PENNSYLVANIA HOUSE OF REPRESENTATIVES
HEALTH SUBCOMMITTEE OF THE HEALTH AND
HUMAN SERVICES COMMITTEE

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

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FRIDAY, OCTOBER 10, 2008

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BEFORE: HON. JAKE WHEATLEY, JR., CHAIRMAN
HON. DOUGLAS G. REICHLEY, CO-CHAIRMAN
HON. KATHY MANDERINO, CO-SPONSOR
HON. THOMAS R. CALTAGIRONE, MEMBER
HON. LOUISE WILLIAMS BISHOP, MEMBER
HON. MARK COHEN, MEMBER
HON. DANTE SANTONI, JR., MEMBER
HON. BRYAN LENTZ, MEMBER

ALSO PRESENT: Stan Mitchell, Staff Attorney
Sandra L. Bennett, Executive Director (D)

Held at People's Emergency Center, 325 North 39th Street, Philadelphia, Pennsylvania, commencing at 1:30 p.m., on the above date, before Virginia Mack, Professional Court Reporter and Notary Public.

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I N D E X T O T E S T I F I E R S

P R O C E E D I N G S

MEMBER MANDERINO: I'm going to start because it's Friday afternoon.

I'm Representative Kathy Manderino. I am not the Chair of the Subcommittee, but Representative Wheatley, from Pittsburgh, Allegheny County is and Pittsburgh is a long way away. So I understand he is somewhere within blocks of the facility, but in respect for everybody's time, we're going to start and he's going to slot in.

This afternoon is organized into three panels. There is a Government panel, an advocacy panel and then a provider panel and our opening panel, the government panel, includes Secretary Estelle Richman -- Secretary, if you want to come on up to the table -- Dr. Arthur Evans, from the Mayor's Behavioral Health and Mental Retardation Office and I think we will slip him in when he arrives. I understand, he's on his way. And also Roberta Cancellier -- Hi, Roberta -- Deputy Director for Policy and Planning for the Mayor's Office of Supportive Housing. Roberta, we're going to do this as a panel so if you are testifying, please come up to the table.

MS. RICHMAN: This is Joan Erney.

MEMBER MANDERINO: Hi, Joan. I'd introduce you, but they didn't give me you on the script. For the purpose of the stenographer, Joan Erney.

MS. ERNEY: Deputy Secretary, Office of Mental Health and Substance Abuse Services Department of Public Welfare.

MEMBER MANDERINO: And with us on the Panel, so far -- Tom, you want to start?

MEMBER CALTAGIRONE: Sure, Thomas Caltagirone, State Rep., Reading, 127 Legislative District.

MEMBER SANTONI: I'm Dante Santoni, I'm also from Berks County, 126 Legislative District.

MEMBER MANDERINO: I'm Kathy Manderino, again, most of my district is in the City of Philadelphia, but I also represent part of Montgomery County.

MR. MITCHELL: Stan Mitchell, Staff Attorney.

MEMBER MANDERINO: Estelle, shall we start without Jake and Arthur and hopefully they will be joining us --

MS. RICHMAN: There he is.

It's always good to wait for my colleague from Allegheny County, where I was yesterday.

THE CHAIRMAN: Oh, really?

MS. RICHMAN: Yes.

MEMBER MANDERINO: We did introductions. We're flying without a sound system here, but our stenographer is nice and close to us all, so we should all be good. And Dr. Evans, somebody will just -- Joe Willard will slide him up to the table when he gets here. We're ready.

MS. RICHMAN: Good afternoon Representative Wheatley, Representative Manderino, Committee members and staff. Thank you for the opportunity to discuss today important initiatives within the public sector behavioral health sector.

Specifically, I would like to address housing for persons with behavioral health needs, pharmaceutical issues, drug and alcohol services, and the certified peer specialists.

First housing: The Department of Public Welfare has a long history of promoting community living alternatives for persons with disabilities. We remain steadfast in our vision that every person can live

successfully in the community if they have the services and supports they need. In 2005, the Office of Mental Health and Substance Abuse Services, or OMHSAS, released the report, “Call for Change.” Transforming housing for people with mental illness to support their recovery has been a top priority for the State and each of our 67 counties ever since.

The need was clear then as it is now. The lack of housing for people with disabilities is a national crisis. A recent study found that the typical monthly rent for a studio or efficiency unit averages $633. This exceeds the entire monthly income of people with disabilities who receive Supplemental Security Income. Likewise, in Pennsylvania, the average monthly market rate rent for a one-bedroom apartment is $630 a month or more than 100 percent of a disabled person’s Supplemental Security Income or SSI.

In the greater Philadelphia housing market, rents are even higher. And a one-bedroom rental unit is 122.3 percent of a monthly SSI check. In the Lehigh Valley it is 106 percent and in the Pittsburgh area it is 99 percent of a person’s SSI monthly check. What these numbers show is that the biggest housing problem is often not that a person is living with a

mental illness, but rather that they are poor.

We created a Housing Work Group in 2005 and it released its report the following year. One of the primary recommendations was that the Department, in conjunction with Pennsylvania Housing Finance Agency and the Pennsylvania Department of Community and Economic Development, worked with counties to develop more supportive and supporting housing.

We set a goal to create 5,000 homes for people with serious mental illness and co-occurring disorders by 2012. Supportive and supported housing envisions that every individual will have an opportunity for a lease. Treatment and supports are made available, but not required as a condition of the lease. This assures that individuals have a home, a place to return to and a place that provides consistency and permanency.

The treatment community must have greater accountability and responsibility to that person, to the family and to the community to be available as services and supports are needed. Stable, affordable housing is an essential component of recovery.

Housing is not only a basic necessity for life, it is a cost-effective alternative to

homelessness, the possibility of incarceration and other undesirable alternatives. The Housing Work Group identified three major initiatives for the Department: Embark on a supportive housing agenda, address issues related to persons with mental illness living in personal care homes and provide opportunities for alternatives to traditional community residential rehabilitation or CRR programs.

The Office of Mental Health and Substance Abuse Services committed resources to bring experts to Pennsylvania as well as utilize in-state resources and partners to build a comprehensive housing agenda. The Community Hospital Integration Project Program, or CHIPPs, was critical to this effort by providing the funding for the initial residential infrastructure in most counties. CHIPPS promotes community living as opposed to institutionalization for individuals living with a mental illness.

Traditional residential settings were developed ranging from CRRs, Community Residential Rehabilitation to Long Term Structured Residences, LTSRs. Long Term Structured Residences are residential settings with clinical and support staff that may be locked and have the capacity for up to 16 individuals.

Most counties spent approximately 60 percent of their base funding as well as their designated CHIPP funds on structural residential programs.

As a result of our work, many more options have been developed, based on the choices and the needs of the individuals with mental illness. Our most successful initiative is our supported housing agenda, which is beginning to deliver real options for individuals. Its success is due in large measure to the commitment and expertise the PHFA and the local Development and Housing Authorities has brought to the initiative.

Due to the efficiencies achieved by the housing programs, while still maintaining quality service, they have been able to direct funding from their managed care savings funds to assist in securing permanent safe housing for persons with mental illness. We are developing a variety of housing options as well as support services to enable people to live in individual or shared residences, ranging from independent apartments to fair-weather lodges to recovery houses. Studies show that persons who move from unreliable housing or homelessness to supportive housing increase their earned income by 50 percent and

their employment rate by 40 percent. They also decrease their use of costly services such as emergency room visits and incarceration.

We need to work with the counties to expand the availability of appropriate housing options. We are offering technical assistance to engage counties and help them develop effective partnerships with Local Housing Option Teams, local housing authorities, county homeless planning activities, DCED and PHFA.

Additionally, we have encouraged counties to look at existing housing resources such as CRRs, and determine if there are better uses and ways to leverage those resources. For example, through a strong partnership with their local housing authority and reducing their CRR capacity by six units, Cumberland County has been able to expand supportive housing to 40 individuals and develop a drop-in center,

As Pennsylvania reduces its reliance on institutional settings, the financial resources invested in the institutions needs to move with the people to the community. Financial strategies, such as Representative Frankel's House Bill 1448, ensure funds that support institutions are available to community-based options. This bill would create a Mental Health or Mental

Retardation Community savings account to reinvest funds from the sale of a state facility in the event of a closure.

We are fully committed to working on this particular issue to ensure that an effective financial strategy, using existing funds, is in place to ensure people with mental illness will have decent affordable housing to support their journey towards recovery.

Pharmacy: A second area of importance is improving access to medications. Access to behavioral health medications has been difficult for mental health consumers. Communication from consumers, families and advocates indicate that they are having difficulty accessing behavioral health medications that are life sustaining, particularly those medications that treat psychosis.

Access to medications and the control of those medications by the physicians that prescribe them is essential. Health plans each have different formularies, prior authorization guidelines, policies and procedures to access information and provider services around medications. This creates difficulty accessing services by consumers and providers and

sometimes lead to gaps in the coverage of medications.

In order to help address some of the pharmaceutical issues that consumers face with mental illness, The Office of Mental Health and Substance Abuse Services recently created the Behavioral Health Clinical Committee which provides consumers, families, advocates and providers input into the development of policies and procedures that affect medication access in the medical assistance program.

Decisions that are made need to be evidence-based using the highest quality of data available within behavioral health and substance abuse services. We are working on improving the quality of this process so we can make the changes to the system.

Drug & Alcohol Services: Improving access to drug and alcohol services is a major priority for the Department and the Commonwealth. Research estimates that only 1 in 6 persons in need of substance abuse treatment can access the service. Substance abuse services and funding are fragmented between a number of state agencies in Pennsylvania, including Public Welfare, Health, Corrections and Education resulting in service delivery inefficiencies, conflicting regulations and administrative costs.

We need to do a better job to improve coordination across this complex system. One initiative to address this challenge is a joint effort by OMHSAS and the Department of Health's Bureau of Drug and Alcohol Programs, (BDAP), to convene a Drug and Alcohol Coalition that brings together over 50 participants to discuss innovations, research, barriers to services, and regulatory changes that will improve the access to and success of substance abuse services. This collaboration is a small but important step that will lead to better service delivery.

Another challenge is the behavioral health workforce is becoming increasingly limited. The workforce issues include aging out, high turnover, low wages, lack of a career ladder, stressful administrative burdens and burn out. The rate of new professionals seeking entry positions is decreasing as the majority of the workforce enters other fields with higher salaries and more opportunities for advancement.

We need the skilled workforce to improve our treatment models. The current treatment system has been predicated on an episodic, acute care model and a one-size-fits-all treatment philosophy. We must develop programming focused on chronic disease models and

recovery oriented systems of care that address the individual's needs and target populations such as adolescents, young adults, older adults, women with children, and returning veterans that would result in positive outcomes and long term recovery.

I would also like to take this opportunity to encourage you to support the Department of Health's proposed drug and alcohol treatment confidentiality regulations. Pennsylvania's existing drug and alcohol confidentiality regulations seriously interfere with the ability of our citizens to get the drug and alcohol treatment services they need. I know that many legislators have a misconception that the proposed regulations will weaken current confidentiality protections. And I'd like to briefly explain why I believe this position is incorrect.

The basic problem is that treatment providers can be prohibited from releasing information about their clients, even when their clients give consent. Without the ability to share information about treatment history, prescribed medications and co-occurring medical conditions, clients cannot get the services they need. Under the proposed regulations, Pennsylvanians seeking drug and alcohol treatment will

have the choice to release their own medical information so that they can access clinically appropriate services.

Currently, we are working with the Department of Health to review the comments we received. We are revising the regulation to address some of the concerns we heard and look forward to working with interested parties on a final regulation, which we hope can be supported by stakeholders, including the General Assembly.

Peer Specialists: Finally, I would like to describe the role of peer specialists in helping promote and sustain recovery. The Office of Mental Health & Substance Abuse Services has long recognized that individuals with mental illness and their families offer a unique perspective on what is needed to support individuals with mental illness. We have made a commitment to support consumer and family advocacy organizations as well as provide resources and technical assistance to counties to assist in the development of consumer operated services.

We also realized that true transformation is not possible unless people recovering from mental illness are empowered to fully participate in the development and operation of services and take

lead with regard to directing their own recovery. To that end, we support the development of a workforce engaged in assisting recovering individuals in a peer-to-peer engagement as this work develops across the Commonwealth.

Research shows that including recovering individuals in a wide range of roles within agencies and the system at large serves to transform the system into a partnership of roles between consumers and treatment providers. In 2007, with approval from the federal government, OMHSAS amended its State Plan Amendment to support the development of Certified Peer Specialist Services as an in-plan service for Medical Assistance.

To date, 894 Certified peer specialists are trained; 544 CPS supervisors are trained to date. Certified peer specialists are available in every county in Pennsylvania. They have already made a tremendous impact on their local communities and have engaged in wide array of activities, including working with individuals in prisons and in nursing homes, participating on warm lines and in assertive community treatment teams.

The recognition of peers as valued employees within our system is the most transformational

activity we have engaged in to date.

Thank you for allowing us to discuss our work with you. We feel proud of the work we have done and the progress we have made in transforming our systems. However, we recognize there is more to be done and many challenges in front of us.

I and Joan Erney, the Deputy Secretary, will be happy to address any questions you may have at the end of the Panel.

THE CHAIRMAN: We have been joined by Representative Bryan Lentz, Delaware County.

Next up on the Panel is Dr. Arthur Evans who is the Mayor's Behavioral Health and Mental Retardation Director, here in Philadelphia.

If I can, just because we are very tight on time, I was late myself, we will have your testimony written, so if you want to lift up some of the important things of your testimony and give us an opportunity to have some interaction with you toward the end.

MR. EVANS: I will try to do that.

Good Afternoon, I'm Dr. Arthur C. Evans, Director of the Philadelphia Department of Behavioral Health and Mental Retardation Services.

To Representative Jake Wheatley, members

of the Health and Human Services Committee, distinguished guests and friends, I want to thank you for this opportunity to provide testimony on mental health and substance abuse treatment system in Philadelphia.

I would like to begin my testimony by briefly reviewing the system transformation efforts that are happening in Philadelphia.

System transformation is the framework under which we are organizing the various initiatives to move our behavioral health service system to a recovery oriented system of care. A recovery oriented system of care is committed to supporting people to move beyond their problems and challenges to develop a full and meaningful life in the community. This process involves using the assets of individuals and family members as well as the community to achieve long term recovery.

We are aligning the way we think about services, how we deliver services with the regulatory and financial mechanisms that create accountability structures. Transformation refers to the effort to bring all services in line with the vision that was first expressed by people in recovery, supported by the President's New Freedom Commission and the Pennsylvania

Call to Action. This expressed vision was to pursue a fulfilling and contributing life in the community. Our treatment services are being changed to support this goal.

The three initiatives I will be discussing today are Drug & Alcohol, Housing and Peer Specialist Services and they embody this transformation.

Within the Drug and Alcohol area, we face challenges, but are providing substantial services to addicted individuals and their families. According to the last national Surveys on Drug Use and Health Information, 2005, there are approximately 116,000 persons in Philadelphia in need of treatment for substance abuse. During the past year the Department of Behavioral Health treated 25,000 unduplicated clients, primarily through Community Behavioral Health and the Behavioral Health Special Initiative program.

While this program does not serve all people in the City who have disorders this low number really raises two issues, (1) the level of unmet needs and (2) the limited resources available to meet those needs. Funds supporting services to those without insurance have remained level funded for many years while the demand for those limited resources has

gradually climbed.

Less treatment means more public health issues, lost employment, higher crime and more public dollars allocated to prisons. Research has documented that a dollar spent on addiction treatment saves approximately seven dollars on health/medical and criminal justice expenses.

Despite limited resources, some examples of projects that have helped with our system transformation efforts include the following:

We've improved access to care by implementing the principles of NIATx, the Network for the Improvement of Addiction Services. This project, to date, has trained over 15 providers to reduce the wait time for people who first request assistance. It's also designed to reduce client no-shows, to increase addiction treatment centers' admissions, and to increase the treatment continuation rate between the first and the fourth treatment sessions.

The next phase is sustainability and expansion to additional providers. We have already demonstrated that these strategies improve access to and retention in treatment programs.

We have expanded the community’s

capacity to promote recovery capital by developing the first Recovery Center in Philadelphia with PRO-ACT. We believe it is also the first recovery center of this kind in the Commonwealth. The center was developed and is operated by people in recovery who volunteer their time to support other people who are in recovery or their families. This is a place that provides hope, health and healing to individuals and families affected by the disease of addiction.

We've established the Peer Leadership Academy that trains people in recovery to become leaders in the Recovery Transformation Initiative.

We've implemented 4 new residential programs to address the needs of women and children, medically fragile individuals, adolescent males, and adolescent females who have co-occurring mental health and substance use disorders.

We've implemented the Network of Care website that allows people to have access to treatment information 24 hours a day. There are more than 500 services and supports in the Philadelphia area which can be searched through this website.

I would also like to add that the City of Philadelphia's Department of Behavioral Health and

Mental Retardation Services not strongly endorses the proposed amendments to Pa. Code 255.5, Pennsylvania's Drug and Alcohol Confidentiality Regulation, that the State Department of Public Welfare and the State Department of Health, including the Bureau of Drug and Alcohol Programs are supporting this legislation. We believe that as written and interpreted today, the confidentiality regulations restrict access to clinically appropriate services.

The proposed revisions will allow people in recovery to have control of their own medical information, while continuing to receive confidentiality protection provided under other state and federal statutes and regulations. Presently, even if a person wants to release more information than specified in the current regulation in order to obtain benefits, a provider is prevented from sharing that information. This barrier hobbles payors, leaving them with insufficient information to reach decisions about coverage and causing them to deny coverage in situations when they might have given approval.

We strongly believes, to quote Secretary Richman, in earlier testimony, that we must revise the existing regulations to allow individuals "to have the

choice to release their own medical information so they can access clinically appropriate services".

In terms of Housing: The number one challenge we face in our service system is assisting people in long-term recovery and helping them to sustain the recovery is adequate housing. It is critical that more housing be made available to people experiencing behavioral health problems.

To that end, this past spring the Department developed a white paper on housing that begins with the following statement of vision: "People in recovery should have access to safe, decent, affordable, and integrated housing of their choice with services available to support them in the housing that they desired. The Department should support this access through funding and providing behavioral health-related services, while working to ensure that any other services as well as the housing are funded and provided by other systems.

The white paper identifies eight principles of Housing, for persons in recovery, that were developed by a Recovery Advisory Committee. It also clarifies the rationale for embarking on the difficult journey toward solutions to the crisis of

housing for people in recovery face.

With this White paper as our call to action, the Department invited 23 individuals representing various stakeholders to come together and form a Housing Advisory Board. I'm happy to report that the Housing Advisory Board met for the first time this past Tuesday afternoon.

Their main charge is two-fold: First, to plan for the transformation of the current residential and housing-related programming to become increasingly recovery oriented to assist individuals with behavioral health disorders in reaching their full potential and to live independently as good neighbors and good citizens.

Secondly, it is to develop working principles and to identify best practices to drive the development of new housing opportunities that will assist individuals who have behavioral health disorders.

This Board is full of inspired people participating as liaisons from a variety of groups, all expected to bring the voices of their groups to the Board, and to also bring the questions and ideas of the Board back to their group.

The Board will develop the framework and

plan to guide the Departments housing strategy. People in recovery have a hard time accessing safe, decent, affordable housing in the community of their choice. Using the Federal guideline of housing affordability that states if housing consumes more than 30 percent of a household's income then it is unaffordable.

Most people in recovery have the added challenge of extremely low incomes, at or below 30 percent of Philadelphia's median income, forcing them to pay more than 50 percent of their income for housing in the current market.

To add to this, I must stress that Philadelphia's inventory of residential-based support for persons with behavioral health issues is so far below the need. We have had three recent opportunities to begin increasing permanent, affordable housing opportunities to people in recovery that we are currently engaging in. They are the direct result of the City working together with partners who hold the keys to housing opportunities.

These opportunities are: First, as we partnership with the City and the Philadelphia Housing Authority to address the pressing need for permanent housing for homeless households; Secondly, a new

partnership among the State's Office of Mental Health and Substance Abuse Services, OMHSAS, the Pennsylvania Housing Finance Agency, private owners of low-income housing, and our Department to provide permanent, subsidized housing to people in recovery; and thirdly, a partnership between the City's Office of Supportive Housing and the Department of Behavioral Health and Mental Retardation Services implementing a housing first initiative.

With regard to what the Commonwealth could do to support Philadelphia, as we work to address the needs of housing for persons with behavioral health needs, let me first say that we are very appreciative of OMHSAS' leadership in forging a partnership with the Pennsylvania Housing Finance Agency to make the PHFA Initiative and the housing subsidies and partnerships with private property owners a reality. There are many ways in which we can build on this initiative and we look forward to that.

Next, I would like to indicate our support of the State Foreclosure Relief and Affordability Housing Initiative. This legislative package includes Senate Bill 1400 and House Bill 2600, the Housing Affordability and Rehabilitation Enhancement

Act, known as PHARE. The PHARE Act would invest $10 million to create a housing trust fund, a flexible, dedicated new revenue source for affordable housing that would have as one of its goals to build new low-income housing. The housing trust fund would be administered by PHFA with assistance from a Community Advisory Board composed of housing consumers and providers.

This type of measure has already been adopted by 38 other states and is desperately needed to increase the funding available for affordable housing, to address the needs I have outlined today.

Finally, I would like to provide a brief testimony on the Department's Certified Peer Specialists Initiative. I believe that one key to any type of behavioral change is motivation. Positive change cannot occur without some degree of optimism and confidence. Attitudes long embraced by the society at large and held by traditional behavioral health practitioners have served to reinforce counter-productive beliefs that people with serious mental health and substance use disorders are beyond hope.

However, research over the past 20 years has demonstrated that recovery from severe mental illnesses and substance abuse disorders is much more

attainable than previously believed. We now know that recovery is facilitated by relationships and environments that provide hope, empowerment, choice and opportunities. These new findings have begun to fuel a radical and welcome transformation in both attitudes and behavior.

A prime example of this change is the statewide Certified Peer Specialist Initiative. As a result of this initiative, people who were once relegated to the status of passive, long-term behavioral health care recipients are now being trained and hired to support and motivate their peers. These positions are competitively paid, full or part-time jobs that enable Peer Specialists to serve as models of recovery for behavioral health program staff and participants and to serve as uniquely effective advocates.

This initiative is a direct result of the leadership and vision of the Office of Mental Health and Substance Abuse Services and State Deputy Commissioner Joan Erney. Most notably, OMHSAS was successful in rewriting the State Medicaid plan which allowed Pennsylvania to become the 7th and as of this writing, the last state permitted to pay for peer support services for individuals with serious mental

illness using Medicaid dollars.

Access to Medicaid funding allowed Philadelphia and other counties to implement and progressively expand this resource. We began the process of transforming these programs by hearing from the community of people in recovery and family members about what services and supports should look like.

This was followed by an inclusive process which resulted in the transformation of seven programs to date with the rest due for transformation over the next 12-18 months. Currently we see a decrease in crisis response, center utilization, and an increase in community activity. We also have anecdotal evidence of an increase in positive connections with family members and key supporters, increased confidence and hopefulness and an increase in education and employment.

I would like to briefly highlight what has been accomplished to date in Philadelphia and what we have planned with regard to the future provision of Peer Specialist program. I'll just give a couple of examples. Prior to the federal approval to utilize Medicaid dollars to pay for Peer Specialists, Philadelphia aggressively began the certification training and hiring process using Health Choices

reinvestment dollars. As a result, we have succeeded in recruiting and training over 120 Certified Peer Specialists over the last two years.

Feedback from multiple sources confirms that the CPS staff brings a new and contagious energy to transforming programs. In fact, it has become apparent that day programs that embraced this concept early on and quickly created positions have been the most successful in transforming their services.

Approximately half the CPS training graduates in Philadelphia are working and most are employed on a part-time basis. A survey of training graduates was completed by the Mental Health Association of Southeastern Pennsylvania in March, At that time 49 of the first 80 trained were employed. 40 of the 49 were employed as CPS personnel in the Philadelphia behavioral health system. 8 of the other 9 employed CPS staff were working in the local behavioral health system in other positions.

Finally, there are a variety of things that we are doing to promote the CPS programs and to expand the number of people that we train. An area of key concern is that under Health Choices only adults with serious mental illnesses are currently eligible to

receive support provided by CPSs.

There is a comparable need for this resource within the field of addictions services and for children. Assistance is needed to enlist the support of the three state level substance abuse authorities to permit the regulatory relief needed to extend CPS resources to the substantial numbers of people striving to overcome substance disorders.

I want to thank you for providing me with this opportunity to provide this testimony on these important topics. I will be happy to answer any questions that you have.

THE CHAIRMAN: Thank you. Next we have Roberta Cancellier, who's the Deputy Director of policy planning for the Mayor's Office of Supportive Housing.

MS. CHANCELLIER: Good afternoon Representatives Wheatley, Manderino, Subcommittee Members and guests. This Office of Supportive Housing is pleased to testify today on the future of Mental Health Care and Substance abuse treatment as it relates to an important subpopulation with a critical housing need and that's homeless individuals and families.

The Office of supportive housing is the City Department responsible for planning and

implementing the local government's response to homelessness. Our roles include coordination of creating homes, strengthening communities and improving systems, Philadelphia's 10-year plan to end homeless, which was embraced by the community and administration in 2005 and recently updated and recalibrated to include some of the housing commitments that Dr. Evans spoke about specifically a Philadelphia Housing Authority Commitment of 200 Section 8 vouchers for single individuals who are homeless and 300 housing opportunities in conventional PHA housing for homeless families.

In addition, our office is responsible for planning data collection and submission of the City's annual HUD-funded Continuum of Care application, which is in excess of $25 million a year.

And our Office directly oversees an inventory of emergency housing, transitional housing and permanent housing comprising more than 6500 beds.

We thank you for the state and DPWs acknowledgement beginning in 2005 with the "Call for Change" toward a recovery-oriented mental health service system for adults" and subsequent housing workgroup through OMHSAS, that housing is indeed a critical need

and appropriate housing not only saves money, it promotes consumer choice and recovery.

Philadelphia is an active participant in the statewide agenda to end homelessness in Pennsylvania, through the statewide Steering Committee and Entitlement Committee. The Steering Committee is composed of representatives from 4 regional Continua of Care, which covers 54 counties and includes representatives from key state agencies, coordinated by DCED and including DPW, PHFA, Department of Military and Veterans Affairs, Labor and Industry, Pennsylvania Department of Health, and the Department of Corrections.

The purpose of the structure was to strengthen coordination and increase HUD and other funding coming into Pennsylvania to address homelessness. In addition, in 2004 Philadelphia with the state developed an Entitlement Committee, to bring in the 13 larger counties that apply as counties directly for federal Continua of Care, McKinney funding. Counties included are Delaware, Montgomery, Allegheny, Lackawanna, et cetera.

Improved coordination has been a result, with a major milestone being that we're now doing annual point in time count of homelessness individuals and

families statewide. We do it the same date every year. We also share best practices and principles across the state.

So in January 2007, for example, the total homeless population count at a point in time was just under 16,000 men, women and children; 35 percent of that about 5600 are severely mentally ill and 49 percent or 7700 are chronic substance abuse.

The state has also developed a plan to end homelessness and the vision and guiding principles align well with DPW's goals for housing and recovery. Pennsylvania envisions a state where there are not homeless individuals or families. Each person will have the support services needed to live as independently as possible in permanent housing of his or her own choice. The mainstream services will be adequate, well coordinated, consumer driven and recovery oriented. All housing and services will be offered with dignity and respect and will provide hope.

Philadelphia's Continuum of Care is a system or collaborative funding and planning approach that helps communities plan for and provide a full range of emergency, transitional and permanent housing and other service resources to address needs of homeless

persons.

HUD goals and national standards, as driven by Congress, also support the DPW priorities for individuals in recovery. HUD seeks to promote and measure: Residential stability, increased skills or income, greater self determination.

In the areas of performance measurement used by HUD, I'm please to say that Philadelphia's homeless programs are on track and exceeding HUD's national standards. In the area of housing stability, Philadelphia exceeds the standards, with more than 80 percent of people in permanent housing many of these into recovery, staying more than six months and many for seven years or more.

In the area of increased income Philadelphia, has also kept pace with the national standard, which is that 22 percent of people leaving these programs would leave with increased incomes.

In Philadelphia's HUD funded continuum there are 1,777 households in transitional housing; of these 808 or 45 percent have at least one person in them with serious mental illness; there are 2,064 permanent housing units; of these, 62 percent of 1,282 people have a serious mental illness.

I'll skip a little bit and talk about the local contributions to homeless housing efforts.

In Philadelphia, we are fortunate to have an excellent partnership with the City's Department of Behavioral Health, who supports homeless initiatives, much of it housing-related, at a value of more than $23 million every year, including partnering around the following critical services that support the housing goals of homeless individuals and families with behavioral health needs.

Joint programs include the following: Overnight cafes. In 2005, after seeing rising numbers of individuals on the streets and concerned about lives lost during winter months and after we visited a similar program in Denver, CO, Philadelphia opened up an overnight Cafe, a safe place that happened to be in a church that was offered for homeless people on the street to come in and stay over night. These are people typically with severe mental illness who avoided shelter stays.

And this turned out to be a very safe place. We've now expanded the model to multiple sites and the hours of the model so that our cafes now have behavior health staff presence on some extended morning

hours, and this has absolutely increased the ability to connect individuals to housing and treatment.

Safe havens with a local inventory of just under 200 beds, and safe havens have been an important entry level housing step for individuals living on the street with mental illness.

Drug treatment beds last year, DBH made an enormous contribution to homeless housing efforts through the development of 60 beds, specifically, for homeless individuals tailored to them in the sense that they have longer stays, using models like peer counseling. They have remained full, which is wonderful evidence that people will come in from the streets and will pursue recovery if we create the right model.

Housing First: Dr. Evans indicated the City's Housing First model. This is a model of housing paired with services for some of the most chronic or difficult individuals living on the street whereby a person is offered housing as opposed to the several steps before they've earned housing and services needed everything from psychiatrist to medical care to peer support to home skills help are brought in to assist that individual in maintaining housing.

The House First Inventory through a new

partnership under the 10-year plan with the Mayor's support will increase by 125 units to a total of 340.

A major part of our City's inventory is permanent supportive housing through the HUD supportive housing program and the shelter plus care programs whereby more than $5 million annually as cash and service match are provided that serve individuals and families who are homeless with the Behavioral Health Disability.

Behavioral Health participation in these programs is absolutely essential to ensure that the highest quality services that incorporate the most current thinking and promising best practices. It is through Behavior Health participation in these programs that a peer counseling component can be incorporated. These are absolutely thought of as part of the Behavioral Health housing inventory, with eligibility established in Behavioral Health and admission managed that when combining funding sources, meaning here HUD and Behavioral. HUD funding there are challenges that result.

For example, HUD funded housing for people with mental illness or substance abuse is permanent supportive housing, with HUD's intent that an

individual could remain in the housing for the rest of their lives and receive only the services that are needed to continue to be stable. In fact, HUD performance standards in this competitive grant gives credit for Continuums of Care that demonstrate longer stays in permanent housing, because it's an indication of housing stability. However, as part of the City's continuum and due to the demand on the system, we need to encourage individuals to move to higher levels of independent living when possible and both Departments have worked together to reconcile the application language and service planning to accommodate both.

In Philadelphia, we have an exceptional non profit service delivery system, with strong partners on the housing and services side. They tolerate multiple contracts and multiple funding sources and multiple funding requirements. We have coordinated our efforts to ensure that monitoring expectations with HUD funding and Behavioral Health funding are not in conflict and that both systems understand sometimes changing eligibility requirements sometimes HUD hamstring's our efforts despite best intent, HUD policy with regard to eligibility entrance into permanent supportive housing for people with disabilities was

mirrored in 2004 to target the resource to homeless individuals and families with a street or shelter history.

HUD now required that people admitted to permanent supportive housing must come either directly from the street or emergency shelter or from a transitional housing program originally from street or shelter. While understandable, this has given local challenges as we work to identify the best possible housing and service package for the person.

The need to reduce funding to maintain current programs. HUD McKinney, while at $25 million a year to Philadelphia hasn't increased measurably over the last years, but our need to increase housing for homeless individuals and families has. We request funding for new housing programs every year which causes the eventual problem, the funding doesn't cover renewals for the current programs and leave enough money for new programs.

HUD has developed a response called "hold harmless," which covers one year renewal funding for every existing program even if it means the request exceeds our pro rata share. But in order to create new housing in these conditions, you must reduce or

eliminate existing programs. Last year, we found ourselves in that predicament and made the difficult decision to require service reductions of 25 percent for most programs.

We need the service money to keep coming and be committed in the future. HUD in an effort to dedicate new annual funding to create housing specifically for chronic homeless individuals, and these are people living on the streets, unaccompanied adults who have been homeless at least 4 times over 3 years, or continuously for one year, and who have are disabled, typically with mental illness, substance abuse or co-occurring disorders. HUD created a "Bonus" category in their annual funding application. Which is up to 15 percent of the total award, in Philadelphia, $2.7 million a year. This must be used to create new, permanent housing for chronic homeless individuals. This is great, but HUD will only permit 20 percent of the funds to be used for case management. Meaning that additional sources of funding must be used for the services.

Because these are consumers with mental health, substance abuse, or co-occurring disorders, the natural place to look for the funding is the behavioral

health system, but this of course, as you know, has a system that has its own set of funding priorities and limitations.

As a final example of a terrific collaborative effort that support consumer recovery, independence and housing, I need to take a moment to tell you about the SOAR Program. SOAR is a national initiative that stands for SSI/SSDI Outreach, Access and Recovery. It is a train the trainer model that essentially teaches case managers how to complete an approvable SSI application through building functional evidence.

In 2006, the Department of Health and Human Services invited the Commonwealth to participate in SOAR as part of the Federal Policy of the Homeless Academies on Homelessness and the Federal Interagency Chronic Homeless Initiative. To test the SOAR initiative in Philadelphia, the City's Office of Supportive Housing agreed to contract with the Homeless Advocacy Program, a local advocacy organization. The program has been an out of the park success for some of Philadelphia's most vulnerable and needy individuals.

42 individuals have had assistance with submitting SSI applications. All 42, 100 percent have

been approved in an average of 30 days. This is a system where typically a consumer assumed they would be denied a first application, wait a year or more for a rehearing and become frustrated, a case manager frustrated that this could not come to fruition.

In several cases this was the additional income needed to move a person into housing. For, example, one person left hospitalization and was able to return, instead of to the streets, to a boarding home bed. HAP has provided two trainings, and will train behavioral health case managers later this month.

There are the State can do in continued support of all of these efforts on behalf of individuals and families who are homeless and experience behavioral health needs. Support and invest in best practice initiatives like SOAR that require cross system collaboration.

Recognize and encourage continued long-term financial support to programs like HUD's Supportive Housing Program or Shelter Plus Care Programs, where behavioral health participation is needed because of the target population and because funding in highly leveraged with either development funding or rental assistance funding.

Continue to foster and promote new partnerships, like that brokered with PHFA in support of behavioral health housing plans: Offer financial incentives to participate across departments. An excellent example is the HUD, HHS, and VA grant to provide housing and services to Chronic Homeless Initiatives. Philadelphia was one of 11 cities across the country that was awarded this multi-funded competitive grant. It allowed us to beef up our housing first approach and resulted in a much stronger partnership with the VA than we'd had previously.

We've focused largely on individuals in my remarks. Families are just as critical and the needs just as critical. We are seeing real hope and improved ability to cope by both shelters, staff and consumers that have gone through Sandy Bloom's Sanctuary training to assist individuals who have experienced trauma.

I thank you again for the opportunity to testify on behalf of the Office of Supportive Housing in the City and mindful of those of us who travel everyday on pathways to recovery.

THE CHAIRMAN: I want to thank all of the Panel. I didn't say at the beginning, I'm not sure if Kathy did, for your background information, this is

now the third hearing we have had. The original hearing started in Harrisburg. We tried to get a broad overview of what are the challenges, what the system looks like and what we didn't want to do is go out across the Commonwealth and have some specialized hearings and focusing on certain areas that we saw were most critical.

Yesterday we were in Scranton and we talked about families and support mechanisms there for families and youth and how we deal with those and assess those and what systems we have to support those.

Today is focusing on, of course, the housing, the access to pharmaceuticals and the peer specialists, and then we'll go out next week, in Pittsburgh, talking about the Department of Corrections and Mental Health and how that all comes together and in the hearing we'll also focus on the issue of the role of assessing the treatment that they need and the support they need.

I wanted to say that because one of the things that keep coming up, in many of these conversations, is this whole thing around housing. So one of my first questions, from a State perspective and maybe, Secretary Richman, you can help me with this:

How do we fund the housing question? Meaning, there is always going to be this need that seems to have this availability of housing. Who supports that? How is that supported and what can we be doing more of?

I heard you in your testimony. What, with us facing this new reality that's coming down, the economy the way it is -- yesterday there was a question that was put forth by Doug, who's here now, my Co-Chair, and he was actually the member who asked the question.

He said, We can be facing a billion dollars, maybe more, deficit and all of these great things that we want to do, all of these services that we want to provide, but the reality of that situation is we are going to have to make tough choices. How do we get to those --

MS. RICHMAN: Let me give some overview and say that I probably agree with Representative Reichley, but I won't give you my gloom and doom one day a dollar plus problems that we're going to have because I think we're all going to get to discuss it in the future and it's going to be incredibly painful. And as I think we're all tracking the financial condition of the country, I'm not sure there is anything positive right now to share. If we wait long enough, maybe there

will be.

I'm going to give an overview, but I would like Joan to answer the question more precisely because she's at the front line with it, but let me -- One, the first reminder is Medicaid is a funding source, which is our primary provider of treatment dollars and support services, does not pay for housing. So that we cannot use Health Choices dollars or Fee For Service dollars from Medicaid, per se, as a major housing resource.

And that has been our primary dollars to be able to sort mental health treatment substance abuse treatment in ways. What we have been able to do is convince the feds that we can do some exchanges where housing might be part of a treatment continuum and that we would explore that.

In our exploration of that in which we bundle all the services together, one of which housing, the feds promptly returned to not only Pennsylvania, but several other states and said debundle, because what they're looking for is to see have you snuck housing in there somewhere when it's not there.

Therefore, we've looked at other partnerships. The primary partnership being towards the

Department, whose job it is to do housing, which has been the Pennsylvania Housing and Finance Agency, and they have indeed stepped up to the plate and been a good partner. And what they allow us to do is leverage dollars.

So we can take a small amount of dollars that we have and begin to do different ways of leveraging their dollars, federal dollars, private development dollars to be able to get and use that kind of resource.

Our first effort into this field, as of 2005, is producing good results in several of our counties and we're encouraging people to think creatively. The days when the general assembly would give the Department millions more dollars to spread out to the counties to invest in housing resources have been gone for many years many, many years.

MEMBER MANDERINO: I didn't know we even use to do it at all.

MS. RICHMAN: That's when the county grants were growing at a fairly more consistent rate. Right now the grants to the counties barely cover the needs of the personnel which I touched very briefly.

Let me have Joan talk about our housing

initiative and how we have been able to get that to work for us.

THE CHAIRMAN: In your response to it, if I can, if you can help me see the picture clear as it relates to the number, meaning do you see a projection of shortages at X number and what you're doing will get to this number, but we still will have a gap. That's what I'm hearing that no matter what we do, as it relates to your partnership, there is going to be a major gap in finding suitable housing for people who are impacted by these illnesses.

MS. ERNEY: I probably don't have a statewide number for you, and as the economy turns south it's getting bigger, we know that. And I would say, this year, every county submitted a housing plan, so I can, in fact, compile -- it really is very unique per county. We have a specific rural issue where housing generally is a challenge but we also certainly have an urban and suburban problem with affordability.

I think as establishing, first off, people are poor who have substance abuse and where substance abuse is a greater challenge is often times they're not eligible for some of the Federal Housing, so that really pushes it back to the state to really try to

manage through that and often times you will have someone who has co-occurring that you really put forward that mental illness is their primary disorder because you had to make sure they can get whatever benefit possible.

I think as Roberta and even Arthur referenced, the key to housing is the coordination that you have to do. You need to have folks who know how to bundle the dollars because you are constantly looking for how to really work with developers so that, Number One, they will allow and support people with mental illness living there with some substance.

So what we want to be able to do and what we have been working with developers around is why it is that people with mental illness are good neighbors. We fight stigma quite a bit, which you're going to hear about in another location. We want to be able to assure the developers that we want to be neighbors. We want to have access to housing generally. We don't want to be only limited to the certain parts and areas in order to have people with mental illness.

And the integration that we're moving forward with is people want to live within all kinds of areas in their communities, so we want to be able to

have access. We want developers to know that if we rent from you, we'll respond when there is an issue, when there is a problem, when there is a challenge. That the treatment side and the support side will really be there for them. So that's one issue is working with developers, looking at the resources there.

The second is the bundling of the dollars in order to, one, be able to leverage the building. One of the things we have been able to do with PFHA and others is when you have savings and reinvestment with health choices, we have one opportunity to do one time funding.

It really is savings that the counties have done, and we have started an initiative where we have worked with PFHA to say let us use those resources for one time only shot to help you build some of these residential and housing and apartment complexes so that, in fact, we can get access. So we've been working on that as far as resources.

The third is that most of the dollars in the county-based program have already been targeted to residential programs. Group homes, you have them all over the state. Group homes and these long term structured residents. What we know is that a lot of

people really can live more independently and so instead of all the bricks and mortar and building these residential facilities, which most neighborhoods don't want, moving to a supported housing model where people really are integrated into the fabric of the entire community and then making sure that we're not paying for the bricks and mortar, we're paying for the treatment and the support is really the other strategy.

So most communities, including Philly, are looking at how many group homes and long-term structured residences we have and how can we really convert that. The example we gave in the testimony is Cumberland County just recently did this; they maintain a group home because some people need that, but they are actually able to look into the group home and decide, you know what, we don't need this many, because we have folks in there who have been there for a long time, they really could live differently in a different place and they converted that and they were able to serve 40 additional people from six slots in a group home.

So it really is working in collaboration with your housing partners, with your community. We have a lot of challenges with folks not wanting us in their community so we struggle through that, but I think

it is the notion of really integrating it more fully into the fabric of the community.

THE CHAIRMAN: I've got to let Kathy ask her questions.

MS. MANDERINO: I'll be brief. One of them follows up on what Jack just asked. On a statewide level, but with regard to Philadelphia I mentioned to Attorney Mitchell I sometimes feel like sometimes we're running just to stand in place and it feels like that's what we're doing here with all the, kind of, best efforts put forward with the coordinated strategy on housing, but where do you think we are, in terms of -- I mean you look at a number like 6500 transitional housing and you think, wow, that's a lot.

Where do you think you are with regard to unmet needs?

MS. CANCELLIER: It's depends on how you look at it. If you're talking about people who are paying more, you can have numbers as high as 60,000, but who are not able to rent in the current market. Homeless numbers are different there about 3,000 people in emergency shelters on a given night men, women and children.

Our homeless street count was down about

20 percent from this time last year. We put a lot of emphasis on and there has been a lot of additional resources to help us. We pulled new tools out of the tools box and made an investment, but even so it's still 580 individuals on the streets of Philadelphia, in the August 2008 street count. So I think you're right. I think it's running faster and it still feels like you're standing still and then hearing financial news.

MEMBER MANDERINO: I don't want to put two and two together wrong, incorrectly, you touched on the issue putting aside emergency services, just the whole affordability issue. Where did you -- you said something about 60,000. Where is that numbering coming from?

MS. CANCELLIER: It's a study from a couple of years ago that sort of looked at affordability overall for households in Philadelphia. We have sort of used it as we have done our planning.

MEMBER MANDERINO: So that's a Philadelphia number 60,000.

Do we have any sense of what it is -- because rural Pennsylvania has just as much of a problem.

MS. ERNEY: We do, but I just don't have

it in my written testimony. I can tell you, one of the things that is unique, when you go to the northwestern when you hear this in Erie, is that they actually did use their base money for the traditional CRR and group homes because they didn't have a lot of resources.

They are a bit further ahead of us in a sense that people have always lived within the community program, they've lived in an apartment building. They have had two or three people within an overall apartment complex or a personal care home or assisted living, et cetera.

So they are a little bit further ahead of us in some regards in a sense that they've been more independent, but certainly the notion of affordability is still there. They don't necessarily have as many people on the street, per se, as you're going to have in an urban center, but the affordability is an issue. So we did break it down and I will certainly --

MEMBER MANDERINO: We have those numbers.

MS. RICHMAN: The other thing is what you're going to find in the rural areas, you're going to find much more use of personal care homes.

MS. ERNEY: Right.

MS. RICHMAN: The homes are going to be smaller, but more efficient. In the western half of the state there are almost triple the number of personal care homes you have here in the eastern half of the state, but they're small. While here you may have two or three homes of couple 100, there you're going to have maybe 100 homes that are all going to be less than 15 or less than 20. So your housing stock differs as your availability differs and the housing is a general need, but I again would end with housing is connected to income as opposed to illness.

So poor people don't have housing resources. People who have mental illness and substance abuse tend to be poor because they live on SSI, that doesn't give you much money. So those are where they begin to come together.

MEMBER MANDERINO: And one other question, pardon me. This is just making sure that I'm kind of a basic -- but I realize now that everyone mentioned the component of peer counseling because that was one of the things that Jake asked folks to talk about, but I have this recollection and I'm just not putting all the pieces together that some changes were made a number of years ago, I don't know if they were

state or federally required, with regard to who could be drug and alcohol counselors and there was a credentialing process and there were all these folks who were providing services through different drug and alcohol recovery services that were recovering folks themselves and they were bumped out of being counselors. Now are we going all the way back to that? Help me catch up in my knowledge gap here.

MS. RICHMAN: First, what we have done is required a State plan amendment to our overall State Medicaid plan in terms of making this a reimbursable service. It is a peer service, it's not a treatment counseling service.

Do you want to pick it up Joan.

MS. ERNEY: Right now the state plan is limited to people with mental illness and co-occurring. They are currently under the State's plan, it does not include people who only have the substance abuse disorder. So let me make sure that on the Medicaid side we know that.

What we have seen, as peers, is that they act often as partners with the treatment process. So part of the challenge on the drug and alcohol side, and in some extent I think we really have overcome it on

the mental health side, is that I think there were some concerns around a CAC for someone in recovery only also being able to be a counselor and be credentialed at the same level or thought of at the same level as a licensed therapist who has gone through a masters program and who has gone through a clinical education program. So you have the tension between the two.

In this instance we're not having a peer necessarily replace a therapist. What we have is the peer is really acting in concert with the therapist to offer a whole set of other kinds of activities, and what we find is that really the more we use peers, the less you need the therapist often. It is not replaceable. One does not equate to the other. It really is two separate activities.

MEMBER MANDERINO: What was the change to begin with? Was it a reimbursement issue?

MS. RICHMAN: The peer specialist didn't exist in the past for mental health.

MS. ERNEY: On the drug and alcohol side I believe it was the licensing issue that changed.

MS. RICHMAN: That's right.

The mental health side, we didn't have peer specialists before, not only do we have them, but

we also wanted to make sure we got reimbursed for them by the feds.

MEMBER MANDERINO: Okay. This a new concept that they have.

MS. RICHMAN: This is a new concept on the mental health side.

MEMBER MANDERINO: Okay.

MS. RICHMAN: And this one you need to separate the two strategies; mental health versus substance abuse.

THE CHAIRMAN: I just want to stress for the members and the Panel, we do have a lot of presenters left in a shorter period of time, and I know members have a lot of questions. So if we're not able to get all of our questions answered, we will submit them to you and ask for your response.

With that, Representative Lentz.

MEMBER LENTZ: I'm not on the Committee. I'm a guest here of Representative Wheatley.

Does anybody track the type of substance that is -- what percentage of substance abuser are on cocaine or alcohol, and do you also track the recovery rate within those categories?

MS. ERNEY: The Bureau of Drug and

Alcohol Program and the Department of Health does do that tracking by substance. Also the federal government, through Sampson does a study of state, and whether they have in the rate of recovery -- they probably have some aggregate information. As you know, because of the confidential rules, we don't get information. We only have it on the aggregate, but we can certainly share what we have with you and the Department of Health has that and we use that information.

MEMBER LENTZ: Is that entered into the computer program at all?

MS. RICHMAN: The peer program and the peer specialist are really focused on people with mental illness and with co-occurring so it is not geared to a way. That's part of, I think, the change many of us at my level and probably Joan's level would like to see the Health and Human Services, through the Center for Medicaid and Medicare services, change as they begin to look at what kind of change is needed as we go forward within the Medicaid program as being more comprehensive.

Clearly, at this point, Medicaid does not fully recognize substance abuse services at the same level on which they recognize mental health services.

And all of us who have been in the field for many years believe that's a mistake. We will be doing obviously some lobbying with the new administration on why we need to do a better job of both integration and treatment of people who have co-occurring and people who have substance abuse addictions.

MEMBER LENTZ: Thank you.

THE CHAIRMAN: Because of lack of time, we weren't able to get to a lot of the questions around pharmaceutical access. We do have some questions around that and we also, I think we're going to have it -- at our first hearing there was a gentleman who talked about the fact that we do not evaluate our programming and look at what is working and what is not working, we just kind of continue to fund things just because they're fundable and they have been funding the way they have and he made this really strong argument around the fact that if, in fact, our drug and alcohol programs were working and how do you -- what's the goal of working? Meaning, if you go to the same program and you're recovering, then you come back six months later and you have to recover again, has it worked?

MS. RICHMAN: I agree. I think that is

a critical area. We are instituting strong on paper performance, but I do believe that we need to be able to establish that on paper performance that if someone is being treated and they're back in treatment within that given period of time, we need to determine, and I think particularly now that we're looking at financial crises that are going to trickle down to all of us, is how do we make the best use of the taxpayers' dollars.

I would strongly argue that that's one of my concerns.

MR. EVANS: Can I just say something about that. I think it's real important to understand addiction and how long it takes for people to get into long term sustaining recovery. I think one of the things the State is doing is really aligning our service system with what we know from the science and what we know from clinical practice about how long it takes for people to get into long term recovery.

So the latest research shows that for people to get into recovery, where their chance of relapse dramatically decreases, takes about 4 to 5 years. We have an acute model service system. You heard Secretary Richman mention that in her testimony. That is a problem.

That means that we put all of our resources in the front end where people are initiating recovery and then we don't have many resources to support people long term. We don't need the same level of intensity, but people need something to support them.

I mentioned in my testimony, the Recovery Center, which is really a low-cost resource that we put into the community that's run by people in recovery, operated by people in recovery, who volunteer, by the way, people come into those centers to get support and getting jobs, they get support in learning how to use computers, how to write resumes, all of the basic life skills that people miss while they are active in addiction.

We believe that those are the kinds of supports that people need to sustain their recovery. Again, it's not treatment dollars, but it is the kind of supports that allow people to have the stability that they need to get to that point at which chances of relapse drop off precipitously.

So I think it's incumbent upon us, in terms of how we look at our services, to really expand what we see as or responsibility for people. I think that takes a lot of those kinds of things we're talking

about in terms of transforming our system.

THE CHAIRMAN: Thank you again. I really appreciate your sharing your perspectives and your time. I really appreciate it.

Dr. Brandon Roscoe, Debbie Plotnick, Naasiha Siddiqui and Robert Martin.

We'll begin with Dr. Brandon Roscoe.

MR. ROSCOE: Representative Wheatley, Representative Manderino, members of the Health Subcommittee of the Health and Human Services Committee, representatives of the media and invited guess.

My name is Brandon Roscoe. I am currently a third year family practice resident at Heritage Valley Hospital, Beaver Campus in Beaver, Pennsylvania. Our family practice program provides care to clients in Beaver County who are often impoverished or disabled and in need of medical care. During my tenure as a house staff, I also follow clients in the Family Practice Center in Beaver Falls, Pennsylvania who need ongoing longitudinal care. I am speaking at the request of NAMI Pennsylvania, the National Alliance on Mental Illness of Pennsylvania that has its main office in Harrisburg, Pennsylvania. NAMI Pennsylvania is the largest mental health advocacy organization in the state

of Pennsylvania with over 60 local affiliates in virtually every locale throughout the state.

NAMI Pennsylvania is composed of mental health consumers, family members of persons with mental illness, interested providers such as myself, and friends of people with mental illness. NAMI Pennsylvania is also the state affiliate of the larger NAMI National organization based in Arlington, Virginia that has over 1100 support groups and greater than 200,000 members.

My statement today focuses on access to pharmaceuticals and the importance of housing for my clients. I serve in the behavioral health clinic in Beaver Falls, Pennsylvania where I am the primary behavioral health provider for many consumers who struggle with severe and persistent mental illness. An American Journal of Psychiatry article, authored by Orleans, George et al in the January 1985 issue documented that 22.6 percent of patients cared for by family practitioners have significant psychiatric disorders.

And of adults with psychiatric disorders, 54 percent are treated exclusively in the primary care sector. These statistics are even more

lopsided in rural and under-served areas such as Beaver County and speaks to my experience to discuss these issues.

First I'm going to talk about access to pharmaceuticals. Access to pharmaceuticals is one crucial lynchpin in care for persons with behavioral health needs. Mental Health consumers routinely discuss the barriers they face daily in accessing needed psychiatric medication, and sadly speak about how this adversely affects their ability to adhere to physician prescription regimens. Clients who receive Medicare and Medicaid benefits are usually persons who are disabled by their illnesses and therefore in the most need of treatment.

Medication cost sharing in State Medicaid Programs have been an issue of concern to four of the most influential organizations for mental health advocacy in this country: They are NAMI, the Mental Health Association, the American Psychiatric Association and the National Council for Community Behavioral Health Care. I will be discussing their recommendations today using five crucial discussions points. NAMI Pennsylvania has had significant concerns about each of these points.

Number One, cost sharing shifts the burden to vulnerable patients. Medication cost sharing occurs when a person is required to pay out of pocket for medications, it's usually in the form of a copayment or a copay. Cost sharing shifts costs to patients and disproportionately affects persons with chronic or ongoing health problems, like major mental illnesses, while increasing administrative costs for states and providers.

For very low income Medicaid participants, even minimal cost sharing can result in reduced use or discontinuation of needed medications, which can lead to serious health problems and higher overall medical costs. States use of copays in their Medicaid plans runs counter to the trend in many large corporations that are reducing or eliminating copays, or in some cases, providing free medications for their employees with chronic health conditions to improve healthcare outcomes and reduce costs.

Second point: The administrative costs of copays. The Federal Deficit Reduction Act of 2005 gives states greater leeway to impose copayments and other cost sharing within Medicaid. However, states and providers can expect to spend significant amounts on

administration to collect copays. Arizona's state Medicaid agency concluded that the state would incur almost $16 million in administrative costs to collect just $5.6 million in copays and other cost sharing measures.

This figure factors in lost federal matching funds, a result of having to return much of the copays back to the federal government. That Arizona study noted that administrative costs of collecting copays do not take into account increased health care costs that result from the use of medications by patients in need.

The third point: This creates a heavy burden for vulnerable patients. Medicaid patients with serious mental illness often live on sparse monthly disability incomes, averaging $637, in 2008, leaving many struggling to afford basic housing, let alone food, transportation, medical costs and other necessities.

A focus group study found that participants had difficulty affording copayments and described instances in which they were unable to obtain prescription drugs because they could not pay. As one participant remarked, being able to afford $2.00 is a lot of money when you have absolutely nothing. Not

surprisingly, copays for prescription drugs reduce the use of needed medications for persons living with mental illness.

Fourth point: Costly lessons in the effects of copays. The effects of reduced medication use due to copays are serious. A study of Medicare Part D patients with mental illness found that nearly 1 in 4 had problems accessing their medications because of copayments, with the following consequences; more than 1 in 4 ended up in the emergency room, and 1 in 10 were hospitalized. Significant adverse events that included admission to a psychiatric hospital, an emergency room visit, being homeless for more than 48 hours, having an increase in suicidal ideation or behavior or having violent ideation totaled 37.4 percent of the 1100 patients in the 2007 study.

The fifth point: Corporate America leads the way. Another large study found that after cost sharing was implemented, emergency room use increase 88 percent and hospitalizations, institutionalizations and death increase by 78 percent. In a recent national survey, 60 percent of surveyed physicians said that rising numbers of psychiatric patients seeking care at an emergency departments is

increasing wait times and negatively affecting access to emergency care for all patients.

Similarly, the introduction of copays for prescriptions led to reductions in pharmacy expenditures in the Oregon Health Plan, but large increases in per person spending for other medical services such as hospital outpatient care. Copays shifted costs to other parts of the healthcare system and did not provide expected savings.

Multiple studies concluded that copays reduce adherence to critical medications, resulting in serious health effects. Employers and insurance plans have discovered that reducing or eliminating copays for medications that treat chronic diseases makes better medical and financial sense. This model, often referred to as the Value-Based Insurance Design, or VBID, offers an alternative that is now being used at corporations such as Marriott, Procter & Gamble and Eastman Chemical. Experiments providing free medications for chronic diseases have found that employees are less likely to need emergency services or hospitalizations.

Andrew Scibelli, manager of health management programs at Florida Power and Light states, cost shifting onto employees is the easiest way to

attack cost. But it comes right back at you because you're not attacking the root cause.

Many states, including Pennsylvania, have adopted formulary strategies for Medicaid consumers including fail first strategies, preferred drug lists and cumbersome prior approval procedures which all add further dilemmas for care for both provider and patient.

The last thing I'm going to talk about is the lack of affordable housing for persons with mental illness. Another concern for my patients is the lack of affordable housing. Beaver County has seen a rise in homelessness that is so marked that articles have run in our local newspaper, the Beaver County Times. These articles correctly noted that many people who are homeless are persons with chronic and persistent mental illness.

Homelessness is found to be a significant risk factor for hospitalization and criminalization. In the state of Pennsylvania, jails have replaced longer term state-funded mental hospitals as the place for persons with psychiatric symptoms who are disruptive in the community.

Additionally, Pennsylvania OMHSAS's policy of closing state hospitals such as Harrisburg

State Hospital and Mayview State Hospital each over a one-year period instead of a more reasonable three-year period, has been one factor for clients in the community having difficulty accessing supported housing beds in Beaver County. Cutbacks in budgets that support Section 8 housing as well as resource shortages produce current housing programs such as Supportive Services and Harbor Point Housing in Beaver County that have no openings for community's clients in crisis. Homeless shelters in Western Pennsylvania have seen an increase in the number of seriously mentally ill clients needing shelter over the last few years.

The lack of viable housing options that are easily accessed by consumers who need support in the community or have a past history of being unable to maintain housing is a significant barrier to recovery. Many individuals with severe mental illness, who are at risk for homelessness, have co-morbid substance abuse issues that further complicate this situation. Novel programs such as Housing First, which provides housing to consumers with substance abuse diagnoses that are not tied to treatment or sobriety has shown that long term housing stability and improved outcomes are possible.

In summary, cost sharing in Medicaid

programs shifts the burden of medication costs to vulnerable patients, reducing adherence to medications for serious conditions and leads to poor health outcomes as well as higher costs. For policy makers and Pennsylvania constitutes they represent, cost sharing carries high risks that can be easily avoided. Pennsylvania should follow the lead of corporate America to reduce or eliminate medication copays for those with chronic diseases including mental illnesses. NAMI Pennsylvania also believes that improved access to sustainable housing, including a marked expansion of supported housing, using novel models such as Housing First, is as crucial component to recovery for persons with mental illness as pharmaceutical access.

THE CHAIRMAN: Thank you, Dr. Roscoe. You have to leave soon so if I can do a little change in the program and allow for any questions directed to Dr. Roscoe before he has to leave, and I also want to recognize Representative Louise Bishop, who has arrived.

MEMBER REICHLEY: Not to be argumentative with you, if you don't believe -- if you believe that the copay is implemented into access to care, what do the corporations do when you need medication about the copay?

MR. ROSCOE: Provide the medications without copay or even for free, taking on that cost themselves and I guess they're reducing the overall cost of the healthcare in general.

MEMBER REICHLEY: Are you suggesting that just with behavioral drugs?

MR. ROSCOE: No. I think all medications for chronic illness should have that.

MEMBER REICHLEY: The cost factor associated with that?

MR. ROSCOE: I don't have a good answer for that. I can get back to you on that.

MEMBER MANDERINO: Thank you for your testimony. I kind of was a little surprised too, because I think that this is one of the areas that I'm pretty knowledgeable about, yet I was not aware that there was this movement within the private health insurance sector to eliminate copays.

My question is and if you don't know, that's fine. I'm sure we can get the answer from DPW. Much of our Medicaid population is served through managed care organizations. I think manage care organizations have the flexibility to design their benefit packages as they want.

Have any of our, meaning DPW, say to the managed care companies you have to charge copays. DPW has also, within their fee for service program, not necessarily pharmaceuticals, but just in the provision of the care, been implementing kind of a chronic care model to try to get folks to take good care of their chronic cares?

So I guess my question is, if you know, have any of the managed care organizations kind of seen the efficacy of what you're saying folks in private sector has move toward? Are other states -- do you have any other examples of other states publicly paid for benefits that are moving in the direction that you're citing the private sector is moving?

MR. ROSCOE: Not that I know of. I believe it's mostly in large corporations trying to do that within the corporation themselves.

MEMBER MANDERINO: Is it a new thing so that we don't have a track record yet?

MR. ROSCOE: I believe it is, yes.

MEMBER MANDERINO: Thank you very much. Very interesting.

THE CHAIRMAN: And I was going to add, I didn't have your prepared testimony, if you can submit

that to us.

MR. ROSCOE: Yes.

THE CHAIRMAN: Also one quick question. You talked about the floating of the state hospitals.

MR. ROSCOE: Yes. One of the things I thought was suppose to happen, when they closed or before they were to close, they were supposed to have a plan that shows the support services available for people who are coming back into the community.

THE CHAIRMAN: What you said in your testimony kind of contradicted that, in a way, because you said that impact has had some negative impacts to people that you are serving. Can you clarify that for me?

MR. ROSCOE: I think mostly it was a timeframe. It was done over a year. There was a lot of fall-out from that over just a one-year period, but I think it was suggested at the time that it would be over a three-year period just to give us some more time to make other plans for those people in need.

THE CHAIRMAN: Okay. Thank you.

MR. ROSCOE: Thank you very much.

THE CHAIRMAN: I'm sorry, Representative Bishop.

MEMBER BISHOP: Doctor, I caught a portion of your testimony, by us not having the full one, I didn't get to follow along. I want to go back to your statement about the homeless situation among the mentally ill, and you cited a large portion of homelesss population were people who were suffering from symptoms from mental illness, which I agree with you on.

How can we fix that? What suggestion -- or did you make any suggestions that, looking at this issue, this Committee might be able to take back to work with?

MR. ROSCOE: That's a good question. As far as suggestions, I think the issue is providing a stable home for these people in and of itself will provide better outcomes for them. If we can provide them a place to live that's not affected whether they're mentally ill or abusing substances, that, in and of itself, will help those conditions and stabilize them in the long run.

MEMBER BISHOP: Thank you.

MR. ROSCOE: Thank you.

THE CHAIRMAN: Ms. Plotnick.

MS. PLOTNICK: Good afternoon, Representative Wheatley, Representative Manderino,

members of the Panel. Thank you very much for giving me the opportunity again to give testimony on mental health care and substance abuse treatment. I'm happy that you're here in Philadelphia and this time I get to see you here.

What I will do today is I will put some faces and some names to much of the story that you heard from Secretary Richman and Dr. Evans and the folks who are creating programs. We're hearing it in our advocacy division at the Mental Health Association from the folks who are affected and our advocates are seeing on the ground and we'll also be talking about peer services with folks who train peer specialist and folks who are peer specialists. So thank you again.

When we think of housing and mental health conditions we picture the man or woman in filthy clothes dragging his or her meager belongings aimlessly walking down the street or muttering aloud to him or herself to no one in particular and stopping only to ask for spare change or to sleep on the sidewalk or in a doorway.

It's really true that a disproportionate percentage estimated anywhere from 20 to 50 percent of those folks have a serious mental health condition and

they're also highly likely to have a co-occurring substance abuse disorder as well.

But individuals such as those are only the tip of the proverbial iceberg of people with mental health conditions who are homeless or nearly homeless. The housing deficit is the number one problem that impedes mental health treatment educational and employment options and community integration opportunities for the people for whom we advocate.

This is true no matter what the age cohort, be it families with children, young adults, adults or elderly folks at every age and stage of life, people with serious mental health conditions are profoundly affected by the derth of affordable and safe housing options, and most of the times their housing problems fall below the radar.

A disproportionate percentage are people with serious mental illnesses who have recurrent periods of hopelessness, but because they are not chronically homeless, they are not reflected in any of the statistics you hear about on homelessness.

Research is bearing out what our advocates have been long seeing. Those with serious mental illnesses cycle in and out of homelessness. They

use a disproportionately high percent of shelter services and other high cost services, such as emergency departments and jails and prisons.

Let me tell you about a gentleman that really exemplifies the kinds of things I mean about falling below the radar. Mr. H is highly engaging. He is handsome, intelligent and well-educated. He was one of the first African-American students to graduate from Girard College with a really bright future, but a very heart-breaking thing happened for Mr. H in his family and that was his college education was cut short by a diagnosis of schizophrenia.

Over the years, he has done well in many areas. He has held employment, he was unemployed, he lived with family members, he lived on his own, but even though he is highly motivated in his recovery, he ended up having some issues that kept landing him back in front of mental health hearing officers for an involuntary commitment when he had an acute episode of his illness this past year.

What happened in his recent cycle is Mr. H was released from the inpatient hospitalization, but when he was discharged the address he was given for discharge was 401 East Girard Street. Now this is an

address that frequently appears on inpatient discharge as well as discharge from the prisons and the jails. This address is formally known as the Brotherhood Mission. Everybody here in Philadelphia knows it as the men's shelter. Not surprisingly, being barely stabilized on new medications and living under the stressful conditions of shelter life, Mr. H quickly cycled back into inpatient into the hospital, but as soon as he was stable enough to leave the hospital and he was discharged to the type of housing although never intended as permanent housing is often the end of the line for folks with disabilities, and especially true for folks with psychiatric disabilities, a personal care boarding home, you heard it mentioned several times earlier, but even space in a personnel boarding care home can be hard to come by in Philadelphia, and Mr. H was assigned to sleep on a couch in the kitchen of a very large personal boarding home.

And it didn't take long before routine comings and goings of residents entered, what is now, his sleeping space is really the kitchen, turned confrontational and Mr. H was asked to leave and he once again landed on the street and was quickly back in front of the hearing officers, being observed by our advocates

needing to go back into inpatient.

Right now we really stand at a crossroad of conflicting realities for folks like Mr. H, who has a mental health condition. As a decade of rigorous research bears out significant recovery which includes living very successful and productive and fulfilling lives in the community is becoming the rule and not the exception for those with even the most serious mental health conditions.

Dr. Patricia Deegan, a clinical psychologist and well-respected researcher on psychiatric rehabilitation from Boston she, herself, was diagnosed with schizophrenia at 17, she says that recovery is real it is science-based and its not just for a few exceptional people of some sort.

What people need, Dr. Deegan explains, is support, opportunity and hope. Support includes the means to maintain wellness, such as treatment that may involve medications and cognitive therapies but there must also be opportunities for real education and vocational paths that lead to meaningful work and lives that include full community participation. And the very best way to provide hope is through peer support services that you have heard about and you'll hear more

about in a few minutes. These are folks who are role models for their peers, working to achieve recovery, but there is also a competing reality for those facing this serious mental health condition and it involves the extremely high rates of unemployment, incarceration and poor health that folks with mental health disorders have.

We have recently learned that they die on average of 25 years sooner than those without a serious mental health condition and it includes incredibly high usage of all kinds of expensive services, like the ones we have been hearing about.

Researchers at the University of Pennsylvania and others have concluded that the common factor in this reality is not the mental illnesses themselves that cause people to use these higher services. It's what we heard Secretary Richman say, it's poverty. It's poverty into which people with mental health conditions are forced.

Throughout Pennsylvania and especially in urban areas, the most common living situation for folks with severe mental health condition is personal boarding care homes and in large areas and in areas as we heard in urban areas, they tend to be very, very

large and technically they might meet the terms the U.S. Supreme Court of the Olmstead decision which requires that people have the opportunity to live in the community in the least restrictive setting, but they are not unrestricted in anyway.

Because what has happened in areas, such as Philadelphia and other urban areas where there is large homes located in areas of extreme poverty and high crime, these personal care boarding homes, the most commonly used housing for folks like we're talking about, perpetuate a life of poverty. They effectively ghettoize folks with mental health conditions into lives of poverty, into areas of poverty and offer them no way out.

As we heard Secretary Richman talk about $633, I believe is the figure for living on SSI, if you live in a personal boarding home, that $600, all but $50 of it now goes to the home and have you to pay copays like we just heard the doctor speak about. That leaves folks virtually nothing that they can work to get out of their life of poverty. They can't get out of their personal boarding care homes when they literally have zero dollars left at the end of the month. Out of that allowance they have, they have to pay for their

clothing, their shoes, their copays, their shampoos and soap. That doesn't leave any money for buying a pizza or going out or having a life, let alone saving money to have an independent living situation.

So what is happening is that folks with serious mental illness, the mental illness it's the great equalizer. It takes folks, no matter where they were beforehand, and if they weren't in poverty, but they lost their job or they have lost their place to live and they're cycling, they're going to end up in that poverty situation and it really makes it difficult for them to get out of it.

But numerous studies have shown that when housing issues are taken out of the equation, when we remove the housing problem from them, amazing things happen. There are dramatic drops of course in the use of shelters, but also incarceration rates go way down, the use of emergency rooms goes down, but what is really surprising is the number of all types of inpatient hospitalization goes down.

The length of stay of all types of inpatient hospitalization goes down. These are folks who they are paying for their services out of Medicaid, but if they had a place to live that was stable those

costs now paid from our Medical Assistance, as we call it in Pennsylvania, go down now.

There is an increase cost in the use of some services. The use of some services go up, but what goes up is out-patient health care, out-patient mental health care and substance use services. These are exactly the types of things that we want to see go up. The use of psychiatric medications goes up. This helps solve some of the most difficult problems that all of social services deal with, that Secretary Richman deal with everyday. It's getting people who have refused or resisted services and treatment to accept them.

So if housing came out, we'd get more folks into treatments, we'd be saving money across the board. When stable community-based housing is achieved outcomes are so much better for folks than your standard services where housing is not part of the equations. And even though housing supports are upfront expensive, another piece of good news is that overall there is a net savings.

The legislature can take some steps to promote community integration and foster recovery by helping to remove some the obstacles that you have heard

about getting people out of the lives of poverty in segregated and supportive programs that put housing into the equation.

Some things where the legislature can help is to create mechanisms that provide grants or loans to pay for housing start-up costs to get people that security deposit that furniture household cost, that's a terrific place to begin, providing incentives for programs to move away from outmoded concepts like housing readiness and Secretary Richman addressed this a little bit, that's another great place to start. We need to incentivize programs to move out of those old models. No one can be fully ready to engage in treatment or vocational training without adequate housing, but everybody really is ready for a safe place to live. So to say that housing readiness is an oxymoron. Everybody is ready for a place to live.

I'll conclude my remarks by sharing a conversation that I had with one of the researchers, whose work I cited today, other folks cited today, Dr. Steven Metreaux. He says, "We must make housing a mental health service because we can't get anyone stabilized until they have stable housing. Thank you.

THE CHAIRMAN: Please, Ms. Siddiqui --

MS. SIDDIQUI: Siddiqui.

THE CHAIRMAN: Please pronounce your first name.

MS. SIDDIQUI: Naas.

THE CHAIRMAN: Naas. Thank you.

MS. SIDDIQUI: Good afternoon. I would like to thank Chairman Wheatley and Representative Manderino and the members of the committee and our guests for the opportunity to speak here today.

My name is Naas Siddiqui. I'm an employee of the Institute for Recovery and Community Integration, a program of the Mental Health Association of Southeastern Pennsylvania. You have to bear with me a little bit, I have a bit of a cold. I'm a little stuffed up.

We train people to be Certified Peer Specialist in the state of Pennsylvania and in Virginia and provide them with technical assistance after they are certified. Today I'm going to talk about our training program and the importance of having certified peer specialists working in the behavioral health system.

My belief in the necessity for peer support services strongly stems from my experience with

mental illness and mental health services. During my junior year at Yale, I experienced a crisis and was involuntarily hospitalized, and eventually forced to withdraw. I felt very scared and lost. Being in the hospital was a very scary, harsh and invalidating experience. Many of the interactions with the hospital staff made me feel powerless, from having the door slammed in my face when I went to ask a question at the staff station, to being ignored, patronized or babied. I wanted to be treated with dignity and respect.

In an effort to reclaim my sense of being a valid human being, I talked to the head psychiatrist about the need for change in the mental health system and the need for changes in that hospital, even small changes. He answered, quite sarcastically, "Sure, Naas, you let me know when that happens." What I needed in that time of crisis was not someone to scoff at my ideas, but someone who understood how scary that experience I was going through was, someone who could really support me through it, like a peer.

I did graduate from Yale in 2007 and I can tell that psychiatrist, who was so doubtful of change, that change is happening now. At the National Association of Peer Specialists Conference, this past

August, Joseph Rogers, Chief Advocacy Officer at the Mental Health Association of Southeastern Pennsylvania, said to a room full of 300 Peer Specialists that "It's okay to talk about revolution." It actually brought tears to my eyes. The conference was called "Recovery Revolution: Peer Specialists on the Front lines." Imagine how validating it was for me to have a respected leader in the consumer movement announcing that change is okay and that change is happening. What a contrast to the hospital. There, my passions and my strong hopes for change were probably attributed to symptoms of mania.

Peer Specialists are bringing the Recovery Revolution. They are changing the system. They are stigma-busters and role models of recovery. They are the proof that recovery happens. And studies show that peer support works. For example, a study by Dr. Phyllis Solomon of the University of Pennsylvania, in 2004, showed consistent findings of decreased hospitalization or shortened length of hospital stays for both people receiving peer provider services and for the peer providers themselves. Another study, by Dr. Solomon and Dr. Jeffery Draine and others, showed that peer-provided services are as effective or even more

effective than non-peer provided services.

Peer support works, but how are Peer Specialists changing the system? Change starts at the individual level, and at the Institute for Recovery and Community Integration's, Certified Peer Specialist Training, which is a highly interactive 10-day training, the participants are taught creative and effective ways to really support people with mental illnesses. Our motto is "Transforming Lives by Transforming Systems." In our trainings, we teach individuals paradigm shifts and useful skills to transform systems.

In the training, we teach that peer support is based on respect, shared responsibility and mutual agreement of what is helpful, a concept promoted by Sherry Mead, one of the pioneers and leaders in developing the concept of peer support. These concepts are often thrown aside when it comes to the relationships with consumers and many other staff. Participants in our class shared how many of them didn't even see their treatment plans and that their goals were decided for them. Peer Specialists are helping their peers make their own decisions about their treatment. Instead of doing for, Peer Specialists do with. We teach our participants how to empower their peers.

In the training we also debunk the common myths about mental illness. For example, there is a myth that people with schizophrenia just get worse and worse with time when, in fact, many people with schizophrenia are in recovery and are living fulfilling lives. This stresses to participants of our training that there is hope for everybody. We stress hope, instead of maintenance and stabilization, another paradigm shift.

We also teach communication skills in the training, such as how to attentively listen and reflect back what you are hearing. In class, participants share how, time and again, they have had trouble being heard, that is, really being listened to, by the people who provide services. Certified Peer Specialists are taught the skill of how to really listen.

We teach the importance of helping people find meaning in their lives, instead of just being compliant with what others tell them. During one class, one of my co-trainers, who is a Peer Specialist Supervisor, in Pittsburgh, told the class how he was able to reach out to someone who had previously been unresponsive and distant and just sat in a corner at the

hospital. He found out that the peer had been a cook before he was hospitalized, five years earlier, and got permission from the peer's doctor to allow the peer to go to the grocery store, bring back ingredients and cook. The peer cooked up a storm and the other staff had never seen him so alive. Peer Specialists help their peers find their own meaning in their lives.

We stress the importance of life experience, more than educational degrees. Certified Peer Specialists and the people that they serve both have experience with mental illnesses and receiving mental health services. Numerous Peer Specialists have told me that the peers at their programs have connected to them with ease because of this, whereas it was hard for them to form such close connections with other staff. This is yet another paradigm shift: Life experience as a valid way to connect and help people professionally. We are taking classrooms of approximately 20 people who are in recovery and letting them discover that their life experience is valid and can help and heal others.

I was talking to a recent graduate of our training the other day, whose eyes lit up when he talked about the prospects of working as a peer

specialist. He said, it gave him hope. He was used to cold hospitals and unfulfilling day programs. Now he could really help people as a career.

I am involved with the Philadelphia Certified Peer Specialist network. The Philadelphia Peer Specialists are a really passionate bunch including Robert. Many tell me that they love their jobs, especially connecting with their peers and watching them grow. They tell me that they review the curriculum binder from the training to brush up on the concepts.

The Certified Peer Specialist Training, as a whole, is a transforming, validating experience. Participants develop a sense of camaraderie and connectedness. Participants who have taken the training have described it to me as life-changing. They have told the trainers that we are an inspiration. People have told me that I instill hope. That's what we are trying to do at the Institute for Recovery and Community Integration: We are trying to instill hope in people who live with mental illnesses and who have sometimes gone through abuse, addiction, poverty, and/or homelessness, so they can learn to instill hope in their peers.

Thank you for inviting me here today and

I'm happy to answer any questions.

THE CHAIRMAN: Thank you.

Robert Martin, Lead Certified Peer Specialist at WEDGE Medical Center.

MR. MARTIN: Good afternoon. Thank you so much for having me here. It's always an honor to be able to testify in front of such distinguished people.

First let me start off by saying it's a great honor to be asked to testify about the recovery transformation and also what it's doing for people like myself. With that said, I would like to give my deepest gratitude to the People's Emergency Center for extending the venue to us to allow a person like myself to express their story to people like yourselves so that we can make some changes because people do recover if they have the chance to and are supported in the right manner and have the right system.

I'm here to testify that already I have seen so many people go back to school and get in jobs. The mindset as a whole has been so positive that it had truly been a domino affect. One person moves up then another person wants to do something just as positive. Working at the WEDGE, the Recovery Education Center, I have not only been able to support others, but I have

received so much support back from the staff team and recovering individuals themselves.

My Director, Jason McLaughlin has not only supported his team, but I know he believes in recovery education and the growth in each individuals which comes in contact with him every day for support. I would just like to say this, that I am a person in recovery and this is my testimony and these parts are on paper, but this part is my testimony.

I'm a person who was homeless, I was out there for many, many years on and off, so I probably wouldn't be one of your statistics because I was one of those who would be on the streets for a couple of months, then be in a psyche rehab for a couple of months then maybe be at a friend's house for a couple of months, so they didn't know where I was, but I was definitely homeless.

I suffer from bipolar, I suffer from depression. I'm recovering from being HIV positive. I am recovering from substance abuse. So you can say, like, I'm working with a lot of issues, but today I'm living life because people like yourselves are taking the time out to find out what a person like myself needs in order to recover, and that's a blessing in itself.

So now I'm no longer homeless. I have a beautiful home. I'm living independently now, which we are talking about and so much fighting for because that's a very, very important key to a person, such as myself, who is in recovery. I was not able to even begin my recovery status on no level until I had some stability, a place to lay my head, a place to bathe, a place to just think and sit for a minute and say, okay, this is mine. I have a life to look forward to in order to move up and take care of myself.

Today I do hold the only lead CPS position in the State of Pennsylvania I'm very, very proud of that. I was in the Inquirer yesterday. I'm very, very proud of that. God has just been blessing me so much that any time Naas or anyone of the representatives ask me to come out, I love to do it because it's so important because I heard the young lady say, "Wow, there are that many people still out there homeless." Yes, there are and I'm hoping I can be part of the system to bring them in as some people and my peers have brought me in.

With that, I want to thank you so much for letting me testify.

THE CHAIRMAN: Let me say this, I'm very

moved by both yours and Ms. Siddiqui's testimony and one of the things -- again, one of the reasons why I'm going back to here, I'm sure there are a lot of important pieces to this complex subject and how we address it and make sure that we are providing the best net for people to pull themselves up with support.

You said something about your particular circumstance and I wanted to just comment on it.

MR. MARTIN: Sure.

THE CHAIRMAN: I have a very close friend at home who is diagnosed schizophrenic. He has been in and out of the system, as you will call it, but he had a stable home, has one. His family home is still there, his siblings take care of him. When he comes out -- because he has learned how to manipulate the system -- when he comes out, he has the home, but he's not able to function inside of that home by himself because the support isn't there, meaning, the family doesn't understand how to support him and the system doesn't really have a support mechanism to make sure he is taking his meds or make sure when he is in that home that he is doing the things to live a productive life.

What do you do for that, even though you have a house or home, what are the missing pieces that

also supports them when they are in a home?

MR. MARTIN: Can I say this?

MS. PLOTNICK: Sure. Of course.

MR. MARTIN: This is the beautiful thing about what we do now, as a Certified Peer Specialist, a person like that would be able to come to our home and we would find out the things that would empower them, that they want to do so we could be their support system instead of their family because I have to say this, I understand exactly what you're saying. My family is a well off family, they have a beautiful funeral home, but they don't understand my issue. They can't support me. They don't take the time out "they might be ashamed" that their grandson has mental illness, but with all that said and done, a person like myself, I would be able to walk with, say, your friend and say what is it that you want to do in life, where is it that you want to go so that we can walk together.

And now the system is set up that it allows me to go in the field -- excuse me, I don't have a tie on today -- it allows me to go in field with the peers and do the things that they want to do such as retain birth certificates, Social Security card because a lot of us will lose them living out on the street. So

we just lose them even living at home because we don't have anything to do. So we will help them obtain the things they need so that they can find what they want to do in life.

THE CHAIRMAN: Does the system connect them to a Peer Specialist when they are processed in the system or is that up to them to reach out for a Peer Specialist; do you understand?

MEMBER MANDERINO: How do you make the connection?

MS. PLOTNICK: The connection could be made a number of different ways, if they're receiving services through an agency that uses Peer Specialists is one way and another way would be to come to our Peer Resource Center. We have many of them throughout the five counties and this is a place where people who have these types of conditions, such as your friend, come and meet other people who are in recovery and all different stages, and interact with them and they can help not only with the people who are coming and the people helping each other, but help put them in touch with the certified peer specialist.

There are a number of ways in. If your friend is in Philadelphia, calling the City and they

will help connect them into their regional services that are -- many of them do have peer specialist on staff right now, but not all.

MR. MARTIN: We have currently now eight sites and we are working on the last five sites in Philadelphia.

THE CHAIRMAN: But the onus is on the individual to reach for the system, the system doesn't necessarily reach for the individual, correct?

MS. PLOTNICK: That's true.

THE CHAIRMAN: And not every county in the Commonwealth has Peer Specialists?

MS. PLOTNICK: That's correct, not every county does.

THE CHAIRMAN: I want to recognize one of our democratic leaders Representative Mark Cohen from Philadelphia County.

Representative Bishop.

MEMBER BISHOP: Robert, when you were at your worse end, no home, no friends, didn't know who you were half the time, what light shown in your live that gave you the hope that you reached out to catch onto that was there that the system had there that could pull you back into the right direction?

MR. MARTIN: Well, to be honest with you, when I found my light, there was a place called the Consortium and they are currently transforming over now, but before when I found my light, they were a partial program, so I would go there and sit for eight hours in the day.

The light was they had the CPS training program and when I went there one day, I was kind of doodling and there was a CPS training packet sitting on my therapists desk, and I'd like to think I'm very well educated even though I use to drift in and out when I wasn't on my meds. So my therapist technically challenged me. Why don't you fill that out and see if you would like to do that.

So I tried it, and to be honest, with a fluke, I got in, but once I got in and saw all the things that they were doing, there was no turning back. There was no turning back. And at that time I had just transferred from living in the street to in-house shelter. So I was living in a shelter and going to the training program and my light was just constantly getting brighter every day.

It was an intense two-week training and when you get out of there, you're a brand new person.

You learn how to walk with people and have people walk along side of you. We're giving treatment. What we do is definitely not treatment. We are just giving support and hope, and that's what the difference is.

I didn't respond to treatment. When I was in a partial, I wouldn't respond to somebody just giving me meds and at the end of the 8-hour day, they'd send me back out to the street. I never saw a light like that.

MEMBER BISHOP: So is there something different about Ottley House that is available or that the other places do not have?

MR. MARTIN: No. Ottley House is a decent shelter, let me put it that way and it was a place for me to get my first little bit of stability because living on the street -- I was on the street about seven or eight months.

MEMBER BISHOP: Tell me how you got into Ottley house from the street?

MR. MARTIN: They call it -- what is it when it's real cold outside.

MEMBER MANDERINO: Code blue.

MR. MARTIN: Code blue, thank you.

It was a code blue and they send an

outreach van out to pick up the homeless who are sleeping on the street and of course I was in Center City bundled up and they picked me up and they took me to Ridge Avenue Shelter, and I stayed there one night, but I was so messed up, they transferred me up to the Ottley house to get me some more help and to get me into a program because I was at that point, like you were saying Bishop, I had no memory what was going on.

MEMBER BISHOP: What I'm trying to get to is do we have the State, the City, do we have in place facilities that will help those who want to be helped or do they have to find their way to the place and some of them are not capable of actually finding themselves there?

Do we have places where somebody, who is totally out of it, don't know who they are, where they are, can wonder into or does somebody bring them into it or do you have to commit a crime to get into it?

MR. MARTIN: I have to be honest with you, we don't. We need it. We don't have enough systems out there who bring people in. Most of the time people come in either by fluke, by jail or mandated. They might not even be in jail, they might be on parole or something and the parolee will tell them, you have to

go to this program, and they will find light that way, but it's generally most of the time people aren't being pulled in, they're just not. And that's one of systems we're trying to work on now as far as building up.

We, as certified peer specialists, when we're out there on the streets, we know the people so we do pull them up, we do. I pass out cards, I tell them, but when you only have, say, 100-120 certified peer specialists and we have 60,000 homeless people across the state of PA, it's a fight.

MEMBER BISHOP: Would you say that most of those homeless people out there are people who are in need of the kind of services you've gotten but don't get the opportunity to go there?

MR. MARTIN: Definitely.

MEMBER BISHOP: Families, you came from a very good family, a well-educated family, they couldn't have gotten the service for you if they tried or did you walk away and they didn't know that you needed it?

MR. MARTIN: Well, I'm going to speak for my family. My family was very embarrassed of who I was, in terms of --

MEMBER BISHOP: So the door was closed

on you?

MR. MARTIN: The door was closed. I was, what they call, black-balled from the family, and I have to also, to be honest, I had done some things to hurt my family because of my substance abuse. You know, we do a lot of harm to the ones closest to us. So they also didn't want me there for those reasons too, but with the mental health issues reasons on top of it, it was definitely like he doesn't even come on our block. He is not allowed in the town, because we are from a small town and my father is kind of like the mayor and everybody respects him and I'm the black sheep, don't come through the town. So it was kind of like that.

So I can understand what the gentleman was saying, not everybody has to be homeless in order to need the type of help we are saying and we're trying to give now or that we are giving. You can live in a million dollar home and still have mental issues, but through the right proper supports you will receive that help because now we're not telling you what type of treatment you need. We are giving you support so that you can do your own treatment.

Nobody can tell me how to fix me better than me. Just like Naas, nobody can tell her how to fix

her better than her, but if she came to me and said, Rob, I want to get this done in my life. I can say, Okay. Let's go walk and see about getting it done. What is it that I can help you with to get it done.

MEMBER BISHOP: If I'm hearing you -- and this is my last question, if I'm hearing you correctly, the medication alone is not what really does the trick?

MR. MARTIN: Exactly.

MEMBER REICHLEY: I think we are all very impressed by your testimony this morning. I will try to ask my question real fast. Do you get paid as a Certified Peer Specialist?

MR. MARTIN: Yes.

MEMBER REICHLEY: Who are you paid by?

MR. MARTIN: WEDGE Medical Center.

MEMBER REICHLEY: And how many Peer Specialists are there throughout the City of Philadelphia?

MS. SIDDIQUI: Close to 130 people who graduated our program.

MEMBER REICHLEY: And are they all paid through various medical facilities or are they paid by the City?

MS. SIDDIQUI: They are paid through the behavioral health agencies.

The people who graduated from our program are not all working as Certified Peer Specialists like Rob.

MEMBER REICHLEY: It's easier to fall back to your example, but just generally, the people out there that you see, are they having their worse situations because of a lack of access to treatment or they had some consultation, some therapy and they can't get the medication, as Dr. Roscoe, I think, was implying?

What's the plan or is there just a series of --

MR. MARTIN: No. There are a multitude of answers that can go along with that question because in some situations, some people don't want partial treatment any more. They have been there, done that. And to go to a place and just get medication and sit for eight hours, just didn't do it for them. So they chose to live out on the streets.

I have some friends right now, I could go to the corner right where they sleep and know they are sleeping there because the place that they were at

didn't suffice. Just medication is not enough, but that wouldn't be the only reason. We also have to have more outreach systems where we can actually go out and grab people and say, there is a new way.

And so Naas is fighting hard to build this team up and like she said we have 130 maybe a little more, somewhere around there. And we are trying to get the system to grow. I know we have some way out in Norristown, so it's really building up.

MS. PLOTNICK: It's about 600 statewide certified peer specialists.

MEMBER REICHLEY: And Ottley House, did they essentially give you a bed? Was it a room?

MR. MARTIN: At the Ottley House?

MEMBER REICHLEY: Yes.

MR. MARTIN: No. That's a shelter, 300 to a floor and there are like four floors.

MEMBER REICHLEY: There was some sense of stability there.

MR. MARTIN: There was a sense of stability. It was broken down into dorms, almost if like, you're in boot camp. Maybe 70 guys to a dorm, but there were clean showers, they fed you twice a day, breakfast and dinner because usually during the day at

least you would be out doing something, so they wouldn't feed lunch, so you know.

MEMBER REICHLEY: And it's kind of issues you identified with regard to housing. This is by and large going to be a local issue on zoning ordinance. A lot of the problems you run into, I believe, the issue is you're limited to no more than five unrelated adults in a resident.

MS. PLOTNICK: Yes.

MEMBER REICHLEY: So the kind of housing answers, you're talking about not something we can dictate from the state.

MS. PLOTNICK: No, it's not, but it is something that can incentivized to make housing more inclusive. That was something the Deputy Secretary, Erney, addressed, the zoning issues are really problematic. People don't want housing, but here are some other ways that we can get around that is by making moneys available and programs available that are master leases. So enabling mental health providers to take master leases on housing in certain areas, but not just segregated areas, like we're seeing.

We don't want people just put in little tiny pockets, but spread all around whatever the area,

be it Allentown, be it Philadelphia, be it Pittsburgh.

That the master lease is held by the agency, but it's individual houses. So those types of programs incentivizing them and making it easier to have will help eliminate some of those zoning issues.

THE CHAIRMAN: Because I want to respect everyone's time, we are running a little bit late, I know Representative Bishop has another question. I want to honor my more senior member.

MEMBER BISHOP: I will be very brief.

I know that this body, and most of the people who have not had experience with mental health mental illness, have some feelings about certain things because there is knowledge we don't understand. I do a lot of speaking at a lot of places to entertain where they are there for the day, and I just want you to elaborate on it, because my analysis is that there are some very, very, very intelligent people who are in the system who have some difficulty.

They are not just people who go out and commit crimes or just people who are on drugs, some of them are college graduates, some of them are people who have had great professions and dropped out.

I just want you to briefly, any of you,

speak on that for a moment so we can get a clear picture of who those people really are that suffer from schizophrenia, and that one moment it's clear as a bell and then another minute they don't know who they are.

MS. PLOTNICK: Representative Bishop, you've raised the most important point there is. Which is mental health conditions affect everybody. Every family is touched at least in some way, know someone or has a close family member. It doesn't matter if they're a wealthy family, if they're a poor family, if they're a well-educated family, if they never made it past high school, it happens across the board, and that's reflected in the fact that you see folks from all different walks of life, all different backgrounds, but what they have in common is that they are discriminated against and if they find themselves cycling deeper and deeper into the system, they will be reduced to living in poverty, no matter what their circumstance, unless we can solve some of the underlying issues, like, making housing part of mental health treatment.

THE CHAIRMAN: Thank you. We appreciate your testimony.

Next up we have Dr. Jeffrey Naser Pennsylvania Psychiatric Society.

MR. NASER: Thank you, sir.

Jeff Naser. Let me also introduce, very quickly, Deb Shoemaker, who is the Executive Director of the Pennsylvania Psychiatric Society, who is joining me today.

I'll start with my testimony. Good afternoon, Chairman Oliver, Kenney and Wheatley, Representative Manderino and esteemed members of the House Health and Human Services Subcommittee on Health.

My name is Jeffrey Naser. I'm a physician specializing in the field of psychiatry. Specifically, I am a child and adolescent psychiatrist practicing in Wayne, Pennsylvania. I currently serve as President of the Philadelphia Psychiatric Society, a chapter of the Pennsylvania Psychiatric Society. The Society is the district branch of the American Psychiatric Association and represents over 1,700 physicians across the Commonwealth who practice the medical specialty of psychiatry.

It has been my pleasure to serve in various capacities in local, state and nationally organized psychiatry for the past twelve years. I am presenting testimony on behalf of Pennsylvania Psychiatric Society. We appreciate the opportunity to

provide comments on this important issue.

The Society's primary concern is the care of patients with mental illness and substance abuse issues. The nature of these illnesses, and the stigma which society attaches to them, makes it often difficult for our patients to advocate for themselves in public settings like this. This is unfortunate, since the nature of psychiatric illness also makes it difficult to maintain employment, or relationships with others who are employed.

Since our health care system relies on employment for health insurance, many, perhaps most, persons with serious mental illness must rely on the Commonwealth for the provision of health care, including mental health and substance abuse care. For this reason, hearings such as this can have a great impact on mental health care.

While there are many aspects of the mental health system which deserve attention, there are a few which I will highlight which concern us greatly, and which the legislature is in a position to influence.

One of the greatest barriers to care is the relative lack of psychiatrists, especially in the public mental health system, and in more rural parts of

the state. There are many reasons for this, starting with the training required to become a psychiatrist. Every psychiatrist is a medical school graduate, having first attended college. Following medical school, all psychiatrists complete four years of additional training in a residency program, working for a teaching hospital while learning to care for patients under the supervision of more senior faculty. It is a rigorous training, which provides us with the knowledge and experience to provide the complex care needed.

The legislature needs to recognize the value of such training by carefully examining efforts by other less completely trained practitioners to expand their scope of practice. Expansion of the scope of practice of nurses, psychologists, social workers, and others, serves to make medical school, and psychiatry, a less attractive career path, and over time will lead to a less well-trained workforce.

Efforts to provide educational loan forgiveness for psychiatrists, among other physicians who commit to practice in an under-served area, should also be considered.

Many of the illnesses we treat can be effectively managed with medications. Access to

medications, however, is often impeded by a variety of factors. It's important to understand that psychotropic medications, even in the same drug class, can vary for each person in regards to tolerability and response time. Depending on the medication, it can take up to three to six weeks to see any positive impact for a patient. Side effects for medications within the same drug class may widely vary. For these reasons, we have always advocated for an open formulary for psychotropic medications and will continue to do so at every opportunity.

In my practice, many of my patients are children and adolescents who suffer from a range of mental health issues including Attention Deficit, Hyperactivity Disorder, Autistic Spectrum Disorders, Anxiety Disorders and Mood Disorders, including Bipolar Disorder. Psychotropic medication is often an integral part of their treatment, helping improve their day-to-day functioning at home, in the community, and in school. It is also not uncommon for patients to require more than one medication to treat their psychiatric condition or co-morbidities.

As minors, patient's parents are liable for the costs associated with their medication needs.

For parents or guardians who have an employer-related health insurance plan, the co-payments are often excessive and can create a financial hardship for the family. I have many patients in my practice, both children and adults, who are unable to take their medications consistently or at all due to the high cost associated with their co-pays. For some this problem is only exacerbated by their need for multiple medications. This not only creates a financial burden for the family, but also an emotional one. Although, those patients enrolled in Medical Assistance often pay a lower co-payment than those patients receiving commercial third-party insurance, the co-payment is still sometimes a financial burden.

Compliance with and access to medication is an essential part of treating a patient with social, emotional, behavioral or academic concerns. Our members want to encourage you and your colleagues to pass any legislation that would release patients on Medical Assistance from paying co-payments for their medication if they cannot afford it. In the case of third party insurance, we would also encourage legislation that prohibits excessive co-payments for all insurance company plans or that would allow for a 90-day supply of

medication at a retail pharmacy for one co-payment.

I have attached a copy of a joint statement from the American Psychiatric Association, Mental Health America, NAMI, and the National Council for Community Behavioral Healthcare which perfectly details various reasons why we support the elimination of medication co-payments in both the public and private sector and that's been previously discussed already.

At this point I also want to briefly mention that we are also pleased that President Bush signed the Paul Wellstone and Pete Domenici Mental Health Parity & Addiction Equity Act of 2008. Coverage

In addition to cost issues associated with medication, our members are often frustrated by prior authorization and medical necessity criteria guidelines that need to be addressed prior to the prescription being available to be dispensed at the pharmacy. There are times when, inexplicably, prior authorization attempts may be denied even though the medication requested is clearly the appropriate choice in the psychiatrist's clinical opinion.

When treating children, extreme care is exercised when prescribing all psychotropic medications. As an example, consideration needs to be given to the

type, amount and frequency of a given stimulant medication to ensure that the patient is receiving the appropriate amount of medication to help them focus throughout the day, both in school and after school while performing a variety of tasks and activities. The Food and Drug Administration scrutinizes dosage limits, strength of medications, tolerability and side effects before they approve a medication for children.

As physicians, we are trained to look at co-morbid conditions and the side effects of a medications before prescribing them or adding them to a pre-existing treatment regimen. Based on our extensive training and experience, we feel that we are uniquely qualified to make the appropriate medication decisions for our patients.

While we recognize that there is a need to regulate the use of medications to protect the safety of the public and to guard against abuse and diversion, we believe that medical necessity criteria and prior authorization requirements need to be better streamlined to avoid a delay in treatment, or even a denial of treatment, that can result in adverse outcomes for those suffering from mental illness.

We look forward to working with you and

the Department of Public Welfare to come up with a more flexible prior authorization process that will assist patients in receiving their medications in a more efficient manner.

We applaud Representative Wheatley for trying to address concerns with providing access to adequate treatment for those suffering from mental illness and substance abuse issues. I extend our willingness to work on these important issues with you. Our members relish the opportunity to provide their own clinical perspectives at future public hearings to be held by your subcommittee across the state next week.

We also look forward to working with members of this committee, House and Senate leadership, and specifically the Department of Aging, Health and Public Welfare, to develop policies and procedures that state and local municipalities can use to better serve those patients and their families needing treatment and services for substance abuse and mental health disorders, while preserving the patient's right to freedom and individualized recovery.

I am now available to answer any questions or address any concerns at this time.

THE CHAIRMAN: I have a question that

has been in my mind since we first started these hearings.

I understand that this is a very complex set of things and there are many different pieces of it. Let me move through the spectrum of, when you talk about mental illness and substance abuse, there are people on all spectrums of that issue. A lot of our attention goes to the most serious of those illnesses or disorders, but help me understand what we do preventatively, if possible, to; One, assess in the early enough stages and then to treat and work with those as we move through the spectrum?

MR. NASER: Yes, I think you're right. I mean, we are talking about a spectrum of issues and a wide array of diagnoses, if you want to use that word.

As I said at one point, in my clinical practice, I'm working with children that have difficulty with focusing and attention in school, yet they're being streamed in school socially or functioning adequately or better and we're working with them around supports and medication or not medication in terms of function in school. That's sort of an example of one end where we talk about children or adults that struggle, but they're functioning in other areas of their lives, at least

adequately.

And as you said, we go to the other extreme where we're talking about, as has been outlined today, issues around housing, you know, relationships, day-to-day issues where people struggle just to have an adequate living day-to-day.

So I think in terms of preventative, again, I primarily work with children and what I tend to find is the first steps, in terms of diagnosis and assessment, really comes from pediatricians, from families, from the schools. I see a lot of kids that are referred in through all three of those routes around issues and it may be behavioral issues in school and that may be aggressive behavior, but it also may be other forms of impulsivity, difficulty just sitting still in class, difficulties learning.

I see kids also that sort of go to the opposite end. If I'm treating, say, an adolescent for depression, who tend to be functioning well and then at some point start to withdraw, their social interactions really deteriorate, they develop difficulties with their families, in terms of relationships, isolate themselves, that kind of thing.

THE CHAIRMAN: I guess part of my

question was really the system. Do we have a system that is functioning in a way that we are assessing people in -- let's take out the stigma for a minute. Do we have a way of assessing children? We heard yesterday in Scranton that primarily kids are found to have these problems when they get in trouble in school then from that it turns into something else.

There is no systematic way of trying to really analyzing and trying to assess and then trying to bring in the support without stigmatizing a child or a family and also working with a family on what their role is in the support; do we have a system?

MR. NASER: My personal opinion is that the system is very fragmented. I think it really depends on what part of the system you come into it from. One of the things I struggle with, and it's incredibly frustrating, is let's talk hospitalization versus outpatient treatment. There is no consistent system, as you heard already today on the adult side, in terms of how to sort of maintain that continuity of care.

So if somebody is hospitalized and they had no previous out-patient treatment, frankly, it's kind of a crap shoot whether they end up in out-patient

treatment or not and who they end up with. Some of it is based on the insurance, what their insurance plan is, who is offered with that. At the same time, not to be negative, I found that a lot of times families will go to their insurance plan, go to their provider list on the web and 90-plus percent of the people that are in their geographic area where they live are no longer providers or have a close practice and there is no communication around that with the family.

I find, just breaking into the system, especially if there is not a need for intensive care, like in-patient treatment, it's really difficult. Families will wait months for appointments, even for private out-patient treatment for service practices.

It's just a shortage of psychiatrists. I think it's hard to find people -- one of the things that comes up is people struggle with how do I find somebody who I can trust, who I feel like I can work comfortably with. Frankly, a lot of treatment today, if you want to use that word, is about the relationship. You heard that with the Peer Specialists when they gave their testimony.

You're talking about a peer situation where there needs to be a level of trust in the working

relationship with the treatment team. It's not just with the psychiatrist, it's the therapist, it's the psychologist, it's the peer specialist, it's the school, it's everyone else.

I don't know if I answered your question.

MS. SHOEMAKER: One of the things that we've notice too is a lot of the people -- as you said, take stigma out of it, that's a big part of it -- a lot of people, especially we have noticed with a lot of our geriatric patients tell us, I'm not going to see a psychiatrist. They are afraid to see a psychiatrist. So we work really closely with primary care doctors because sometimes if you have a really good primary care doctor, they might be willing to say, well, I'm a little depressed to their regular doctor, but they don't want to go that way.

And we have a consultation project, that we started a couple of years ago, and we got a grant from the American Psychiatric Association where we hook up with primary care doctors. We have a network where they can call up and say somebody is afraid to go to a psychiatrist, but they want to find out this person seems depressed, what should I do, what medications?

And sometimes it comes as there is a referral that comes out of it. Sometimes there is not. Sometimes it's something where just being able to ask a question works and I think it depends where you connect on who is really in tune to it and where you connect.

There are times with schools that you might have a good teacher that may notice it or family members who are attuned to it. It is really, like Dr. Naser said, it's very fragmented and it depends on where you can hit it. And unfortunately, there are breakdowns in the system and those are things we try to work through to assist them on.

MR. NASER: One other thing -- just as an example. I talked about the schools a little bit. One of the things that are frustrating is that in general, I believe the State mandates certain forms of support for kids with ADD and other types of emotional issues. And what I find is the supports themselves in theory are wonderful and they work for a lot of kids. But for a lot of kids, it gets down to that stigma issue. I don't want to be the 10th grader that's going to the resource room instead of study hall because everybody knows who goes to the resource room, the kids with ADD, those types of issues. So the stigma piece

makes it really difficult.

THE CHAIRMAN: I will say, I asked this question yesterday, If we had an integrated system with mental health and the physical primary care and we don't, but I asked were we moving toward that? I think there are some steps to try to move towards that. So, hopefully, as we go through this we will find ways to do that.

MS. SHOEMAKER: As a society, we do support universal health care if there in deed there is a behavioral health component and since this was the focus of this hearing was pharmaceuticals and others, when we go to other hearings, such as in Erie, we will have one of our Presidents of our society will be able to address some of the things that we really feel are good solutions all across the board, not just access to medication, but we do see that that is a big component of it because these psychiatrist illnesses are biologically based.

And probably Dr. Naser can tell you better, but it's one of those where it's not a cookie cutter approach, it's not one like someone breaks their leg and you can look at a text book and say, Okay, you broke your leg, where there are so many different parts

of it and there is a stigma, like I said, that's involved in it and people don't understand it's not their fault that they have mental illness.

It could be a chemical imbalance, it could be so many things where medication is a huge part of it, but there are other parts of it. Some people don't need medication and some people just want to be able to talk to someone, such as a peer specialist or a therapist, some people need more, some people need less. That's why any way we can help work through that, but we do support universal health care and some of these things where it increase the physical behavioral health it is important.

THE CHAIRMAN: I know that in some committees and I hope this Panel, there is a whole conversation around medication is very touchy situation and so how do you bridge those gaps as far as questions as you go through this?

MR. NASER: Just to say quickly, part of that is cultural competence and the treatment team.

THE CHAIRMAN: Representative Bishop.

MEMBER BISHOP: Doctor, are their times, and if so, how often is it possible for a diagnosis that has been diagnosed as mental and it turns out to be a

physical diagnosis and they didn't catch it until it was too late; how do we avoid that?

MR. NASER: That's my job. That's what I do. When I see somebody initially, that's part of my practice. I'm taking an extensive family history, physical history, psychiatric history. Part of what I will really need to make sure of is that there is not -- at least we are addressing the physical side of this also.

As Deb mentioned, we think of many of these issues as being stemming from at least a biologic predisposition and then being influenced by the context of somebody's life for a variety of other issues.

I'm always looking at things like -- just as an example, thyroid conditions. I want to make sure that there aren't other issues, in terms of central nervous systems, auto-immune disorders those kinds of things. Part of my job, very early on when I'm meeting with somebody is to get as best an assessment of not just the symptoms in that moment, but the symptoms that are occurring over time, when did they start? How did they present? Did they wax or wane or not and is that consistent with other kinds of things that I need to be thinking about.

MEMBER BISHOP: For those who may not have insurance, are there insurance problems with ordering MRIs or that kind of thing; did that interfere with it?

MR. NASER: All the time. Just this week I had two people, it's Friday today, two or three people this week that are on medications that we need to -- you know, already on medications doing well and relatively stable, that need to be monitored, the blood levels and other labs that go along with that. And one person got them this week, had not gotten levels within two years. I like to do them every three months on average. Hadn't got them in two years because she couldn't afford it. Doesn't have insurance, doesn't have a job that provides insurance and couldn't afford it. So it happens all the time.

MEMBER BISHOP: A few times crisis were brought up, payments were bought up. Isn't 51 percent of the Medicaid paid for by Medicaid or am I lost on that piece?

MR. NASER: In terms of the medications?

MEMBER BISHOP: Yes, prescriptions.

MR. NASER: I don't know specifically.

MS. SHOEMAKER: I would have to go back

and check, but I know that is a problem. There is a big problem with the reimbursement.

MR. NASER: I can tell you that even if 51 is covered, it isn't enough.

MEMBER BISHOP: But it is suppose to come form another source, I guess is State Medicaid?

MS. SHOEMAKER: It depends on what they have as their secondary or third.

MEMBER BISHOP: Are you telling me that you can have a patient they, they are on Medicaid, but Medicaid doesn't pay for all the medications or prescriptions so therefore, they cannot get any treatment. There is no source for them to get it?

MS. SHOEMAKER: Yes. It depends on if they have a secondary insurance that picks it up and it depends on Medical Assistance how its -- some of the things with Medical Assistance on the state level will take it. It just depends. And there are a lot of people who don't have a lot there and they have to determine, do I want to eat this food or have medication. That is a big problem. Pharmacies technically are allowed to give you a 5-day emergency supply, but that's not a whole month of medication.

And unfortunately, with a lot of people

with mental illness, depending on what illness they have, we tell people it's hard enough for them to go even get into a pharmacy and then when they get there, they're told well, I have to pay $20 or I have to pay even $2. If they don't have that money or they have to think of how it's going to stretch the rest of the month, they'll just leave and they won't get the medication and then you have an adverse outcome where they don't take it and later on they will be in the emergency room.

MR. NASER: 20 or 2 is bad enough. Again, if we're talking 49 percent, some of these medications are brand name medications, we're talking about, unfortunately, hundreds of dollars a month. And if you have two or three medications, psychotropic meds or otherwise, we're talking about sometimes hundreds of dollars for these medications.

MEMBER BISHOP: And psychiatric medication is there a real difference between the brand names and the generic names?

MR. NASER: Well, I'm assuming you're talking about -- let's talk about serotonin reuptake inhibitors like the Prozac, Zoloft group. Prozac and Zoloft are now available in generic. There are two

parts to your question. One is, is there is a difference between Prozac and Zoloft that have generic and the brand-name version, of those same medications versus something like Lexapro, that only comes in brand name. Each separate medication, I think they are very different. They are in the same class but different patients respond differently to all these medications.

MEMBER BISHOP: It's not a question of one being better than the other?

MR. NASER: No, not at all.

MS. SHOEMAKER: Probability.

MR. NASER: Probability side affect profile effectiveness. The other question is, I have some patients I see, as an example, Prozac recently went to a generic version and most primary plans require that in-patients switch to the generic version. That works great for a number of patients, but I have a few people that that doesn't work as well. I have to dose them on average 20, 30 milligrams higher on the generic to get the same level of effectiveness, which increases the rate of side affects, then we're talking about compliance. So it gets complicated. So if we go to brand name, we're talking about a potentially higher co-pay, you know, $50 versus $5.

THE CHAIRMAN: Representative Cohen.

MEMBER COHEN: I'm fascinated by your statement, you're enclosing the joint statement on Medication Cost Sharing and State Medicaid Programs, which indicates the overall cost are greater with co-pays than without co-pays. Does the psychiatric side in general have any recommendation on eliminating co-pays?

MS. SHOEMAKER: We prefer that there aren't co-pays.

MR. NASER: That's our position.

MS. SHOEMAKER: But in an idea world, unfortunately, like Representative Manderino said, previously in testimony she said, You know, the state cannot mandate to MCO and say, you know, we are $2 and $8. They cannot say you're forced to do that and I need to check with the National Association because I know I think maybe, as Representative Manderino asked, if that is the way of national companies if they are trying to eliminate copays.

I think some of the cost shifting and some of the things that are involved there are a lot of the companies, if they are reducing or eliminating, they are kind of weighing the pros and cons. The pros are

people are taking the medication because there is no copayment versus the cons, okay, I'm paying a little bit more in my insurance plan however, they are not being hospitalized as much.

They're not having a lot of places where they're being diverted, maybe through a jail or somewhere else. I think that's where the weighing is. They are looking at the medication cost is a lot less money than being hospitalized. And like I said, if you want specifics, I can talk to one of the people from the American psychiatric Association to see if I can get more examples of what companies are looking at eliminating co-pays.

MEMBER COHEN: Yes.

MS. SHOEMAKER: Because I'm more than willing to do that and I'll send it. Should I send it to --

THE CHAIRMAN: You can send it to me and I'll make sure members get it.

MEMBER REICHLEY: Just a follow up. Do they do a rebalancing? Do they make a higher copay in general without the copay of medication side then?

MS. SHOEMAKER: That, I would have to check into because how all the companies work, a lot of

them go into buying pools so bigger companies, such as maybe a Blue Cross, they can get their medications because they're buying such bulk or volume, they can get better than say maybe a small plan.

So it's something I can look into and let you know, but I know that's where even some of the cost -- even if you start looking into, if you go to a CVS, if you go to Rite Aid, you'll see different costs of different medications of different plans and you sometimes see in the paper, CVS will show, if you have Walgreen's and you can see a difference even those pharmacies have, based on volume they get different discounts and it depends on the kind of rebates they get from manufacturers.

So I can find out, but I'm guessing somehow, whether it's the volume of the pharmaceutical company is saying, Okay, you're buying millions of this drug, we will give you a better price, I'm not sure. It would be something I would have to look into. It is possible there is some cost shifting a little bit there.

MEMBER REICHLEY: Doctor, I know it's probably not optimal, but before you write the prescription, do you know what the insurance plan is of that patient who has come to you is under?

MR. NASER: Sometimes. Again, the way my practice is structured, I don't always. A lot of times, the problem is the formularies shift and could change. I think the heart of your question, I'm not sure what's on formulary and what's not usually when I'm writing for medications.

I can tell, in general, for example, when we talk about stimulant medications again, you know there are a couple of different Ritalin-based medications and amphetamine medications like Adderall that tend to be usually covered. Although, what I'm also finding is in the last 10 years that I have been in practice, every year I'm doing more and more pre-authorizations. It's a lot of time and that's an issue, it doesn't matter in terms of for my situation, but it's time away from caring for patients from working with people that's difficult.

THE CHAIRMAN: Stan Mitchell.

MR. MITCHELL: Thank you, Mr. Chairman. I'll be brief.

The issue surfaced last night in Scranton when we had a hearing, and you've alluded to it here today as well, and it pertains to the scope and practice of there was a clear misdiagnosis by an

individual who, let alone didn't have a medical degree, did not have a master's degree. I think it was a lower level counselor who misdiagnosed a juvenile in a juvenile detention center. Long story short, the individual had a type of autism and the parent testified, the last speaker, indicated how troubling it was for her to go through that, and the years and time that was wasted and the frustration.

And I know that your testimony you highlights the fact that you have a Masters degree social workers, you have master degree psychologists, you have nurses, there is ethics amongst a certain level of professionals.

Question: Are you comfortable with some of the Master degree level individuals, licensed social workers, people like that, not necessarily invading your field of psychiatry, but almost paralleling what you're doing, with the exception of prescribing medication. Are you comfortable with what is happening right now with the field -- I mean not the field but what's happening right now with the expansion of the scope of practice?

MR. NASER: I'm not. In terms of representing the Society I'm not, but also in terms of

my own personal experience I'm not.

For full disclosure, I employ a nurse practitioner in my practice and I think he's excellent at what he does, he is trained to do, he's a pediatric nurse practitioner, he's got a lot of psyche experience, but the way he is working is with a lot of supervision with me. And actually he would say the same thing. He is comfortable with that, and that works for both of us.

What I'm very uncomfortable with is diagnosis with treatment without supervision. I always want to be careful not to offend anybody, but at the same time, like I said in my testimony, I have had eight years of schooling, six years of residency training for the child work that I do and a lot of experience. There has been a lot of supervision a lot of -- what's the word I'm looking for?

MR. MITCHELL: Hands-on?

MR. NASER: Yes, hands-on experience with supervision to get to that level. So all of that makes me very nervous.

MR. MITCHELL: Thank you, Mr. Chairman.

MS. SHOEMAKER: Just for the record, if they were diagnosing they were violating their scope of practice because they are not allowed to do that.

THE CHAIRMAN: Thank you very much for your testimony. Thank you for staying a little bit past the time you said that you would be on. I really appreciated your testimony and look forward to hearing other members of your organization at the other meetings. So thank you.

MR. NASER: Thank you very much.

THE CHAIRMAN: Thank you all, and I especially want to thank our host from People's Emergency Center. Is the young man gone already?

Thank you, sir.

I definitely want to thank Representative Manderino for helping us pull it together, for the staff of the Committee for being here and for the members from Philadelphia and my Co-Chair Doug Reichley for being here. Thank you all.

(Whereupon, the above-entitled matter was concluded at 3:35 p.m., this date.)

C E R T I F I C A T E

I hereby certify that the proceedings and evidence are contained fully and accurately in the stenographic notes taken by me on the hearing of the within cause and that this is a correct transcript of the same.

VIRGINIA JONES-ALLEYNE
PROFESSIONAL COURT REPORTER