COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HUMAN SERVICES
COMMITTEE HEARING

STATE CAPITOL
HARRISBURG, PA

MAIN CAPITOL BUILDING
ROOM 60, EAST WING

THURSDAY, APRIL 2, 2015
10:03 A.M.

PRESENTATION ON
ELIMINATING STIGMA IN MENTAL HEALTH

BEFORE:
HONORABLE RUSS DIAMOND
HONORABLE THOMAS MURT
HONORABLE CRAIG STAATS
HONORABLE DAVID ZIMMERMAN
HONORABLE ANGEL CRUZ, DEMOCRATIC CHAIRMAN
HONORABLE LESLIE ACOSTA
HONORABLE MIKE SCHLOSSBERG

* * * * *

I N D E X

TESTIFIERS

* * *

NAME PAGE

TIM CLEMENT, MPH
SCATTERGOOD FELLOW ON STIGMA REDUCTION.....6

ALYSSA SCHATZ, MSW
DIRECTOR,
ADVOCACY AND POLICY DIVISION,
MENTAL HEALTH ASSOCIATION OF SOUTHEASTERN PA.....19

JEFF SHAIR
MENTAL HEALTH CONSULTANT.....26

SUE WALTHER
EXECUTIVE DIRECTOR,
MENTAL HEALTH ASSOCIATION IN PA.....33

MARY ANN VENEZIA, MD
PENNSYLVANIA PSYCHIATRIC SOCIETY.....41

SOL VAZQUEZ-OTERO, JD
SENIOR MENTAL HEALTH ADVOCATE,
ON BEHALF OF
DISABILITY RIGHTS NETWORK OF PA.....54

SUBMITTED WRITTEN TESTIMONY

* * *

(See submitted written testimony and handouts online.)

1 P R O C E E D I N G S

2 * * *

3 DEMOCRATIC CHAIRMAN CRUZ: Let's start with the

4 custom that Gene does. Let's all stand up and say the

5 Pledge of Allegiance, please.

6

7 (The Pledge of Allegiance was recited.)

8

9 DEMOCRATIC CHAIRMAN CRUZ: Good morning,

10 everyone. I'll be leaving in about two, three minutes but

11 I just want to come in to start this hearing, turn it over

12 to Representative Murt and Schlossberg to run the meeting.

13 But I wanted to excuse myself and I apologize, but there's

14 a hundred things going on today. So I wanted to come into

15 the hearing and I'll be leaving and the two gentlemen will

16 be running the meeting. So thank you everyone.

17 I also want to remind everyone that on April the

18 9th, which is next Thursday, there will be public hearings

19 on the conditions that mental facilities are running their

20 practices. And so I'm inviting everyone in Philadelphia

21 April the 9th, public hearings with this Committee. Thank

22 you.

23 Any other questions for me?

24 UNIDENTIFIED SPEAKER: [inaudible].

25 DEMOCRATIC CHAIRMAN CRUZ: The public hearings

1 are in Philadelphia, yes. We are having the Department of
2 DHS, we have the Department of License and Inspection, we
3 have multiple speakers because there are some practices
4 that are being practiced with these mental facilities that
5 don't abide by State law. So we're trying to bring that
6 and take it to all of Pennsylvania, whoever wants public
7 hearings, but we're starting the first ones in
8 Philadelphia.
9 UNIDENTIFIED SPEAKER: May I, Mr. Chairman?
10 DEMOCRATIC CHAIRMAN CRUZ: Sure.
11 UNIDENTIFIED SPEAKER: I believe the notice just
12 went out today. I think I just saw an email about it so
13 it's probably there waiting for you now.
14 DEMOCRATIC CHAIRMAN CRUZ: Thank you.
15 REPRESENTATIVE MURT: Thank you, Chairman Cruz.
16 Welcome and thank you for attending the Human
17 Services Committee hearing on "Eliminating Stigma in Mental
18 Health." My name is State Representative Thomas Murt from
19 the 152nd Legislative District. I represent parts of
20 Philadelphia and Montgomery Counties. I'll be chairing our
21 hearing this morning along with Representative Schlossberg.
22 More and more frequently we hear about mental
23 health and the news and it's often troubling. From the
24 pilot of the German jetliner that flew into the Alps to the
25 returning veterans suffering from posttraumatic stress

1 disorder to average families conducting their lives across
2 the Commonwealth of Pennsylvania, no one is immune to bouts
3 of mental illness. Unfortunately, the stigma associated
4 with mental illness may become a barrier to seeking
5 treatment and can impact a person's hope for recovery.
6 Today, we'll focus on stigma and what can be done to
7 eliminate it.
8 I would call your attention to the fact that this
9 hearing is being streamed live on the PCN television
10 network. It is also being recorded, so your attention to
11 using the microphone when you speak will be a big help.
12 As is our custom here on the Human Services
13 Committee, we will listen to each of our presenters in
14 turn, and then at the end we'll open it up for discussion
15 and questions. We find this works best to assure that
16 everyone is heard.
17 Before I ask the House Members to introduce
18 themselves, I just want to recognize an intern who's with
19 us today. Simran Singh is with us here. Simran is a
20 senior at Conestoga High School in Chester County. Simran,
21 welcome.
22 MS. SINGH: Thank you.
23 REPRESENTATIVE MURT: We'll go around the table,
24 introduce ourselves.
25 REPRESENTATIVE ZIMMERMAN: I'm State

1 Representative Dave Zimmerman, the 99th District
2 [inaudible].
3 REPRESENTATIVE DIAMOND: Representative Russ
4 Diamond, 102nd District, eastern part of Lancaster County.
5 REPRESENTATIVE STAATS: Good morning. My name is
6 Craig Staats and I represent the 145th District in Bucks
7 County.
8 REPRESENTATIVE SCHLOSSBERG: Good morning,
9 everyone. Representative Mike Schlossberg, 132nd District
10 in Allentown. Along with Representative Murt, Chairman
11 DiGirolamo, and Chairman Tony DeLuca out of Allegheny, the
12 four of us are the co-Chairmen of the Mental Health Caucus,
13 which was just formed this session.
14 REPRESENTATIVE ACOSTA: Good morning. State
15 Representative Leslie Acosta from Philadelphia County.
16 REPRESENTATIVE MURT: Before we call our first
17 testifier, I did want to recognize and thank Representative
18 Schlossberg because he was truly the driving force behind
19 forming the Mental Health Caucus, and I want to thank him
20 for taking that initiative.
21 Our first testifier is Tim Clement, Scattergood
22 Fellow on Stigma Reduction from the Thomas Scattergood
23 Behavioral Health Foundation.
24 Tim, thank you very much for being with us today.
25 MR. CLEMENT: Thank you very much for having me.

1 I consider it an honor and a privilege to be here.
2 So let me give you a little background on myself
3 and my project and the Scattergood Foundation. The
4 Scattergood Foundation is a nonprofit behavioral health
5 organization in Philadelphia. We're a grant-making
6 organization. I happen to be a grantee of the Foundation
7 on my stigma reduction work. I originally have a
8 background in public health. I graduated from Drexel
9 School of Public Health with a concentration in health
10 policy.
11 So you might be wondering how does somebody with
12 a public health background end up working on stigma in
13 mental health. So one thing I realized when I was in
14 public health school a number of years ago, reading about
15 behavioral health and mental illness and people seeking
16 treatment, I realized how dire the situation was. So right
17 now in America in the adult population, 26 percent of
18 American adults have a diagnosable mental illness. So
19 that's roughly 60 million Americans or a country the size
20 of France. Of that 26 percent, only 30 to 40 percent of
21 them seek treatment. That's seek treatment, not receive
22 treatment or get access to treatment, but even seek
23 treatment, going out and looking for treatment. And stigma
24 has been identified as one of the leading factors that is
25 behind that.

1 So that means right off the bat of those 60
2 million adult Americans who have a diagnosable mental
3 illness, 40 million of them are staying home and not even
4 bothering to seek treatment. So that right there by itself
5 is a major public health implication, and that's not even
6 to speak of those who do seek treatment. Many of them do
7 not get access to treatment, and even those that do get
8 access to treatment, many often drop out because of stigma,
9 because of some of the fear associated with that. So when
10 you look at some of the numbers, it can get pretty dire in
11 terms of the percentage of people with diagnosable mental
12 health conditions that actually do receive treatment. It's
13 a very, very low number.
14 And also another thing we know about mental
15 illness is there's a lot of comorbidity with physical
16 health conditions like diabetes, heart disease,
17 hypertension, and we know that patients with those
18 conditions and a comorbid mental illness have much worse
19 health outcomes for their physical condition. But when
20 they seek treatment for their mental health condition,
21 their physical symptoms improve and they have better health
22 outcomes overall.
23 So when we realize how small the percentage of
24 people are who have diagnosable mental illnesses that
25 actually received treatment or even seek treatment are, we

1 realize that this is a major public health crisis. In
2 fact, I shouldn't say that. That's not even true. It's
3 not a major public health crisis; it's a major public
4 health catastrophe. So that's how a person with public
5 health background gets involved in stigma and stigma
6 reduction.
7 So what I've done is I've just now said why
8 stigma, why we're doing something to address stigma, why
9 it's so important to address stigma. The one thing I've
10 realized in the last three years is that one of the biggest
11 issues is defining stigma because if we go around this room
12 and ask everyone what's stigma, what does that mean, I can
13 guarantee you will get a different answer from every person
14 because that's one thing I've noticed is there's a lot of
15 ambiguity associated with stigma. There's a lot of
16 vagueness.
17 Some people even talk about it as if it's this
18 vapor or mist that floats in the air and harms people with
19 mental illness and stops them from seeking treatment. But
20 that's not true. Within the research literature there's a
21 very clear definition of what stigma is. It's prejudice
22 and discrimination informed by inaccurate and negative
23 stereotypes about people with mental illness. So stigma is
24 stereotypes, prejudice, and discrimination. If you take
25 nothing else from what I say today, just please remember

1 that. That's what stigma is, stereotypes, prejudice, and
2 discrimination.
3 I'll tell you what stigma is not. Stigma is not
4 shame, stigma is not embarrassment, stigma is not fear of
5 seeking mental health treatment. Those are all effects of
6 stigma. People are afraid of seeking treatment because
7 they fear prejudice and they expect discrimination. Those
8 are the effects, but stigma itself is stereotypes,
9 prejudice, and discrimination.
10 Now, if it seems like I'm belaboring that point,
11 I think I've said that now five times, stereotypes,
12 prejudice, and discrimination -- that's six -- that's
13 because I really need everyone to understand you have to
14 know that. You have to know what the problem is before you
15 can solve it. When we're dealing with reducing fear and
16 embarrassment and shame, those are all very important
17 things to do because there is a lot of shame out there.
18 There is a lot of embarrassment, there's a lot of fear, and
19 when that exists, we do have to do something. We have to
20 ameliorate that as well, but that's just putting out fires.
21 That's not reducing stigma. That's dealing with the
22 effects of stigma.
23 And going on with that fire analogy, let's say
24 someone asks me what's fire prevention? And I said oh,
25 fire prevention, that's putting out fires. That's wrong.

1 That's the wrong definition of fire prevention. But let's
2 say going with that definition of fire prevention I was
3 appointed the commissioner of fire prevention to the United
4 States of America if such a position existed, and they
5 asked me, what is your number one recommendation for
6 preventing fires? And I'd say, well, put a fire
7 extinguisher in every house. That's not going to prevent
8 any fires. That's a great thing to do and it's going to
9 save lives but if you really want to prevent fires, you
10 have to do other things. That's just putting out fires.
11 So with stigma reduction and stigma, we have to make sure
12 we're defining this problem correctly so we can correctly
13 address that problem because if we don't have the
14 definition right, we're not going to come up with a
15 solution.
16 Let me run through what some of the common
17 stereotypes are that inform this prejudice and leads to
18 discrimination. So when people endorse these stereotypes,
19 they can result in prejudicial attitudes and discriminatory
20 behaviors. The first, the most common stereotype that is
21 very frequently inflamed by the media is that people with
22 mental illnesses are dangerous and they're violent, they're
23 unpredictable. That's simply not true. Ninety-seven
24 percent of people with a mental illness will not commit a
25 violent crime in any given year. That's 97 percent.

1 That's a very high number. I mean if 97 percent of a
2 population doesn't do something, it's completely inaccurate
3 to say that that population is that something. You just
4 simply can't say that. It's just not true.
5 And, by the way, if you're interested in where
6 I'm getting these figures, a lot of these figures are from
7 research in the field. If you want access to this
8 research, I'd be very happy to send it to you through an
9 email. So if you want to know where any of these figures
10 come from, I'd be happy to share that.
11 One of the next most significant stereotypes
12 that's out there is that people with mental illnesses are
13 incompetent or they're always on the verge of psychosis.
14 There irrational. One, there's no consensus in the
15 research that there's any correlation with IQ and mental
16 health status one way or the other. People with mental
17 health conditions are not necessarily more intelligent or
18 less intelligent. There's nothing in the research that
19 would suggest that.
20 And the idea that people with mental health
21 conditions are always on the verge of a crisis or
22 breakdown, that's just simply not true. People may notice
23 the person who is on the verge of psychosis or is in a
24 psychotic episode or is having some sort of breakdown but
25 you don't notice all the people that aren't doing that

1 because that's not something for you to notice. So that's
2 just simply an inaccurate portrayal of people with mental
3 health conditions.
4 And then the most damaging stereotype that's out
5 there probably, and this is damaging because sometimes
6 people with mental health conditions accept this
7 themselves, is there's no hope for recovery. You're not
8 going to get better. You can't lead a fulfilling life;
9 don't bother. But actually, the research shows that when
10 people do receive treatment and effective treatment, it's
11 effective 80 to 90 percent of the time. So that's a very
12 successful track record where they see significant clinical
13 improvements. So that's just again a misleading stereotype
14 that's simply not true.
15 One of the biggest problems that we have with
16 stigma, one of the reasons why it hasn't really gotten any
17 better in the last 15 to 20 years, despite efforts being
18 made to ameliorate stigma, is that prejudice and
19 discrimination are so firmly entrenched within our culture.
20 Surveys show that -- and when I say surveys I'm talking to
21 the general social survey -- that a majority of Americans
22 endorse negative stereotypes and a majority of Americans
23 wish to have social distance from people with mental
24 illness. For instance, 62 percent of people wouldn't want
25 to work with a person who has schizophrenia, 53 percent of

1 people wouldn't want a family member to marry a person with
2 depression. So you have shockingly high numbers of people
3 who highly endorse the stereotypes and harbor prejudicial
4 attitudes.
5 Let me give you an example of how accepted and
6 condoned -- I don't want to say condoned but it's certainly
7 not condemned in our society, the prejudice. So I think
8 everyone here knows who Brian Williams is, the former
9 anchorman of NBC Nightly News. I don't want to assume that
10 everyone here knows who Ariel Castro is but he was a man
11 from Cleveland who in 2003 kidnapped three teenage girls.
12 He held them captive in his house for 10 years, raped them,
13 tortured them. He was caught and thankfully the three
14 girls did survive. He was never diagnosed with a mental
15 health condition, Ariel Castro.
16 In July of 2013 Brian Williams described Ariel
17 Castro as the face of mental illness. So he was saying
18 that Ariel Castro, the man who was sadistic and tortured
19 teenage girls, that's indicative and representative of all
20 people with mental illness. Brian Williams got in no
21 trouble for that. There was no reprimand. There was
22 nothing. Nothing was heard about that.
23 Imagine if he had said instead of saying that
24 Ariel Castro was the face of mental illness, what if he had
25 said Ariel Castro is the face of Latino America? What if

1 he had said that? I mean he wouldn't have had to wait a
2 year-and-a-half to be reassigned because of lying about his
3 status during the war. He would have been fired the next
4 day. That would have been the end of him. You wouldn't
5 have heard of Brian Williams the last year-and-a-half.
6 But he said something about Ariel Castro being
7 the face of mental illness, highly endorsing and
8 perpetuating a stereotype of dangerousness and violence.
9 And the best response that I saw was somebody wrote a
10 letter and wrote a blog to it to the NBC Nightly News
11 producers and they said Mr. Williams realized the error of
12 his ways and you'll be happy to know the broadcast was not
13 shown on the West Coast. So, there you go, problem solved.
14 So that just shows you how we accept prejudice.
15 And I'm sure people saw that and didn't even blink when
16 they heard him say that, but that's how highly entrenched
17 and firmly placed the stigma and prejudice are in our
18 society.
19 Discrimination, so if you want to be an attorney,
20 you have to pass the bar exam, and part of passing the bar
21 exam is taking the Character and Fitness Exam. And one of
22 those questions asks you about your mental health status,
23 if you've ever received treatment for a mental health
24 condition. If you answer yes, in some States such as New
25 York up until this year, that's it. You're not being an

1 attorney. You're not passing the bar. Some States,
2 they'll make it conditional if you turn over your medical
3 records and prove that you've been getting treatment, then,
4 yes, maybe you can become an attorney. And in a few States
5 they don't make a big deal about it. But that's flagrant
6 discrimination. It's flagrant and that's something that
7 the Department of Justice even looked into that and they
8 got slight changes made to the Character and Fitness Exam
9 but not many. And a lot of people would say, well, yes, I
10 don't think someone with mental illness should be an
11 attorney. That's not someone I want representing me in
12 court, and that's again just endorsement of stereotypes.
13 And these reasons I just said here, this is why
14 people avoid seeking treatment. You don't want to be
15 labeled as someone who could be dangerous and sadistic.
16 You don't want to potentially not be able to pass the bar
17 exam or get a job or you might be fired or you might be
18 denied housing. That's the stigma that leads to people
19 avoiding seeking treatment.
20 So everything I've said up to this point has been
21 I think what we put in the category of bad news, but I do
22 have good news and that's that stigma reduction does in
23 fact work. There are evidence-based methods to reduce
24 stigma and they're very easy to do and they're very
25 effective. The most effective method is called a contact

1 strategy, and it's pretty simple. A person with a
2 diagnosed mental health condition speaks to a group of
3 people of the general public in a way that disconfirms
4 those stereotypes. And the reason that's so easy is
5 because most people with mental health conditions do
6 disconfirm the stereotypes. So you take a person who has a
7 diagnosed condition and announces that he has that
8 diagnosed condition in a way that doesn't reinforce any of
9 those stereotypes, you are likely going to see
10 statistically significant improvement in people's
11 attitudes.
12 But the most important thing to take out of this
13 is we need to do that. That's what's necessary. We need
14 to follow these evidence-based methods rather than using
15 unproven or even invalidated methods. That's one of the
16 major problems we have right now is even though we know
17 what works, there's a track record for what's successful,
18 many organizations that are trying to reduce stigma,
19 they're not following these evidence-based methods. And
20 even if they are, they're not tracking their outcomes. Are
21 they having an effect or are they not having an effect?
22 They don't know. They're not bothering to try.
23 The good news is in Philadelphia we are using
24 evidence-based methods. We are tracking our outcomes. We
25 are seeing what kind of an effect. I believe all of you

1 might have a sheet in there. It's a one-page data analysis
2 summary of a program I worked on in South Jersey. It's a
3 contact strategy, plain and simple. It's for high school
4 students. And we've also been doing this with police
5 officers and college students. But when people are exposed
6 to these contact strategies, they have statistically
7 significant improvements in their attitudes towards people
8 with mental health conditions. We know that this works
9 because the evidence says it works and we also know it
10 works because we're doing it and it is working and we have
11 the proof. You have the proof right in front of you.
12 So I'll just end on one more thing, or two things
13 actually. So just remember that. Just remember what the
14 definition is and remember that we need to use evidence-
15 based methods. We have to do that and we have to measure
16 outcomes.
17 And just one other thing is one form of
18 discrimination that's very pervasive is insurance companies
19 not offering equal coverage for people with mental health
20 conditions versus patients with physical health conditions.
21 There was a Federal law that was passed in 2008 by
22 President Bush that mandates that many insurance plans have
23 to offer mental health benefits and substance use benefits
24 at the same level and no more restrictively than they do
25 for physical health benefits.

1 But most insurance plans are just simply not
2 following the law, and that's a law that is left up to the
3 States to enforce for the most part. And unfortunately,
4 most States throughout the country are just not enforcing
5 the law. So that's one thing that you as legislators can
6 do is help the State of Pennsylvania take steps to start
7 enforcing that law because the insurance companies are
8 flagrantly abusing that law. And it's discrimination
9 that's leading to people not getting the care they deserve
10 if they do in fact seek that care.
11 Okay. Well, thank you. Thank you for your time.
12 REPRESENTATIVE MURT: Thank you. Thanks, Tim.
13 Appreciate your testimony.
14 Our next two testifiers will be Alyssa Schatz,
15 the Director of Advocacy in the Policy Division of the
16 Mental Health Association of Southeastern Pennsylvania; and
17 Jeff Shair, Mental Health Consultant.
18 Good morning.
19 MR. SHAIR: Good morning.
20 REPRESENTATIVE MURT: Thank you for being here
21 today.
22 MS. SCHATZ: Good morning. Thank you so much for
23 having us here today. My name is Alyssa Schatz and I'm the
24 Director of Advocacy for the Mental Health Association of
25 Southeastern Pennsylvania. And, most importantly I'm a

1 family member of someone living with a mental health
2 condition.
3 Before I start, I just want to say that at the
4 Mental Health Association we greatly admire the work that
5 Tim has been doing and we plan on partnering with him
6 around his stigma reduction efforts. And we certainly
7 endorse everything that he just said.
8 So the Mental Health Association of Southeastern
9 PA is one of the three largest MHA affiliates in the Nation
10 with more than 40 programs throughout southeastern
11 Pennsylvania and Delaware. And one of the things that
12 makes us unique is that the vast majority of people that we
13 employ identify as having lived experience with a mental
14 health condition either as an individual or as a family
15 member. And so that really drives the work that we do.
16 So at MHASP the issue of stigma is very personal.
17 Despite a wide body of evidence to the contrary, the
18 general public still largely views individuals with mental
19 health conditions as being more violent, lacking
20 intelligence, and being unable to recover. Today, I'll
21 discuss the consequences of these beliefs, including social
22 isolation, unemployment or underemployment, and poor
23 physical health outcomes.
24 Tim briefly mentioned this study but I'm going to
25 expound upon it a bit. In 2006 there was a study conducted

1 that found when asked about their willingness to engage in
2 various social activities with someone with a mental health
3 condition, more than half of people reported they would not
4 want someone with depression to marry into their family,
5 nearly half would not want to work closely with them, and
6 1/3 would not want to socialize with someone with
7 depression.
8 The same study found that for someone living with
9 schizophrenia, the numbers drastically increase to nearly
10 70 percent of respondents not wanting them to marry into
11 their family, more than 60 percent being unwilling to work
12 closely with them, and more than half of respondents being
13 unwilling to socialize with them. So as you can imagine,
14 these beliefs are very socially isolating and have a
15 significant impact on the way an individual interacts with
16 their community.
17 One of the most meaningful ways that any one of
18 us can be involved with our community is through
19 employment. Unfortunately, despite research indicating
20 that the majority of people with a serious mental illness
21 would like to work, their unemployment rates remain
22 drastically higher than the general population. And one
23 contributor to these high unemployment rates is stigma in
24 the work place.
25 Surveys of employers have found nearly half are

1 reluctant to hire someone with a history of a mental health
2 issue and 70 percent of employers would not want to hire
3 someone taking an antipsychotic medication. Further,
4 people with mental health conditions who are working are
5 more likely to be underemployed in menial jobs that require
6 less skill than the qualifications they actually possess
7 and are also less likely to be promoted once a psychiatric
8 history is disclosed. Now, all of those things are of
9 course illegal underneath the Americans with Disabilities
10 Act. We are protected from those types of discrimination,
11 but I think those beliefs are still pervasive and it's
12 difficult to legislate some of that away.
13 Unfortunately, as a result of this, many people
14 will decline to disclose their condition and will fail to
15 take advantage of many of the employment programs they're
16 entitled to, including requesting a reasonable
17 accommodation underneath the ADA, utilizing the Family
18 Medical Leave Act, the Employee Assistance Programs, and
19 requesting to use sick days for their mental health.
20 Without accessing these available resources, many
21 individuals become sick and stop working.
22 So that leads me to the next area of
23 discrimination that I think is deeply impactful, which is
24 in healthcare provision. A few years ago, a report was
25 released that actually sent shockwaves through my system.

1 As a family member, it felt like a punch in the gut when I
2 saw it. And the report found that individuals with mental
3 health conditions, just simply by having a diagnosis of a
4 mental health condition without factoring in substance use
5 or anything else, will die an average of 25 years younger
6 than the general population. And the primary causes were
7 not self-harm or injury but were largely preventable
8 physical health conditions like heart disease and diabetes.
9 Sadly, people with mental health conditions face
10 greater barriers to accessing care and are more likely to
11 experience discrimination once there. A survey conducted
12 by the Mental Health Foundation found that 44 percent of
13 respondents with a mental health condition felt they had
14 been discriminated against by their physician, and the most
15 common complaint was that their physical health problems
16 had not been taken seriously.
17 A 2012 study further found that people with
18 mental health conditions were less likely to be prescribed
19 medication for common conditions like heart disease than
20 their counterparts without a psychiatric history were.
21 When self-reported physical health symptoms are not taken
22 seriously, it can truly be a matter of life and death.
23 Additionally, despite the fact that people with
24 mental health conditions have one of the highest rates of
25 tobacco use -- I believe they actually consume 40 percent

1 of cigarettes that are sold so it's really quite
2 significant -- both physical and mental health providers
3 are unlikely to suggest tobacco cessation. And I think
4 this is due to a lot of myths that are out there. There
5 are a lot of myths that if you encourage somebody to quit
6 smoking, their psychiatric symptoms will become worse or,
7 well, let's deal with the other things that are more
8 important than that. But as we know, with lung cancer
9 rates, that a very important intervention to be proposing.
10 Of course, none of this is rooted in ill will.
11 Physical and behavioral health providers have all pursued
12 these careers to help people and they care, but we need to
13 make a commitment to taking these health disparities
14 seriously and looking at some of our own biases and beliefs
15 and working to improve our practice.
16 So in relation to interpersonal stigma and
17 discrimination, as I've discussed with the examples of
18 employers and physicians, MHASP echoes the Scattergood
19 Foundation's recommendation to invest in contact
20 strategies, which have been shown to be the most effective
21 method of combating interpersonal stigma.
22 However, in addition to the interpersonal
23 discrimination that individuals with mental health
24 conditions experience, there is also institutionalized
25 discrimination. As Tim mentioned, historically, people

1 with mental health conditions have faced significant
2 barriers in accessing care, particularly through the
3 private insurance market. Medicaid has always kind of been
4 a safety-net insurance, but as you know, your income cannot
5 go above a certain level on Medicaid. So when someone
6 needs to resort to that, it essentially keeps them at a
7 lower income level.
8 Thankfully, in 2008 the Mental Health Parity and
9 Addiction Equity Act was signed into law by President
10 George Bush, and that act said that private insurers could
11 no longer, when they provide a behavioral health benefit,
12 include higher copays for mental health services, higher
13 deductibles more restrictive limits on treatments, more
14 restrictive limits on providers. And so this was really a
15 huge victory in the mental health world and we were all
16 celebrating.
17 Unfortunately, as you all know happens sometimes
18 with laws, it all comes down to enforcement, right? We can
19 do this great thing and pass this law but it all comes down
20 to whether or not we implement it. And primary enforcement
21 authority has been left with States. So some States, as
22 you can imagine, it varies. Some States are further along
23 in implementing parity and some are not so far along. And
24 our State is one of the States that's lagging behind.
25 Pennsylvania has not passed a State-level law to

1 direct the insurance department to enforce this, and so
2 discrimination is still happening in our insurance systems.
3 Particularly I see it a lot with the provider network
4 adequacy. Getting to see a mental health professional is
5 far more difficult than getting to see a physical health
6 professional.
7 So one way that the General Assembly can reduce
8 institutionalized stigma is by passing a law supporting the
9 enforcement of parity.
10 So I thank you for your consideration of this
11 important issue. And I'm going to turn it over to Jeff
12 Shair, who's been very involved with MHASP's work. He's
13 been involved with several of our advocacy groups and he's
14 a Mental Health Consultant for the Department of Behavioral
15 Health as well.
16 MR. SHAIR: Thank you, Alyssa.
17 REPRESENTATIVE MURT: Thank you, Alyssa.
18 MR. SHAIR: My name is Jeff Shair and I'm a
19 consultant for the Philadelphia Department of Behavioral
20 Health and Intellectual Disability Services. And I've been
21 part of the Department since the inception of the
22 transformation of the programs going back to 2006. The
23 whole idea with the transformation with the programs with
24 Dr. Arthur Evans coming to Philadelphia is to give people
25 in recovery the choice to do things in the community, go to

1 school, work, go to a place to worship, and not just be
2 regulated to day programs indefinitely. And I've seen a
3 lot of changes with the people being served in Philadelphia
4 with that.
5 I also do work for the Mental Health Association
6 of Southeastern Pennsylvania. I'm very involved in their
7 Advocacy Division, primarily the Advocacy Fellows Program
8 where we go and speak to legislators and highlight what is
9 important for funding and mental health services in the
10 region.
11 Another initiative I do for the Mental Health
12 Association is the Successful Aging Task Force where we
13 address concerns for senior citizens who have mental health
14 issues.
15 I work with also Tim on stigma reduction and the
16 strategy of course is to speak to as many groups and the
17 public as possible to show that people with mental illness
18 can be productive and contributing to society.
19 I'm also involved with the Southeast Regional
20 Support Committee. That's one of the various committees
21 I'm involved with. And this year I am the co-Chair of the
22 Retreat Planning Committee. We have an annual event at
23 Norristown State Hospital. This year the theme is Partners
24 for Progress. And we partner with the community
25 organizations and that's going to be held on May 4 at

1 Norristown State Hospital, Building 33. So if people can
2 go, that'd be great.
3 So I have paranoid schizophrenia. I was
4 diagnosed when I was 17. I wouldn't be doing any of these
5 activities today if I hadn't benefited from mental health
6 services. Two primary organizations that I benefited from
7 was Horizon House in Philadelphia in 1980. I was there in
8 the early '80s as a client. I made friends in the program.
9 I had a counselor who encouraged me not just to talk to the
10 friends in the program but go out on the weekends and
11 weekdays, and I maintained those relationships for several
12 years. And what's important about that is my parents and
13 my brother Paul, my entire immediate family had died but I
14 had people in my life to go out with.
15 Now, prior to going to Horizon House, I was
16 hospitalized three times from 1969 to 1977. After
17 enrolling at the Horizon House program as a participant,
18 I've been hospitalized once in 35 years. So that shows you
19 the power of being treated with respect and having friends
20 and doing things in the community to make a difference.
21 Later on in the '90s I became a staff member at
22 Horizon House and taught adult basic education. I had two
23 classes that I taught twice a week and I helped develop the
24 curriculum and it was a diverse class. I really had a lot
25 of responsibility. Now mind you, the entire '70s I was

1 basically home just going to a psychiatrist and really had
2 no hope. So that was very important, Horizon House. That
3 was really the beginning of my recovery.
4 Later on in the '90s while I was teaching at
5 Horizon House as an adult basic education teacher, I was
6 referred by a mental health professional to be a volunteer
7 in the Compeer program in Philadelphia. Compeer is an
8 international organization, and the purpose of the
9 organization is to help people who've been isolated with
10 mental health issues go out with a volunteer as a friend
11 who shares similar interests. And that really benefited me
12 a lot because I was helping people who were isolated like I
13 was in the '70s. And the staff had a lot of confidence in
14 me. So the volunteers could be peers or from all walks of
15 life. They could be in business, they could be students.
16 So the first guy I was matched with, we went to
17 so many places in the city. We went to movies, concerts,
18 sporting events that I was asked to write a column about
19 the different venues that we went in the city. And the
20 whole idea of that was to give the other matches an idea
21 where to go on their outings.
22 That was the beginning of my writing career. It
23 also motivated me to go back to college. I went to
24 community college. I had a creative writing teacher. One
25 day I was looking at the bulletin board in the lounge and

1 my creative writing teacher comes up to me and says, Jeff,
2 you're a natural. And he encouraged me to go into the
3 community college newspaper office, and they hired me as
4 the movie critic.
5 I later went to Temple, took journalism, and I
6 wrote for the Temple student newspaper. And I covered the
7 arts at Temple.
8 In high school I had a guidance counselor, not in
9 school but private service. I went to him after taking a
10 battery of tests. First thing that comes out of his mouth
11 at the interview, he said you'll never be a writer. So if
12 I didn't get the opportunity to write a column each month
13 about the different activities I went with my friend, I
14 wouldn't have gone back to school and I wouldn't have
15 written for community college or Temple newspapers.
16 I also have two writings that have appeared in
17 national publications. One is in the Compeer International
18 Book. It's called "Compeer: Recovering through the Healing
19 Power of Friends." And I have another article that was
20 published in the National Spasmodic Torticollis
21 Association, a quarterly magazine, NSTA Quarterly it's
22 called. And I talk about how I benefited from doing tai
23 chi, all the health benefits I've received, physical
24 benefits, emotional. I go in detail. It's a remarkable
25 change and nothing is exaggerated in the article.

1 And going back to Compeer, I'll show you, Compeer
2 has lost its funding in Philadelphia about three years ago.
3 It was a very successful program for 20 years, and Compeer
4 is also when it was in Philadelphia under the Mental Health
5 Association. And it's a very needed program. And there's
6 a lot of people who would benefit today by having someone
7 to go out as a friend and share similar interests with.
8 But the ironic thing about it, the funding was
9 lost in Philadelphia but my cousin in Florida saw how much
10 I benefitted from Compeer in Philadelphia and after reading
11 my article in the book, while she was in her 90s five years
12 ago started Compeer in Sarasota. She founded it. She's
13 not a mental health professional. She used to be the
14 former Bird Lady of Sarasota, Ann Hartka, and Compeer in
15 Sarasota is established. And I'm going to go down at the
16 end of the month to visit my cousin Ann, who's going to be
17 97 in June and attend a Compeer event in Sarasota.
18 So that's an amazing story. I'm very proud of my
19 cousin Ann. She's an amazing woman. And she signs up
20 volunteers wherever she goes in her community.
21 So also I have tardive dyskinesia, which is a
22 neurological disorder caused by prolonged used of the old
23 psychiatric medications like Haldol, Thorazine, Stelazine.
24 And I got that from taking those medications for
25 schizophrenia for several years. Even though I'm on

1 different psychiatric medications today, even though I
2 don't take the old medications, they don't prescribe it
3 anymore, I still grimace. And I experience discrimination
4 with that. When I go into a restaurant, and this is not
5 just one restaurant, it's several restaurants, when I say I
6 want to stay in the booth, the host or the hostess many
7 times would direct me into the smaller dining room, which
8 is the former smoking room. And the reason obviously they
9 do that is to keep me away from most of the customers in
10 the restaurant. But what I say is -- and this happens a
11 lot -- there's an open booth in the main dining room and I
12 say I want to sit there and they never deny me because that
13 would really be discriminatory.
14 And also my faith is very important to me. I
15 attend a church in the northeast, Bethel Baptist Church.
16 And I'm the Sunday school teacher for the adults. So what
17 we do is we do a DVD series of a TV evangelist. So one
18 week we'll see the video, the following week I'll do the
19 lesson. I spend hours preparing for this and it's very
20 rewarding.
21 I'm also part of the ministry team at the church.
22 We speak at Sunday breakfast Rescue Mission once a month.
23 Years before, I used to give for Thanksgiving meals to that
24 organization. I never thought I'd be talking to the men
25 directly. So each month I'll take a passage from the

1 Bible, try to interpret it, and see how it applies to my
2 life. And I also collect the offering at each Sunday
3 service.
4 So I just wonder how many people can really
5 benefit by being accepted, getting the support from mental
6 health services, and make dramatic changes in their life.
7 Thank you.
8 REPRESENTATIVE MURT: Thank you. Thank you,
9 Jeff. Thank you, Alyssa.
10 MS. SCHATZ: Thank you.
11 REPRESENTATIVE MURT: Our next testifier is Sue
12 Walther, the Executive Director, the Mental Health
13 Association in Pennsylvania.
14 Good morning, Sue.
15 MS. WALTHER: Good morning.
16 REPRESENTATIVE MURT: Thank you for being with
17 us.
18 MS. WALTHER: I even brought cards for everybody
19 so I will make sure you all get them when I'm finished.
20 I am Sue Walther. I'm the Executive Director of
21 the Mental Health Association in Pennsylvania. We are a
22 statewide nonprofit organization with affiliate membership
23 across the Commonwealth. We strive to achieve the ultimate
24 goal of a just and humane healthy society in which all
25 people are accorded respect, dignity, choices, and the

1 opportunity to achieve their full potential free from
2 stigma and prejudice.
3 I want to thank the Committee for providing this
4 opportunity to take a closer look at stigma and
5 discrimination connected to mental illness.
6 Today, and we already have heard a number of
7 people, I am sure you will hear much about the stigma and
8 discrimination that exists and the negative impact it has
9 on individuals, their families, and communities. So I know
10 you're going to get a lot of information, a lot of
11 statistics and data, so I'm going to focus more on what we
12 have chosen to do in our efforts to reduce and maybe
13 eventually eliminate stigma.
14 We support and promote principles that facilitate
15 the recovery and resiliency of individuals and their
16 families. We recognize that all too often stigma and
17 discrimination are barriers to opportunities: employment,
18 community engagement, housing, healthcare, and education,
19 all of those that support recovery.
20 Guided by a 1999 U.S. Surgeon General report on
21 mental health that said stigma leads people to avoid
22 socializing, employing, or living near persons who have a
23 mental disorder. For many years, Mental Health Association
24 of Pennsylvania worked to eliminate stigma and
25 discrimination by raising awareness about mental illness in

1 our communities. Our messages included mental illness
2 affects everyone regardless of race, income levels,
3 employment, age, gender; and people living with mental
4 illness make important contributions to our families and
5 our communities. Recovery was part of our message at that
6 point but our emphasis at the time was breaking down the
7 negative attitudes about mental illness by educating people
8 about it, the facts, the figures, the realities.
9 These are all powerful pieces of information and
10 are all needed, and these are conversations that have to
11 happen. But we also recognize that over time things do
12 evolve. And while we've heard a lot of negative examples
13 of stigma, we also know we have made some progress. We're
14 not exactly where we were maybe 10 or 15 years ago.
15 But four years ago a group of individuals with
16 lived experience approached MHAPA with a new message. They
17 were inspired by a poem. It's called "I'm the Evidence,"
18 and it was written by Karen Morton of Support the Journey.
19 And they brought that poem to me and they suggested we
20 shift our focus from the negative attitudes that work
21 against mental health recovery to focus on people who are
22 the evidence of recovery and those who support this
23 recovery journey. This poem is about values that support
24 recovery: belief, hope, giving, connectedness, action,
25 example, encouragement, and possibility. The more I

1 listened to their ideas, the more excited I became about
2 the possibilities.
3 A number of studies, and that was mentioned
4 earlier today, have highlighted the idea that significant
5 improvement in attitudes about mental illness occur when
6 people have direct contact with individuals who have lived
7 experience. More recent efforts kind of take that direct
8 contact and make it indirect contact through blogs and
9 videotapes and people maybe not meeting someone
10 individually but hearing their story, and I think that
11 takes that concept of direct contact to a broader audience,
12 and that's what we try to do.
13 So the campaign we were now talking about
14 developing was a way to bring the recovery journey to a
15 broader audience, not just focusing on stigma and
16 discrimination but talking about the positive, the recovery
17 journey. We thought it was time to stop talking about
18 stigma and discrimination and start talking about
19 discovery. We should stop wagging our fingers at people
20 and telling them what they do wrong and how they use the
21 wrong language and what they might say that's wrong and
22 instead focus on celebrating the many living examples of
23 recovery, honoring what people are doing right for
24 themselves, their friends, their families, their
25 communities, focusing if you will on the positive.

1 This marked a monumental change in how MHAPA
2 approaches our efforts to promote inclusive communities and
3 impact how people think about mental illness. After a year
4 of planning, the campaign known as I'm the Evidence Mental
5 Health Campaign launched in 2011. We try to use our
6 network of advocates, advocacy organizations, counties,
7 providers to reach individuals and communities with our
8 messages of hope and recovery. Through our network and
9 community-based events and programs, we've built a growing
10 ambassador program of individuals and organizations, people
11 in recovery and their individual and community supporters
12 because it is not just the person in recovery that has a
13 story to tell; it's also the people that are around them.
14 It's also communities have figured out how to support
15 people with mental health issues. And so we want to
16 celebrate that. We want to focus on that.
17 So they've joined the campaign. They've joined
18 the campaign to honor recovery and provide encouragement
19 and example to others. To date, we have more than 500
20 ambassadors, and I checked before we came here to get an
21 exact number and it's 560. We ask organizations to
22 implement the campaign into their everyday work providing
23 them with a toolkit of materials, action ideas, and the
24 presentation to assist with their implementation.
25 All of our affiliates, all of our network have

1 interaction with community groups at the local level, and
2 we encourage them to bring our message to community groups,
3 to groups outside of the mental health community. We're
4 pretty good at talking to each other. What we haven't been
5 as good at is reaching out to a broader community and
6 trying to bring them into the conversation.
7 We also developed a public art project. It's
8 called "Faces of Mental Health Recovery." And it's
9 specifically designed to engage community-based
10 organizations in an out of behavior health. In fact, in
11 order to do one in a community we have to have a community
12 group. We've done at one in Perry County where the
13 community group was the Arts Council. We've done one in
14 Montgomery County where the community group was the
15 Montgomery County Community College. Again, this is groups
16 outside of our normal audience. We try to make sure that
17 we try to go beyond who we normally talk to. We offer the
18 basic framework and empower those organizations to
19 implement the project in their communities with their
20 constituents.
21 Our campaign has grown and evolved over the past
22 three years but our core purpose remains the same, to
23 celebrate the uplifting values of the campaign and the
24 remarkable strides people make every day as they walk the
25 recovery journey or support others on their journey.

1 With my testimony and your packets I've included
2 the poem by Karen Morton and I would like to take just a
3 minute to talk a little bit about the poem, what we believe
4 is the use of the words "I'm the Evidence" makes plainly
5 visible our belief in the values weaved throughout the
6 poem. Whether you're facing mental illness, addiction,
7 cancer, or some other distressing, disabling life
8 experiences, we know the need for hope and support is
9 paramount. You can't do it on your own. And seeing and
10 sharing the words "I'm the Evidence" offers an opportunity
11 for empowerment and connection with others.
12 I would like to take this opportunity to read the
13 poem. "I'm the evidence for how belief inspires, how hope
14 transforms, and how giving heals the soul. I'm the
15 evidence for what can be achieved, how feeling connected
16 can ground, and how there is invaluable worth in an act of
17 faith. I'm the evidence for how an example can lead, how
18 far encouragement can take you, and how one step begins a
19 journey toward endless possibilities."
20 Also in your packet is a sampling of our
21 ambassadors. We also have a blog. We encourage folks to
22 submit blogs that we are again trying to get out to a vast
23 audience. We have pictures, we have stories, and if you
24 will look at the pictures and then behind each picture
25 there is their story. Some of these pictures are of people

1 on their own recovery journey, some of these pictures are
2 of people who have supported folks on their recovery
3 journey. But when I look at the pictures, I know their
4 stories. I am aware of their stories. But I see my
5 friends, I see work colleagues, I see mothers, I see
6 fathers, I see board members, I see students, I see
7 employees, I see community leaders, and in one case, I see
8 a State Representative in my group of pictures.
9 And as I read their journeys, I feel honored that
10 they shared that story with our campaign to help others.
11 That's one of their main reasons for sharing their stories
12 is to help others and to increase understanding in
13 communities across Pennsylvania.
14 We believe that shining the light on recovery
15 will lead to a day when stigma and discrimination don't
16 exist at all, at least we hope that. Maybe belief is what
17 we're holding onto but we certainly hope that's where we're
18 headed.
19 Thank you for the opportunity and I'm going to
20 give these to Melanie because the bottom line is the fact
21 that you are here and the fact that you have a hearing
22 about stigma tells me you're the evidence, and I would
23 encourage you to look at the cards, to go sign up as an
24 ambassador so we can also add you to our list of people who
25 support folks in recovery.

1 Thank you.
2 REPRESENTATIVE MURT: Thank you, Sue.
3 Our next testifier is Dr. Mary Ann Venezia from
4 the Pennsylvania Psychiatric Society.
5 Dr. Venezia, thank you for being with us today.
6 DR. VENEZIA: Thank you for having me.
7 Good morning. I am sorry that I'm going to
8 repeat some of the things that have already been said but I
9 think they're important concepts and bear repeating.
10 I'm a member of the Pennsylvania Psychiatric
11 Society, which represents over 1,700 psychiatrists across
12 the Commonwealth. I practice at Lenape Valley Foundation,
13 which is the mental health treatment center serving
14 primarily residents of central Bucks County. I wear
15 several hats at Lenape. I am the Director of the Partial
16 Hospital which takes care of patients who are transitioning
17 from inpatient hospitalization to outpatient. We also
18 handle patients who are experiencing exacerbations of
19 mental illness and are trying to avoid inpatient
20 hospitalization.
21 Through Lenape Valley Foundation, I also see
22 teenagers who are remanded to the Bucks County Youth
23 Center. I do the psychiatric evaluations for the court and
24 I also follow the teenagers through their time at the youth
25 center.

1 Lastly, I'm the Chairman of the Department of
2 Psychiatry at Doylestown Hospital, which is staffed by
3 Lenape Valley psychiatrists. We provide consultation in
4 the emergency room with the assistance of Lenape's Crisis
5 Center, which is located adjacent to the emergency room,
6 and we also see med-surg patients for consultation who are
7 at Doylestown Hospital.
8 I'm not here to provide you with a list of
9 statistics but there are some very striking stats that
10 should be mentioned. The lifetime prevalence of mental
11 illness is staggering. Fifty percent of the population
12 will experience a mental illness during their lifetime. As
13 Tim Clement told us, at any given moment more than 25
14 percent of the psychiatric population is suffering from
15 psychological symptoms.
16 The impact of mental illness is vast. It brings
17 with it increased risk for other life stressors including
18 but not limited to more severe medical illness, lack of
19 education, increased risk for accidents, homelessness,
20 substance abuse disorders, incarceration, premature death
21 -- someone already mentioned to you that the life
22 expectancy of patients with mental illness is much reduced
23 -- and poverty. Like the ripples in a pond, the effects of
24 mental illness spread out from patients to their families
25 to their schools to their workplaces, in short, to

1 everywhere in our communities.
2 Our patients are overrepresented among the
3 uninsured or underinsured, hence the financial
4 responsibility for their care often falls to government,
5 which of course means those of you who are seated here
6 today. Thank you for taking that responsibility seriously.
7 Despite how hard you have worked and how hard we have
8 worked, we are falling short of our responsibility to
9 persons with mental illness. There are many barriers to
10 care and one of those most difficult to overcome is the
11 barrier of stigma.
12 I am no stranger to the impact of stigma in the
13 care of the mentally ill. I see it every day in one form
14 or another. There are many misconceptions about mental
15 illness. I have heard discussions describing one patient
16 or another as lazy, entitled, weak, incompetent, whiny,
17 aggressive, hopeless, Recently, the daughter of one of my
18 extremely depressed patients told her mother "It's time to
19 put on your big girl panties and get a job." I could not
20 believe my ears. Those were her exact words.
21 I have heard caregivers in the emergency
22 department grumbling that they have no time for people who
23 just don't want to get well and create their own problems.
24 It's already been mentioned here today that the physical
25 complaints of persons with mental illness get short shrift.

1 I can give you numerous examples of patients coming to the
2 ER, my patients, complaining of physical symptoms and being
3 told, oh, it's your depression, it's your anxiety. Often
4 the patient herself has already internalized blame for her
5 illness. She thinks it is her own fault for not getting
6 well.
7 I'm here today to tell you that mental illness is
8 just that, it is an illness. It is not a character flaw or
9 an irresistible impulse to embody the sick role and live
10 off the State. Substance abuse is an illness, not a
11 character flaw or a decision to abdicate responsibility in
12 favor of the high life. Both of these illnesses require
13 and deserve ongoing treatment. No one would choose to be
14 an addict or a psychiatric patient any more than one
15 chooses to have diabetes or heart failure.
16 We are increasingly coming to understand the
17 biology which underlies mental illness and substance abuse.
18 The fact that we do not fully understand yet the causes of
19 schizophrenia, which by the way most people have no idea
20 what it really is. Bipolar disorder, schizoaffective
21 disorder, panic disorder, PTSD, or the brain chemistry
22 which underlies the development of substance abuse does not
23 justify our patients receiving second-class status in
24 everything from funding, from treatment, to respect from
25 those treating them.

1 The effects of stigma are everywhere. Look at
2 the physical plants of many of our community mental health
3 centers and psychiatric hospitals. Contrast them to the
4 Taj Mahals of many medical facilities where administrators
5 obsess over the decor. In our hospital the maternity unit
6 was recently redone and gorgeously redecorated. I'm on the
7 med exec committee and I was therefore many of the
8 deliberations. I don't begrudge mothers a lovely delivery
9 room, but when was the last time you saw such care being
10 taken to update a psychiatric unit or an outpatient
11 facility?
12 In one of the facilities I worked, not Lenape, in
13 the last several years, I was told by a patient that flakes
14 from the ceiling were falling on my head. She said please
15 move your chair. She was afraid that it would collapse on
16 me.
17 Recently, I took a wrong turn in Norristown and I
18 wound up driving around Norristown State Hospital looking
19 for the exit. I thought about how many patients have been
20 sent to facilities like this in large numbers. The
21 institutionalization of the mentally ill was one of the
22 effects of stigma. Mentally ill patients were hidden away.
23 I worked at Norristown State Hospital for three years as a
24 member of the Public Health Service. There are still
25 patients being treated on the Norristown campus. I can

1 only wonder at the effect that the many rusting, rotting
2 buildings now empty but still standing as a monument to the
3 stigmatization of the mentally ill.
4 Deinstitutionalization has caused its own share
5 of problems for those with mental illness. While well-
6 intentioned, it has resulted in many patients with no place
7 to go as the facilities in the community have often been
8 insufficient and inadequate to care for their needs due to
9 inconsistent funding, another consequence of stigma.
10 We have only to read the headlines to understand
11 the importance of taking good care of persons with mental
12 illness. Mental illness likely plays a role in the tragic
13 shootings that have plagued our country and in the recent
14 downing of a jet. Mental illness plays a role in our
15 burgeoning prison population. It plays a role in
16 homelessness, joblessness, and poverty. But funding
17 continues to be reduced. Stigma has played a role in such
18 reductions of funding.
19 There are those who would label mental health
20 treatment as not cost-effective or unscientific. Compare
21 and contrast reimbursement for mental health services
22 versus med-surg services. You do not need me to tell you
23 the difference. Inpatient psychiatric units have
24 disappeared across the country because they're not
25 profitable. In many places there are no facilities. If a

1 person needs hospitalization, they remain in the emergency
2 room for many nights. Mental health treatment centers
3 struggle to stay in the black or breakeven.
4 There are many who are insured but have no mental
5 health coverage despite parity laws. We are encouraged
6 that Governor Wolf's proposed budget increases funding for
7 combating heroin addiction and for additional funding to
8 replace funding cuts of the past. We are grateful for the
9 work of Chairman DiGirolamo and his tireless advocacy on
10 behalf of mental health consumers in light of insurance and
11 budgetary challenges.
12 Stigma invites silence. Persons with mental
13 illness and their families have been invisible for too
14 long. They have been unable to advocate for themselves for
15 fear of being seen, or worse yet, discounted. NAMI has
16 allowed those affected by mental illness to increasingly
17 have a voice and be heard.
18 We are grateful to Representative Mike
19 Schlossberg, who bravely detailed his own struggles with
20 depression in an editorial in "The Morning Call" after the
21 death of Robin Williams. He has become a voice for
22 consumers across the State and Nation advocating
23 legislation that does not discriminate between physical and
24 mental health needs. We as providers must speak up and
25 educate the public as we loudly advocate for our patients.

1 We would like to suggest some areas where effort
2 might go a long way towards assisting those in need to
3 receive treatment, increasing awareness of mental illness,
4 and reducing stigma:
5 Increased availability of screening for children
6 and youth of transitional age is our first thought.
7 Suicide is the third-leading cause of death for individuals
8 ages 15 to 24 in the Commonwealth. I will point out I
9 heard a report yesterday that overdose has now overtaken
10 accident as a leading cause of death in Pennsylvania.
11 Suicide, as I said, is the third-leading cause of death for
12 individuals ages 15 to 24 in the Commonwealth. Mental
13 illness played a tragic role in the shootings for which the
14 United States has become known. A very small percentage of
15 persons with mental illness act out violently, yet
16 untreated severe mental illness may increase the risk for
17 violence.
18 I would also like to point out something that is
19 often ignored. Persons with mental illness are more likely
20 to be the victims of violence. I'm sure most of you heard
21 about the incident one month ago where a mother called the
22 police asking for help to hospitalize her son and he wound
23 up being shot by police. I heard a report on the way here
24 about that very issue. I heard law enforcement officials
25 talking about the need for more knowledge and understanding

1 and more programs for them so that they know how to deal
2 with mentally ill patients when they come upon them. In
3 fact, one of them suggested that there should be a mental
4 health worker in every police car when they go on their
5 assignments.
6 The enactment of House Bill 1559 has required
7 the development of suicide prevention materials for
8 distribution to parents and students in grades 7 through
9 12. This is a step in the right direction. The American
10 Psychiatric Association's initiative "Typical or Troubled"
11 created and sustained with private funding, trains school
12 personnel to distinguish between students who are "just
13 being kids" and those who may need further assessment and
14 treatment.
15 Such efforts must be ongoing and supported
16 through the work of groups present here today.
17 Collaboration such as that seen in the Pennsylvania
18 Physical Health/Behavioral Health Learning program will go
19 a long way to understand the impact of exposure.
20 To increase mental health and substance use
21 funding for treatment and research, after a tragedy occurs,
22 there is much soul-searching. The mental health system is
23 often deemed to have failed. The reality is that $4.35
24 billion in mental health funding has been cut over the past
25 four years at the Federal level. Additionally, the

1 Pennsylvania budget for community mental health center
2 services has been cut by 10 percent in just two years.
3 We would ask legislators, those of you here today
4 and all of our legislators, to look at your family, your
5 friends, and your community. I suspect you will not have
6 far to look to see the impact of mental illness. Keep this
7 in mind the next time you vote on a bill to appropriate
8 funding for us. We need support for mental health and
9 substance use services, in early intervention and
10 prevention services, housing, vocational training, suicide
11 prevention, jail diversion. Spending to ameliorate the
12 effects of mental illness will reduce spending in jails,
13 unemployment, homelessness, and medical care both in the
14 hospital and emergency room, and on and on. Quality of
15 life will be enhanced not only in the life of the
16 individual, but remember those ripples on the pond in
17 society at large
18 Third, spending for psychiatric medication
19 deserves special mention. We have many new drugs that are
20 more effective and have far less adverse effects than some
21 of our older drugs. Many of you are probably not aware
22 that formularies vary greatly from insurance company to
23 insurance company. Psychiatrists like me spend much time
24 and effort on the phone chasing approvals for necessary
25 medications for our patients. We have a whole department

1 devoted solely to phone calls to insurance companies to get
2 medications approved.
3 We advocate an open formulary with prior
4 authorization if needed done electronically. Certain
5 medications work better than others for our patients, and
6 there is much variation as to the efficacy of one
7 medication over another. I am old enough to remember how
8 some of our older drugs contributed greatly to stigma. The
9 previous presenter Jeff pointed out to you that many of our
10 older antipsychotics caused side effects resembling
11 Parkinson's disease. To be free of hallucinations and
12 delusions several years ago, you had to look rather
13 zombielike.
14 Despite this, we are still forced to use these
15 medications because insurances will not pay for newer, more
16 expensive drugs. Medications like Haldol, Thorazine,
17 Prolixin, Navane are still being used even though we have
18 better alternatives that are more effective and far less
19 stigmatizing.
20 We would like to suggest that copayment for
21 psychiatric meds be waived if our patients cannot afford to
22 pay. Waiving the copay would in the long run pay dividends
23 in reduced rates of hospitalization and greater well-being.
24 We would like to suggest that consideration be
25 given to loan forgiveness programs for those who enter

1 psychiatry. Nationally, there is a shortage of
2 psychiatrists, especially child and adolescent
3 psychiatrists, and addiction psychiatrists. When I
4 finished medical school, the Public Health Service placed
5 me at Wernersville State Hospital. I worked there for
6 three years. It was considered primary care because it was
7 a shortage area.
8 Two other areas to which attention must be paid
9 include forensic psychiatry and expanded involuntary
10 outpatient treatment. Many persons with mental illness and
11 substance use disorders are languishing in jail. They
12 receive inadequate treatment there; I can testify to that
13 from my own experience with many patients who have recently
14 been released from prison. Many suffer from comorbid
15 psychiatric illness and substance use. Increased funding
16 must be provided for treatment preferably before
17 incarceration, preventing incarceration.
18 We support State Senate Bill 631, which
19 solidifies funding for the Mental Health Justice Advisory
20 Committee, bringing together a variety of representatives
21 from law enforcement, the courts, county government, mental
22 health and substance abuse providers, consumers and family
23 members to assess the need for additional treatment and
24 services.
25 Finally, regarding the issue of expanded

1 involuntary outpatient treatment, the Society anticipates
2 further efforts this session to introduce legislation
3 providing for mandated assistant outpatient treatment
4 system, similar to Kendra's Law in New York. This is one
5 area where the Psychiatric Society has other thoughts
6 recommending that we better implement the current Mental
7 Health Procedures Act which already has provisions for
8 mandated outpatient treatment. It is felt that more
9 funding, not more legislation, might improve outcome. We
10 hope for renewed dialogue about this issue.
11 Many of these suggestions I have made may seem at
12 first glance unrelated to stigma but all of them are
13 related to this very important issue. Stigma is a
14 principal barrier to care. It is the reasons why our
15 patients have suffered so much and continue to suffer
16 despite improvements over the years. Expanding
17 understanding and awareness of mental illness, improving
18 access to treatment, funding advances in treatment,
19 providing for the needs of all our patients, including
20 those languishing in prisons, can serve to break down the
21 barriers that stigma has created and foster greater
22 understanding and well-being not only in persons with
23 mental illness but in the community as a whole.
24 Our mental health community depends upon you and
25 your decision to advance our cause. We stand ready to help

1 you in any way we can.
2 Thank you.
3 REPRESENTATIVE MURT: Thank you, Dr. Venezia.
4 Our last testifier is Sol Vazquez-Otero, Senior
5 Mental Health Advocate on behalf of the Disability Rights
6 Network of Pennsylvania. Thank you for being with us
7 today.
8 MS. VAZQUEZ-OTERO: Thank you.
9 Good morning. I am Sol Vazquez-Otero, a Mental
10 Health Advocate with the Disability Rights Network, or DRN.
11 DRN is the organization designated by the Commonwealth
12 pursuant to Federal law to advocate for and protect the
13 rights of individuals with disabilities, including those
14 with mental illness. We thank you for taking the time to
15 hear testimony regarding stigma in mental health, how it's
16 manifested, the impact it has on individuals' lives, and
17 what can be done to reduce it.
18 My testimony comes from a recovery perspective.
19 Thus, other than now or when I am quoting a source, you
20 will not hear me talking about "seriously mentally ill"
21 individuals but individuals facing mental health
22 challenges, who, by the way, are working towards well-being
23 and mental health. These challenges run on a spectrum from
24 mild to severe and, in daily living, any of us can be found
25 at any point on that spectrum.

1 In 2003, The President's New Freedom Commission
2 on Mental Health Final Report, "Achieving the Promise:
3 Transforming Mental Health Care in America" described
4 stigma as "a cluster of negative attitudes and beliefs that
5 motivate the general public to fear, reject, avoid, and
6 discriminate against people with mental illnesses. Stigma
7 leads others to avoid living, socializing, or working with,
8 renting to, or employing people with mental disorders,
9 especially severe disorders such as schizophrenia. It
10 leads to low self-esteem, isolation, and hopelessness.
11 It deters the public from seeking and wanting to
12 pay for care. Responding to stigma, people with mental
13 health problems internalize public attitudes and become so
14 embarrassed or ashamed that they often conceal symptoms and
15 fail to seek treatment." That description by members of
16 the President's New Freedom Commission on Mental Health
17 encapsulates most of what there is to say about stigma.
18 I'd like to elaborate a little more.
19 Now, how are the fear, rejection, avoidance, and
20 discrimination which the report mentions manifested? One
21 of the most grievous outcomes of stigma is the ongoing
22 link, fueled by the media, between individuals with mental
23 health challenges and violence. A widely held idea is that
24 people with mental health challenges are much more violent
25 than the general population, and those with schizophrenia

1 are among the most dangerous.
2 However, the opposite is true. Research
3 published by the American Psychological Association last
4 year found that "of crimes committed by people with serious
5 mental illness, only 7.5 percent were directly related to
6 symptoms of mental illness." Furthermore, according to the
7 research, of those offenders, 2/3 also had committed crimes
8 for other reasons such as poverty, unemployment,
9 homelessness, and substance abuse.
10 We must also look at the other side of the coin.
11 Individuals with severe mental health challenges who live
12 in the community are at great risk for crime victimization.
13 In an epidemiologic study conducted in 2005, researchers
14 found that "more than one-quarter of persons with SMI" --
15 severe mental illness -- "had been victims of a violent
16 crime in the past year, a rate more than 11 times higher
17 than the general population rates. Depending on the type
18 of violent crime (rape/sexual assault, robbery, assault,
19 and others), prevalence was 6 to 23 times greater among
20 persons with SMI than among the general population." These
21 statistics clearly demonstrate that the prevalent
22 stereotype of individuals with mental health challenges as
23 mostly violent is not true.
24 The recent tragedy of the crash of Lufthansa's
25 Germanwings Flight 9525 in the French Alps will once again

1 intensify the virulent discussion on mental health
2 challenges, violence, and what can be done to address the
3 needs of individuals. We must withhold judgment on what
4 Andreas Lubitz, the copilot, who's gone from being a
5 "suicide-murderer'' who kept all information of his mental
6 health challenges hidden, to being an individual who was
7 facing multiple mental health issues, to now being someone
8 who shared with Lufthansa his previous mental health
9 struggles. Rather than pointing fingers, what is needed in
10 this situation is to gather all relevant information, view
11 Mr. Lubitz as a person in need, and determine which systems
12 failed or need improvement, and what systems need to be
13 developed.
14 This is very similar to what needs to happen here
15 in the United States and Pennsylvania. We must not rush to
16 judgment when incidents of this magnitude or others that
17 are not as tragic take place. We must look at the root
18 causes, individual, systemic, and structural, and from
19 there decide what could have been done better.
20 Making this type of change takes money. Funds
21 are needed to develop appropriate treatment approaches, a
22 broad array of community-based services, safe residential
23 options, and meaningful employment. We cannot afford to
24 wait until an individual is at the end of their rope before
25 we reach out and lend a hand.

1 Closely related to the purported link between
2 individuals with serious mental health challenges and
3 violence is the idea that gun violence is directly related
4 to mental health challenges. Again, this strongly held
5 belief is debunked by research. Last year, research was
6 published in the Annals of Epidemiology concluding that
7 "evidence is clear that the large majority of people with
8 mental disorders do not engage in violence against others,
9 and that most violent behavior is due to factors other than
10 mental illness."
11 There are those who hold antiquated beliefs and
12 based on a deficit mentality, the type of thinking that
13 only looks at shortcomings and not strengths, and postulate
14 that people with serious mental health challenges are
15 incapable of recovery and therefore are in need of
16 institutionalization. In January of this year three
17 ethicists from the University of Pennsylvania published an
18 opinion piece in the *Journal of the American Medical*
19 *Association* where they argued that "seriously mentally ill
20 people cannot help themselves or live independently." At a
21 very personal level, I am confounded that such a
22 paternalistic and dehumanizing myth is being promulgated by
23 members of what is considered as one of the premier
24 institutions of research and education in medical ethics in
25 the world, my alma mater.

1 Rather than locking up those individuals facing
2 serious mental health challenges who commit nonviolent or
3 violent offenses, what is needed is appropriate treatment
4 in the least restrictive environment, access to that
5 treatment, and collaboration between the criminal justice
6 and the mental health and behavioral health systems to
7 provide appropriate treatment for diversion from both
8 systems and assistance for successful re-entry into the
9 community.
10 Speaking of access to appropriate treatment, a
11 perturbing issue is the disconnect that exists between
12 mental health and physical health. Oftentimes, because of
13 stereotypes held, physical health doctors do not believe
14 what patients who have mental health challenges say about
15 their physical health and minimize, ignore, or attribute
16 their symptoms to the individual's mental health condition.
17 It is imperative to integrate physical and mental health so
18 that the individual is treated holistically.
19 In other situations, people with mental health
20 challenges who express an opinion contrary to that of their
21 treating physician are labeled "noncompliant" with
22 treatment and are considered to be in need of forced
23 treatment. In reality, the opposite is true. People want
24 treatment that works for them and they want to be heard and
25 involved in designing their treatment and to have easy and

1 reliable access to community-based acute and extended acute
2 treatment.
3 One last example of the impact stigma has on
4 individuals facing mental health challenges relates to
5 housing. Based on my experience as a Mental Health
6 Advocate, I have seen the most repugnant manifestation of
7 stigma when counties and providers attempt to establish
8 community-based housing options for individuals with mental
9 health challenges who no longer need active psychiatric
10 treatment in inpatient settings. The uproar and opposition
11 are fierce. People's ignorance of the mental health field
12 and the stigma attached to those who face mental health
13 challenges leads them to express the cry "Not in my
14 backyard," or NIMBY. Many a project has been stopped and
15 individuals have had to unnecessarily wait in psychiatric
16 institutions for new sites to be found and for the lengthy
17 zoning process to be started once again and, hopefully, be
18 completed successfully. In the battle against stigma, we
19 must aggressively address NIMBY.
20 Eliminating stigma is a lofty goal. It is a
21 monumental undertaking, especially in the world in which we
22 live. I do believe that like recovery, it's something we
23 need to be intentional about in order to create change. It
24 cannot be a one-time event, or short-term action, or
25 another task on an agenda, or something we only do when

1 we're at work.
2 If we're truly committed to working on
3 eliminating stigma, we must own the process; we must be the
4 process. By that I mean we must set the example. We must
5 think of mental health challenges as obstacles to be
6 overcome, not as psychiatric labels impregnated on
7 individuals for perpetuity. We must model the type of
8 behavior and attitude we want to achieve in a society free
9 of stigma. We must exude acceptance, compassion, and
10 understanding while openly rejecting intolerance, narrow-
11 mindedness, and injustice.
12 Education and engagement are important, but there
13 is no better stigma-buster than actually knowing a person
14 as a person. When community living is made possible, we
15 get to know our neighbors as individuals and friends first
16 instead of relying on nothing more than a label to describe
17 a life.
18 It is our hope that as a result of the
19 information you receive in this hearing and other related
20 work, concrete recommendations for change come out of this
21 Committee. Let this not be another unfulfilled promise of
22 hope but a palpable attempt to rectify the misunderstanding
23 which surrounds individuals' views of those facing mental
24 health challenges. We can talk about eliminating stigma as
25 a long-term goal, but for now, we must take great strides

1 in reducing it.
2 I am Sol Berlin Vazquez-Otero, and I am an
3 individual living with mental health challenges.
4 REPRESENTATIVE MURT: Thank you very much for
5 your testimony.
6 Also, thank you to all the testifiers for staying
7 for the question part of our program.
8 Do any of my colleagues have questions for any of
9 the testifiers?
10 Representative Diamond.
11 REPRESENTATIVE DIAMOND: Thank you. And let me
12 also say thank you for coming up here and testifying today.
13 For us here we do this just about every day, but I know
14 that it's a big deal to come to Harrisburg and testify in
15 front of a Committee. I really want to commend you for
16 taking the time out of your schedule. And I know how
17 important it is for you to come here and do that.
18 What I try to look at when we look at these
19 issues is what can we do as legislators? And, Alyssa, you
20 mentioned one thing. You talked about the 2008 Mental
21 Health Parity and Addiction Equity Act on the Federal
22 level, which essentially has given us an unfunded mandate
23 to enforce here in the State. So I wanted to ask you, and
24 if any of the other experts can chime in -- and if you do,
25 when you do, just come up and use the microphones -- who

1 would you envision in State Government enforcing the
2 provisions of that act? Would it be the Insurance
3 Commission or an outside group?
4 MS. SCHATZ: So I think most States that have
5 been successful have directed the insurance department to
6 enforce, which is how it's laid out in the law. But I
7 certainly understand the concern about funding and
8 resources. And as community-based organizations, I know
9 that we would certainly be happy to assist with things like
10 development of educational materials for the website,
11 assistance with raising awareness about the law.
12 So there are multiple pieces to enforcement.
13 There's raising awareness, there's identifying what
14 consequences are, and then actually rooting out the
15 violations. But we'd be happy to assist in whatever way we
16 could to ease the burden.
17 REPRESENTATIVE DIAMOND: I'm glad you mentioned
18 the developing sanctions I mean because what sanctions or
19 penalties for not having parity would you envision putting
20 upon an insurance company that's --
21 MS. SCHATZ: Sure. Yes, so what other States
22 have done is they've outlined fines.
23 REPRESENTATIVE DIAMOND: Okay.
24 MS. SCHATZ: And I can't recall the actual
25 amounts off the top of my head but I could send you some of

1 that model legislation --
2 REPRESENTATIVE DIAMOND: Okay.
3 MS. SCHATZ: -- if you're interested.
4 REPRESENTATIVE DIAMOND: And what sort of
5 particular activity would trigger enforcement? I mean how
6 would this --
7 MS. SCHATZ: Right.
8 REPRESENTATIVE DIAMOND: -- agency find out that
9 there's a problem and go out and enforce? Would it be
10 simply consumer complaints --
11 MS. SCHATZ: Yes.
12 REPRESENTATIVE DIAMOND: -- that sort of thing?
13 MS. SCHATZ: So there are many different venues.
14 One is certainly consumer complaints and we are actually
15 working at the Mental Health Association now because the
16 insurance department has not developed a process
17 specifically for parity complaints thus far, although I
18 should say we have not yet spoken with the current
19 administration. So to their credit we haven't chatted with
20 them about this yet. But the previous administration did
21 not express an interest in developing their own parity
22 complaint line so we are actually doing that at MHASP so
23 that people can call us and we'll assist them with a
24 complaint to the Department.
25 So one thing that they can do is the complaint

1 line. Another is that many States require that they
2 certify annually that they're in compliance with the law
3 and that they submit that certification.
4 I'm trying to think. There are other -- oh, the
5 Attorney General sometimes. So when there's State
6 legislation, that in court cases has been shown to be a
7 better precedent. It's a stronger case if there's
8 statewide legislation and when Attorneys General go to take
9 insurance companies to court, they've been more successful
10 when there's been legislation.
11 REPRESENTATIVE DIAMOND: Okay. And I'm glad,
12 several times you mentioned other States because my final
13 question to you is what other States are doing this well --
14 MS. SCHATZ: Yes.
15 REPRESENTATIVE DIAMOND: -- and is there a
16 chance that you could provide the Committee with perhaps
17 some model legislation that other States have used --
18 MS. SCHATZ: Yes.
19 REPRESENTATIVE DIAMOND: -- and how they carried
20 this out? I would sure appreciate that.
21 MS. SCHATZ: Absolutely. I would be thrilled to
22 do that. A number of States have but off the top of my
23 head in the Northeast what I'm thinking of, Vermont has
24 actually a more stringent requirement than even the Federal
25 law. Maryland has a parity law. New York has been doing a

1 lot of great work recently. Their Attorney General just
2 took some action that was successful. So I can send you
3 some of that legislation.
4 REPRESENTATIVE DIAMOND: Okay. That would be
5 great. Thank you very much, ma'am.
6 MS. SCHATZ: Yes, thank you.
7 REPRESENTATIVE DIAMOND: Thank you.
8 REPRESENTATIVE MURT: Any other questions?
9 DR. VENEZIA: Can I make a comment about that
10 question?
11 REPRESENTATIVE MURT: Yes, Dr. Venezia.
12 DR. VENEZIA: Dr. Certa gave me instructions
13 before I came. I think you all know Ken, and he wanted me
14 to point out that EPA has launched lawsuits in eight States
15 concerning mental health parity and are considering what
16 they might do in Pennsylvania.
17 But I want to personally tell you that getting
18 insurances to comply with the terms of their contract is
19 not just an issue for psychiatry. I don't know how many of
20 you have fought with your insurance companies over things
21 which are not according to contract. I have routinely told
22 patients and have myself gone to the Insurance Commissioner
23 for patients. It's hard enough for a person like me who
24 knows the ropes to get through to the insurance company.
25 It's even harder for a layperson and even harder for a

1 psychiatric patient.
2 So I think if you want to do something about
3 enforcing the laws of parity, there has to be a system in
4 place. And those of us working in mental health treatment
5 centers have to know how to access the system and go up the
6 line so we can help our patients, direct them, because it's
7 very, very difficult and most people give up fighting an
8 insurance company even when they're trying to get their
9 colonoscopy paid for. And it's exponentially harder for
10 our mental health patients who don't advocate for
11 themselves because of a lot of the reasons we've mentioned
12 today.
13 REPRESENTATIVE MURT: Dr. Venezia, while you're
14 at the microphone. I have a question about services in
15 Pennsylvania that are available or not available to the
16 rural parts of the Commonwealth. I mean there are large
17 swathes of the Commonwealth --
18 DR. VENEZIA: Yes.
19 REPRESENTATIVE MURT: -- that are underserved I
20 would assume. And can you comment on that?
21 DR. VENEZIA: This is a huge, huge issue, and I
22 can tell you what's happening. Many places are resorting
23 to telepsychiatry. In fact, we have considered that. We
24 are not rural Pennsylvania. We're Doylestown, and we have
25 an ever-dwindling supply of psychiatrists. Our youngest

1 guy is about 48 for the crisis service at Doylestown
2 Hospital. One guy just has been diagnosed with a serious
3 cancer.
4 So this is an issue everywhere in Pennsylvania.
5 So telepsychiatry has been one of the solutions. There are
6 certain places where they've set up sort of freestanding
7 expanded crisis centers where patients who are on a 302
8 commitment can stay for a few nights. People are being
9 housed in emergency rooms for nights at a time. Families
10 have said in our crisis center when we can't find an
11 adolescent bed, well, I guess we'll take the patient home
12 and we'll just stay up and watch them until we can find a
13 bed. I mean it's a big, big issue and there is no
14 solution.
15 Doylestown Hospital had an inpatient unit. We no
16 longer have it. It wasn't profitable. As I said, psych
17 units are disappearing. Mental health treatment centers
18 are increasingly burdened. We have probably a one-month
19 waiting list for outpatient therapists in our clinic. To
20 see a psychiatrist for the initial evaluation for
21 medication is over a month wait. Lots of times we'll try
22 and funnel people through the Partial Hospital, which is
23 where I work, and I'll do the evaluation just to get them
24 in. Sometimes they'll stay. Sometimes then at least I can
25 get them into see a psychiatrist for a shorter visit.

1 I also want to point out to you that because of
2 this, the amount of time patients spend with their
3 psychiatrist is dwindling considerably. There is a
4 psychiatric outpatient clinic in Montgomery County who
5 books six outpatients an hour for medication checks. How
6 do you communicate anything in 10 minutes? It's one thing
7 to be taking care of a strep throat in the average eight-
8 minute family medicine checkup. It's another thing to take
9 care of a whole person who's struggling in 10 minutes.
10 So this is a very big point and this is why we
11 would advocate for psychiatry being considered a primary
12 care specialty, so we can draw more young doctors into our
13 specialty.
14 REPRESENTATIVE MURT: Dr. Venezia, has the
15 telepsychiatry been successful or is it too early to assess
16 that?
17 DR. VENEZIA: We've resisted it. Doylestown
18 Hospital has not accepted the idea of telepsychiatry. I
19 understand that it's going well in some parts of the State.
20 I can't really speak to it from personal experience. I
21 know the youth center is actually using it when if there's
22 a patient I can't get to quickly enough, they actually have
23 a telepsychiatrist. But I asked the nurse yesterday how
24 long does she spent with the kids? She said to me, oh, 10
25 minutes, sometimes less.

1 So I think even with the use of telepsychiatry we
2 have to adhere to the same standards of practice that we
3 would like to see optimally in face-to-face therapy.
4 REPRESENTATIVE MURT: Did someone else want to
5 make a comment?
6 Could we ask you to please give us your name and
7 your organization, please?
8 MS. SHOEMAKER: Deb Shoemaker. I'm the Executive
9 Director for the Pennsylvania Psychiatric Society, and I
10 work with Mike on a lot of issues, Representative
11 Schlossberg.
12 To kind of counterbalance the two questions you
13 had on both the rural and also about telepsychiatry and how
14 we can help, to advocate for a bill that's currently out
15 there is Dan Miller, Representative Miller had just
16 introduced, I don't know if the bill is out yet, but the
17 psychiatric bed tracking, which has been a concern,
18 especially rural, other areas where one of our consumers
19 unfortunately has presented emergency department.
20 A lot of the problems, as everybody alluded to,
21 is that you sometimes sit for hours upon days in the
22 emergency department and you can't get access to services,
23 whether it's extended acute bed or whatever the case may
24 be. So there's a piece of legislation that we've been
25 working on, other groups have been working with

1 Representative Miller on is to have an outlet so that as
2 soon as someone presents that emergency department, it's
3 assistance for social workers and others trying to find
4 someone that either need the bed or needs to be evaluated.
5 So that's just one of the other things that may be able to
6 assist in that effort.
7 As you talk about telepsychiatry, a lot of our
8 members we hear it's been successful. If you consider Erie
9 rural, which when I was there in November to me it was
10 rural, but I'm from Philadelphia so it was rural to me, but
11 they do have telepsychiatry and it's been working
12 wonderfully. I know that there have been other pilot
13 projects that at one point in Einstein's -- which is not
14 rural -- but Einstein's emergency department they had a
15 pilot program for child and adolescent children who were
16 there.
17 One of the other things with telepsychiatry and
18 telemed -- it's not just telepsychiatry, telemedicine is
19 now becoming another option for barrier-to-care issues is
20 that to reduce stigma telepsychiatry or telemed is a
21 wonderful thing. What we're hearing is when you think of a
22 college student who is like going to North Carolina and
23 they still want to get services, they don't feel
24 comfortable going to a counseling center, they have a good
25 relationship with their psychologist or the social worker

1 or whoever they do psychotherapy with, they have that
2 opportunity to be able to talk to them and respond.
3 And from a stigma, it's like looking at
4 television. I know my 12-year-old son and my daughter,
5 they would probably much rather talk to someone over the
6 computer than they would in an office, so there are a lot
7 of opportunities I think for that even from reducing stigma
8 to other ways to do that. So it's also getting through to
9 kids because kids are technology-driven much more than
10 probably I am. But that's just a couple options so just
11 wanted to give you --
12 REPRESENTATIVE MURT: Thank you. Tim Clement, I
13 have a couple questions for you if you don't mind.
14 Tim, you mentioned contact strategies. What
15 exactly are contact strategies and why are they effective?
16 MR. CLEMENT: So what a contact strategy is --
17 and contact strategies can come in two forms primarily,
18 maybe even three forms: in-person contact strategies and
19 video-based contact strategies, and you can also have
20 written contact strategies. What they are very simply is a
21 contact strategy, let's pretend I was conducting a contact
22 strategy right now. I would be someone who would make it
23 known to the group around me that I have a diagnosed
24 condition, and the group around me would be just members of
25 the public. It could be a targeted audience. It could be

1 landlords. It could be police officers. That's one thing
2 we do in South Jersey. It could be a various range of
3 things but it's people that are not necessarily there
4 because they have any connection with mental illness or
5 individuals with lived experience.
6 And the person who has the diagnosed condition
7 just talks about his or her life in a way that disconfirms
8 the stereotypes, nothing that reinforces the idea they
9 might be dangerous or unpredictable or incompetent or
10 irrational and that he certainly does have a hope for
11 recovery.
12 In doing that, what that enables -- so what the
13 research has shown is that that's very effective in
14 reducing stereotype endorsement. The sheets of paper that
15 you have come from a test that's valid and reliable. The
16 people are given a test before they have these contact
17 strategies. They are exposed to them, and then afterwards
18 what they've seen is there's significant reductions on all
19 the stereotype endorsement of dangerousness, blame, anger,
20 all sorts of things like that.
21 And the way it's believed that it works is that a
22 person who might endorse stereotypes about a person with
23 mental illness, when they see that that person does not
24 match those stereotypes and they hear stories of that
25 person's life that resonate with them and they can say to

1 themselves, oh, that's just like my life, that's how it
2 works, the shared humanity and commonality the person with
3 lived experience has with the people in the audience.
4 Because that's what most people will find when they spend a
5 little time with someone with a mental health condition is
6 they are just a "normal person" like everybody else. So
7 that's the hearing behind a contact strategy.
8 REPRESENTATIVE MURT: Thank you.
9 Representative Schlossberg has a question for
10 you.
11 REPRESENTATIVE SCHLOSSBERG: Thank you, Chairman.
12 And thank you very much, Tim.
13 Contact strategy, it makes all the sense in the
14 world. Is there a way you can replicate that in the form
15 of some sort of public service campaign?
16 MR. CLEMENT: So do you mean when you say --
17 REPRESENTATIVE SCHLOSSBERG: Advertisements,
18 commercials, Facebook ads, how can you take a contact
19 strategy and mass produce it?
20 MR. CLEMENT: Yes, that's a good question.
21 That's one thing we've been trying to develop in the last
22 year or so. I've been trying to develop it just for the
23 lack of funding and cooperation from some parties has
24 gotten in the way. But now with the Web 2.0 era where you
25 have user-generated content and people go to YouTube and

1 things like that, you can make video-based contact
2 strategies where somebody like Jeff or somebody with lived
3 experience speaking in a video setting and that's basically
4 a contact strategy in a box. That's not even a box. It's
5 through fiber-optic cable. So you can get that anywhere.
6 Now, if you're talking about making something
7 that's, say, 30 seconds that you could put on TV, I'm going
8 to just caution you. I would not recommend that because
9 the research on that has shown that that's very
10 ineffective. You're just flushing money down the toilet
11 when you do that. So I mean I wish I had better news on
12 that front but that's just the reality.
13 REPRESENTATIVE SCHLOSSBERG: Is there anything,
14 forgetting contact-based strategies then, from a PSA sort
15 of perspective? And again, I come back to billboards, TV
16 ads, Facebook ads, whatever, what can be done that is
17 effective?
18 MR. CLEMENT: There's an organization in
19 Sacramento called I believe it's Stop the Stigma,
20 Sacramento or Slow Stigma, Sacramento. I can't remember,
21 but you can make little pamphlets and brochures that can be
22 mass distributed that correct some of the stereotypes and
23 the myths that are out there. Or they say Paul is a
24 father, Paul works in business, Paul is active in his
25 church, Paul has bipolar disorder. This organization in

1 Sacramento, they made these and they put them on the top of
2 gas station pumps, taxicabs, little pamphlets that would
3 just be handed out.
4 Now, that's what would be called an education
5 strategy where you are specifically educating someone about
6 a person and how they disconfirm stereotypes, and also you
7 can maybe list on one side some of the stereotypes that
8 exist and correct those stereotypes like I did earlier
9 today, point out the facts.
10 Those education strategies, they do have some
11 marginal effect. Unfortunately, it's not very long-
12 lasting. They usually find that someone exposed to an
13 education strategy might show improvement in attitudes
14 today but three weeks later it's all lost.
15 And the only caution I would add about that
16 organization in Sacramento is they were not doing any kind
17 of outcome evaluation to see if it really was having any
18 sort of effect. And let me just stress that. I don't know
19 if I made it clear enough when I spoke earlier. It is
20 imperative that we measure outcomes on all this as far as
21 this is concerned because there are ways to do it. It's
22 not that hard to do it, and if you don't measure outcomes
23 to see if you're having an impact, how do you know if it's
24 working? And you could just be lighting money on fire if
25 you are going to fund something that doesn't have proof

1 that it's actually working.
2 REPRESENTATIVE SCHLOSSBERG: Thank you very much.
3 MR. CLEMENT: Thank you.
4 REPRESENTATIVE MURT: Dr. Venezia.
5 DR. VENEZIA: Why not get some of our high school
6 students like your high school intern there and sponsor a
7 statewide contest and get these kids to develop videos, the
8 faces of mental illness.
9 My son is a high school teacher in North Philly
10 and I've seen some of the videos these kids have produced.
11 They are unbelievable. These kids are so technically
12 savvy, many of them, and I'm talking about a high school in
13 North Philadelphia. This is where we want to hit. We want
14 to hit young people to help them understand mental illness.
15 And it seems to me you have an intern here --
16 REPRESENTATIVE MURT: Simran's already been
17 accepted to numerous Ivy League schools so she's probably
18 up to the challenge.
19 DR. VENEZIA: Well, not necessarily -- well, hey,
20 colleges, too. We want to hit young people, teenagers,
21 college students, and they have the tech savvy to do this.
22 REPRESENTATIVE MURT: Dr. Venezia, before you
23 leave, Alyssa, I would just ask you maybe to address this
24 question also. The Federal parity law passed in 2003, is
25 this working in Pennsylvania?

1 DR. VENEZIA: I don't think so. That is not my
2 impression. And again, Dr. Certa told me that they are
3 considering strategies to pursue this legally as they've
4 done in other States. I certainly do not see parity for
5 the patients that I'm taking care of. They have higher
6 copays for psychiatric medications. They do not have the
7 coverage for visits, two-hour, Lenape Valley Foundation. I
8 would have to say no it has not trickled down into the
9 small villages of Pennsylvania. It's a big, big, big
10 issue.
11 REPRESENTATIVE MURT: Alyssa, any --
12 MS. SCHATZ: Yes, I would agree with that. I
13 think some of the more common things I've seen are in that
14 work adequacy as I mentioned earlier and then certain
15 treatment limitations, so where you might have a step-down
16 therapy on the physical side, you don't have it on the
17 mental health side. You may not have residential treatment
18 which might be something that's required that's medically
19 necessary. And again, I think that's because we don't have
20 anybody actively enforcing it right now.
21 DR. VENEZIA: Inadequate networks is a big issue.
22 Many of the lists that are provided as being in network,
23 they're not network. Basically, they provide lists of
24 facilities that have doctors who are cooperating through
25 the facility but they are not cooperating private practice,

1 so they're largely completely inaccurate.
2 Just yesterday, we had a patient come in to the
3 Partial Hospital and we always go over the coverage before
4 they start, and the patient that was to be admitted could
5 not be admitted because her copay was huge and we could
6 find no local network provider to do Partial Hospital for
7 her. So it's an everyday issue.
8 REPRESENTATIVE MURT: Sue.
9 MS. WALTHER: I just wanted to briefly talk
10 about, we do have a coalition that was looking at the
11 parity issue and whether we're successfully implementing
12 that in this State, and I think Alyssa alluded to the fact
13 that the former administration did not show an interest in
14 establishing criteria, in measuring insurance companies
15 against the criteria. The way they were responding is when
16 they got individual complaints.
17 And what we know is that people get frustrated
18 very quickly because there are only so many phone calls
19 you're going to make, you get put on hold, and complain
20 before you're going to just quit. And so the idea that
21 people that are trying and struggling to get treatment are
22 going to spend hours on the phone calling a variety of
23 different people until they get to the right person to
24 complain is kind of unrealistic I think.
25 But what I would also say and caution is that we

1 haven't had the opportunity to meet with the new Insurance
2 Commissioner and to determine is she more willing to kind
3 of begin the process of looking at insurance companies,
4 determining a definition, defining what that criteria is,
5 measuring -- we weren't asking them to review every
6 insurance policy, but what we were thinking would be
7 possible is that you would sample and you would pull
8 samples out and you would measure and you would take a look
9 at it and you would decide. Because in Maryland, for
10 example, what they found, there was some lack of parity
11 that were very easy to find. It was easy to find it once
12 people have the time and will to look for it.
13 And so I think we do have an opportunity with the
14 new Insurance Commissioner, at least I'm hopeful, that we
15 want to go back and again have that conversation again and
16 see if we can encourage them to do something a little
17 different than what we were experiencing with the last
18 administration.
19 REPRESENTATIVE MURT: Any other questions for any
20 of the testifiers?
21 We heard some really great testimony today. You
22 could see us up here taking notes feverishly, and there are
23 some things that we need to follow up on.
24 I just want to tell you a personal anecdote. I
25 have a constituent in Hatboro in Montgomery County and the

1 mother and father are neighbors of mine and the father is
2 somebody that I went to school with for 12 years. And they
3 have a son who's 23 years old, and I coached him when he
4 played soccer when he was five and six years old, but their
5 son has some mental health challenges and he was removing
6 caps from his teeth and things like that until they were
7 able to get the right diagnosis and medication. And the
8 medication has been very, very effective. The young man is
9 doing well. He's working a job and there's been no
10 recurrences.
11 However, every time the course of medicine runs
12 out, they absolutely, positively need the brand-name
13 medication. Generic brand will not do it. And the
14 healthcare provider -- I won't mention the name -- but they
15 fight with the family over this. And of course the family
16 would gladly embrace a generic medication if it was
17 effective, but it's not. Their psychiatrist calls for the
18 brand-name drug and they have to fight for this every time.
19 And this is very painful because this is a family
20 in crisis. They were down to a few days' worth of
21 medication when we finally got permission to get them
22 another course of medication to get them through May up
23 through Memorial Day, but they're going to be fighting this
24 ongoing. So this is another issue that I think that we
25 have to address relative to mental health and mental

1 illness in Pennsylvania.
2 We want to have some more of these hearings in
3 the next several months, so please remain connected to the
4 Human Services Committee and we'll let you know when the
5 next hearing is going to be.
6 Any of my colleagues have any comments?
7 Representative Schlossberg.
8 REPRESENTATIVE SCHLOSSBERG: Thank you.
9 Thank you all very much. The only thing I have
10 to say is thank you. This is bar none one of the most
11 informative hearings I've ever attended. I'm so grateful
12 for all of your testimony and your personal stories. And
13 as a side note, I apologize. I'm not trying to be rude;
14 I'm late to another meeting so I'm going to run out the
15 door when we're done. I would thank you all. But thank
16 you all so much. This has been so informative.
17 REPRESENTATIVE MURT: Okay. Thank you very much.
18 Thank you to my colleagues for remaining here. Thank you.
19
20 (The hearing concluded at 11:55 a.m.)

1 I hereby certify that the foregoing proceedings
2 are a true and accurate transcription produced from audio
3 on the said proceedings and that this is a correct
4 transcript of the same.
5
6
7 Christy Snyder
8 Transcriptionist
9 Diaz Transcription Services