COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HUMAN SERVICES
COMMITTEE HEARING

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HARRISBURG, PA

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MONDAY, MARCH 10, 2014
11:01 A.M.

PRESENTATION ON
ACCENTUATING THE POSITIVE: WHAT WORKS
IN MENTAL HEALTH TREATMENT

BEFORE:
HONORABLE GENE DiGIROLAMO, MAJORITY CHAIRMAN
HONORABLE MINDY FEE
HONORABLE LEE JAMES
HONORABLE STEVEN MENTZER
HONORABLE TOM MURT
HONORABLE BERNIE O'NEILL
HONORABLE PAMELA DeLISSIO
HONORABLE MADELEINE DEAN
HONORABLE STEPHEN KINSEY
HONORABLE ERIN MOLCHANY
HONORABLE MARK PAINTER
HONORABLE EDDIE DAY PASHINSKI

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ALSO IN ATTENDANCE:
HONORABLE MARGO DAVIDSON

COMMITTEE STAFF PRESENT:
MELANIE BROWN
MAJORITY EXECUTIVE DIRECTOR

ASHLEY McCAHAN
DEMOCRATIC EXECUTIVE DIRECTOR
LYNETTE MHANGAMI
DEMOCRATIC RESEARCH ANALYST

I N D E X

TESTIFIERS

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

P R O C E E D I N G S

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MAJORITY CHAIRMAN DiGIROLAMO: Welcome to this hearing of the Human Services Committee, and I might ask everyone just to stand for the Pledge of Allegiance as we begin.

(The Pledge of Allegiance was recited.)

MAJORITY CHAIRMAN DiGIROLAMO: Okay. Welcome, everyone. We have a HEARING this morning on mental health issues.

And it seems like we get so much feedback and we've had hearings on where the problems are and what doesn't work. Representative Murt came up with the idea of having a hearing on what does work when it comes to the issues of mental health. And that's why we're here this morning.

And I'll set a couple ground rules just so everybody knows. The cameras are on in the front and the back so we are being recorded. And we have a really good agenda today. So I thought what we might do is let everybody testify first, and then if we have time at the end, we will come back, if you're able to stay, for questions and answers. We do have to be done at one

o'clock. We're in session at one o'clock so we have to be done at one o'clock so that way we'll give everybody an opportunity to testify.

And I thought I might just at the beginning here let the Members who are here present right now just say hello and let you know who they are. I've also asked Representative Margo Davidson, who is not a Member of the Committee, from Delaware County to join us today. So if we could start with maybe Mark, just say hello.

REPRESENTATIVE PAINTER: Hi. I'm Mark Painter from Montgomery County.

MAJORITY CHAIRMAN DiGIROLAMO: Margo?

REPRESENTATIVE DAVIDSON: Representative Margo Davidson from Delaware County.

REPRESENTATIVE MURT: Tom Murt. I represent part of Philadelphia and part of Montgomery County.

MAJORITY CHAIRMAN DiGIROLAMO: Gene DiGirolamo. I'm the Committee Chairman from Bucks County.

REPRESENTATIVE MENTZER: Steve Mentzer, Lancaster County, 97th District.

REPRESENTATIVE FEE: Mindy Fee, 37th District, also in Lancaster County.

REPRESENTATIVE O'NEILL: Good morning. Bernie O'Neill, 29th District in Bucks County.

REPRESENTATIVE PASHINSKI: Good morning.

Representative Eddie Day Pashinski, Luzerne County, 121st District. Thank you.

REPRESENTATIVE KINSEY: Good morning. State Rep. Stephen Kinsey, Philadelphia County.

MAJORITY CHAIRMAN DiGIROLAMO: Okay. And also up top is Lynette and Ashley from Representative Cruz's staff. And next to me is Melanie Brown, who's the Executive Director on my side of the aisle.

Since this was Representative Tom Murt's idea to do this and he is the Subcommittee Chairman on Mental Health, I am going to let him chair the meeting and conduct the meeting.

So, Tom, I'm going to turn it over to you.

REPRESENTATIVE MURT: Thank you, Mr. Chairman. Thanks to everybody for attending our hearing today.

Just to segue on a remark that Representative DiGirolamo made, most of us who have followed this issue are well aware of the challenges that exist and have existed in the past, but there are many initiatives that have worked relative to treating our family members and our brothers and sisters who have behavior health and mental health issues. And we're going to explore some of those issues today and hear from some of the practitioners in the field that have worked so hard to treat those Pennsylvanians who have mental health issues.

And just special gratitude and thanks to Melanie Brown and Pam Huss for doing such a great job in putting together today's hearing.

Could we ask our first testifier to please come forward, Tony Salvatore from MAX? Tony, thank you for being with us today.

I also wanted to recognize Representative Madeleine Dean who joined us and Erin Molchany also who has joined us. Thank you.

Tony, welcome.

MR. SALVATORE: Thank you having this hearing.

First of all, MAX is Moving Agencies toward Excellence. It's an acronym. We're a mental health/behavior health provider organization. We serve four counties in southeastern Pennsylvania: Bucks, Chester, Delaware, and Montgomery. We also draw a strong constituency from the developmental disabilities community as well as mental health and some folks from drug and alcohol.

Today, we're here to tell you about three initiatives in Montgomery County related to mental illness. The first is known as Mental Health First Aid. This is an international, nationally recognized program that basically enhances trainees' knowledge of mental health, builds their awareness of the needs and the problems experienced by

individuals suffering from mental illness, and provides some basic skills in helping people, especially if there's a kind of emergency situation or something that should be brought to the attention of an ER or a crisis center.

Second, I'm going to speak to you about suicide prevention, which is a major problem in Montgomery County, a fairly serious problem statewide. We lose 1,700 Pennsylvanians every year to suicide. In Montgomery County we took some initiatives some years ago to try to do something about this. A couple examples of things we're doing are At Your Place. We'll talk about that in a little more detail.

The last thing we're going to talk about is the Certified Peer Specialist program. This builds on a long-standing tradition in our country of mutual self-help. It also builds on the recovery model that has taken hold over the last 10 or 12 years in mental health, provides individuals suffering with mental illness an example of somebody in recovery that they can model their behavior on. The peer specialist program, Montgomery County took that on very early on. It's one of the leaders in implementing the program in Pennsylvania, and it's very pervasive throughout the provider community in Montgomery County.

So with this, I'd like to turn it over to Tory Bright, Tricia Malott, and Genny O'Donnell, who'll tell you

about Mental Health First Aid.

REPRESENTATIVE MURT: Thanks, Tony.

Our next three testifiers will be Tory Bright from the Southeast Regional Mental Health Services Coordination Office; Tricia Malott from Access Services; and Genny O'Donnell, Coordinator of the Homeless Outreach Center.

Good morning and welcome.

MS. BRIGHT: Good morning. Thank you for having us. My name is Tory Bright. I am the Coordinator for the Regional Mental Health Services Office on behalf of the five southeast counties, Bucks, Chester, Delaware, Montgomery, and Philadelphia. I'm also a certified instructor for adult and youth Mental Health First Aid. I'm also a quality evaluator for the National Council for Behavioral Health, and a member of the Mental Health Advisory Board for Philadelphia.

When you think about mental health problems and mental illness in our country, what image comes to mind? Maybe you think of the mass media coverage of tragic acts of violence, the homeless persons, or persons who are addicted to drugs or alcohol. Likely, the image is not that of your neighbor or your family member or young person who's in our schools or the professional that lives in my suburban neighborhood. Mental health problems in our

country are not discriminating, they are not just affecting the socially and economically disabled, and they affect everyone in our communities.

I'd like to share some startling facts about the common mental health problems. An estimated 26.2 percent of Americans ages 18 and older, about one in four adults, have a diagnosable mental illness. Major depressive disorder is the leading cause of disability in the United States ages 15 to 44. Serious mental illnesses, which afflict about 6 percent of Americans, cost this country $193.2 billion a year in lost earnings. And suicide rates have increased dramatically over the last five to seven years. Suicide is the 10th leading cause of death among general population in the United States and the third leading cause of death among youth.

So how do we respond to this epidemic? Mental Health First Aid. The Mental Health First Aid program comes from the National Council for Behavioral Health in partnership with the States' Governments in Maryland and Missouri. It was created in Australia in 2001. It's in 20 different countries, and it's in places as diverse as England, Canada, but also Singapore and Japan and everywhere in between. The program was piloted in 2008. A youth version was piloted in 2012.

Mental Health First Aid is an evidence-based

model. It increases literacy, expands knowledge, connects individuals to services, and reduces stigma. And reducing stigma is a very important part of this program because we know that stigma is such a barrier to individuals receiving treatment.

So Mental Health First Aid essentially teaches the general public to recognize the signs of mental health problems and how to respond to the needs of persons experiencing symptoms of a mental illness or who may be in crisis. The Mental Health First Aid program is interactive. It's an eight-hour curriculum designed for the general public so anyone can really take it. We talk a little bit about what you might see and how you might respond and how you might respond to a low-intensity situation or how you might respond to a crisis situation.

Just like CPR, Mental Health First Aid is the initial help that's given to a person who's developing a mental health problem or experiencing a crisis. It's given until the appropriate treatment and support are received or until the crisis resolves, and it's not a substitute for counseling or medical care or peer specialist supports or treatment.

So why do we teach Mental Health First Aid? Well, first of all, we know mental health problems are very common. Stigma is a significant issue because people do

not really seek treatment and they delay in seeking treatment and they don't have insight in what they might need and where the effective help is available. Professional help is not always immediately available. And finally really because many people, many general citizens are not well informed about mental health issues. They don't know how to respond to someone they might know, a family member, a neighbor, or a coworker who might be showing some signs or symptoms and they don't understand how to help this person. So Mental Health First Aid is that answer.

It provides an overview of common mental health problems and teaches the typical signs and symptoms and risk factors associated with mental health disorders such as depression, mood disorders, anxiety disorders, disorders where psychosis may occur, substance use disorders, and eating disorders. It's an early intervention program and it can help individuals strengthen communities.

Research shows that the sooner a person gets the help for mental health problems, the less likely they are to have a crisis in the future, and therefore, there's the cost impact. Mental Health teaches how to engage a person, how to help them get the appropriate professional help, and other self-help supports.

There's an adult curriculum, a youth curriculum,

a curriculum for rural-designated communities, and soon to be a veterans' curriculum.

So nationally certified instructors such as Trish Malott and myself are authored to teach Mental Health First Aid by the National Council. There's a variety of different audiences who are trained, general community members, behavioral health, human resource and business leaders, faith-based communities, higher education, law enforcement and public safety officials, youth-focused entities, and veterans' groups, primary care, et cetera. Again, Mental Health First Aid is really for the general public and for anyone who is interested in learning how to help.

Participants at the end of the course receive a three-year certification as a Mental Health First Aider, which is from the National Council for Behavioral Health.

So I'd like to pass this over to Trish Malott, who's my colleague, who's going to talk about the youth Mental Health First Aid, and then I'll talk a little bit when she's finished.

MS. MALOTT: Thank you, Tory.

Hi, good morning. My name is Trish Malott and I'm just so happy to be here this morning to talk to you all about Mental Health First Aid and I really wanted to also thank you so much, all of you, for taking an interest

in this important topic.

So I'm from Access Services and we're a human service agency. We're located in Fort Washington, Pennsylvania, but we serve 10 counties on the eastern part of Pennsylvania and the four suburban counties outside Philadelphia.

And I want to stress that although I represent the mental health system and I think all of us on the panel represent the mental health system, Mental Health First Aid really isn't a mental health approach; it's really a community public health approach. So it really benefits everyone. So regardless of whether you live with a mental illness, Mental Health First Aid, you just have to be human. So it really benefits us all.

Like Tory, I too teach Mental Health First Aid, both adult and youth. And I've had the pleasure of being Tory's co-facilitator teaching the class and my role really is the youth portion. And I do have a copy of the curriculum as well. I have one copy so if anyone's interested in taking a look at the curriculum, there's also the adult curriculum as well, but I have it here for your review. So really my role is to kind of talk to you just briefly about the youth curriculum and why it's so important.

Like Tory said, Mental Health First Aid helps the

layperson develop skills for recognizing signs and symptoms, de-escalating someone who may be in crisis, or, if appropriate, help lead the person to appropriate treatment or self-help.

So just to give you an idea of the structure of the class, it's an eight-hour class, and so the first four hours of the class really helps us understand what you might see an a person who's developing a mental illness or struggling emotionally, and then the second half of the class is what you might do to help the person, so really teaching very specific hands-on skills for engaging the person in a conversation about what they might be feeling, thinking, or experiencing.

So the difference between youth and adult Mental Health First Aid is that the youth course is designed to teach adults who work with youth or adults who live with youth, so whether you're a parent, teacher, a coach, youth leader, neighbor, family member, principal, teacher's aide, basically anyone or everyone that comes in contact with a youth can take the class and learn the skills for supporting a youth who may be developing a mental illness or struggling emotionally or experiencing a crisis.

Like the skills taught in regular first aid, the skills taught in Mental Health First Aid do save lives. So I want you to consider this. In general, we as a society

are typically not a help-seeking society when it comes to mental illness. We wait. And we talk about this in Mental Health First Aid. From the time someone experiences symptoms of a mental illness, we as humans wait an average of 10 years before we actually go get treatment because we're really not a help-giving society when it comes to mental illness. In general, we are better prepared to help a person having a heart attack than we are helping a person having a panic attack.

So if someone shares that they're struggling emotionally or even suicidal, not only do most of us feel ill-equipped but we really feel scared and uncomfortable about it. We've heard about mental illness being referred to as a touchy subject. It's an illness. Mental illness is an illness like cancer, like heart disease, like diabetes. We would never refer to someone as having cancer as this is a touchy subject.

So one of the things that we talk about in youth Mental Health First Aid and adult Mental Health First Aid is the stigma that really surrounds mental illness, which keeps people from talking about it openly. So Mental Health First Aid really truly increases mental health literacy and basically takes the fear out of mental illness and more importantly takes the stigma out of mental illness. It makes it okay to talk about it.

So why is youth Mental Health First Aid so critical and so necessary and why is it an innovative approach? Well, we know just the mere experience of being a youth is difficult and we've all been there. There are extreme changes happening in the body of a youth, hormone changes. There's a lot of stress related to academic and social pressure. We know youth can be really very stressful.

So Mental Health First Aid really helps us to re-familiarize ourselves with really what it's like to be a youth and really better understand the typical struggles of youth but it also helps us to understand some of the deeper disabling emotions that our youth are experiencing. For example, one in five teens experience depression before their 18th birthday, the number one cause of suicide among youth, rooted in everything from circumstance to genes to coexisting mental illness.

Depression can be very difficult to prevent. One of the reasons it's so difficult to prevent is that our teens typically don't reach out to adults for help. Why? Because of the stigma that surrounds mental illness. Teens may feel embarrassed, ashamed, or they may feel weak if they experience an emotional struggle. And we've seen this.

The good news is that treatment works. Studies

show that treatment works for 80 percent of teens that seek treatment. The tragedy is that less than 33 percent of depressed youth get help. More tragic is our suicide rates among youth. Suicide is the third leading cause of death in middle and high school and the second leading cause of death in college students.

In the highly publicized recent suicides at the University of Pennsylvania in January, University President Amy Gutmann stated in a Philadelphia Inquirer article that the deaths of the students were not connected but raised the issue of significant stress that needs to be addressed immediately. I'm sure what she meant by that was that none of the students knew one another.

I would ask you to consider this: The deaths of these students, as well as the suicide that claim the lives of 1,300 Pennsylvanians each year, are very much connected, the connector being the hopelessness, the helplessness, the aloneness, and the darkness that these young, talented, bright, aspiring people felt, not just at the moment that they completed their suicides, but the hours, days, weeks, months, and possibly years before taking their own lives.

Mental Health First Aid doesn't turn you into a mental health professional, as Tory said. It also doesn't make you responsible for another person's actions. We say in our class that you get a certificate; you don't get a

cape.

We do know, though, that our youth are struggling and that the data from the Center for Disease Control tells us that nationally approximately 500,000 teens attempt suicide each year. So having more people out there with eyes, ears, a heightened skill level, and really what we call radar for recognizing when a youth, when an adult may be struggling and specific skills for helping each other is truly lifesaving and it's truly innovative.

And once again, I thank you so much for taking the time to hear about youth and adult Mental Health First Aid and how it can really save lives.

MS. BRIGHT: Thanks, Tricia.

MS. MALOTT: Tory.

MS. BRIGHT: So a little bit about some of the public policy going forward, Mental Health First Aid is in all 50 States. Many of you may know that President Barack Obama endorsed Mental Health First Aid as part of his reduction in gun violence suggestions. And there is current legislation nationally for the Mental Health First Aid Act, which would increase funding to States to support Mental Health First Aid in schools and elsewhere.

A number of different States have Acts pending and several already have established legislation to support increased funding for Mental Health First Aid. In

Pennsylvania, through the Office of Mental Health and Substance Abuse Services, the Mental Health Matters Initiative has awarded some recent funding grants to available counties and local communities to help build the complement of certified instructors such as Tricia and myself.

In the southeast region fortunately there are a variety of approaches that we have used to implement Mental Health First Aid. Philadelphia Department of Behavioral Health, under Mayor Nutter's Healthy Philadelphia Initiative, established a Mental Health First Aid Department, and there's approximately 130 instructors in Philadelphia who have taught approximately about 3,000 Philadelphia citizens as Mental Health First Aiders with their goal in Philadelphia to train approximately 6,500 citizens by the end of 2014.

Philadelphia's strategic plan is actually considered as a national model from the National Council. It's promoting really kind of the training, the outreach, and marketing efforts. And Philadelphia also, as a model, has established community partnerships. They've reached out to the American Red Cross, National Constitution Center, Philadelphia School District, and are also involved in an evaluation project studying the effectiveness of Mental Health First Aid with Drexel University.

In the four suburban counties we are in the process now of, under the Mental Health Matters grant and through my office, hosting National Council this month in two weeks to train 30 more adult instructors across the four suburban counties. In addition, Montgomery County is hosting a youth instructor training course in July, which would train 30 additional youth instructors targeting local county school districts. We're two of the four trainings that are coming in this year from National Council, and that's all because of funding limitations.

As a mental health professional for a good deal of time, about 30 plus years, I can attest to the curriculum myself. I've used Mental Health First Aid action plan to save a person's life, a colleague, and if I hadn't had the knowledge to assess for the signs of suicide and the right words to say and to engage the person in the conversation, I don't know that my 30 years of professional experience would have really made the difference.

I too am a family member. My eldest brother, who was a veteran, and as a result of his undiagnosed mental illness and substance abuse, died eight years ago. Due to the stigma associated with his mental illness, he would have never sought care.

I'm a parent and I'm a trainer, and I hear countless stories from members in my class, among my

friends and family. Mental Health First Aid is a common sense approach. It really is an understandable way to talk about mental health problems and to begin the conversation about getting help.

You've heard enough from us. I'm going to hand this over to Genny O'Donnell. Genny is the Coordinator of the Homeless Outreach Center in Montgomery County. Genny was a participant in one of my early trainings offered in Montgomery County. So Genny.

MS. O'DONNELL: Good morning. I was. I took the class, one of the first people in Montgomery County to take the class, and I had ulterior motives for going. My ulterior motive, as the director for a homeless center, I am always looking for training that will benefit the staff that work there.

As a homeless center, we are not hiring trained mental health technicians. We are hiring formally homeless people. We are hiring people that might not have college degrees and whatnot. The job is basically to help people to get their laundry done, to get them to their doctors' appointments, and things of that nature. So I'm always looking for something that's going to help staff because something is always going to happen at the homeless shelter. It always does.

So I took the course and I absolutely fell in

love with it. It was the first time I saw a course that the staff at the shelter I felt would benefit from. It's the first time in a long time. And the reason I felt that it was so good was because it touched on everything without trying to make somebody be a clinician or diagnosing. But it gave people the ability to engage with somebody, to speak with somebody, to talk to somebody that might be having a problem and to actually be able to do something about it, to refer them to the right place, to help them recognize their own strengths and abilities and rely on that. And it was just really exciting and we had just about the whole staff trained and we're doing it again.

And then two weeks after the course sitting at my desk, which I rarely do, and I get a phone call and it's from one of the residents at the homeless shelter, and he's like, hey, Genny, I'm just calling to say goodbye. And I'm like what? And I said can you do me a favor? Can you explain goodbye? Are you leaving town? Are you taking a trip? Are you suddenly going on vacation? Did you decide to move to another State? And he said, no. I'm on my way to the bridge and I'm getting ready to jump off it.

I was on a landline, which I am rarely on. I had nobody else in my office, and here I am on the landline. So I had to stretch that cord as far as I could, get the attention of my coworkers who are across the way. I did

not want to get off the phone with him and I got somebody to come in and I said, look, this is what's going on. I need you to call 911 right now and get help to that bridge. I know exactly where he's going. I stayed on the phone with him and we talked for a while and it was hard because he was walking and he was walking quick and he was determined and he really had called to say goodbye.

So as we're talking, I used all the points that were in that. I listened. I determined he was going to commit suicide. I got the help going and then continued to talk to him about what was important to him, about the supports that were in his life, about the things he was planning. And then at some point the phone just went dead. I had no clue what happened.

As luck would have it, in walks his caseworker from another agency and I said please get over to the bridge. In walks an outreach worker from my agency, sent him over to the bridge. He changed his mind. During that conversation, he changed his mind about the jump. However, he changed his mind after he already got onto the other side of the barrier. So when the police got there, he was hanging and unable to get himself back up. So the police managed to actually lift him back onto solid ground and take him to the hospital.

When my staff came back, my staff turned around

and the two people are like, Genny, what did you send us there for? What did you think we were going to do? And I said I didn't expect you to do anything. I was hopeful that he was going to make it and that he needed to see a friendly face and yours would have been friendly.

So he made it. I waited a couple days, went to visit him in the hospital when he was there, and it was just, I got off the phone, I sat back. I can't tell you how long the call took. I mean this happened in seconds. But what I can tell you is the training that came from that, again, I've been in this field for 20 years and for me to have had that kind of key and that kind of tool, I didn't have to rely on myself. I didn't have to rely on second guessing what to say because there's so many wrong things to say to somebody and I didn't want to do that. I didn't do any of that because I had just finished this course and here I am two weeks later going A-L-G-E-E and going through each step and telling him what to expect and being forthright with him and not saying again something that's going to push him a little further off the edge.

Our homeless shelter this year, I have never seen it like this ever. We have had more people come in than any other year previous. We have had to have the county open up another shelter practically overnight because we couldn't serve all the people that were coming. And the

people who are coming are in crisis. I mean we're not talking about people who are your stereotypical homeless person. You're talking about the person who lost their job, the person whose unemployment benefit ran out and now they can't make it. We're talking about people who've relied on themselves and their work and their families forever all of a sudden not being able to make it anymore.

So here they are coming to this shelter that we have and within that we have the people who have been on the streets for years who may not bathe all the time, who may not shower, who may be psychotic or actively using drugs, who may not be getting treatment. So now we have this whole mix of people under this one roof and we are finding more and more people who are having a crisis, not just because they're homeless; now, they're in a homeless shelter. They never dreamed of that for themselves. Now, they're next to somebody and having dinner with somebody who may have been on the street and not bathing and they just never fathomed that's where they would be.

And this Mental Health First Aid training again allows myself and my staff to talk to people and to give them hope not only based on knowing that this is going to come to an end and they're going to be housed again but also based on getting them to tell us what their strength and support has been because that's part of the training is

learning from people who they are, how they handle things, what's normal for them, how would they have handled this before they got here, how can we help you get back to handling it that way again? And that's what really makes a huge difference in the conversations that we have with people.

We have people who are coming in extremely ill, cancer, sciatica. We serve 18-year-olds. We serve 90-year-olds. We serve men, women, and everybody in between. And we are a community, sometimes very dysfunctional but we are a community. And trying to get all these different kinds of people to live too close for comfort is not always easy but this makes a huge difference and it's for anybody and it is for everybody. And it's one of the best trainings that I could say could come around for people that work in a homeless shelter where we are not the mental health system, not the drug and alcohol system, not the youth system, not the aging system, but at any given time we are all that at the same time.

So thank you so much for inviting us here and for listening and have a great day.

MS. BRIGHT: Thank you.

REPRESENTATIVE MURT: Thank you very much for your testimonies. We would ask if you can stay for a little bit because there might be some questions.

MS. O'DONNELL: Yes.

REPRESENTATIVE MURT: Tony, before we turn it over to you, I just want to recognize Representative Pam DeLissio and Representative Lee James who have joined us.

Tony.

MR. SALVATORE: Thank you. First off, I'm not going to tell you I'm happy to be here. I'll be happy the day when I can come and not have to talk about suicide as opposed to bring you up-to-date. I very much appreciate your interest in the topic but it's still very much something we have a lot to do about.

I'm with Montgomery County Emergency Service. We're what you might think of as a psychiatric emergency response center. We have a number of services, a suicide crisis hotline, a walk-in crisis center, and a 73-bed acute psychiatric hospital, along with some other crisis-related services.

We might have the distinction of being one of the few if not the only organization in Pennsylvania that came about because of suicides. Those of you who are old enough to remember the Whiz Kids might remember in the early '70s there was something going on across the State of Pennsylvania called deinstitutionalization. It's when places like Norristown State Hospital, which once had 3,000 or more patients on its grounds in fairly short order let

more than a couple thousand of them go at a time. And two of these individuals ended up in Montgomery County Prison, which if you know Norristown in those days was kind of a Gothic structure, had two huge iron doors, and when those doors closed behind you, you knew you were in prison. It's nothing like the more modern prisons we have now at the counties.

In any case, those were the days when not only were there not mental health services in prisons, there wasn't even a nurse. And these individuals unfortunately took their life and it galvanized the whole community, which was fairly socially conservative at that time, but nonetheless was really taken aback by what they thought were unnecessary losses. And the county commissioners, the health community, the mental health community such as it was, which, again, was only a few years old at that time, the community in general, educators all got together and said we have to do something about this.

Now, as the mental health system in Pennsylvania developed, crisis services were sort of the last on board. More attention was given to treatment services, and that was certainly the case in Montgomery County. What was decided is that they wanted to come up with a place where 24 hours a day, 7 days a week there'd be a psychiatrist on duty and anyone, whether it was law enforcement who

encountered an individual who they thought was showing some of the signs that my friends here described as possible mental health crises or worse, could bring them, get an evaluation, decide what kind of help they needed. And that's how we came about.

For the next roughly 25 years we focused on suicide prevention in terms of crisis intervention. They're not the same thing. Crisis intervention responds to a situation at hand. Certainly, we see a lot of suicidal people. Last night, I was working in our crisis center. Almost all the calls we received, almost all the patients we admitted were related to suicidality.

In your legislative capacity as this session and others, one of the Bills that you've paid attention to has to do with amendments to the Mental Health Procedures Act. We use the Mental Health Procedures Act every day. We use it as a lifesaving tool. The numbers 302 are very, very significant. Most of the emergency psychiatric admissions in Montgomery County, that's 50 to 60 percent of them, are involuntary; 90 percent of them are individuals who are felt to be a risk of suicide.

So we are very much involved in suicide, but like everybody else, it was still something that happened to somebody else. It wasn't something that happened to us. We are on the crisis intervention side of it. Well, about

15 years ago, it happened to us. In quick succession we lost two former employees to suicide, one, an EMT who had gone on to take a job with another organization. We have our own emergency medical service to transport people having psychiatric emergencies. And more recent, a psychologist who left us. One day we heard that they both had taken their lives violently with firearms. That's when we decided that we couldn't sit and wait for people to call us. We couldn't wait for the police to bring people to us, that we had to basically do something about this phenomenon that was claiming the lives of so many people in our community.

So we got started. What's the situation? What's going on? Well, first of all, we've realized that nobody owns suicide. Nobody owns suicide prevention. It's kind of like fire prevention; it should be everybody's business but there's no fire department. The mental health system isn't specifically designed to deal with suicide prevention. A lot of the services certainly relate to that. Mental illness doesn't cause suicide; it's a risk factor. Certainly, individuals with mental illness, particularly serious mental illness are at high risk of suicide, but most people with mental illness do not attempt suicide, let alone take their lives, but there certainly is a high incidence.

But the mental health system isn't the only answer. As you heard from the other presenters, it's something that affects individuals in schools. Certainly with House Bill 5059 you're looking at training 6th to 12th grade faculty to recognize the signs of suicide. You know it's a pervasive problem. But nonetheless, it still hasn't become one that's taken hold of the whole community. It's done so in the military, it's done so in the VA, to some degree it's even done so in the prison system, all locations that have individuals with high risk, but it hasn't translated as yet into the community. And that's kind of what we were doing.

The second thing we found out was when we realized that it wasn't something that anybody owned, anybody took accountability for at that level was the realization that most people didn't believe or didn't understand it could be prevented. I mean certainly you've heard some of the myths of suicide, even you recognize them as such. Once somebody's suicidal, they'll always be suicidal. They'll always find a way to do it. You stopped them; they'll go back and do it. None of those things are true. We've had people discharged from our facility that have never come back, never been suicidal again not because necessarily of anything we've done because most of what happens with us and every other psych hospital is we

stabilize individuals. The individuals that my co-presenters talked about that were rescued or prevented from taking their lives still are at risk. If they made a suicide attempt, it doesn't go away. It's still something that can happen and we need services that address preventing suicide, teaching people other ways to deal with their problems.

But in any case, as a crisis center, we were focused on that. So we realized that one of the things people didn't understand is how much of a community problem suicide was. The State Health Department has lots of statistics but they're not reported on a county-by-county basis. You have to go look for them. They're a couple years behind. There are things like the child death review teams, which look into some types of death which include suicide but there's nothing across the board. So we started basically telling the community how many people were dying in Montgomery County and southeast Pennsylvania, and Pennsylvania on a year-by-year basis and it started getting some attention.

For example, in 2011 there were 122 suicides in Montgomery County. That number doesn't sound maybe like a lot. It's a county of almost 800,000 people. But when you consider in 2005 there were only 62 suicides. And guess what? They went up every single year since then, not

erratically, right up. And they've gone up in the State of Pennsylvania. There were maybe 1,300 back in 2005. There are over 1,700 now.

So it's a problem that costs us not only lives, it costs us productivity and it disrupts some of the things, for instance, when my friend Maureen Feeny-Byrnes comes up and talks to you about what the peer specialists are doing, well, one of the things that's being accomplished in the mental health field is recovery. Well, probably nothing disrupts recovery more than suicidal ideation, more than having thoughts of taking your life, so it's something that has to be addressed.

In terms of what we've done about it in Montgomery County, I don't think we were the first county to do so but we were among the first. We started a county task force has been going on since about 2002. We've brought agencies together, we've tried to coordinate what's going on, we've done a lot of educational stuff and kind of laid the groundwork to some degree for not only the Mental Health First Aid training but also other types of suicide prevention training, what we call gatekeeper training, that trains people, familiarizes them with basic skills to recognize a possible crisis situation and help somebody. But most of all, it enables people to ask are you thinking about hurting yourself and not just think that is something

that's not what happened.

In front of you there's a couple of examples of things that we've done. We put together these little suicide prevention kits. The one in my hand on September 10th last year, National Suicide Prevention Day, we gave 500 of these out to every high school counselor, every SAP counselor, every school psychologist in Montgomery County. We're still giving them out to public and private schools partly to address the problem that my friend spoke about about the risk that's presented there but also because we wanted to put something in somebody's hands beyond the training, something that they could have with them in their handbags or wallet, in their shirt pocket.

What you have in front of you is the law enforcement emergency responder version. Every cadet at the police academy, the Public Safety Academy in Montgomery County gets one of those, every EMT trainee. The organization I work for since 1976 has been doing a three-day police training. Every police officer in Montgomery County, correctional officers, most of the probation officers, a lot of the judiciary have participated in the three-day mental health crisis intervention training. All the trainees get that little booklet as part of it. We were fortunate enough to get the State Medical Society and Mascaro's, which is a local waste removal company, to help

us finance another printing, which is the one we have in front of us.

We are also putting together a version of this to give to the family member of every single patient that leaves our facility. One of the highest risk periods for suicide among people with serious mental illness is the 30 days after a psych hospitalization. Now, you would say, well, that doesn't sound right. That sounds paradoxical. Well, you have to understand that a psychiatric hospitalization is 24/7 support, and one of the things the hospitalization doesn't do is address the problems that Genny spoke to that maybe even result in people going to shelters.

We don't undo the foreclosure. We don't undo the divorce. We don't undo the custody battles. We don't get the job back. All those things that affect a person's self-esteem, that basically may bring them to the point of despair where they feel they're a burden to their families, their lives aren't worth anything, they're still there. We've just basically stabilized them. Hopefully, in the several days that we have them we try to certainly give them some insight into their problem, but the minute they walk out that door, decompression sets in.

Unfortunately, one of the things that hopefully things like Mental Health First Aid will teach family

members is that right now we don't have a cure for most of these illnesses and nothing approaching a cure. They could be managed; people can be in recovery. Schizophrenia is a lifelong disabling illness, bipolar disorder, depression. Nonetheless, when somebody's stabilized, when somebody's been medicated, they look a lot different than when they were in crisis. So families sometimes think they're well. Well, they are well but they're not cured and sometimes people let their guard down. It's not that people need 24-hour surveillance; it's just they need ongoing support. Sometimes people go home alone, things like that. So there has to be more to help people readjust to the community and things like that.

So we had some help from one of your legislative colleagues. Senator Daylin Leach helped us get a small grant from the Department of Economic Development and Community Affairs. The bridge that Genny told you about where that individual almost lost his life, every approach to that bridge now has a sign with our crisis number on it because most people walk out on that bridge. It's the Dannehower Bridge where 202 goes over to Schuylkill. If you've ever been there, it's a darn long bridge. It would cost millions to put fences up. But nonetheless, it's high enough above Schuylkill that when you hit that water, it's like hitting concrete off the top of this building.

So in the course of a two- or three-year period, a number of people do two things. They go out on that bridge to see what it might be like to take their life, and oftentimes, a passing motorist will call 911; or, like the person that Genny told you about, they go there to end their life. And basically, we try to put one little speed bump in their way with these signs. So whether you, from the Upper Merion side, the Bridgeport side, the Norristown side, there's four municipalities plus West Norriton that cover that bridge. Somebody sees those signs.

Somebody who's really acutely ill who's ready to die probably isn't going to pay much attention unfortunately. Somebody who basically is ambivalent, as most people are, will. And we've had people call us.

In terms of other things that we've done, we've gone into the schools, we've given them training. I've got a program coming up at the new parochial high school Pope John Paul II out in Royersford. They reached out. They want their faculty to know a little bit more about what their students are at risk of.

So this is what's going on. None of the things that we're doing in Montgomery County are unique to Montgomery County. It can be replicated elsewhere.

The little ace card that you have in front of you, we got the idea from the Army and the VA. We turned

it into a civilian version because obviously on a military base at a VA hospital you could be a little more forceful in escorting somebody for help. So we use the word "engage" rather than "escort." But nonetheless, the steps are the same.

We've given out thousands of those. We've given them out in schools. Police officers have them to get out. We've taken the approach that -- and again, as legislators this may sound strange -- you don't need a lot of money to do this. I mean we know a lot about suicide prevention. Yes, it costs something to do but there's a lot of literature out there; there's a lot of research.

For instance, in the last couple of days you may have heard the first findings from a study that the Army and the National Institute of Mental Health have taken on when they've gone and looked at the suicides in the military, at least that branch of the military, 2003 and 2009. One of the things they found that wasn't previously known at least in all the stuff I read is that things like the emotion and disciplinary actions were very common among some of the troops that took their life. That ties in with something we know about suicide. Shame has a lot to do with it. And certainly in a military setting discipline and emotion aren't taken lightly. But it's an important thing to understand and it has connotations for the

nonmilitary world.

Before that, the U.S. Air Force had a major problem with suicide back in the '90s. One of the few evidence-based suicide prevention plans is something that they implemented on a service-wide basis. They basically engaged the chain of command, had a program where everybody's your wingman and lowered their suicide rate from 15 per 100,000 to 3. And it's held pretty much since despite what the other services have experienced as a result of our two wars in the Middle East.

We're getting a lot of information but we need a way to put this on the streets so to speak. One of the things I think you can help with, I know you've given some attention to renaming the Department of Public Welfare, lots of luck with that. I mean remember many, many years ago it was the Department of Public Assistance; well, we still hear that. So it takes a while for those things to take on.

But a big problem with suicide is stigma and it's the same problem with mental health, only worse. And it affects not only the person that died, who fortunately isn't experiencing it, but somebody who's attempted suicide is stigmatized by what they've done or hopefully not done and the family members of those left behind by the victims are stigmatized. They hear things like, well, didn't you

know he was mentally ill? Didn't you know he was going to do it? Why didn't you do something, that kind of stuff.

Stigma keeps people from asking for help, especially those of us in here who are men. We don't even ask for direction. Do you think we ask for help when we get depressed? And now that there's GPS, we're never going to learn how to ask for help. That's a big problem. Women have a much lower suicide rate because, among other things, they communicate. They're not ashamed to ask for help. Inside every one of us is a little Army Ranger trying to get out who, the minute things get tough, we hunker down and don't ask. It doesn't make any difference whether you're a fullback or the president of a chess club. You respond the same way.

So one way you can help is to give suicide a home in Pennsylvania. My proposal is the Health Department. You know why? First of all, they have the data; they have the statistics. And guess what? Health, not public welfare, not human services. It de-stigmatizes suicide. I'm not saying set up a department, maybe one person that once a year issues a report to either your Committee, the General Assembly, or the State of Pennsylvania on what's happening with suicide in the State. Instead of having to go to basically a very good website, a very accessible website, but one that takes several steps to ferret out

what's happened in Bucks County, Montgomery County, what's happening in Pennsylvania. I know it would cost something but it would make suicide visible. From there, I think we could do things like build on the programs you're going to hear about today.

Somebody once said, in fact, it goes like this. The gap between what we know about suicide and what we do is lethal. The lethal part of it is we know who, what, where, but we don't know why. I think we're starting to get the research from the military and other studies that are going on but we now we need to put it into effect.

Thank you for your attention.

REPRESENTATIVE MURT: Thanks, Tony.

MR. SALVATORE: Okay. I'd like to turn it over to Maureen Feeny-Byrnes, who's going to tell you about the Certified Peer Specialist Program in Montgomery County.

REPRESENTATIVE MURT: Good morning, Maureen.

MS. FEENY-BYRNES: Good morning.

REPRESENTATIVE MURT: Thank you for being with us.

MS. FEENY-BYRNES: You're welcome. Thank you. I was going to say good afternoon. I don't know what time it is. I'm a little nervous. This is a whole new Committee, and I want to thank you for your support of our Montgomery County regional CSP meeting that you have attended.

And I also want to acknowledge any veterans who are in the room or on the video and thank you for your service. Tony has made reference to them.

It's been interesting sitting here listening to some of the information and I guess I want to start with telling you that I am the evidence. I am a Certified Peer Specialist. I am a person in recovery from a serious mental illness and also from a co-occurring drug addiction.

Listening to Trish talk about Mental Health First Aid for youth is so very exciting to me. During my teenage years is when my three suicide attempts happened and there was no one to talk to. There was nothing out there and I did feel that I was broken, that there was something wrong with me, that I just couldn't function in society.

So when I was 27 I did get into recovery. I got plucked and all kinds of things started happening. One of my alma matters is also Norristown State Hospital. You know, I joke that I have the best job in the world today besides being a mother because I lived in a state hospital and because I'm in recovery. It's pretty amazing.

I'm also the adoptive mother of two challenged children, and the other person that was going to be here today, Patrice, wasn't able to make it but she was going to represent the Talk Line from Access Services. I have given that information to both of my children. They can text

also to this talk line because they're both incredibly bullied at the high school that they're in because they are challenged. They're different is what the kids say to them. So there's an avenue out there for them. I'm going to cry. There is an avenue for my children today that they can reach out and they don't have to be ashamed anymore.

So I want to talk to you about the Certified Peer Specialist Initiative that happened, and I am going to read some of this because I want to make sure that I get all the correct information to you.

So what is Peer Support? Based upon the fundamental principles of recovery, Peer Support Services are specialized therapeutic interactions conducted by self-identified current or former participants of behavioral health services who are trained and certified to offer support and assistance in helping others in their recovery and the community integration process.

And I think I need to interrupt there and say not just community integration. Some people have never been integrated into the community so it's a whole process of getting them introduced. People with mental health challenges have not been part of a community for a long time. So peer support is intended to inspire hope in individuals that recovery is not only possible but probable. I am the evidence. It happens. It is possible.

The service is designed to promote empowerment, self-determination, understanding, coping skills, and resiliency through mentoring and service coordination supports that allow individuals with severe and persistent mental illnesses and co-occurring disorders to achieve personal wellness and cope with the stressors and barriers encountered when recovering.

Peer support is designed on the principles of consumer choice and the active involvement of persons in their own recovery process. This is not something done to people; this is something that people participate in.

It's kind of like driving a car. Somebody explained that to me when I first came into recovery. If you think about you're driving a car and you have a driver and then they talked about it being the doctor sitting in the passenger seat and then in the backseat were the nurse and maybe the social worker or the caseworker and then me in the middle of the two of them.

So we're driving along and they're making all the decisions about where we're going in this car and all of a sudden the doctor kind of defers back to the nurse and to the social worker and then the social worker and the nurse kind of turn and focus and start asking me questions. Well, eventually, I move up to the driver's seat like I don't need all these other people in my life directing my

life anymore. I absolutely need them in my life but I want to be the driver now and support me through that.

So on an ongoing basis, individuals receiving the service are given the opportunity to participation in and make decisions about the activities conducted. Services are self-directed and person-centered with a recovery focus.

Peer support services facilitate the development of recovery skills. Services are multifaceted and include but are not limited to individual advocacy, education, development of natural supports, support of work or other meaningful activity of the individual's choosing, crisis management support, skills training, and effective utilization.

So where did Certified Peer Specialists begin in Pennsylvania? Well, in 2002 the President's New Freedom Commission on Mental Health recommended that the Nation fundamentally transform the mental healthcare system in the direction of actively facilitating recovery.

I'm visually challenged so I have big notes here. It's not a whole lot. I just have big notes.

The Pennsylvania Office of Mental Health and Substance Abuse Services responded to this recommendation by identifying peer support services as an essential way to transform the mental health system. In November of 2004

the Pennsylvania Recovery Work Group generated the following definition of recovery to guide the service system transformation in the State of Pennsylvania: Recovery is a self-determined and holistic journey -- I love that -- that people undertake to heal and to grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members, and community members not in a congregate living, you know, in the community of my choice. And we are working really hard in Montgomery County to make that happen with our whole residential transformation process.

In 2005, the Pennsylvania Office of Mental Health and Substance Abuse Services, OMHSAS, gave full endorsement to the definition and committed to transforming our own mental health system, which included the development of services that facilitate and support recovery. Peer specialist services have been defined in Pennsylvania as one of these services.

In 2004, the Office of Mental Health and Substance Abuse Services received a three-year $300,000 mental health system transformation grant award from the Center for Medicare and Medicaid Services. It provided for the development and refining of a training curriculum and a

peer certification process known as the Pennsylvania Peer Specialist Initiative. The goal and the design of Pennsylvania's grant project was a partnership between OMHSAS and the Mental Health Association of Southeastern Pennsylvania to develop a Certified Peer Specialist training curriculum and to research services designed that could lead to Medicaid-funded peer support services.

In March 2005, central, northeast, and western regions of Pennsylvania were selected for the initiative. The implementation plan was based on the knowledge and experience gained from the CPS initiative in Montgomery County who currently employed Certified Peer Specialists.

We're coming up on our 10-year anniversary. Our first training in Montgomery County was in the year 2004 and we still 10 years later have two peer specialists from that class working in a provider agency where they first started.

So, a brief history consolidated, 2004, the three-year grant to implement the Peer Specialist Initiative; 2005 was a call for a change; 2006, the first class of OMHSAS Certified Peer Specialists graduates; 2007, Medicaid funding for peer support services as a component of the rehabilitative services; May 2007, OMHSAS released the Peer Support Services Bulletin, handbook pages, supplemental provider agreements, frequently asked

questions document, service description requirement checklist, and the Serious Mental Illness Priority Group Bulletin.

I have to tell you. I've been in my position for eight years and I've gone to a lot of conferences throughout the United States. When they find out that I am from Pennsylvania, they are so very excited because they know that we are the frontrunners, the forerunners in peer support services. They want to know how we do it, just everything about it. And in all 67 counties, every one is to have peer support services. That was their mandate so hopefully that's happening.

In 2007 in July the Pennsylvania Peer Support Coalition was created. Peer Specialist Services works through mentoring and service coordination supports that allow the individual with severe and persistent mental illness and co-occurring disorder to achieve personal wellness while recovering. Peer specialists work with individuals who receive hope, empowerment, self-determination, coping skills, and resilience. What being a peer specialist means to me is independence, self-sufficiency, recovery, and career development. And I think you have this handout.

So where are we today in Pennsylvania? In the State of Pennsylvania we have, as of the end of December,

3,212 Certified Peer Specialists. That's phenomenal. I am so excited about that. In Montgomery County we have 252.

In 2010 OMHSAS OVR, Temple University, and the Pennsylvania Peer Support Coalition conducted the first statewide Certified Peer Specialist survey, so I wanted to present you with some of these results. First, I want to tell you about the training. It is a 75-hour training. It's a 10-day training. It's comparable to a three-credit college course and there are some areas that offer three credits for that. I'm in the process right now of setting up our 16th training. It'll happen in July and August of this year. Only 20 people get in. I will have 80 applicants for that training. That's 80 people with severe mental illnesses that want to turn their life around and pay it forward and start living a life in the community.

So what does the training impact? This is what the survey showed. And it used three categories: society, the behavioral health system, and the individuals who received the training. So, as you can see, before the training 63 percent of the people were working, after the training 83 percent; 16 percent unemployed, 3 percent after the training. Societal outcomes: reduced public assistance by 52 percent, decreased hospitalizations by 47 percent, decreased crisis and ER services, 42 percent. This is what Tony was talking about. This is the power of peer support.

This is just one person, you know, I've been where you are. Let's just talk about this for a minute.

System outcomes, these are all the categories, different populations that Certified Peer Specialists will work with. Forensic and veterans, again, this is from 2010. I would venture to say that's much higher now with the effort that has happened pushing that forward. And then you have all the different settings that Certified Peer Specialists will work in.

So one question that I wanted to really identify was survey question 28 and talking about developing new skills. Between strongly agree and agree, that's like 94 percent of the people that took that class said it was applicable to their life in recovery; 73 percent said that the training did not provide me with knowledge; 87 percent more hopeful about their future; 91 percent hopeful about the future of the peers that they work with; 88 percent, the training gave them more confidence that they can do things to further their own recovery; 73 percent, training gave them confidence to seek employment. Some people have never worked because of the stigma, because of the fear. So they take this training and they get the hope handed to them like this can happen for you. Ninety-five percent, the training gave them more confidence that they can do things to support the recovery of others. So the higher

that they can help others and then to help themselves, I love it. And then 84 percent, supportive relationships as a result of the training. They really do become a community. There's 20 people. You're with each other for 10 days, 75 hours straight, and it's just phenomenal.

And then I wanted very specifically to show you where we are in Montgomery County with Certified Peer Specialists from 2008 to 2013 and these are the regions across Montgomery County, the number of Certified Peer Specialists. And, as you can see, I mean it's tremendous the growth that we've had and then also the growth in the participants served.

So the employment rate for Certified Peer Specialists, the national average for this serious mental illness is only 10 percent employed; in Montgomery County, career centers with peer integration. So we have established career centers in six of our provider agencies, and they are Certified Peer Specialists working with other employment specialists. Well, the ones that have the Certified Peer Specialists working in the career center have almost a 60 percent increase in finding jobs with people where without the peer integration it's only 30 percent. So this is pretty phenomenal.

And then I just want to end with the evidence for how belief inspires, how hope transforms, and how giving

heals the soul. I am the evidence for what can be achieved, how feeling connected can ground and how there's invaluable worth in an act of faith. I'm the evidence for how an example can lead, how far encouragement can take you, and how one step begins a journey towards endless possibilities.

Thank you all for your time.

MR. SALVATORE: Thank you, Maureen.

MS. BRIGHT: If I could add, this is not part of the agenda, but I'm going to speak on behalf of Maureen as well among the five southeast counties and also since I'm familiar with the forensic support services as they have been integrated into various different specialized populations in our communities.

I also work a lot with the forensic individuals who are involved in the criminal justice system. We do an awful lot of reentry on behalf of the five southeast counties. We work with the Department of Corrections and the county jails, and I think that one of the things that we have seen as an impact, again, my years of experience as a social worker, as a case manager, I work at MCS as a crisis worker, I've been out on the streets, I've worked in administration, the biggest impact that I've seen in the years is peer specialists because it is lived experience.

I as a professional can work with many people and

say here's what I think you need to do, but as a peer specialist, it's here's what I've done and here's what works, which is a little bit different than professionals telling people in recovery how to live their lives.

So I think that's, again, kind of more of an attestation to peer specialist work. We don't have this in every county like Montgomery County has in Pennsylvania, and that is one of the things that if we can speak to this Legislature about what is needed is to really kind of promote funding.

Public Welfare, our friends in the office of Medicaid, have peer specialist services available to those individuals who then have Medicaid but not every Pennsylvanian who is in need has Medicaid. So the counties can't afford to bring on a Maureen or a peer specialist who maybe has been involved in the criminal justice system and has that experience as well.

So we have the haves and the have-nots, and that's part of the problem. If we were able to kind of balance this out in a different way, it shouldn't only be a Medicaid-funded service.

MS. FEENY-BYRNES: Absolutely.

MS. BRIGHT: And I think that's part of the challenge that we see in many of the county governments right now is how to kind of balance that when it's not

Medicaid reimbursable.

So with that being said, again, I just wanted to add my two cents in, but thank you very much, Maureen.

REPRESENTATIVE MURT: Is the training program a residential program?

MS. BRIGHT: It's not residential. Becoming a Certified Peer Specialist is available in all of the State of Pennsylvania but there is a funding limitation to that as well. I mean it's very costly. I'm actually a Certified Peer Specialist Supervisor, and I took the training program because I work with individuals who are peers and who have lived experience. It's costly and not everybody can afford the maybe $1,000 that it's going to take for 10 days to become a better person. And that I think is part of the challenge so the funding is clearly an issue with the trainings.

So thank you.

MS. FEENY-BYRNES: We have two approved training vendors in the State of Pennsylvania. One is the Mental Health Association of Pennsylvania and the other is Recovery Innovations out of Arizona. And the trainings that we do in Montgomery County, the one that we're currently doing this year will be through reinvestment funds. So some years we do two; some years we have to budget the extra one. I mean it is very costly.

REPRESENTATIVE MURT: Where does the training take place? At the community college or where---

MS. FEENY-BYRNES: It does. We have started having ours at Montgomery County Community College because it is a training. It's like a college course. So, again, to kind of reduce the stigma with that, it's like let's have it at the college.

REPRESENTATIVE MURT: Okay. We have some time so we're going to entertain some questions if that's okay.

MS. FEENY-BYRNES: Okay.

REPRESENTATIVE MURT: Mr. Chairman, do you have a question?

MAJORITY CHAIRMAN DiGIROLAMO: Yes. Thank you for all your good testimony, very informative. Thank you for the good work that you do each and every day. It's absolutely essential, absolutely lifesaving.

And I've always said that you don't know about mental illness until it affects yourself or your family, and then you get an education very, very quickly.

Talking about mental illness and drug and alcohol, and mean I think 80 percent of the people that are incarcerated in Pennsylvania right now and probably across the Nation are there because of mental health, drug and alcohol, or a combination of the two. If we could really get our hands around this problem, and as you rightfully

called it, an illness, if we could get our hands around it, I mean it would make an enormous impact on our State and our communities. And we look at crime.

I heard you talk about Medicaid and that's an issue. And you did say, I believe, that if you're on Medicaid that it will pay for your services. And I guess having a specialist in Montgomery County because you have enough people that are on Medicaid and you're able to have that type of specialist, is that correct? But some of the other counties do not have that type of peer specialist in there?

MS. BRIGHT: Maureen, you can speak to what's available in the counties.

MS. FEENY-BYRNES: Medical assistance, when it was first set up, was the funder. I mean it still is. As far as I know, all the counties have medical assistance, so they would be up to have I think two was the minimum that was required to have in each county.

MAJORITY CHAIRMAN DiGIROLAMO: I mean because that's always the question. How do you pay for these services?

MS. FEENY-BYRNES: Right. Right.

MAJORITY CHAIRMAN DiGIROLAMO: And we're right now tossing around this idea of Medicaid expansion here in Pennsylvania and the plan that's out there, this Healthy PA

plan, and I think it absolutely makes all the sense in the world to do something. I mean I wish we would be expanding Medicaid right now when we're waiting for the Federal Government to come back with what they're going to allow us to do or not, but that's 5 to 600,000 Pennsylvanians that would be qualified for Medicaid and with the Federal Government paying for them for---

MS. FEENY-BYRNES: That'd be awesome.

MAJORITY CHAIRMAN DiGIROLAMO: ---the first year. It makes all the sense in the world to me.

MS. BRIGHT: Right.

MAJORITY CHAIRMAN DiGIROLAMO: One question, I don't know if maybe Trish, among young people, and I think it's a problem that is much more prevalent than anybody actually realizes, and that is eating disorders among our young people. And I'm hearing it more and more. I've experienced that myself in my own family. It seems to be a big problem. Is it a growing problem? It is something that you're seeing more and more? I mean are there solutions? I mean it seems so difficult to get your hands around that problem, especially when you're dealing with mostly young women. I mean I don't think boys are immune to it either but mostly young women to get your hands around and to treat them. I mean what's going on with that with these eating disorders? Trish, I don't know if you

can answer it or---

MS. MALOTT: You know what, I don't have the statistics about eating disorders but I do know in our adult mental health curriculum, we touch on eating disorders. And it's sort of tying into Maureen's testimony about peer support. One of the things, and even with youth Mental Health First Aid is that we also teach mature juniors and seniors in high schools to have that spidey sense. One of the things with eating disorders, it's usually an underlying problem. The eating disorder, either the purging or not eating, it's the perception of self. So the person looks at themselves in the mirror and sees not a good person, an ugly person, a very obese person even though they might be like 80 pounds.

So the thing with Mental Health First Aid is that it does touch on eating disorders. We have a section about eating disorders. And it's that support. I'm okay; you're okay. And it's okay to talk about feelings, what you're thinking, emotions. And I'm not a clinician; I'm not an expert; I'm a trainer. But what we're seeing with eating disorders is that it's a symptom of an underlying depression, anxiety, some other feelings that is happening with the person. And then eating disorders is a result of that.

So the more we can be okay with talking about

eating disorders, and I'll give you an example. We're out there talking to schools, and the parent/teacher, the parent/school partnership is really weakened because parents, they might have a son or a daughter, particularly in females it happens, that may have an eating disorder, but because there is a stigma around mental illness, around eating disorders, that information doesn't get discussed with the school. So the school, the people in the school, the counselors, the teachers, the principals, the psychologists, they may not have helpful information on how to really support this student to be successful in school.

And again, and I want to relay what Tony was saying, the stigma is the barrier. The stigma is the killer. If we can find a place to just be open about the communication and about discussing things like eating disorders, depression, anxiety. Anxiety starts as early as 11. That's the average age of onset for a child suffering with anxiety.

Our mental illness is real and it's prevalent and it's really bigger than we know because it's so shrouded in stigma and embarrassment and really an uncomfortability. So this really gets mental illness out of the closet. It gets eating disorders out of the closet. It gets depression, anxiety. We're all human. We all have the same DNA.

MAJORITY CHAIRMAN DiGIROLAMO: And that's why it's important what you're doing because as a parent, first you don't understand what's happening, then it scares you to death, and then even if you're getting some type of help, you want it to go away and you're hoping that it goes away. And a lot of times it does, and that's why I think it's so important doing what you're doing. So keep up the good work. I don't want to take up all the time, Tom, so if anybody else has questions.

REPRESENTATIVE MURT: Representative Lee James.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman. Thank you all for your testimonies. I'd like to direct this, I believe, at Mr. Salvatore, although you can distribute the question.

But first, I want to tell you how excited I am about the little Army Ranger guy. I can't wait to get back home and tell the other fellows about that.

Early in your testimony you mentioned something about I believe it was the 1970s when the deinstitutionalization started. So from your perspective, is it better to deal with the mental health issues in prisons, which I guess is what we're trying to do today? Or should we start going backwards towards institutionalization?

MR. SALVATORE: I don't think we have to go back

to institutionalization as it was. I think we have to realize how complex serious mental illness is. There used to be an old saying in the field: 1/3 of people get better with treatment, 1/3 get better on their own, and 1/3 never get better. And I think it's still true. While all of us at this table believe everybody's capable of recovery, not everybody is capable of the same levels of recovery. Some people need more supports.

For instance, I described ourselves as acute psychiatric hospital. That means a few days. But we have patients for 100 days; we've had patients for more than a year because there's no place for them to go. There's a few State hospital beds but very, very few. I don't think we need thousands of State hospital beds; I think we need some long-term facilities because unlike some of the meds that some of us may take for asthma, diabetes, things like that where they usually work the first time out of the box, that's not always the case with psychotropic meds. They sometimes take some trials and things like that.

As far as the prisons go, I think there's probably very, very few people left who are in any kind of institution who are left to State hospitals in the '70s. I mean a lot of those folks were up in years to begin with. There's a few but not many. In fact, I know one or two myself.

I think you have to differentiate two problems. First of all, there's people who have contact with the criminal justice system because of mental illness. NAMI, the National Alliance on Mental Illness, basically said that maybe 40 percent of people have that. And again, somebody who's psychotic is not really in control of their behavior might walk into McDonald's and not pay because he thinks he owns McDonald's.

On the other hand, there are people who have criminal issues but also happen to have mental illness, I think the decision has to be made where's the best place to treat them? We treat patients from the Montgomery County Correctional Facility. They're different than the other patients.

We use a building on the grounds of Norristown State Hospital. The State graciously provides us that for $1 a year and they haven't billed us for that $1 for a long time. But we spend maybe a quarter-million dollars to keep the building from falling down every year. But there's a regional forensic facility there where people not guilty by reason of insanity, people who can't participate in their trial, people who aren't ready to serve their sentence because of psych issues go to be stabilized. The people who run that program are correctional officers. They're not mental health workers.

So what I'm saying is I think we have to look at the problem. Is mental illness a problem in prisons? Yes. Are people with mental illness inappropriately incarcerated? Yes. But there are efforts underway, including some of the ones that have been talked about here today that would keep that from happening.

But I think one of the reasons people may end up being warehoused is because there isn't an adequate range of services beyond outpatient services and things like that for people to be served. Meds aren't a panacea for everything. Some people need longer-term residential services; some people need more acute services. But the key thing is the services should be appropriate.

One of the problems with us taking care of somebody for 100 days or 300 days is it's like Gilligan's Island. It's like Groundhog Day. If you're a short stay psychiatric facility, the whole treatment program is geared for people to leave in a couple of weeks. Our groups, you know, we don't have a year's worth of groups. It's really tough on somebody if they're there. They need to be somewhere and we don't have enough places in Pennsylvania for them to go. They don't end up in prison just because there needs to be a place for them to go.

But getting back to your original part of your question, I think we need more facility options because in

the long run I think it'd be less expensive. I think people would learn how to manage their care better. Some of the legislative initiatives like assisted outpatient treatment and things like that that have come up, changes in the mental health commitment criteria, they wouldn't be issues if basically somebody had a chance to get a level of intense treatment they needed, learn how to take their meds, learn how to manage their care. We wouldn't have to basically fine-tune other kinds of legislation.

REPRESENTATIVE JAMES: Thank you very much.

MS. O'DONNELL: Can I add something to that? Working from the homeless side, the big push in this country right now is for housing first. It doesn't have to be a choice of an institution, a prison, or something else altogether. Housing. And a lot of times when you're talking about the people who are in prison who are being treated in prison, some of that is also due to homelessness.

And not only is this a question of humanity and how do you want people to live but it's also dollars and cents. The amount of money it costs to keep somebody in a hospital or in a prison as opposed to in housing is huge. And to have somebody in the community support it where they can get those treatments, where they have the teams, where they can have the peer support, where they can have the

professional teams that actually visit them in the community, again, it's humane and it's cost-effective.

REPRESENTATIVE MURT: Thank you.

Representative Pashinski had a question.

REPRESENTATIVE PASHINSKI: Thank you, Mr. Chairman. And thank you all very much for your work and your testimony today. I have a two-part thing here.

Relative to those that are involved in Alcoholics Anonymous, I know that they've expanded their program to the point where on a daily basis an individual who has suffered from alcoholism is in contact with a mentor, is in contact with support groups, and on a daily basis or every evening they attend these support groups. Would your Mental Health First Aid have a system similar to that?

MS. BRIGHT: The Mental Health First Aid program really is not a service per se. Again, it's teaching individuals, general citizens, how to identify and at the early onset problems, signs, and symptoms. Peer specialist supports, mobile supports, recovery coaching supports, an array of various different types of community mental health services that are in place now do provide sometimes day-to-day support. Peer specialists I think would be probably more in line with what we would consider a sponsor or someone who's kind of a connected person to a person in recovery like in Alcoholics Anonymous.

MS. FEENY-BYRNES: Can I also address that?

REPRESENTATIVE PASHINSKI: Yes.

MS. FEENY-BYRNES: One of the things that we are committed to in Montgomery County is mutual aid, and we are expanding the network that we have. We have two groups: the Wellness Recovery Action Plan, which is an evidence-based practice, comes out of Mary Ellen Copeland. We are running six support groups that we have in Montgomery County for people just like Alcoholics Anonymous that they can go to those groups. There's a whole process, a WRAP plan that they would make prior to getting to this support group.

The other mutual aid group that we have started is for people who hear voices or who have other unusual experiences, and we have a person in Montgomery County who is part of the Hearing Voices Network, the worldwide Hearing Voices Network, and she has brought that initiative to Montgomery County. She also has six support groups. One of them is for young adults. So this is for people to attend these meetings on a weekly basis. I think they run in different areas of Montgomery County.

REPRESENTATIVE PASHINSKI: But that's just Montgomery County?

MS. FEENY-BYRNES: Well, I'm letting you know that there are things happening. It would be great if

other counties would because it's modeled after Alcoholics Anonymous.

REPRESENTATIVE PASHINSKI: It just seems as though you're on those early steps that Alcoholics Anonymous was---

MS. FEENY-BYRNES: Absolutely.

REPRESENTATIVE PASHINSKI: ---many years ago and it's now starting to come to fruition.

MS. FEENY-BYRNES: Yes.

REPRESENTATIVE PASHINSKI: And I would assume that all your data that you're collecting is evidence which will justify certain allocations because in the long run your methods will be in the area of preventive and productivity, you know, far more beneficial to Pennsylvania and far less costly.

And then I was wondering if you could put a price tag on your home healthcare as opposed to prison institutionalizing because that's about $35,000 is a number that they're generally using. Now, if we had a specialized unit for those in the mental health area, what would the cost of their care be in that particular unit as opposed to prison as opposed to housing?

MS. BRIGHT: Well, I can speak a little bit about costs. I wear a variety of different hats, as you might be able to tell. In the last about 15, 18 years I have been

the coordinator for the Regional Mental Health Services Office to oversee the downsizing at Norristown State Hospital. I was involved with Haverford State Hospital. And of course now my attention is now more towards forensics and community education.

The cost to keep someone in an institution we know ranges between about $140,000 a year upwards to about $200,000 a year if they're in the forensic unit. I've also developed very high end specialized programs on behalf of the five southeast counties as we've had individuals leave. Some of those costs average $300 a day. So it's really very equal to that of an institution. There's 24-hour, as Tony puts it, surveillance. We consider it actually providing support services and care. And then downwards to various different kinds of specialized supported housing models and where people are actually living on their own receiving mobile supports in their own home, which can cost less than $40, $50 a day.

I think one of the things that we recognize in terms of housing and treatment is housing's not a reimbursable resource. Medicaid doesn't reimburse for housing or residential supports. Treatment is reimbursed. So what we need more of is housing. And I agree with Genny and I think my colleagues. We know that treatment works. We know that there's community services such as WRAP and

peer specialists and recovery coaches and a variety of different types of modalities, psych rehab programs. We have an array of services in the community in Pennsylvania that we've never had before, not since the 1970s for sure when institutionalization was the only thing.

And I think what we have been able to see is we've been able to shift most of those costs to health choices and to Medicaid reimbursement, but there's still a percentage that isn't reimbursable, and that's part of the problem.

I think that what happens when we also see individuals who come into the criminal justice system, it's because they do not have those services and supports wrapped around them. So we try to look at it from the diversion end and we work a lot with diversionary courts and being able to try and focus on catching the person before they wind up coming into the criminal justice system and costing our State and our local county jails upwards of $125 a day to whatever it may be if they're receiving mental health services. It could be $200 a day.

But I think we know what works for people in the community; we just don't have quite enough of it.

REPRESENTATIVE PASHINSKI: I want to thank you very much for that. I'd like to see if there was a way we could continue this conversation because what's difficult

for us as legislators is to understand $140,000 a year in an institution, $35,000 in the prison. You know, I'd like to see those cost-outs on how that's determined because some of those things sometimes can also be worked on as well.

But thank you very much.

MS. O'DONNELL: It's also important to recognize that for people who actually live on the street where you're paying neither the prison or the institution or the hospital, they're costing an awful lot of money as well because of the emergency services that are entailed with maintaining their life. And it's the emergency room visits and the high cost of that and there's a lot of good articles and a lot of good reports. There was that one article that came out where they call it Million-Dollar Murray. They followed a homeless gentleman who cost $1 million of taxpayers' money, and all of that stopped when they put him into housing.

MR. SALVATORE: One thing to keep in mind when you're considering cost is while none of us are for prolonged institutionalization, coercive treatment, or things like that, the other side is there's nothing particularly beneficial about sequential psychiatric hospitalizations. In other words, it's a traumatic event.

Certainly, as legislators as you've consider the

Mental Health Procedures Act, I think what jumps from the page from that law is that people are forced into treatment, and it might be better to consider providing care for a longer period of time once than to have somebody hospitalized 15 or 20 times a year, 15 or 20 times in the back of a police car handcuffed, 15 or 20 times being led out in front of their neighbors.

And again, I'm involved with an organization that does this and we try to make it as painless as possible. There's nothing painless about it. I mean it's not something that anybody enjoys being associated with even though it's for somebody's benefit.

So what I was trying to say before we certainly understand in the mental health system the problem of coming up with resources for so many different kinds of programs, but I guess what we're thinking about is to, if possible, consider an investment kind of an approach where instead of somebody coming to a facility like ours for a few days, being stabilized, going back in the community, and again, there's no mental health police. I mean somebody may follow their treatment plan; somebody may just not get long with their therapist. And then a couple weeks later either they're threatening suicide or threatening the neighbor's satellite dish because they feel it's beaming signals into their head or something like that.

So maybe it would have been better, again, not necessarily at a place like ours but maybe at a place once they're stable they might go to another setting, not necessarily a State hospital where, again, there could be a little further work so then when they do go home both they and their families, they can make the most of what's been invested in their care.

We don't have a system like that now. I think that's one of the problems. You may hear from family members that are frustrated by feeling people are at risk by being on the street.

Genny's absolutely right in terms of housing being a great need if we could provide that, but again, we have to put people in the housing that are able to manage it where landlords will work with them. We have a housing initiative in Montgomery County that's doing great things. Genny's agency does a great job in placing people from homelessness into -- and certainly one of the things that brings people back to psych hospitals is homelessness. And that's a problem.

And I think all these things are interrelated and lowering cost isn't the only way to solve the problem. In fact, it's sort of pay me now or pay me later.

REPRESENTATIVE PASHINSKI: I hope you don't think that was my only concern.

MR. SALVATORE: I certainly don't, no.

REPRESENTATIVE PASHINSKI: It is a concern that we all have to deal with on a regular basis.

MR. SALVATORE: Absolutely.

REPRESENTATIVE PASHINSKI: And the conversation that we're having right now is extremely helpful. First of all, it's an understanding and a lack of understanding. It's education. It's no different than what the alcohol folks went through many, many years ago. So rather than trying to reinvent the wheel over and over again, I hope we can continue this conversation and get down to some real hard work on setting up some other systems that really produce quality outcomes.

Thank you.

MR. SALVATORE: And if I could just add one thing, I mean these hearings certainly related from the anniversary of what happened in Newtown, and when we have events like that, the mental health system is on everybody's mind. I think what we have to realize the mental health system should be on everybody's mind all the time. And I'm not saying we can necessarily prevent every untoward event that affects our society, but one of the things that's very frustrating for us in the system is to hear that we're broken and things like that. We may be under-resourced and things like that, but the mental health

system can't be the means of dealing with every societal problem.

Again, with all due respect to the correctional system, they're much better financially endowed than the mental health system at every level, and I think they have to have some accountability to deal directly with some of the problems that are there. The drug and alcohol system, the developmental disability system, the mental health system can't fix everybody. It's kind of like we're at the bottom of where all the other silos empty out. And at the same time we're expected to take on new problems all the time. I think some emergencies, for example, should be dealt with by other than -- not every emergency is a mental health emergency.

So again I think we are on the same page. I think there's a need for a dialogue and appreciate you opening up the door to it.

REPRESENTATIVE MURT: Okay. We have three more questions from the representatives, but just a reminder, we have to be up on the Floor by one o'clock.

Representative Pam DeLissio.

REPRESENTATIVE DeLISSIO: Thank you.

Very quickly, and I may have missed it; I was a few minutes late. The Mental Health First Aid training, how many hours or how long does that training take?

MS. BRIGHT: It's an eight-hour program. It actually started out as a 12-hour program and the National Council decided to kind of pull it back after some research that folks would participate more frequently if they were in an eight-hour training.

So we offer it in a couple of different ways. We can do a one-day training or we can do two four-hour sessions, which usually are back-to-back days. Or you can break it out into two-hour sessions and have it on a weekly basis or whatever.

There is some cost associated with the trainings. We actually haven't received a budget in my office through the five counties for this. Philadelphia is a little bit more endowed in this because they've actually put in effort through this public health initiative to be able to pay for Mental Health First Aid training. But the average cost of a training is to have two instructors. The manuals themselves cost about $17, $18. Every participant receives a manual and the cost associated with making sure the site, the location, and particularly food is an incentive for some people to join in trainings.

So the cost is relatively low. On average it's about $1,500 to $2,000 to do a training. We in the southeast region try to find sponsors, providers to cosponsor communities to come together and maybe to have

some of their behavior health staff join, so we kind of bring that network together so they know where and who the professionals are.

And so roughly it's about $30 per person to receive a certification. It's a good deal actually.

REPRESENTATIVE DeLISSIO: And then is it like CPR? You're certified for X period?

MS. BRIGHT: Yes.

REPRESENTATIVE DeLISSIO: Is this a similar thing? You're certified for X period and then you would have to retrain?

MS. BRIGHT: Yes. The certification is actually three years from the National Council for Behavioral Health. And there is ongoing technical support for Mental Health First Aiders. So there's a whole web system. You can be involved in webinars and interactive technical assistance through the National Council's system.

REPRESENTATIVE DeLISSIO: I ask in particular my district office over the three years I've been in has seen its share of folks with a variety of challenges. My staff aren't necessarily equipped to understand in this. I'm very empathetic and sympathetic so it looks like this training could be a good investment for district office staff perhaps.

MS. BRIGHT: It would be a wonderful training for

district office because, as I know, you receive calls quite often from citizens saying I have a problem or a concern and trying to find out where and how and kind of again how to respond to individuals and where to refer them to.

We don't have enough instructors in the State of Pennsylvania. That's part of it. Again, we're rather endowed in the southeast region because we've really put an effort towards building this complement of instructors. But we would be more than willing to try and travel if necessary. And I cover the five southeast counties and can make arrangements to set up and schedule trainings.

REPRESENTATIVE DeLISSIO: And then to Tony's comment earlier about DPW versus DHS, Representative Murt here has made a herculean effort to get that across the goal line. I believe it's sitting in the Senate Appropriations Committee. Is that right, Tom?

REPRESENTATIVE MURT: That's correct.

REPRESENTATIVE DeLISSIO: And the Governor is supportive of it. So we fully expect and anticipate that this will cross that goal line and we invite your voice to help push that and remind us that it should be square in the middle of the radar screen. We've talked about it from a stigma standpoint. This is the year to do it, so let's just get it out of Appropriations and get it to the Governor's desk. That is where it is at.

And then just very quickly, the census for those 73 beds generally run 100 percent?

MR. SALVATORE: Right now, we try to run less than that because the fewer people there, the better care we can provide. But often it does reach the licensed maximum. And that's really very unfortunate because it means something's not going well in the community because 60 percent of our admissions are involuntary.

REPRESENTATIVE DeLISSIO: Thank you. Thank you, Mr. Chairman.

REPRESENTATIVE MURT: Thank you, Pam.

Representative Madeleine Dean.

REPRESENTATIVE DEAN: Thank you, Mr. Chairman. Thank you all for your testimony. I have dozens of questions but I won't do that to you.

On the homelessness front, I'm a Montgomery County Representative and we've had I think a sort of spike in the number of people who have come in our door and they're living in their car, they have children and they are homeless. What's our capacity in Montgomery County for homelessness?

MS. O'DONNELL: The shelter I operate is for single adults. We're a 50-bed shelter. We can do 65 people in the winter and this winter we have been running at about 85, 80, 85. For families there's three shelters,

11 families in Pottstown, 6 families in Norristown, 3 families up near Lansdale area, and then another 6 families I believe in another section. There is not a very large capacity. However, because of all the new stuff, the goal is really to be able to help people leave sooner, which hopefully means people won't have to wait as long to come in.

REPRESENTATIVE DEAN: Well, I think that's great. And I think also just the geography of where the homeless centers are, they're limited I think in capacity but also limited in geography.

MS. O'DONNELL: And geography. I mean it's---

REPRESENTATIVE DEAN: It's very difficult for my area.

MS. O'DONNELL: It is. We had people come down recently from Hatboro to Norristown and they're just beside themselves because not only are they now in the homeless shelter after living in a home but now they're disconnected from their doctors, they're appointments, their churches, and everybody else so---

REPRESENTATIVE DEAN: Right, they're schools and everything. Yes, so it's very difficult.

And then I'm interested in your course, so can anybody sign up for the course?

MS. BRIGHT: Anyone can sign up for the course.

REPRESENTATIVE DEAN: Okay. Terrific. And I think, Pam, you're right. It would be very beneficial for any district office staff who wants it.

Then on the suicide issue, what do you think is the reason for the continuing incline in the numbers of suicides? Because what's wonderful is all the good stuff that's going on, but what's going on that more and more people are dying?

MR. SALVATORE: Well, I think we have a number of trends going on in our society, chief among this is baby boomers are getting older and that's pretty significant because the oldest of the baby boomers are now well into their mid- to late 60s and their golden years don't appear to necessarily be quite as golden as their youth. Well, certainly it's not fair to smear a whole generation with substance abuse and things like that. There certainly was a higher incidence, a much higher incidence of divorce later in life, much higher incidence of people who never remarried. We have a lot of people, what I'm saying, are getting into middle age without the supports that maybe the previous generation had. And at the same time there's things like late life depression, things that come on.

Did the recession have something to do with it? Well, certainly at some point. While the stats I mentioned to you started before the recession, I think the recession

started for some people before we acknowledged it in public policy. I think Genny's program started seeing people who were displaced a lot sooner than when the Council of Economic Advisors put a label on this thing.

And again, people not only lost their jobs. Statewide in Montgomery County suicides were 20 percent women, 80 percent men. Most of the suicides involve adult white males. In Montgomery County, the proportions are shifting. It's going 25/75, 30/70. So we're seeing more women taking their life. And it's women in the mid-50s and up that are doing it. Maybe some of them didn't lose their jobs; maybe they just didn't get a promotion. Maybe they just weren't able to cope as well.

The other thing is the concern that Representative DiGirolamo is concerned about, overdoses. We certainly have an epidemic. We have an epidemic of prescription drug abuse. Well, both these things basically they're not suicide in themselves but they basically inure a person to violent behavior, mortal danger, things like that. So it's very easy for somebody to go from a substance abuse overdose to -- people don't usually take their lives with heroin; they use that to get high, but that doesn't mean they want to overdose on something else. So I think that's going on.

As far as the issue that I know is very close to

Representative Murt's heart, vets, do they play a role in this? They certainly do. But that doesn't appear on death certificates so we don't know for sure. I mean unless it comes up in the investigation, it may not otherwise. But certainly since a lot of suicides involve middle-aged men and in the southeast of Pennsylvania we have 750,000 veterans most of whom are well into their 50s and 60s, which unfortunately is the prime risk age. That certainly plays a role there, too.

So nobody knows for sure but those are some of the things. But the one thing I want to tell you is I don’t think we need to know what causes it to prevent it. I think it's a matter of education. Again, I use the example of very simply adding a little bit to the Health Department's mission. Well, here's something else you can do: 1/3 of suicides involve alcohol. I don't know what the future of the State stores are, but I don't see why there couldn't be suicide prevention information in State stores.

I don't want to get into gun control issues or things like that, but there is a back side of permit to carry. Maybe the National Suicide Lifeline number could be put there because most of the suicides in Pennsylvania involve firearms. Gun safety courses don't typically raise the issue of firearm suicides. I'm not saying that anybody has a firearm is doomed necessarily but it's an issue.

So those are little things that can be done that don't cost a lot.

REPRESENTATIVE DEAN: And I know our time is up. Thank you all. I want to echo what Chairman DiGirolamo said. Many of us believe the Governor should opt into Medicaid expansion now because it would make an impact on the population that you are serving so valiantly and he could still seek his waiver application but he could opt in now and I wish he would do so.

REPRESENTATIVE MURT: Okay. Representative Margo Davidson wanted to have a question has well.

REPRESENTATIVE DAVIDSON: And thank you, Mr. Chairman. I'll be very quick.

I just wanted to thank you all for your testimony and the work that you're doing. And the movement that I see which I think is very important to more community-based care, more continuing care as opposed to more crisis care and particularly the work of the peer counselors in reducing the stigma, helping people not to feel different, helping people not to feel isolated, helping people to feel capable as opposed to incapable, and helping with communication as opposed to silence.

I think what you're doing is amazing. I'm glad it's not as broken as I originally thought because I say that a lot. We need to move towards that in a systematic

way, in a systemic way not only through Medicaid expansion and making sure that these services are paid for but also through private insurance. I didn't have the option for my family member when he was in crisis to get Medicaid. I had private insurance. It took nine months to get treatment. So is that something you all are looking at in helping private insurers to see that it costs them less in the long run and it also saves lives for them to cover community-based care, peer counseling? Is that something you all are working on as well?

MR. SALVATORE: Well, I would say one thing. Remember, we're the ones they pay, so we're kind of in a conflict situation with them. Getting back to Representative Pashinski's thing, I think we need kind of a coalition approach to this. I think we need providers, policymakers, consumers to get across to the folks that we need different services. And basically the same quality services that you have generally speaking in terms of medical emergencies should apply to mental health and psychiatric emergencies as well. They're every bit as life-threatening, every bit as debilitating.

REPRESENTATIVE MURT: Okay. We're going to have to conclude. Thank you to all of our testifiers---

MS. BRIGHT: Thank you.

REPRESENTATIVE MURT: ---for the great

information you have put forth today. Thank you also to everyone for attending. Thank you very much to my colleagues for participating. And as you're probably aware, the Chairman of the Human Services Committee, Chairman DiGirolamo, is extremely supportive of this mission, so we're going to continue to have some of these informational hearings between now and the end of the calendar year.

So thank you to our testifiers for participating. We will ask you to participate again. So thank you very much.

MS. O'DONNELL: Thank you very much.

MS. BRIGHT: Thank you very much for having us.

(The hearing concluded at 1:00 p.m.)

I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.

Christy Snyder

Transcriptionist

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