with mental illness are no more dangerous than your neighbors. There is danger in our neighborhoods, but it's not from people with mental illness.

Another fear is the property values will decrease if we put a group home in someone's neighborhood. The reality is agency group homes are cleaner and better maintained than many of the homes that surround us.

Another fear is that property values will go down when a group home is opened in the community. The reality is -- I think Pat said earlier -- that property values stay level with surrounding communities, and in some cases go up given better maintenance of homes.

The media often portrays people with mental illness as more dangerous. This does a grave injustice to all those who seek treatment. If people think those around them will think poorly of them because they have a mental illness, have a child with mental retardation, or a spouse who struggles with addiction, they often will put off

or never call in for services. This hurts us all.

We struggle as a community of human service agencies in being seen as a valuable and a critical service. Community leaders and the general public tend not to think about human services until a family member or a neighbor's painful struggle becomes obvious. Then we obtain some modicum of respect if perhaps it weren't for funding. This support can be fickle and inconsistent.

New services transform services. We are not delivering the same service we provided in the early seventies. We now provide much of our services out of the office in people's homes, at the job or under bridges.

We have community treatment teams, otherwise known as Assertive Community Treatment, case management, in-home family based treatment, supported housing, mobile medication teams, and supportive employment. These are intensive services that are very customized to the individual and/or families.

Evidence based practice has been developed for many of these services. With payer-led expectation we must maintain and exceed the

fidelity of these evidence based practices that are based on research.

We have a new crisis service here in this county, which includes telephone, walk-in and mobile services, and within a few months a residential component. The capacity of those services has tripled in the last three months.

We also have extended acute services that have been developed as an alternative to the state hospital. They have a longer length of stay than would be appropriate in a private hospital. Anywhere from five to six months.

The community now has a number of new specialized small group homes, long-term structured residential facilities, comprehensive mental health, personal care homes. We have, in this county, been very active in transforming our system of care. We have many efforts to shift the model from a casualty based system or crisis oriented system to an array of recovery oriented supports.

Peer support, peer specialist staff who have utilized mental health services are now employed to reach out to people in the community struggling with a mental illness and to provide

ongoing support. More and more programs have peer staff working side by side with professional staff, which has changed the way we deliver services.

We are transforming the way Case Management Services are being delivered, staff trained and financed. We changed the name from Case Management Services to Service Coordination as people have told us they are not cases and they don't need to be managed.

At the end of five years we expect to develop a service system where the consumer drives service planning, the Service Coordinator effectively coordinates resources on the consumer's behalf, and advocates for change in systemic problems.

We are elevating Service Coordinators to a profession with very effective training and competitive salaries. These are new services that will help stigma as it gets us out into the community working with other services and with people living in the communities and avoids our old casualty based system of care.

Costs increasing, funding keeping current with cost. The cost to deliver this broad array

of services that we provide is like any other business in Allegheny County. The cost of living increase for Allegheny County as of February of 2008 was 4.1 percent. I don't even want to think of what it is today. Other businesses will charge more for services as those costs go up. Gasoline, for example. We are not able to do this.

Allegheny County providers of Mental Health Services will receive a 1.3 percent cost of living increase this year. Most other providers in the state realized a 1.3 percent cut. Some years we may get 2 percent, other years we may get 1 percent, some years we get cut.

Over a period of ten years this means we lose a purchasing power of about 10 percent. Over 20 years it could be 20 percent. That means I can buy 10 or 20 percent less than I could before.

Two-thirds of my funding is based on fee for service rates. Cost of living adjustments that might be granted will not get to me through those rate. These rates are negotiated with managed care companies, and that means we typically see raises in four or five of the services that we provide. And we have a total of 25 or 30 rates that we provide services around.

Some of these services have not seen a rate increase in ten years. We are facing a workforce crisis in the next ten years. The size of our workforce is decreasing, demands for services are increasing as the baby boomers are starting to retire. Baby boomers will demand the better services because the culture they've grown up in expects that.

We will be challenged to provide the best service, given current rates and salaries. The salaries we offer are not competitive with what is paid to state workers and similar positions in State Hospitals or state centers, not competitive with what is paid in other sectors for similar positions.

We are losing other staff who have better salaries to other sectors who have better salaries, better benefits, including tuition reimbursement.

There is tremendous new funding coming into this county and surrounding counties with the closure of Mayview, approximately $30 million. The challenge is always to keep the money relative to the increasing cost over time or five years from now or ten years from now that 30 million

will decrease.

There's several ways you can assure an effective future for Mental Health Services. You can assure that there's a cost of doing business increase for services that are provided in the community.

Demand that the Department of Public Welfare, that the budget for mental health services provided to the community have a cost of doing business equal to the Home Health Basket Index rate of inflation.

Pass House Bill 2160, which would require increases in the mental health services provided in the community to be tied to that same index.

Demand that managed care companies pass on their increased capitation rates to BH providers so that the community provider's unit cost equals the rate of a service.

Lastly, pass House Bill 1448, for which there's hearings going on, that would create a Housing Trust Fund out of the proceeds on the sale of State Hospitals and state centers. That would keep mental health money in the system.

If the services are not adequately funded services will deteriorate, just like our bridges

and roads. When the service is inadequately funded it looks less appealing, doesn't recruit effective staff, and thus becomes ineffective.

I will end up by saying ineffective services contribute to stigma. Thank you for giving me this opportunity to share these concerns.

REPRESENTATIVE JAKE WHEATLEY: Thank you. And next up is Dr. Paul West. And before you begin I should let you know that our last hearing that we'll pull together, you'll probably be invited back because of your statement before at the first hearing around the program evaluation and making sure that what we fund we actually have set goals, and that we do have some way of identifying if they are meeting our goals and so on and so forth.

DR. PAUL L. WEST: Thank you. I appreciate the opportunity to come here and speak to your group tonight. My comments are really going to be real, real brief. Everybody says brief, but go on.

I really want to take notice to what Steve has just said. I've never met the man, but he just told you that his programs, that some of his

programs are evidence based, and he's struggling for funding. Yet there are other programs I imagine in the community -- I'm not from Pittsburgh -- but I imagine there are other programs out here that do diddly-squat when it comes to outcome research, and they get funded. That's an inequity. You know, here's somebody who is trying to do the right thing and struggling. So I really appreciate that.

I'm basically going to talk about accountability, and I know that really wasn't on the agenda, but it kind of is. An interesting thing in Pennsylvania is that we have a title law, a professional title law for social workers, licensed professional counselors and marriage and family therapists.

When that law was passed in 1998 it was a title law, and it said basically that community agencies or agencies that are funded by the state are not required to hire licensed professionals. Well, I can understand it in 1998 because we didn't have any licensed professionals.

Ten years later, social workers are up around 11,000, LPC's are right around 3,900, marriage and family therapists are 700 or 800.

And maybe we're at that critical place now where we start to consider a practice act in Pennsylvania, where people who are working in agencies as counselors must be licensed.

A lot of the opposition to this comes, well, we have to pay them more money. When you take a look at who receives services at the community base, it's usually people who have the greatest degree of problems. You have heard massive problems here tonight. I've been educated on some of these.

And yet when people come out to community services, who do they see? They may see people who have the least credentials, having the least formal training. And then we wonder why we have a recidivism rate? Then we wonder why we have a continuing problem. Maybe we need to get licensed professionals in at that level.

The other two things I want to mention is just a continuation on or reemphasize the idea that Stephen's proven you can do outcome research, site based outcomes research, and we need to expand that. That needs to be required. It can't be voluntary.

Everybody knows there's supposed to be

outcomes. Many places are afraid of the results, so they don't do outcomes research, so they don't have any idea how effective their programs are. We need to move forward on that.

And the third thing is in reference to the letter I wrote you, programs not only need to do outcomes research, but there needs to be a mechanism to verify that the research is accurate, and that can be done by a simple certification. That's the end of my comments.

MS. J. R. BRENNER: Could I testify, please?

REPRESENTATIVE JAKE WHEATLEY: Sure. After this panel is completed.

I want to thank you all for being very brief and keeping us close to our time. I don't really have any questions for you.

I'm going to allow -- okay. So, I really appreciate you. We look forward to working with you as we continue searching through the answers for these very complex questions.

Like I said, there will be another hearing tomorrow in Erie, and we will plan another one for Harrisburg, which we'll get you the whole question around evaluating programs and so on and so forth.

So thank you for your time.

DR. PAUL L. WEST: Thank you. I want to wish you luck in Lehigh in getting the judges with it.

REPRESENTATIVE JAKE WHEATLEY: Ma'am, if you want to come up front? All I would need you to do is tell me your name.

MS. J. R. BRENNER: First of all, I want to thank you. I saw you on the Harrisburg PCN or whatever it is having this service, and I was very happy to see it's being done.

I can do a short scenario real quick. You have -- J.R. Brenner, sorry. You have my paper up there. To go in it very shortly in 1966 when I was 20 years old, I went to Woodville State Hospital for three and a half years.

When my mother asked when I would get out, he said who is it, and she's never going to get out of the hospital. So I really didn't know anything, and even if I did, I didn't. And without any emotions we got in for medication.

I had electric shock and ice pack shock back then. And you will see that I'm one of the serious, whatever that is, people with mental illness. I do have recidivism. I do keep going

back to the hospital. And there's stuff in there you can read yourself.

What I want to say, though, because I'm hearing these people talking, you're saying how can we help children? Let the teachers teach each child that they're unique and they have a creativity. And if a person has self esteem, it's going to be a lot easier to stay out of the system than us who didn't gain any self esteem.

Another thing, a change in experiences, from when I went into the hospital til, say, 1990 is totally different. They're now getting immediate services. They're not being locked up because they don't know what to do with us.

But we do have this generation of people who has been in a situation -- this is 42 years for me -- who has been in a situation a long time. And I just had to drop my therapist because my copay is $20 every time I see her. I can't swing that on SSI.

And the things are, there's a lot of good things. NAMI has a program called In Our Own Voice where we consumers go out and talk to whoever calls in to get us to come out and talk about our mental illness.

The other thing is the Allegheny County Coalition for Recovery also had a group prior that also went out and did talks. I also belong to CORE, which used to be COE, so I'll deal with that. The Center of Excellence, the new acronym I don't know. But what we do, we have consumers and staff of six different agencies coming together to better improve the lives of everybody whether it's us helping with staff or the staff helping us.

As far as how else people can be helped, ProA is training their own peers to become staff to go into the jails to talk to people as far as their drug and alcohol.

Then we also have mental health support. And the only way we're going to get this -- and this is my personal opinion -- if you haven't been there and done that, you can't exactly explain what we're doing.

So we don't have to be professional peers, which they're doing as the certified peer specialist. I can go out and share my experience, strength and hope, whether it's being an alcoholic or being a mental health consumer or whether it's somebody with fibromyalgia and arthritis. I'm not a co -- whatever that is. I have three diseases.

I have the mental, I have the addiction, and I have the physical, now.

And the thing is, we just have to relate to each other. There's no one in this room that hasn't felt depressed over death that isn't concerned about their health. Guess what, we're all the same, but all unique. Thank you.

REPRESENTATIVE JAKE WHEATLEY: Thank you, ma'am, for your testimony (clapping). Rachel.

MS. RACHEL FREUND: I'll be really quick, too. I just want to -- my name is Rachel Freund. I'm from the Pennsylvania Mental Health Consumers Association. I know my organization testified in Harrisburg, but I brought tonight the photos of people who couldn't be here tonight who live in personal care boarding homes across Pennsylvania. And in any given time, about 9,500 individuals with mental illness are living in personal care boarding homes.

They pay their whole SSI check and a state supplement check to live there, and they receive $60 to live on each month. They use that for their medication, for clothing, for shoes, for transportation, for toiletries, for anything over and above their room and board. Four huts and a

cot -- three huts and a cot.

And we just, again, want to bring this to the attention of the legislature. They haven't gotten a raise in their $60 since 1993. Obviously, the cost of living continues to go up. They didn't used to have to pay copays on their meds. They didn't have to pay copays on their visits, like J.R. said, and we just feel like it's an untenable position for people to be in.

If we're going to sit here and say that we're focusing on mental health recovery, how can you recover from a mental illness if you're living on $60 a month? How can you fight stigma if you can't afford clothes that don't make you look like a raggedy bum?

So we just wanted to remind you again that we're hoping that that raise will show up in the 2009-2010 budget. And if each one of those 9,500 individuals got a raise from $60 to $90, that would be about $3 million. And in a $28 billion budget, that doesn't seem like too much to ask.

REPRESENTATIVE JAKE WHEATLEY: Let me ask you a question: Those who are in personal care boarding homes, what condition -- are they the severe mental illness?

MS. RACHEL FREUND: That's a really good question. So statewide there's about 50,000 people who live in personal care homes. Some of them are people like my mom and my aunties and people who can private pay and live in beautiful places like Country Meadows.

But the people who are living on $60 a month are usually people that they don't have very many options of places to live. Maybe they were living in a group home and they weren't able to get along with the other members of the group home. So they're often people who are yes, some of the most complex people in our system. Very seriously mentally ill, very tough making it in the community. So the owners of the personal care homes are the safety net for our system. At this point in time, 13 percent of people leaving Mayview are going to personal care homes, not enhanced personal care homes, just regular personal care homes.

REPRESENTATIVE JAKE WHEATLEY: At one of our previous hearings there was a suggestion that anyone who was severely mentally ill or substance abuse or some other illness that was heavy on medication, we would eliminate or find some way to

eliminate copays for them.

For this population of people if that was to happen would that be -- if not the $60 increase, would that be something that you would be supportive of?

MS. RACHEL FREUND: Yeah, that would really help. Obviously, those guys need a raise because all those costs of living have gone up. But when you talk to people who are on 10, 15, 17, 18 different medications and they owe a copay on every one of those meds, they owe more than $60 each month, just for their medication.

And the owners of the homes are scrambling around trying to help them get their meds. You know, like who died last month, and we can maybe use their medication for somebody else who's on that medication. So yes, that would be a significant help.

REPRESENTATIVE JAKE WHEATLEY: Thank you.

MS. RACHEL FREUND: Sure.

MS. RITA H. STEINMETZ: May I?

REPRESENTATIVE JAKE WHEATLEY: Your name?

MS. RITA H. STEINMETZ: Rita Steinmetz. My address is 1519 Hoff Street, Pittsburgh, Pa. I'm in a different area than people here. I've never

been mentally ill, but I was involuntarily committed because I made a sarcastic statement in a hospital.

Now, I would like some changes made by the legislature. First of all, revise the Mental Procedure Act to provide a hearing for anyone who's been involuntarily committed for five days or less where an individual is given both legal and psychiatric representation. At the moment, you're just dumped, and there's no way, unless you can afford a lawyer, that you can get this challenged.

Secondly, revise the ACT in the criminal code to remove the provision that takes away the constitutional right to own a firearm from individuals who were committed allegedly under the ACT for five days or less.

These individuals have never been adjudicated to be dangerous to themselves throughout this because of mental illness. Under the ACT when an individual is released from commitment after five days or less -- I'm just saying again, this is five days or less -- when people are not mentally ill to begin with a physician must determine that the individual was

not dangerous to himself or others.

The legislature is placing a stigma on these people who have never been adjudicated to be mentally ill to begin with. All the doctor has to do is sign a form. They don't actually have to do an examination. They just sign a form.

Third, pass legislation to expunge mental health records with the Pennsylvania State Police of individuals who are involuntarily committed under Section 302 of the ACT. This deprivation of a constitutional right was done without notification or A hearing. It was made retroactive. People were not even informed this was being done.

This action by the state not only takes away the right to own a firearm, but also classifies the individual as being as dangerous as murderers and rapists. Again, the state itself is placing the stigma on people who have been involuntarily committed for five days or less and have never been found to be mentally ill. And then in some cases, in my case in particular, there was no involuntary emergency examination ever done under the law.

Fourth, revise the ACT to eliminate the

immunity clause. It allows physicians and hospitals to negligently treat an individual who has not agreed to being treated by them and leaves the individual without any recourse for injuries or even death caused by their negligence.

Immunity actually encourages negligent treatment of those alleged to be mentally ill or who are mentally ill because there's no accountability because gross negligence is not defined under the law, and consequently it's difficult to prove. Lawyers will not represent those accused of being mentally ill or those mentally ill. Even if there was willful misconduct by the medical profession, who will falsify applications and medical records? The lawyers would not even talk to the individual and provide them legal advice.

Fifth, revise the application for involuntary emergency examination and treatment. The form right now has open spaces for people to fill in. It should be set up for people to put in specific information as to who did it, where it was, when it happened, what happened.

And sixth, audit the records of counties and hospitals for compliance with the ACT. Was it

reasonable to authorize the warrant? Did the specific behavior provide the required information? Was the specific behavior on Page 3 in agreement with the check box on Page 2 of the application? Was the individual given notice of their legal rights and legal representation? Was the required voluntary emergency exam done within the statutory two-hour frame? When the county submitted information to the Pennsylvania State Police, did it provide complete and accurate information, and did it have a certification of examination done pursuant to the warrant?

These are all things I think you need to address to protect not just me, but everybody else in this room, anybody who is mentally ill or accused of being mentally ill.

People have rights, and the legislature is so in favor of doctors and hospitals and the courts also are favoring doctors and hospitals. Lawyers don't represent mentally ill. And, in fact, if you want to do it yourself, you've got to be able to get a physician or psychiatrist to speak up for you. That costs money, if they're willing to do it. Many will not even do it for someone representing themselves.

So I thank you for your attention in this matter.

REPRESENTATIVE JAKE WHEATLEY: Thank you for your suggestions. We certainly will take it under advisement. And, again, we appreciate you testifying today. Thank you.

With that being said, I will now close out our Subcommittee Hearing. Thank you all for being patient and waiting through it and listening to it. And I would ask you to stay close to us as we go through this. And you're certainly welcome to submit any written testimony to me and the subcommittee on this issue if you weren't able to speak tonight. So thank you.

(THEREUPON, hearing concluded at 8:30 p.m.)

COURT REPORTER'S CERTIFICATE

I hereby certify that I, Donna M. McMullen, RMR, Notary Public, reported in stenotype the record of proceedings in the above-entitled matter, and that this copy is a full, true, and accurate transcript of my said stenotype notes.

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Court Reporter, RMR