COMMONWEALTH OF PENNSYLVANIA

HOUSE OF REPRESENTATIVES

HEALTH SUBCOMMITTEE OF THE

HEALTH AND HUMAN SERVICES COMMITTEE

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PUBLIC HEARING IN RE: MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT: PLANNING FOR THE FUTURE

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BEFORE: JAKE WHEATLEY, JR., Majority Chairman
DOUGLAS G. REICHLEY, Minority Co-Chairman
Eddie Day Pashinski, Ken Smith,
Phyllis Mundy, Frank A. Shimkus, Members
John N. Wozniak, Senator

HEARING: Thursday, October 9, 2008
Commencing at 4:00 p.m.

LOCATION: Dunmore Senior Center
1414 Monroe Avenue
Scranton, PA 18509

WITNESSES: Teresa Osborne, Judge Michael Barrasse,
Kathleen Wallace, Wendy Luckenbill,
Marie Onukiavage, Heather Smith,
Sal Santoli, Ann Leisure, Marybeth Redman

Reporter: Kenneth D. O'Hearn

I N D E X

P R O C E E D I N G S

CHAIRMAN:

Good afternoon, everyone. Four o'clock having arrived, I would like to call the Subcommittee of --- Subcommittee on Health and Human Services Committee to order. Thank you for allowing us to hold this hearing here. We look forward to a wonderful discussion. I want to also thank Representative Ken Smith for helping us find such a beautiful location and providing all the equipment that we need to set up.

I want to --- first, before I begin, I wanted to let the members on the panel introduce themselves and where they're from. And I'll start with myself. I'm Jake Wheatley from Allegheny County, the committee co-chair.

REPRESENTATIVE REICHLEY:

Doug Reichley from the 134th District in Lehigh and Berks Counties.

REPRESENTATIVE MUNDY:

Representative Phyllis Mundy from your neighbors to the south, Luzerne County.

REPRESENTATIVE SMITH:

Representative Ken Smith, Lackawanna

County, right here.

CHAIRMAN:

And we also have our wonderful staff people, Stan and Sandy, here with us. And what I wanted to do --- I'm going to save most of my comments to the end because we have a full hearing. But I did want to offer my colleague, Doug Reichley, who is the co-chair, if he has any opening comments.

REPRESENTATIVE REICHLEY:

No, thank you.

CHAIRMAN:

So we would like to begin this hearing by calling Ms. Teresa Osborne up to the panel. Of course, most of you may know her. She's the executive director of Lackawanna County Area Agency on Aging and the acting director for the Lackawanna County Department of Human Services. And I also wanted to say, and you may not know, but tomorrow is the World Mental Health Day, so this is a very timely and appropriate beginning --- our continuation of a statewide set of hearings we've been having.

And so you have some background to what we have done, about a month ago now, we kicked off an initial hearing in Harrisburg to take a look at mental health and substance abuse and our services and our

programs, and how they are all coming together, if we're providing the appropriate amounts, are there any gaps, where are the challenges, and how can we as policy makers try to address those gaps so that we have --- we make sure we're addressing the mental issue --- the issues of our community and our population, be they with financial resources or just making sure the programs are available and are accessible and that the drugs are there, and so on and so forth. So we wanted to really hear, take a look at each of these components of this very complex set of issues.

So we began in Harrisburg. Then we said we wanted to go out to each area of this Commonwealth and kind of get a good sense from a regional perspective of what's happening in those locations and those areas. So fortunately, or unfortunately for some, this is our first set of regional hearings, and we look very forward to hearing the information that comes out of this and taking that back to Harrisburg and trying to figure out how we as policy makers can make just a little bit better system to make sure we're capturing all of the needs of our citizens.

So that's a little background of what we are hoping to accomplish when we finish these sets of

hearings. Ms. Osborne, it's now you.

MS. OSBORNE:

I appreciate that. Thank you. Good afternoon, Representative Wheatley. Thank you for choosing Lackawanna County to host this subcommittee hearing. Certainly with Representative Ken Smith's assistance, we always like having and hosting events in Lackawanna County. So we appreciate you all being here.

I want to thank you for the opportunity to address all of you today. As was mentioned, my name's Teresa Osborne. I'm currently --- thanks to the generosity of Lackawanna County Commissioners Mike Washo and Corey O'Brien, I have the blessed opportunity to serve as both the Area Agency on Aging director and the acting director of Human Services for Lackawanna County. These positions, for the last five and three years respectively, has forced me to witness the struggles and frailties of those in the dawn of life, the twilight of life, and the darkness of life, children who have been placed in residential treatment facilities away from their families, young adults trying to adjust to life's changes and challenges who unfortunately turn to drugs and alcohol to help them cope, adults with co-occurring illnesses trying to

navigate through the criminal justice system, and seniors embarrassed and afraid to seek mental health treatment services that could very easily enable them to maintain their quality of life.

I consider myself an accomplice to the complexities associated with navigating the vast array of community-based behavioral health treatment and support services. I can attempt to address the many critical issues and concerns, including the children's behavioral health system, the need for adequate community mental health and housing plans, the need for enhanced collaboration between the education system and the mental health system, and the need to develop strategies to help individuals with serious mental illness avoid contact with the criminal justice system.

Similar to the hearing that was held back in August when Secretary of the Department of Public Welfare Estelle Richman, who testified before you, I, too, can testify to the excellent work being done in many counties throughout Pennsylvania to bring together our law enforcement, justice and human services systems to divert, when possible, individuals with mental ailments from incarceration into treatment, and to ensure that assessments and

treatment is available and it be accessed.

I can testify personally to the direction being taken here in Lackawanna County, which has benefited from the successful growth of problem solving courts by diverting less serious offenders into DUI Court, Truancy Court, Adult Treatment Court, Juvenile Treatment Court, and most recently, our established pilot of the Mental Health Treatment Court. I can speak about our county's commitment to end the cycle where the old method of time served and you're out the door with little access to treatment and fewer provisions of services has created a revolving door for persons with mental illness into the criminal justice system.

However, as the Director of the Lackawanna County Area Agency on Aging, one of the 52 in our 67 counties in my --- of this Commonwealth, I will focus my attention and my remarks on the mental health treatment needs of older adults.

It is indeed no secret that Pennsylvania has one of the largest populations of older people in the nation, home to nearly two million persons age 65 and older. Right here in Lackawanna County, approximately 20 percent of our population is over the age of 60. Study after study shows that older adult

are at greater risk than younger people of some mental disorders and their complications, such as depression. And although many of these illnesses can be diagnosed and treatment, often they are not. Why not? Because older adults are unfortunately reluctant to seek psychiatric treatment. Often, there's a lack of understanding. There's feelings of shame and embarrassment, feelings that their symptoms are a normal part of aging. Frequently, the older adults and their family and even their doctor fails to recognize the treatable symptoms of mental illness. In essence, seniors with mental illness go unrecognized, undiagnosed, and untreated.

As this subcommittee visits regions throughout the Commonwealth, I am confident that you either have heard or will hear state leaders' and key stakeholders' comments on the fact that Pennsylvania is indeed in the midst of an exciting awakening of hope, realization and change, change that will transform the behavioral health system into one that assures that every person will have an opportunity for growth and recovery. My concern is that falling behind in this transformation are the older adults that we strive to serve through our local Area Agencies on Aging. This charge is indeed being led by

the Pennsylvania Department of Public Welfare, and specifically its Office of Mental Health and Substance Abuse Services, commonly referred to as OMHSAS. That office has established key goals and objectives that will allow the office to fulfill its mission. And the mission is outlined within by written testimony. And for sake of brevity, I won't read it to you here today.

OMHSAS has also established goals that they desire to accomplish, including a long list of nine goals that they desire to accomplish, one of which focuses on the assurance that behavioral health services and supports recognizes and accommodates the unique needs of older adults. And that is what I want to focus my comments on.

As an advocate for the rights of older adults, and as an individual who desires to be a catalyst for change, I applaud those who boldly develop these objectives and challenge all of you to ensure this vision of transformation becomes a reality for all who seek recovery and resiliency regardless of age. Recognizing that many initiatives support Pennsylvania's transformation efforts, I call your attention to a key objective to ensure that mental health treatment for older adults is available,

offered and accessed.

When an individual is in need of a nursing facility placement and if that individual is considered a target, someone with a mental illness, someone with mental retardation or another related condition, it is the responsibility of the local Area Agency on Aging to assess the individual's situation and complete a pre-admission screening review and evaluation prior to their seeking nursing facility placement and before admission to any Pennsylvania nursing home that participates and accepts medical assistance as a primary source of payment. It unfortunately has become common, all too common, for hospitals and hospital-based inpatient based mental health units to dismiss an individual's mental health diagnosis and their need for mental health treatment when the individual is over the age of 60.

For instance, I ask you to consider the plight of this 64-year-old woman, Martha, who has been involved with the mental health system for 30 years. Martha had two admissions and spent several years in a state hospital in Lehigh County. She eventually moved to Monroe County, where she was involved sporadically at best with the local mental health system, and then ended up at the age of 64 being involuntarily

committed to what is now a Lackawanna County-based inpatient mental health unit. The reason for her 3/02 involuntarily commitment was identified as a complete lack of concern for her safety, health and well-being and severe psychiatric impairment, and she was diagnosed with schizoaffective --- schizophrenic disorder.

Our local Area Agency on Aging was contacted and was requested to petition the court for emergency guardianship, so that Martha could be placed back into a --- could be placed into a locked nursing home for her safety. Operating under the premise that all seniors have the right and deserve to receive care and services that promotes their mental health and responds to their mental illness needs, we automatically questioned the need for guardianship services. We challenged the need for nursing home placement, and advocated for ongoing mental health treatment for Martha.

Intense conversations regarding the discharge plan being developed by the hospital, for example, guardianship and nursing home placement, occurred and intense debates on whose responsibility it was to intervene also occurred, be it the hospital, the mental health system or the aging system, fingers

pretty much pointing at every direction all for the sake of this individual who needed to access mental health services and treatment, and who was destined to go into a locked nursing home facility with a guardian to take over all decision-making responsibilities for her. We indeed challenged all that.

After much discussion, in the end it was determined that Martha did not need emergency guardianship services, which would, in essence, take away all of her rights and responsibilities, nor did she need the care or services provided by a nursing home. Imagine an individual 64 years of age going into a nursing home with other individuals over the age of 64 and often over the age of 85 with compromising mental conditions. How do those two populations meet with staff who aren't even available or trained in order to meet the mental health needs and behavioral health needs of many of the residents within our nursing homes?

What Martha did require was ongoing mental health treatment, and eventually Martha was admitted to a state hospital for treatment. The goal for Martha is now to transition her back into the community.

While this is just one example that I can

give you, countless others of the struggles and challenges faced by many individuals over the age of 60 with a mental illness, there is hope that Pennsylvania can take the steps and risks associated with true transformation throughout the individual's lifespan.

The implementation of Money Follows the Person Rebalancing Initiative is one of the positive steps being taken to assist those who live in nursing homes, institutions with people with mental retardation or in state hospitals to return to the community. This federal initiative will allow states like Pennsylvania to shift funding from traditional institutional settings to home and community-based services. It is vital that all stakeholders engaged in this initiative realize that individuals aged 60 and older with a mental illness need access to the same opportunities and appropriate treatment and services as individuals with a mental illness who are under the age of 60. Regardless of age, we each possess a desire to dream and to succeed, to love and to be loved, to accept and to be accepted. As Helen Keller once said, no matter what our age or condition, there are still untapped possibilities within us and new beauty waiting to be born.

I thank you for the opportunity to present this testimony, and at your discretion, would be available for any questions that you may have.

CHAIRMAN:

Thank you, Ms. Osborne. And I do have a couple questions and then I will open it up for the rest of the members. First, I notice in your presentation you use mental illness and mental health kind of interchangeably. Can you help me understand the difference between those two terms, or do you see a difference in those two terms?

MS. OSBORNE:

Well, I am not a clinician, so in my laymen's understanding, I often do use it interchangeably. Mental illness being the actual diagnosis of an individual, such as depression, or in Martha's case schizoaffective disorder, whereas the optimum level of functioning is to achieve mental health from your mental illness. So that's pretty much the way that I approach it, mental illness being the actual diagnosis. We're trying to achieve mental health within her ability to function daily within the community.

CHAIRMAN:

And I also noticed that you focused on

--- a lot of your testimony on those who have serious mental illnesses and the challenges of providing services for those. Help me understand for Martha, for example, how was she initially assessed? How did she or family members or community know that she had an illness in the beginning?

MS. OSBORNE:

That was a challenge to us, in all honesty. I mean, she --- I mentioned really specifically that she had been involved with the mental health system in three different counties, and ended up here in Lackawanna County. It took us a little while to get our arms around exactly what her state hospitalization was, what those diagnoses were, for how long, at what age. It took a little while to get our arms around gathering that information so that we could say --- advocate for her rights in terms of --- all right, it's an older adult with a mental illness. She's had this full history of mental illness. Now because she's 64, the mental illness doesn't miraculously go away.

So it did take --- it was quite a challenge to gather that information because the hospital's discharge plan is pretty much, you got to get them out, we're not going to get paid for it.

Medicare pays very little. You know, she's in an institution where they wanted her out. The quickest way to get her out was place her in a nursing home.

CHAIRMAN:

Right.

MS. OSBORNE:

So it was quite a challenge to even get to that point of gathering that information. And it wasn't easy. There was a lot of roadblocks in the way and folks saying, I'm sorry, I can't give you that information. But yet if we as a county are being asked to petition for guardianship, rest assured we need every piece of information we can get so we're not violating that person's rights. And we realize that she has a quality of life that needs to be maintained so she gets the mental health treatment that she needs.

CHAIRMAN:

And those challenges to all the information that you would need to be able to help understand her --- or to advocate on her best behalf, was that rules or regulations or laws or policies that were state or were those internal to the institutions or those federal --- or were there a combination of all of them?

MS. OSBORNE:

The last one you hit the nail on the head. It was a combination of both. It was one, release of information from the state hospital. It was two, which county are you in? Here in Lackawanna they get you engaged in the Carbon/Monroe/Pike Mental Health/Mental Retardation Program. Are they going to talk to us and give us information, or is now the Lackawanna/Susquehanna MH/MR Office that has to intervene? So it was a lot of turf war issues, whose responsibility is it to intervene and who's going to ensure that this person gets access to the treatment that they needed.

Compounding the issue is the assessment piece. Area Agencies on Aging are asked to do assessments as an agent for the Department of Public Welfare for any individual that needs access, medical assistance dollars for nursing home placement, or for a waiver program in order to defer institutionalization. That's a rule of ours. We were contacted only for the purposes of petitioning for guardianship services because we happened to be a county who provides that services, and we met those cases very carefully. Yet, if this individual was in --- was in Carbon County, Carbon County was providing

guardianship services. There wouldn't even have been a tool available to this individual for placement purposes.

So it was a combination of rules and regulations at all different levels that got us to the point to try to really break through all of that red tape and get the answers that we needed at the end. And I didn't include it in my testimony for the sake of brevity, but really, it was getting state folks involved to help break down barriers so that we got the information that we needed.

CHAIRMAN:

And do you see --- in the current changes that are taking place, do you see those barriers being taken down more systematically or not?

MS. OSBORNE:

Unfortunately, with the issues of folks within the aging system, I see them coming up almost anecdotally, case by case basis, as opposed to full transformation of the system. That's where my concern is, that through this Pennsylvania initiative of recovery and resiliency that is rightfully so based on the fact that we have children and young adults within the system, but I fear that older adults and their issues are only going to be addressed as case-by-case

basis that comes out on someone's radar screen. And if counties, such as in my case, aren't willing to press those buttons to effect that change, then folks like you aren't going to help push along our state leaders and secretaries to do this, that they'll get lost in the shuffle.

CHAIRMAN:

Sure. I want to recognize Representative Eddie Day Pashinski, who's now arrived for the hearing. Any other member? Representative Reichley?

REPRESENTATIVE REICHLEY:

Thank you, Jake. Ms. Osborne, two different tracks of questions. I'll try to make this as brief as possible. First of all, you mentioned the variety of different specialized courts that had been promulgated here in Lackawanna County. And while there may be other folks out there, I don't know, from the judiciary, are you able to describe for me from Lehigh County any sort of resistance or difficulty you had in getting the bench to go along with things?

MS. OSBORNE:

I can describe our county as unique with the judiciary that we currently do have. All of our judges that are involved in our family court, as we referred to it, I think, truly were social workers

before they went on to become lawyers and judges. And I saw with a lot of admiration and respect for what they do.

So when I have the opportunity to talk to other counties about the specialty courts in Lackawanna County, I attribute that to a great understanding, tolerance, and collaboration of our human service system wrapping itself around our criminal justice system and vice-versa. We have an extremely active Criminal Justice Advisory Board, known as CJAB for short, an outstanding relationship with PCCD, Pennsylvania Commission on Crime and Delinquency. And those relationships have indeed paid great dividends to poise Lackawanna County to be in this position. I do know of the struggles of other counties to get the buy-in from the judiciary, unfortunately. We have not had that challenge before us, and we're grateful for it.

Our judges are truly partners at the table with Human Services across all of our services, Drug and Alcohol, Children and Youth, Aging. And Aging, I think, was left out of the mix until I was appointed acting director, so that opportunity, I think, opened more doors for the Aging system.

But to answer your question, we have not

had those struggles because of the folks that we have at the table, and I pray it remains that situation forever.

REPRESENTATIVE REICHLEY:

Do you know how many judges you have on the bench in Lackawanna?

MS. OSBORNE:

I believe there's eight.

REPRESENTATIVE REICHLEY:

Just eight?

MS. OSBORNE:

In the specialty court, Judge Harhut is our President Judge. Judge Barrasse, Judge Geroulo, Judge Corbett, Judge Munley are the other judges that really engage the most in the specialty court. And I'm sorry, Judge Mazzoni also is stepping up with regard to our mental health court.

REPRESENTATIVE RIECHLEY:

I'm sorry. Go ahead.

MS. OSBORNE:

So those judges really are players at the table with us in our planning and integrating not just our human services, but meshing our systems so that we can hopefully keep people out of jail, get them back on their feet and keep the community safe. It's a

delicate balancing act. It's certain individuals that embrace the concept that we feel that we need to support the best.

REPRESENTATIVE REICHLEY:

Let me just pick up on your last comment of a delicate balancing act and shift to another topic. It's likely --- and I'll speak for myself, but there are others in the Legislature that believe, we're going to face a significant budgetary problem next year. We're already $281 million in the red as a fiscal basis, and we're projecting at least somewhere along the lines of a billion and a half in the red by the end of June. That probably means substantial cuts in funding from the state, and I'm curious as to what you can see as how that's going to impact programs that you are engaged in and if there are other options. Is there a way to promote behavioral health outpatient programs, medications, things like that to alleviate some of the concerns or situations you see already?

MS. OSBORNE:

Obviously, we share in your concern and are bracing for the worst and hoping for the best. With regard to the substantial cuts impacting the program, that is indeed real. Engaging in the

opportunity to draw down monies, federal funds that we can such as through the Money Follows the Person Initiative and moving people into waiver programs is obviously something that's occurring across the Commonwealth, and there's greater emphasis being put on that. As a county key individual, we certainly are stepping outside the box from where we currently have been, looking at our work. That just is business as usual. The tactics employed 20 years ago are no longer going to be employed today. And we need to be a catalyst in change with regard to even our provider network, that it just can't be money from the state to the county to the providers, and miraculously people are going to engage in the system. It's actually prioritizing our priorities. And it's being as creative as we can with going after other sources of funding which we, as a system, have never really done successfully before. We have shown some minor successes with regard to going after grants, grant opportunities that are available in order to support the services that we currently have in place. And it's transforming the system to encourage resiliency so that people embrace recovery and resiliency. And I think we need to support this to happen. But it doesn't happen overnight. The money certainly is part

of the process, but it is --- we are bracing for an enormous impact.

With my aging hat on, I can only say buy more lottery tickets. With the lottery fund, we continue to support older adults and the service that we provide them. And I know the lottery fund has been a hot topic of discussion in probably your conversations, I'm sure, as well as in the Senate, you know, with regards to the lottery funds usage and what gaps does it have to plug and the medical assistance system because of folks that need nursing home care versus those we desire to keep at home. Counties that have waiting lists versus counties that don't. The senior centers such as this one that just opened within the last three years, other senior centers in other counties closing because of the need to balance and rebalance our system and focus on those who are most vulnerable in our community, encouraging people to purchase long-term care insurance so that they don't rely on medical assistance. I wish I had a nickel for every call I got from a family saying, how do I hide my mom and dad's money so that I can get on medical assistance, and I'm like, you don't want to talk to me. That's what they save their money for. So it is a change of entitlement versus

responsibility. And unfortunately, the economy is really the way for us to embrace those changes.

REPRESENTATIVE REICHLEY:

Thank you.

REPRESENTATIVE SMITH:

Teresa, let me say thank you very much for taking your time and sharing your talents with us. Before I let you go, let me say thanks for all the representatives for being here today. Representative Wheatley, thank you for bringing your subcommittee hearing here to Dunmore. We appreciate it. And Representative Reichley, I appreciate it.

Communication from the state to the county level, how is that done, and do you think it's adequate? And if there's improvement needed, what's the best way to do it? Am I putting you on the hot seat?

MS. OSBORNE:

Are there any secretaries here? Communication. Obviously, communication, I think, can always be improved from my level to my staff, from the state secretaries to the local AAAs to the mental health, you know, MH/MR system across the Commonwealth. How is it done? It's done in a variety of ways. Within Human Services, we rely a lot on the

County Commissioners Association to share information with counties in terms of the key legislative initiatives, priorities with the House and with the Senate, and how that could potentially positively or adversely affect Human Services, especially with the budget and what to brace for, what to prepare for. So that's one source and a good source of information that we get.

When it comes to our individual departments, and since I chose to address seniors in particular, we do have the Department of Aging, which has changed in a dramatic fashion over the course of the last 18 months in terms of its scope; the services there are directly under the provision of the Secretary and now vacant Deputy Secretary position, the creation of the Office of Long-Term Living and its impact with its relationship with the Department of Public Welfare.

So for us in the aging network, it's been the time of transition in and of its own self where we use the aging program directors coming from the Secretary of Aging. We now get memorandums from the Office of Long-Term Living. And all of those folks are in it for the right reasons and are committed and dedicated to rebalancing and transforming and really

maximizing our resources. But sometimes communication is sporadic and sometimes you're not quite sure where it's coming from. And I'm not quite sure which secretaries are going to listen to this or watch this, so I'll stop there.

But it is difficult. I think it can always be enhanced, but it's not impossible, in order to make sure that we understand what the expectations are of the local programs in the county and which direction that we need to go. What's the vision of the Commonwealth? And when those things are shared, it's easier to get the buy-in and bring counties on board.

As I mentioned earlier, many of us are used to sticking our heels in and saying, well, 20 years ago we didn't do it this way. Even ten years ago we didn't do it this way. And in some instances, five years ago we didn't do it this way. But you can't do that any longer. And you need to embrace where we're at, where we're going, realizing that there's a limited amount of funds, and how do we serve the most vulnerable people within our Commonwealth.

REPRESENTATIVE SMITH:

Thank you, Teresa. Jake, just if I could for a minute, we have today the great fortune of

having Judge Michael Barrasse here and Judge Vito Geroulo from the Lackawanna County Court. And Judge Geroulo, I believe he does a lot with the Family Court. Of course, Judge Barrasse does a lot with the Drug Treatment Court. And they are a direct reflection of the great bench that we have in Lackawanna County. They take a proactive approach. And I'm not sure if they want to make a comment, but if they do while we have Teresa here, if you want to come forward and say a couple words and share your thoughts with us, feel free to do that.

MS. OSBORNE:

Were they here when I said nice things about them?

JUDGE BARRASSE:

I missed that part.

MS. OSBORNE:

It's on tape.

JUDGE BARRASSE:

Good afternoon, everyone. My name is Mike Barrasse. I'm a judge in the Lackawanna County Court of Common Pleas. The only thing I really would like to point out is that both myself and Judge Geroulo do the treatment courts, which include Drug Court and Mental Health Court, Family Dependency court

and DUI Court. We also participate in providing funding from Secretary Beard from both the RIP and IP programs.

If more is not done --- we recognize the shortfall that you're talking about with regard to the budget. As a matter of fact, just before now, we had our treatment court meetings, and afterwards, we talked about our concerns next year for funding, and we have grants drying up, federal government, state government. One of the things that we do realize, though, is that one of the budgets that's always increasing is the Department of Corrections. And the reality is your mental health care and substance abuse treatment monies are not provided substantially and increase substantially. That the only thing that's going to really increase substantially is your population in the Department of Corrections, because the reality is we've become an imperium for people that suffer from mental health and from substance abuse that end up in the criminal justice system and end up in our county prisons. And because our county prison can't give them services that are necessary, they end up in the state correctional. You know how much longer they stay in state correctional because they have a mental illness, and therefore, are not

released and don't have the proper community care when they're released.

So we feel like this is really a priority item in regard to reducing crime, as much as it is a humane way in which we should treat our fellow citizens. And we really believe that if we don't address this up front services, it's going to end up at the back end with the criminal justice system.

REPRESENTATIVE MUNDY:

Thank you, Judge Barrasse, for being here. And Teresa, thank you so much. You do a great job in Lackawanna County. We need to clone you and transport you all over the Commonwealth.

Judge Barrasse, could you just describe for me --- I'm familiar with the concept of a drug treatment --- well, let's --- let's focus on Mental Health Treatment Court. Just can you explain to me how that works?

JUDGE BARRASSE:

There's various different doors in which a person could come in. For some people, it might be a diversion. For other people, it may be in the way in which they are handled once they get into the criminal justice system. What it would include is the multidisciplinary approach where every week, myself

and Judge Geroulo sit with the counselors from mental health, your community resources, whether it's Scranton Counseling or Tri-County. We also meet with different housing alternatives we have, whether that be Harbor House or Step by Step, another place in which the person is a resident. We also have a probation officer there. We'll also have somebody from our substance abuse treatment centers there. We will talk about the individual, how they progressed that week, did they make their meetings, how was their sessions.

REPRESENTATIVE MUNDY:

So these are mostly outpatient people?

JUDGE BARRASSE:

Correct.

REPRESENTATIVE MUNDY:

They're not in prison and getting these services?

JUDGE BARRASSE:

Well, what we try to do --- the way in which the court started was we looked at the people that were in the jail who don't belong in prison. The only reason they're in prison is because they're suffering from a mental illness. The hardest part for the individuals that are in the prison is not in

one of our programs, it is they literally burned the bridges back into the community. They don't have a residence to live at. The family can't take them for various reasons. A lot of the placement centers won't take them. So the treatment court, the Mental Health Court was meant to be a bridge to put them back into society and make sure they're hooked up with services, do they have their medications, are they taking their medications, are they going to their counselor meetings, are they doing everything they need to do, are they removed from a toxic situation, are they getting tools they need to survive on a daily basis. We're very fortunate. We have, for example, a NAMI representative at all of our meetings. We have individuals who come in that want to help out.

REPRESENTATIVE MUNDY:

It sounds like a really good idea. Who pays for, for example, the medications?

JUDGE BARRASSE:

The medications are --- those that are on MA obviously get funded through there. We received a small amount of monies last year to utilize, if we needed, on stopgap measure. But really it's a matter of hooking them up with their medications and making sure the person is getting adequate care that they

need. Quite frankly, sometimes there's long waiting lists in regard to our outpatient. It's not adequate in regard to the person's need once they get out of that prison. It might be a couple weeks away. So we need to bring that a lot closer. Often we don't have parallel treatment in regard to the individual that has a co-occurring mental health and substance abuse. And as you know, more than 50 percent of the individuals have that. So our programs are trying to bring those two styles together to say we need to treat this individual holistically as one team, not as separate individuals.

REPRESENTATIVE MUNDY:

Are you finding any areas of state law that are making it more difficult to operate this type of court for any specific type of individual?

JUDGE BARRASSE:

One of the biggest problems that we're having right now --- can I say it's a state law, no. But we are concerned about the state hospitals, what concern the closing of those beds are. What's happening for forensic evaluations, and our inability to get people in at different times? We have to wait --- there are cases --- last time we had a person in Lackawanna County Prison over a month and we can't get

them down to Norristown until almost November 25th for timely evaluation. That person is being held in a prison just because they're mentally ill. They're not in there for any other reason. They haven't committed a crime, but we have no other place to put this individual at this time. So if anything, sometimes the red tape of us being able to get a bed to transfer an individual and to get back an adequate assessment.

We have resources within our own community that I believe we should have greater access to, that being Clarks Summit. We have also --- so far away from some other resources that we feel that we should be able to tap into better. And obviously, the community resources have to be better funded and more realistically available for our people.

REPRESENTATIVE MUNDY:

I guess what I was thinking about when I asked that question was the notion of mandatory minimums for certain crimes and whether that is a barrier in any way.

JUDGE BARRASSE:

It is a barrier, quite frankly. I'd be a hypocrite to say that back in my days of being a DA, I was not a person that looked in favor upon mandatories. The reality now that I see ---

especially even in regard to DUIs, I find if there's going to be one explosion in the state prison, it's going to be the DUI law with the mandatory one year, the fact they want it to be in prison and not in an outside ---. Many of these people suffer from various mental health illnesses, and they will do well in an outpatient setting. They would be doing well if we're able to restrict them to a house arrest with monitoring.

In regard to concern, obviously, the DA Association, last week we meet with the Supreme Court members in Philadelphia to see what could be done, looking at some of the mandatories that are out there and whether or not they can be changed, because they do hurt our ability as a local judge to say that you won't be housed in a prison for that year, but rather you'll be placed in Step by Step or Harbor House or another place that you can be monitored and you can still get your treatment during that time period.

REPRESENTATIVE MUNDY:

Interesting how the DAs take a different approach to mandatory minimums than the judges who give the sentences.

JUDGE BARRASSE:

We also have different rules.

REPRESENTATIVE MUNDY:

Right, right. Well, thank you.

JUDGE BARRASSE:

Thank you.

REPRESENTATIVE MUNDY:

Your court system sounds very progressive.

CHAIRMAN:

Thank you. And I wanted to thank two other members who have come to the hearing, Representative John Wozniak and Representative Frank Shimkus. They both have joined us at the hearing. Thank you, Ms. Osborne and Judge, for your presentation. Next I would like to call up Kathleen Wallace, policy director for the Advocacy Alliance in Scranton.

MS. WALLACE:

Thank you.

CHAIRMAN:

Good afternoon.

MS. WALLACE:

Good afternoon. My name is Kathy Wallace, and I'm the director of advocacy and community mental health services with the Advocacy Alliance. The Advocacy Alliance is a nonprofit

corporation founded over 50 years ago, and is now providing services in over 32 counties in Northeastern and Southcentral Pennsylvania, Poconos and Lehigh Valley. Our mission is to promote mental well-being, support recovery for adults who have a mental illness, resiliency in children and adolescents who have emotional disorders, and everyday lives for persons who have mental retardation and other developmental disabilities and provide to them advocacy and culturally competent services. My remarks today will refer to the Lackawanna and Susquehanna Counties only, and it will refer to the testimony on youth with a mental illness and access to services for children.

I would like to offer the following, starting with the strength of our area. Strength of the children's system in Lackawanna and Susquehanna Counties is many. The counties have a strong provider network which offers families choice in the services that they receive for their child who has an emotional or behavioral health disorder. Our county office, MH/MR office, is not a very large office, so therefore --- thereby maximizes the available dollars for supports and services to both adults and children and their families.

The Lackawanna-Susquehanna Counties

Mental Health/Mental Retardation Program has funded a Child and Family Peer Advocacy Program for the last ten years in Lackawanna-Susquehanna, and previous to their separation, in Wayne County. This program utilizes family members of children who have a mental illness, most often parents, who are paid for all their time and paid to attend trainings, both in agency trainings and statewide conferences. They're supported and supervised by a Master's-level clinician. Parent Peer Advocates offer individuals and systems advocacy, information, support, training for families, older adolescents and child system provider staff as well as for school personnel. The Family Peer Advocacy Program is a paid, not a volunteer program, and this is the only area that we know of that financially supports the Parent Advocate Program.

Our county also has a Children and Adolescent Service Systems Program, CASSP, Committee supported through the MH/MR Program that meets once a month to identify training needs, challenges and gaps in services. The County MH/MR Program, in turn, facilitates identified trainings, many through our agency, the Advocacy Alliance, that are open to not only child serving systems and providers, but also to

families. This Committee reports directly to the Behavioral Health Committee and ultimately to the Board at the county level.

The Advocacy Alliance has really acknowledged an increased collaboration between child serving systems in Lackawanna County and for --- we see more reaching out by Children and Youth Services and Juvenile Justice Systems for a child who has an emotional/behavioral disorder or sometimes for a parent with a mental health disability. We see child systems reaching out for our mental health advocacy for assistance and we see more parents and guardians, grandparents being referred by these systems for our advocacy to help planning for their child who has a mental illness.

Now on to the concerns. Our major concern is the high staff turnover and low retention. Families as well as children's mental health systems throughout our areas as documented in our records from our Child and Family Advocacy calls and meetings show that because of a high turnover of staff in all children's mental health agencies in Pennsylvania as well as in the Northeast, there exists a limited pool of experienced, trained staff that are asked to deal with the complex children's mental health system as

well as many times, other children serving systems who also have new staff, Children and Youth Protective Services, Juvenile Justice, and most of all, a very challenging education system that does not work well with children with disabilities.

Please consider the following. Families as well as other child serving systems are asked to work with therapists, case managers and other mental health staff that are continually changing and often inexperienced. Very often families report that the system is not a resource to them. In some situations, families drop out of services because they feel they just can't keep breaking in new staff. Because of lack of trained staff, some children are not receiving comprehensive treatment planning, often resulting in crisis and/or referrals to more restrictive and higher costing services.

Children with a diagnosis of Asperger's Syndrome or higher-functioning autism do not have appropriate partial hospitalization or residential treatment services that are appropriate to their diagnosis. And children flounder in this level of chaos of existing residential and partial hospitalization programs. Partial hospitalization programs in the Northeast are oftentimes overused and

have long waiting lists.

Recommendation for residential treatment facilities, we feel, are made too easily without appropriate planning for that level of care. There is no criteria that needs to be met before recommendation for residential treatment facility is made, although there is medical necessity that has to be met prior to the service approved. Unnecessary referrals cause families additional stress and take time away from the system. Staff at residential treatment facilities is also new staff. And RTFs also have a very high turnover.

Families are often not told their rights or given all their choices, because new staff do not know the children's mental health system. Our Consumer and Family Satisfaction Team surveys at the Advocacy Alliance for the past two years show that approximately 80 percent of families have never heard of the Children and Adolescent Service Systems Program, CASSP. This is presently being addressed by the Northeast Behavioral Health Care Consortium, which is the Lackawanna, Susquehanna, Luzerne, Wyoming Counties health choice oversight company.

Because staff is difficult to keep, many providers do not work well with children who are

challenging. Families who have challenging children are often told by the children's system providers to call Children and Youth or Juvenile Justice for help. On paper, Pennsylvania has a rich continuum of children's services, but in reality, staff recruitment and retention issues provide challenges to deliver appropriate services and supports to children and their families.

Transition-age youth. There is a need for services to help transitional-age youth when they prepare to leave the child system and go into the adult mental health system. There's a gap of knowledge between a child case manager and an adult case manager, and with the high turnover of staff, it's very, very difficult for 18 to 21-year-olds and their families to receive information on what is available for them. We also need housing, as young adults should not be placed in community group homes or personal care homes with older adults.

School placement for children with a mental illness. We have a long history of documentation of public schools not having adequate placement for children with emotional and behavioral disorders. The Lackawanna CASSP Committee has identified for the past two years this as our major

concern. Recently, our county MH/MR Program has approved the hiring of an educational advocate to work at the Advocacy Alliance for children who are identified at risk of losing their school placement or are refused a school placement.

We are seeing an increase in homebound prescriptions from psychiatrists because an appropriate educational plan is not available to children with a mental illness. The Advocacy Alliance Child and Family Advocates document that schools are increasingly referring children to partial hospitalization programs for school placements and not accepting the children back from their --- to their schools from partial placement in a timely manner.

We are seeing families threatened by some school systems with a referral to Children and Youth Protective Services if the family does not want their child to go to a partial hospitalization program. Again, because of medical necessity, if it's not proven, a school cannot make a referral to a partial hospitalization program, but families don't know that. So a child will not be accepted at the partial hospitalization program, but the unnecessary referrals cause families additional stress and take time away from the mental health and education system.

Some parents are at risk of losing their jobs because their child is frequently sent home from school, does not have an appropriate school placement, or has taken the school or therapist's advice of homebound instruction. Families struggle to meet employment demands while a child is on homebound instruction. Some children who are in foster care are moved frequently because they do not have a school placement and foster families cannot miss time from their own jobs. This lack of school placements usually result in a crisis for the child and a lost foster placement.

We would recommend increasing salaries for direct care staff, college loan forgiveness programs and mental health advocacy services be made available to families throughout Pennsylvania to help them understand the complex children's mental health and educational systems. We would recommend that partial hospitalization programs be time limited and that residential treatment services be monitored by a county level committee expressly for that purpose. Thank you.

CHAIRMAN:

Thank you. And actually, I'm going to take a step back and apparently we're going to have an

advocacy panel. So I'm going to call a couple more folks up. Before we ask any questions, we're going to hear from all of those individuals. So Wendy Luckenbill --- Madam, you can stay --- child policy coordinator with the Mental Health Association in Pennsylvania. Also, and I apologize if I tear this name up, but Marie Onukiavage.

MS. ONUKIAVAGE:

Onukiavage (corrects pronunciation).

CHAIRMAN:

Onukiavage, who's the executive director for Scranton/State Board member.

MS. LUCKENBILL:

Should I come up now?

CHAIRMAN:

Yes. National Association of Mental Illness. And Heather Smith, who is the director of development of Active Minds on Campus in Washington, D.C. So Wendy, we can pick up with you.

MS. LUCKENBILL:

Thank you, Jake and other legislators. Thank you very much for convening this meeting. I also want to thank my co-panelists, because I'm familiar with all their work.

First of all, I want to say something

about Heather. Her organization has really changed the face of campus mental health for students on colleges. We all know what happened in Virginia Tech, and we know how important it is for kids to get the information that they need. And having raised two young people with mental illness who went on to college campuses and found the kind of, you know, struggle that we've already heard about this morning and this afternoon amplified on the college campus, I'm just so happy to partner with Active Minds, who provides technical assistance. It's a wonderful organization.

Kathy's group is an affiliate of the state organization, and we do a lot of work with them to provide really important work for our state.

I wanted to frame an issue which I believe is mental health and youth. Youth aged 14 to 21 are perched precariously between the adult and child mental health systems in Pennsylvania and nationally. They are served by a multiplicity of often poorly coordinated and configured services and systems. And their families often find themselves in constant conflict with systems designed more for the system's convenience and operated from an outdated vantage point developed before the significant

research conducted during the last two decades on what promotes mental health in youth, children, and families, and what is effective when that mental health is compromised. Tossed from system to system and more restrictive and punitive services as less intensive services fail, youth are medicated and undereducated and too frequently leave for the adult world with no clear handle on the tasks they were supposed to master to be able to navigate the world on their own.

First, let me introduce myself and my role in this landscape. My name is Wendy Luckenbill and I am the child policy coordinator for the Mental Health Association in Pennsylvania, which is the state affiliate of Mental Health America, formerly the Mental Health Association in America. The Mental Health Association in Pennsylvania is a membership organization which represents our 17 local affiliates who in turn represent most of Pennsylvania, including all five major geographic areas and every mid-size and large urban center in the Commonwealth. At the state level, we work promoting mental health for children, youth and adults through advocacy, education and public policy.

I come to you today to speak from the

family and youth perspective on the state of current mental health services, including prevention and general wellness services. Each year for the last two decades, I have worked with families and their children in order to access needed services and supports. Additionally, I have partnered with them to develop and oversee public policies and programs which will be responsive to their needs.

A clear takeaway from my work is that where families and their children are receiving earlier and evidenced based services, there are dramatic and long-lasting benefits. However, as the Pennsylvania Legislature's own report found in 2006, children and their families often do not find those services due to the complexity of their configuration and delivery. I will address this report later in my testimony. The good news is that we know how to promote and care for children and youth's mental health. Additionally, in Pennsylvania, we have a fiscal structure that supports public mental health services, although those services traditionally focus primarily on acute need rather than on the prevention end.

The challenge becomes how to mobilize political will and engage the community in the work of

bringing to scale evidence-based practices for children, youth and their families, and disincentivizing outdated services which are, at best, ineffective, and at worst, do harm. A discussion of such an effort begins with a recommendation from the Pennsylvania Legislative Budget and Finance Committee's report, which I'm going to cite more fully later on. This report found that we needed to develop a comprehensive plan which would provide for a continuum of services for children, youth and their families and would be accessible and provide the most effective services in the least intrusive, least stigmatizing and least restrictive manner.

Such a plan would most certainly identify services like psychiatric residential treatment as a response which is not effective and which isolates and developmentally impedes youth with acute mental health needs. In contrast, there is a body of interventions that are evidence-based and focus on healing and growing those development competencies that children and youth need to be productive, contributing members of society. These services are less restrictive and markedly safer and more effective for the child, the family and the general community. These community-based services ironically provide a much higher level

of clinical care than what is available in psychiatric residential facilities, or PRTFs.

Pennsylvania recently mandated national accreditation for all PRTFs, but accreditation standards still allow these costly placements to provide services primarily by high school and Bachelor level staff, often with no actual mental health training beyond on-the-job experience and employee mini-courses. This differs significantly from community-based, evidence-based services, where Master's or higher level mental health clinicians provide intensive, often daily care. While these services can be as costly as residential provided care, when they are provided with fidelity to the research model, they are significantly more effective, resulting in less utilization of service overall and better outcomes for the youth.

Let me pause to tell you two brief stories. Both youth were residents of Pennsylvania publicly funded psychiatric residential facilities. I saw both --- I helped both these youngsters this summer.

The first was a 16-year-old who had been in the facility for eight months and was due for discharge. His mother called MHAPA seeking

assistance. He had been placed in the facility because he suffers from serious depression and would not go to school. His discharge was being postponed because although he was meeting most of his treatment goals and was a model resident, he was still not meeting his educational goals. In a meeting with his parents and therapist, it was mentioned that he had significant neurological problems that made school work difficult, if not impossible, for him, especially without major accommodations and interventions still not being provided. After years of not receiving this support, he was, in fact, I think, responding normally to unreasonable demands. It is probable that early diagnosis and response to this youth's needs from education and mental health systems when he first had trouble in elementary school would have prevented the full court press that he now found himself in. That is, he was committed by education, mental health, child welfare and juvenile justice systems to a residential facility because of the truancy charges his now uninvolved home school district had pressed on him and consuming the high end, highest cost services offered by the mental health system.

The second youth I saw on an advocacy visit to a Pennsylvania residential facility. The

youth was 20 years old. He was sitting on the floor surrounded by comic books. The staff explained that he had graduated from their on-site school and they did not have a day program for him, so they had assigned him to the janitor so he would get some job skills. That was the extent of his vocational training and support. The staff said they thought it was an inadequate solution and he needed much more, but that was all they could figure out. This staff was the unit supervisor and had a law degree. On my questioning, she admitted she had never heard of the Office of Vocational Rehabilitation, which provides services to transition-age youth, including operating a residential job training facility, Hiram G. Andrews Center, where the youth could have continued to work on some mental health needs in a coordinated program that supported his acquisition of needed life competencies. Certainly, the janitorial staff does not have the training or skills to be preparing this young man for employment, let alone the complexities of an independent adult life coping with an ongoing disability.

There was no discharge plan in place. And the assumption was that he would live in this facility until he aged out at 21, being dropped

unprepared into adult life and an adult disability system that was far different from the bleak, but totally structured existence he lived in for the past five years. Sadly, the youth told me about how hard it was to live in this place, with nothing to do, and the fear of his peers losing it constantly, putting him in a constant state of fear and vigilance.

I want to now cite two reports, the one that I've included in my testimony and the other which you'll have access to because it's your report. From the Pennsylvania Commission on Crime and Delinquency. The Pennsylvania Commission on Crime and Delinquency released a report in the spring of 2007 named The Economic Return on PCCD's Investment in Research-Based Programs: a Cost-Benefit Assessment of Delinquency Prevention in Pennsylvania. And I'm sure you'll take a minute to look through that booklet, but on page five there's a really handy chart that shows the kind of cost savings that I'm supporting. This research focuses in great part on providing mental health and prevention interventions to youth and diverting them from the traditional responses which are supposed to change behaviors, but which, in fact, were designed based on hunches and anecdotal, at best, evidence.

In the report summary, its authors make

the following assertion. Recently, economics and policy researchers have begun to conduct cost benefit analysis of prevention and intervention efforts to determine whether to the potential benefits of a variety of strategies justify the funds necessary to implement them. In this report, we examine the return on investment for seven research-based programs that are supported by PCCD and in widespread use throughout Pennsylvania.

Using conservative and widely accepted methodology, we determine that these programs not only pay for themselves, but also represent a potential $317 million return to the Commonwealth in terms of reduced corrections cost, welfare and social services burden, drug and mental health treatment and increased employment and tax revenue. The programs described in this report produce returns of between $1 to $25 per dollar invested, can generate cost saving as great as $130 million for a single program.

And from the Pennsylvania Legislative Budget and Finance Committee. In 2006, the Pennsylvania Legislative Budget and Finance Committee released the findings and recommendations of a year-long study of the Pennsylvania mental health service systems for children and youth. The report, titled

Pennsylvania's Mental Health System for Children and Youth, was made through extensive interviews with system stakeholders including families, providers and state government administrators. The report is available online and gives guidance how to find it.

Your report identified gaps, including services are not well integrated, outcome data is lacking, there's not respite services, there's not adequate training. All the kind of things that you've already heard today, it hits on the nail. It's actually a wonderful report and it's very useful and it's not outdated at all. Recommendations also include developing a strategic plan, encouraging evidence-based services and amending the Juvenile Act, many of which we've now done.

There's a national charge and a state mission. The national charge is the Surgeon Generals' report and the President's New Freedom Commission is that there's a clear charge and mandate to transform what the Commission found to be a broken mental health system, both public and private, for citizens of this county. At the national level, the US Substance Abuse and Mental Health Service System Administrative, SAMSHA, has committed to support states in transforming their behavioral health systems. For

children, SAMSHA has provided that transformation impetus through a system of care approach, based on over 20 years of community research grants, many of which Pennsylvania has hosted. And I would note, Jake, that your county has hosted most of them as it provided a national model and leadership and vision that's allowed us to see what can happen when we do it right. Allegheny has just been sensational. Currently, we have system of care grants in Allegheny County and also Beaver County and folks are working very hard to do things right in those counties.

Let me just tell you a little bit about system of care because it's really important to understand that children do not fit into one system and silo. A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth and families function better at home, in school, in the community and

throughout life.

Let me tell you about some things we were doing in the state since that 2006 report. Pennsylvania's Office of the Mental Health and Substance Abuse Services has been responding to both the national call to action, the state report and firsthand experiences of children and families' frustrations with inadequate behavioral health services through a concerted effort to transform them. This actually began in 2002, when we reinstituted the Bureau --- the Children's Bureau within OMHSAS. So we didn't have that for eight years, and the progress within the system really languished. So we really need to keep that. The Children's Bureau director and staff have partnered with stakeholders to institute lasting changes, including the creation of Youth and Family Institute to reform wraparound services. And if you folks have been hearing about TSS or therapeutic staff support, we are working to really change the way that's going to be implemented.

These changes are responsive not only to the national mandate and stakeholders, but do, in effect, respond to the many recommendations of the LBFC report. OMHSAS annually creates priorities and plans now for transformation. OMHSAS recently

implemented an evidenced-based practice center process which is critical for this kind of work. They have implemented a monitoring system to catch payment fraud. And through the MacArthur Foundation's Pennsylvania Models for Change Initiative, which focuses on juvenile justice but has a mental health juvenile justice targeted area of improvement, OMHSAS and MHA are key leaders in that. We are working on amending the Juvenile Act, and actually I just got an e-mail today that the Legislature passed it and we're waiting for Governor Rendell's signature on that, which will address issues of confidentiality and self-incrimination. We want kids to get a mental health assessment immediately on their first contact with juvenile justice and try to put appropriate services in place and hopefully divert them from the wrong kind of care. Much more work is needed, however, to resolve the gaps that the report, the Legislative Budget and Finance Committee report so aptly spotlighted.

Let me finish addressing two more areas. Continuing the commitment to transformation for children --- for Pennsylvania's children, youth and their families. The Mental Health Association works with a network of local family advocates. I just want

to clarify something that Kathy said. Kathy said Lackawanna County has the only family peer advocacy program in the state, which is correct. It's a very specialized approach that's based on some really tight standards and oversight. However, there's 30 counties that pay for family peer advocacy to support families in negotiating this more as of systems and services.

Additionally, we work with that network of local family advocates, both mental health affiliates, MHA affiliates but also other volunteer and paid family advocates across the state. These advocates provide vitally needed local leadership in systems policy and reform. They also provide vitally-needed guidance to families and their youth on being effective self advocates and consumers. By galvanizing community buy-in and support for effective systems, they are able to ensure the frontline changes that cannot be dictated from afar by the state and national government. MHAPA supports these frontline stakeholders by providing essential information through the monthly online newsletter, Pennsylvania Children's News, which I gave you a flier on, and represents the family and advocacy voice across the child serving systems in Harrisburg.

There is stakeholder consensus on one

central point. We must, in Pennsylvania, have a public health approach to children's mental health. To accomplish this, Pennsylvania must have a coordinated response based on evidence-based practice, which responds early and effectively to children's needs. All children have mental health needs, just as all children have physical health needs. If we can meet those mental health needs early and appropriately, we can avoid many of the mental illnesses that we hear about on the other end.

There is finally a nationally recognized approach that can address this public health model and it's going to address some of the educational problems that Kathy talked about. The Mental Health Association in Pennsylvania has joined with other leading state advocacy groups, as well as the Pennsylvania Departments of Education and Public Welfare, to advance a universal approach to children's mental health resiliency and wellness. Many other states have adopted this approach, some by embedding the reform in legislation. This approach is called School-Wide Positive Behavioral Supports and Interventions. It is housed within the school system because that is where our children live. It is merged with the No Child Left Behind Act, an academic

standards reform already in place in our schools. School-Wide Positive Behavioral Interventions and Supports is an evidence-based practice which demonstrates that by addressing the social and emotional needs of students, there is significant improvement in academic performance, school climate and reduction in disciplinary problems. Rather than a program of services, however, School-Wide Positive Behavioral Interventions and Supports is a framework for effectively organizing the current services provided in the schools and training staff in approaches which promote positive outcomes and decrease negative ones. From prevention to diversion from high end services including Juvenile Justice placements, School-Wide Positive Behavioral Interventions and Supports has revolutionized the way we support and intervene with children.

And you'll read more about this in a plan that we developed specifically for the Legislature. We've given it out already. I'm not sure if it has come across your desk, but I provided a web link. And what I am asking, what we are asking you is that you support this implementation, because it's really going to change the way that we catch kids and support them, and also benefit the kids in terms of their academic

improvement. It works for suburban schools, challenged urban schools, very rural under-resourced schools.

I'm not going to read this last page, but this is an excerpt from my most recent newsletter, and we have an article function called Speak Out. A father wrote to me about his son being in an adult prison because his son's psychiatrist told him he didn't have to take medication anymore. I also contacted the youth and asked him to respond to the issue of medication, and he writes very eloquently, I think, about what it's liked to be forced to be on medication. So medication, I think, in my closing remark, is one approach, but it needs to be part of a larger system of care approach and it can't be, as it is too often in Pennsylvania, the only thing that we throw on kids and families.

CHAIRMAN:

Thank you. Next we'll have Marie ---

MS. ONUKIAVAGE:

Onukiavage.

CHAIRMAN:

--- Onukiavage.

MS. ONUKIAVAGE:

All right. Representative Wheatley and

Representative Smith and everyone else, thank you for inviting the Scranton Chapter of the National Alliance on Mental Illness. We appreciate the opportunity to identify challenges we see in the mental health system as well as to highlight the success both of the state and local mental health system and of our organization. And Wendy, thank you for your kind words before.

I am Marie Onukiavage, executive director of NAMI PA, Scranton Chapter. I'm also a member of the board of directors of NAMI PA, our state organization. NAMI Scranton is part of a nationwide grassroots nonprofit organization dedicated to helping mental health consumers and their families rebuild their lives and conquer the challenges posed by severe and persistent mental illness. Our purpose is to help all people who are affected by mental illness. We strive to educate the public about mental illness and to combat the stigma and discrimination often faced by persons with mental illness. We are one of 60 affiliates across the Commonwealth who meet monthly to provide support, education and advocacy in their communities.

My testimony today is intended to present a balanced perspective on achievements and challenges

we face as family members and consumers. It's important to remember that mental illness is an equal opportunity disease. It respects no barriers, real or imaginary. It does not respect levels of education or background, nor does it respect ethnic or religious backgrounds or, as you know, political affiliations. It's a disease that affects everyone.

First, some of NAMI Scranton and along with NAMI PA, we have many accomplishments we're proud of, and just to name a few, we have 60 affiliates throughout the Commonwealth. These affiliates provide supports to family members and consumers in need. They sit on MH/MR and other community boards. They also work with members of the criminal justice system including judges, attorneys and others to assist in education and advocacy for consumers and families. Locally, we're represented on many community boards, including the Lackawanna-Susquehanna MH/MR Board. As Judge Barrasse said before, we have a designated liaison to the Mental Health Treatment Court locally, and we also have a government liaison who does outreach to our local legislators.

Education is at the core of our advocacy activities. These educational programs have a profound impact on persons who take them. We provide

classes free of charge to families and consumers. Locally we offer the Family to Family Program every fall with classes of about 15 to 20 family members. We also offer several informational and educational programs throughout the year that feature usually local speakers. Our members themselves have spoken at Marywood University, the University of Scranton, Lackawanna College, Keystone College and Step by Step.

Positive developments in the system. There are many positive developments to our current mental health system on the local, state and the national levels. Research has created a better understanding about mental illness and the workings of the human brain resulting in, to list a few, enhancements in treatment for persons with mental illness, including improvements in development of new medications, endorsement and support for the recovery concept, and development of community-based services. Psychiatric rehabilitation will soon be a billable service in Pennsylvania with our local community mental health centers offering psych rehab to help people identify their personal goals while on their own individual road to recovery. Drop-in centers and clubhouses recognize the need for persons with mental illness to engage with each other to regain their

productivity and self confidence, to resume their lives and re-enter society. Locally, the recovery center is a person-driven center where persons receiving mental health services come together in an atmosphere of mutual support for the process of supporting their individual recovery.

We at NAMI see the downsizing of state psychiatric hospitals and the reduction in inappropriate hospitalizations in the state and community as a positive. Locally, the Service Area Planning Committee has been meeting since 2002 to address the goals identified by OMHSAS.

Promotion and support for the peer specialist program. Here in the Scranton area, there are six persons who have been trained and four of them are currently working in either a peer specialist capacity or in other capacities, but --- as a result of the training that they received. Another positive is the greater focus statewide on housing and employment. OMHSAS now requires our counties to include a housing piece in their housing plan. Locally, we have created a mental health housing subcommittee.

We talked before about the Mental Health Treatment Court. Last year, Mental Health Treatment

Court was established in Lackawanna County. This court has been diverting individuals with mental illnesses from the prison who historically may have been unable to meet normal court mandates due to the impact of mental illness on their level of function.

Insurance discrimination against persons with mental illness denies treatment to consumers and places a major financial burden on families and the public system. After 20 years of fighting this battle, mental health insurance parity was included in the recent passing of the Emergency Economic Stabilization Act of 2008. We believe this will not only result in fair and equal treatment, but also in a reduction of the stigma that continues to be attached to mental illness.

They were some of the positives. Now, for the challenges. I think it's important to begin by noting that NAMI ranks Pennsylvania as number two in the nation for overall funding for mental health services, but that does not make our system perfect. Every system has its challenges. The following is a list of some of the challenges we have identified.

NAMI sees as a major challenge the lack of a comprehensive state plan for hospital closure which looks at the entire mental health system. Such

a plan would address the impact of closures as it relates to community services currently in place. It would provide strategy for funding to support both the closure activities and to maintain community programs. This plan would include identified funding.

As Judge Barrasse said before, there's a growing trend to incarcerate persons with mental illness. Inmates with mental illness are likely to max out because of the lack of programs and services in the community, as well as an inability of the individual to comply with expectations while in prison. This places an unrealistic burden on our corrections facilities with minimal hope of reducing recidivism. This problem has been identified by OMHSAS in the service area plan, but not enough has occurred beyond problem identification.

NAMI Scranton continues to get advocacy calls from persons in the community with loved ones entangled in the criminal justice system. Once in the system, it is --- once in the system, it seems as if it is virtually impossible to become disentangled. There's a vast need for education and training for members of the criminal justice system, including police officers, attorneys, prison guards, administrators and judges.

There are increasing challenges presented to families and to the system by veterans with mental illness who will only increase our soldiers --- increase as our soldiers return from the wars in Iraq and Afghanistan. There's a need for better coordination and funding and treatment for persons with reoccurring disorders --- co-occurring disorders, I'm sorry.

The need for additional housing and better comprehensive services in communities to match the diversities of consumers. Pennsylvania has a critical need for additional housing with appropriate residential services for persons with mental illness. There's a strong need at every element of the spectrum that extends from those requiring only occasional services to those who require enhanced care on a 24/7 basis.

There's a system backup which results in long waiting lists for services. Many calls to our NAMI Scranton office are from persons who have finally arrived at the point where they will accept services, but were told when they reached out that they would have to wait sometimes weeks. Other calls are about phone calls that are not being returned.

This leads us to the next identified

challenge: inadequate wages for direct service workers. It was touched on a lot here today. This results in a high turnover of staff and a reduction in quality and quantity of services being provided. I have the unique perspective of being the executive director of an advocacy organization and also a member of our Local Providers Council. A major focus of this council every single year is the attainment of fair and competitive wages for direct care workers. Cost of living allowances, something many of us take for granted, are hard fought for and not always won. It's very discouraging when a person can make as much flipping burgers as they can make for caring for our loved ones.

The following are challenges to you, our legislators. Develop a comprehensive plan for hospital closures, forensic mental health inpatient services and community services. Review the current budget and develop a plan to meet the funding requirements of this comprehensive plan. As state hospitals close or are downsized, insist that all funds appropriated for state hospital care be transferred to the communities to provide the needed services. It is important that these funds not be transferred to other programs. Use of funds that are

currently set aside for hospital operations will move communities forward and make them better able to meet the service and support needs.

Moving persons to a community setting should be a positive improvement in the care of those persons. The move should result in a system that is better than the one from which they are leaving. It also should not result in the denial of services to those in the community who are currently in need of services outside of the state hospital system. And think outside of the box regarding the use of state hospital grounds. We believe that revenues generated related to the use of this state property should be used to help fund community-based services.

Support a statewide innovative and evidence-based programming such as assertive community treatment and mental health courts. Support family and consumer education training, such as the NAMI Family to Family Program and the Peer Specialist program, and support education programs for the general public. Recognize the importance of better integration of programs for co-occurring disorders.

And locally, like much of PA, we have urban communities surrounded by rural communities. Rural communities are limited in terms of available

services due primarily to their size. However, they face the same challenges experienced in larger communities. We encourage the exploration of options that would enable small rural communities to full resources that community services --- so that community services are available to persons who are in need. And finally, support a bipartisan review of the current mental health system inviting input as you have done here today from persons with mental illness, family members, advocates and mental health providers.

On behalf of NAMI, I would like to say we applaud the efforts being made here today, which may provide relief to families and consumers who are in need of appropriate treatment for mental illness. Thank you.

CHAIRMAN:

Thank you. And can we have a copy of your testimony?

MS. ONUKIAVAGE:

You can. Can I e-mail a better copy?

CHAIRMAN:

You can e-mail it to me, yes. We'll make sure ---. Ms. Heather?

MS. SMITH:

I'm terrible with these microphones, and

I'm a loud talker anyway. It's an honor to speak with all of you today. Thank you, Representative Wheatley and the rest of the members of the House Subcommittee. My name is Heather Smith, and I'm the director of development at Active Minds, a nonprofit headquartered in D.C. Unfortunately, my boss, the founder, Alison Malmon, couldn't be here, but I'm happy to pinch-hit for her. I'm pretty good at being an expert myself, so ---. It's a pleasure to be able to speak with you all today. I thank you.

Active Minds works tirelessly as the nation's only peer to peer organization dedicated to raising mental health awareness issues among college students. In working with students and administrators on the college and university campuses throughout North America, it is our mission to promote awareness about mental health, help students identify symptoms of mental illness in themselves and their friends, and encourage students to get help immediately when they need it.

In doing so, we direct them to available professional resources on campus, online and in the community. By engaging young adults in advocating for positive mental health and empowering them to tell their stories, Active Minds works to break the stigma

that causes too many to suffer in silence and prevent the tragic loss of life to suicide.

Active Minds itself was founded as a student group right here in Pennsylvania at the University of Pennsylvania in 2001 by then undergraduate student Alison Malmon. Alison had lost her college-age brother Brian to suicide just a year earlier and felt strongly that the silence surrounding mental health issues had caused her brother to suffer in silence for many years, thinking he was alone or at fault and there was no hope for the future. And ultimately, he was led to take his own life.

Upon graduating from Penn in 2003, she launched a nonprofit organization to start chapters of the student group on campuses nationwide and create a space for young adults to advocate and become empowered to tell their stories. Now, in just our fifth year, I'm proud to be one of five full-time staff members of the organization and even prouder to boast that we have 160 chapters of the organization through North America, including the 18 now active chapters in Pennsylvania. And we're working diligently to register our 300th chapter, our goal, by 2010.

Like older adults, children and

adolescents have mental health disorders that interfere with the way they think, the way they feel and the way they act. When untreated, mental health disorders can lead to school failure, family conflict, drug abuse, violence and even suicide. Untreated mental health disorders can be very costly to families, communities and health care systems. Studies show that at least one in five children and adolescents have a mental health disorder. At least one in ten, or about six million people, have a serious emotional disturbance. With such alarming statistics, it is imperative that we address this problem immediately through education, and most importantly, changing the conversation about mental health.

Oftentimes mental health programs involving youth and young adults are responsive to tragic events. Or those that are purported to be preventative are aimed towards an audience of adults. The fact of the matter is, research shows that most people who suffer from mental illness experience their first episode of depression, bipolar disorder, anxiety disorder and others during the critical years of adolescence and young adulthood. Half of all 19 million adults with depression report onset before the

age of 20. Seventy-five (75) percent of people with schizophrenia become ill between the ages of 15 and 25. Estimates are that as many as 30 percent of college age women display behaviors evident of an eating disorder. And tragically, all these mental issues are robbing us of precious and promising lives every day.

Suicide is the third leading cause of death for all 18 to 24 year olds and second for college students alone. Over 1,100 students die by suicide each year. As many as 1.3 percent of all students have attempted suicide within the past year. That means that the 18 million students enrolled, 234,000 students every year, or 19,500 every month, or 642 students every day of every year, feel so lonely and isolated that they attempt to take their lives really before their lives ever have the chance to begin. These issues are real, and they are really affecting our children, our families and our peers.

This isn't in our testimony, but I spoke with one of our students at Active Minds, and she had a very public piece on national public radio just recently. Her name is Juliana and she's a senior at Johns Hopkins University in Baltimore. Juliana has suffered from mental disorder, primarily depression,

for most of the life she can remember. But starting at the age of 13 is where she began to physically harm herself. First, it was cutting and then it was hair pulling and then it was more cutting, more intense cutting and then it was burning.

And then one day she decided that she, in college, was going to take her own life. Her biggest concern was no one would find her puppy and be able to feed it and walk it. And so her plan was that there was a hotel next door to the college and she checked herself into a room into the hotel. The cleaning lady would come within 24 hours and would find the note, and somebody would be able to come and clean and care for, walk and take care of her puppy.

It's unacceptable for students to get to that level where they feel that they need to devise a plan and can look ahead and see that people need to take care of others and no one's taking care of them. And that's such a sad story to see that such a beautiful, intelligent, wonderful woman at the age of 23 has felt like that for ten years of her life.

The point is, waiting to educate and engage children until we deem them old enough, such as adults in the working world, is unacceptable. Oftentimes mental health issues for young adults have

already become unbearable and affect their quality of life on a daily basis. While we may not deem them old enough to understand, they are old enough to experience the effects and already be talking about the issues with their friends. Websites, blogs, Myspace, Facebook profiles and YouTube are chock full of discussions about real mental health issues and how they are really affecting our kids. It's time we stop projecting our fears and ignorance onto our children by keeping these issues under the rug, and instead help them understand what's going on in their head and help them thrive.

Active Minds' student-run chapter gives students the opportunity to discuss mental illness and take a proactive approach to their health and that of their friends in an effective, empowering manner that produces results. Through over 150 chapters across North America, our students are planning events and hosting informational programs that bring their students together, teach them about the issues that affect them the most, and create an environment on campus that is comfortable for healing. All of our chapters are run by volunteers, students who are contending with their own academic, financial burden and often mental health issues on their own. But they

find this cause important enough for them to throw their time and energy into it. If our youth are willing to discuss mental health with each other, the mental health community and the government needs to be involved in this life changing conversation as well. It is imperative that we all work together to support our children and create an environment where they can thrive.

I want to thank you for allowing me to speak about this very important matter. But I want to tell you something about myself, and why it's so important to me. This is a problem that is not going to stop. You are not going to fix this problem by ending the issues with youth mental health or senior mental health or drug abuse or substance abuse and things like that. You need to address the nature as a whole.

It's October, and October's my favorite month. It's my favorite month because it's football and it's my birthday. And there's one thing I want to do is I want to call my dad and harass him about the Steelers and tell him I'm hysterical because my Tom Brady isn't going to play for the rest of the season, but I can't do that. I lost my dad to suicide last year from his battle with depression at the age of 50.

I wasn't doing mental health before this. I didn't recognize the problems on the level of a child or a senior and I didn't recognize the struggle as a long --- a long, long battle and that everyone needs to take a part of this, all of these wonderful associations, all of the people like myself who are affected by this and decided to change their lives to do this and all of you who can really make a difference in legislation and appropriations and the government. Everyone needs to work together, because no one can fix this problem themselves.

And so I'm thrilled that you let me come here, because my organization is worth throwing more money and effort than all the world has. But I think together we can work together on this fight and really make a difference. But thank you for having me, and I'm happy to answer any questions. You don't have to ask me about, you know, my personal stuff or football, but the mental health stuff I can do.

CHAIRMAN:

We appreciate all of the testimony that we received, and I want to remind the members --- I know there's many of us who want to ask questions. We are a little over our time commitment. And I'm willing to sit here all day, but I want to be

respectful of you all's time as well as the members' time. So if we could, try to be very brief and concise with our questions, and also if you all could respond in a brief and concise manner, that would be helpful. I want to start with Representative Wozniak.

SENATOR WOZNIAK:

Thank you, Representative Wheatley. I hope one of you can explain to me, how does someone identify someone, especially a young child, maybe a 13 or 14-year-old? If you talk to any parent, they say everybody thinks their child is, you know, crazy at that age. How does somebody identify --- is that something that our school teachers are taught in education, or even so, like you said with your father, how do you identify it as an adult? Or you know, maybe you're not sure, if you can help me understand that.

MS. WALLACE:

In my past life, I was a child adolescent family therapist, and I can tell you 90 percent of the referrals would come from --- came from the schools because of behavior problems. And so the schools can do a very good job of identifying children who have an emotional/behavioral disorder. What I would like to see is more awareness of what mental health issues are

by teachers.

We just developed a mental health curriculum framework that we're really trying to help teach teachers to teach children about mental health disorders. So your question --- I think it's a two part question. One is how is that usually identified, how does someone tell. When it gets to be the level where it really interferes with their life, and that's the standard answer. I think schools are more rigid than they ever were before and aware of liability issues and aware of maybe another parent suing them or whatever. But in this area, we have a lot of partial hospitalization programs for children and adults, and we frequently have a history and we frequently try to break that history of referring a child out of a school system and receive services within that school. And so children are identified in school. Sometimes parents can identify problems at home, but mostly when the problem gets to the level where it really interferes with the child's education or well-being or interaction with their siblings, it's identified.

The second part is schools do not know. And unfortunately, I think they're too afraid of the topic of mental health and mental well-being and mental illnesses that they say, well, I'm not a

therapist, I can't teach this or I can't help this. But you don't have to be. They teach other things that they're not experts on. And so when it gets to interfere, they refer them out instead of, I think, understanding emotional disorders and working with the family and the therapist as a team to address that child's problems.

SENATOR WOZNIAK:

And if I could, I'll be quick, Representative. So do our teachers have that training? Do they have that training now?

MS. WALLACE:

No.

SENATOR WOZNIAK:

So with that be ---

MS. WALLACE:

Absolutely not.

SENATOR WOZNIAK:

--- a suggestion ---? Are you seeing universities use that now? Are they putting it in or continuing education or ---?

MS. WALLACE:

No, I don't think so.

MS. LUCKENBILL:

I just want to say a couple of brief

things, and then I'll hand it over to Heather. It's not just acting out behavior that we want to be concerned about. When I talked about school wide positive behavior interventions and supports, that model develops an approach so there's an accurate response to kids.

And I want to briefly tell you that across Pennsylvania we're looking at two issues: assessment and evaluation. Any child who thinks they have a problem or any family who thinks they have a mental health problem will be the same as a physical health problem. If you're concerned about your child's physical health and you've applied soap and water and a hug and a band-aid and there still seems to be something wrong, you come to the doctor. The same thing needs to happen with a mental health problem. The worst that can happen is you go and talk things through and find out that everything's okay. But that's the best, I guess. But, you know, it's a good idea to get a mental health checkup. It never hurts to ask a question. Heather, I know you want to say something.

MS. SMITH:

I don't have any percentages to throw out at you, but most people, when they get to the level of

having severe mental disorders or illness and discuss things like suicide or discuss their illness, they're discussing it because they want help. And the problem is that --- with addressing it and recognizing it is that people are uncomfortable to really ask and listen for an answer, are you okay. And instead of saying, oh, it's all right, oh, you're just having a bad day, oh, you're going through a mid-life crisis or, you know --- or you're too young to understand what real life is, just --- I understand you're sad or I understand you're going through this and I just want to let you know that's okay and is there anything I can do for you. Because most people that talk about suicide and on that extreme level discuss it before it gets to that level. And you have plenty of opportunity if you have an open area to --- and a helping hand to just be open to the process and don't treat them differently as though they're --- as though suicide is something that no one would ever do or mental health --- really isn't mental health. You can beat it. You're just having a bad day. And a lot of people --- you don't have to recognize it. You just have to listen and don't downplay peoples' problems because the people that can verbalize reaching out are already at such a state that it is beyond just a bad

day. It's a bad life at this point.

And about the college programs, college coaches, resident advisors, athletic trainers, teachers are not trained on the college and university level and it's a huge problem. And I know I can tell you only what Active Minds is doing, training and program director. We are looking to do videos and training programs specifically for the athletic coaches and directors as well as the RAs so that they go through these training videos and they go through them with their students. And so if you're a coach with athletes who typically don't want to discuss mental illness, much as coaches don't want to themselves either, or you're an RA and you have kids coming to you that don't really want to admit they have a problem, but they do, you have --- you're already ahead of the game with the signs. And then you can either show this video to the students, you know, as a hands-on approach of yes, you do have a problem, you can see if for yourself. And we just implement programs where they're willing to work together or at least, at the very least, the athletic coaches, teachers, directors and the RAs can recognize these problems so if there is a problem and the student refuses to speak about it, that the counseling

center can be brought in as a mediator in the least uncomfortable manner.

But to get those programs to those people so they're already waiting for students to come in on day one in September, then you're ahead of the game rather than to be confused of why this student's locking themselves in a room seven days a week and won't eat. So we're trying to get that on college campuses this fall.

MS. ONUKIAVAGE:

If I can add something, NAMI Scranton --- NAMI --- as I said before, education is a big part of what we do. The very first thing we tell our --- we tell family members when they come to one of our support group meetings, and they're wondering if there hasn't been a diagnosis yet, is educate yourself. Kathy said the teachers don't want --- you as a family member, you know better than almost anybody. And when you go to that doctor, you want to understand what the doctor's telling you. You want to understand what you're explaining, and you may come away with saying, oh, no, it is just that childhood craziness. It is all right. We just need to handle it this way.

There's a wealth of literature out there. With the Internet, there's access to everything. You

can find some good, really reputable websites. But educate yourself as a family member and as a consumer.

REPRESENTATIVE MUNDY:

I'll try to be brief, although we're on one of my favorite topics. Wendy distributed this booklet. This should be required reading for every legislator.

The economic return on PCCD's investment in research-based programs, it's really about prevention. And yet, it is incredibly difficult to get any kind of funding for an investment in new preventive research-based programs. And I tell you after 18 years in the Legislature I still can't figure out why the brain is not connected to the pocketbook, but it took me 12 years to get my ounce of prevention bill, the nurse home visiting bill enacted into law. And thanks to Governor Rendell, he has very, very nicely funded that a little more each year. But still, I mean, the need is huge for all these prevention type programs that could do so much and save us so much over the long haul.

And the research quantifies the savings. But I can tell you that I'm very concerned about this next year and what human services funding is going to look like with $1 billion deficit. It's not going to

be a pretty picture. And yet, you know, it's interesting because I see this enormous disconnect between people who talk to us about what we need to do and what we need to fund, and it seems like there are so many of those people who come to my office all the time, whether it's college students for, you know, more money for their college so we don't have to raise tuition, you folks talking about mental health, others talking about other kinds of services, whether it's Alzheimer's or nursing homes or personal care homes. And then you wonder, you know, how do these people continue to elect folks who don't believe in government services and don't believe in taxes? Because less government, lower taxes sounds so appealing until you understand what it really means in the lives of real people. So that's my --- I'll get off my high horse now.

I did want to ask Heather, Active Minds, how is your program funded?

MS. SMITH:

By very generous people and by me running the streets begging and soliciting money. No. Active Minds, we are so --- you know, it's our five-year anniversary. We're still very small in terms of budget and revenue. We've been lucky enough to

receive foundation grants from a few wonderful folks that have heard of Alison's story of losing her brother and coming straight out of college and making this her life mission, which is amazing.

So in the beginning years, Alison worked out of her family's home and made no salary and did this on her own for years with this budget that she had to build this out. And then at five years later now we're 160 chapters from one. We have an office in D.C. But my job is to raise money. I look at foundations that support mental health throughout the United States and ---.

REPRESENTATIVE MUNDY:

So it's primarily private funding, not ---?

MS. SMITH:

It's all private.

REPRESENTATIVE MUNDY:

It's all. Okay. Foundations and individuals?

MS. SMITH:

Yeah. It's an individual giving program ,which can always be strengthened. I need to find more and more people to support this cause. It's foundations like Mental Health, and it's the

corporations that are happy to put their name on things of that nature. But up until this point, there's been absolutely --- until I walked in the door, there had been no corporate funding, no federal funding. It was all individual giving and a small number of foundations. So we're hoping for a considerable amount of growth in the next year. Especially as Senator Durbin is introducing his --- reintroducing his College Suicide Prevention Bill again, and we're working closely with them to be on that letter of support and we're really hoping that that will appropriate a substantial amount of revenue we can work with and then in turn work with our universities and colleges. But private funding for now. And we're hoping to build on that in the next five years.

REPRESENTATIVE MUNDY:

Well, good luck with it.

MS. SMITH:

Thank you.

REPRESENTATIVE MUNDY:

And I am sorry for your loss.

MS. SMITH:

I appreciate it. Thank you.

REPRESENTATIVE REICHELY:

I just have a couple. The first statement probably seems so open ended and maybe difficult to get your arms around it. But the experiences I've had with people who have mental illness seem to focus upon an inconsistency within their own lives that they'll be on medication, which causes them to have a stomach disorder or they can't sleep, or their psychiatrist changes the medication because of thinking it will help them in some way. So a lot of times it seems to me that they are trying to do the right thing to address the dilemma in their life, but through circumstances our of their own control, they get put in a situation where they keep continuing on that same path.

I don't know if there's an answer to that kind of problem. You have varying interpretations. And, you know, in terms of the school-based situation, I have never really heard about, at least in Lehigh County, a school trying to get into partial hospitalization situations and not take them back. IU units are dealing mostly with the IEP and the autistic children rather than ones that have mental illness. The question, is that accurate?

MS. ONUKIAVAGE:

Every IU is really different.

MS. LUCKENBILL:

I think the IU in Lehigh County area is the one that has a partial hospitalization license themselves.

REPRESENTATIVE REICHLEY:

Okay. On the issue, though, of how to reduce, I guess, the frequency of people who are trying to deal with their mental illness and getting thrown into a lurch, is there any way of sort of safeguarding them or ---?

MS. WALLACE:

Pennsylvania really does have a very, very good reputation when it comes to mental health and treatment of mental illnesses. There is a program now --- not a program. It's a philosophy of recovery. And as Marie mentioned, a certified peer specialist, it's people who've gone through treatment, who knows some of the problems. Some of the problems may be that just like we're taught to partner with our family physicians, people should be able to partner with their psychiatrist. And that's very, very slow coming. If I don't want to take a certain medication because I do have serious side effects, there may be other medications that I could try if my doctor partners with me.

Sometimes as a mental health association, sometimes we get calls from family members, from individuals that they're prescribed one medication in the hospital and they come out and their insurances don't cover that medication. And that's a significant problem. And the same thing within the criminal justice system. They may be off their medications, end up in prison. Maybe they did well on one medication and discontinued it for a lot of different reasons and not necessarily that they just didn't ---. There really is, in my experience, a very small percentage of people, but they're widely publicized, the people who just go off their medications. There's usually a reason that precipitates that, that they feel that they have no control over. While they're in prison they may be put on something that's totally inadequate, or come out and not be able to have the medications or the partnership with the psychiatrist that they --- that would be successful for them.

And so this whole philosophy of recovery and peers helping peers, certainly when you're looking at cost savings, that's a tremendous opportunity for cost savings because you cut out all these things that just don't work, and we know this. Wendy kept saying everybody --- we know they don't work, but yet we

still keep the system the way it is now and it's very disheartening. So people --- if there was more of a partnership, I think people would stay on medications that worked for them much longer and then not use a higher functioning, the higher cost services like hospitalizations, inpatient. And so really it just makes sense.

REPRESENTATIVE REICHLEY:

I don't know if that's a problem of access to psychiatrists or if there aren't enough psychiatrists on call just for MA patients and if they get --- they have problem with medication and they say, you can't get back in.

MS. LUCKENBILL:

I think that --- yeah. I worked primarily with kids, so I want to just talk a little bit more about recovery, because recovery is the philosophy that comes out of consumer-led movement, in other words, consumers who have schizophrenia or major depressive disorders and grapple to find ways to live with those disorders and began to find that it was really important that they learn how to live with their illness and how to look forward. And that's why they embrace the idea of recovery and that yes, we can live with this mental illness and we can still be

mentally healthy with a mental illness.

I had a wonderful conversation recently with an adult who lived in a state psychiatric facility for a long time. And medication now allows him to not have the level of hallucinations and delusions that made it impossible for him to really live and take care of himself. But he still has problems. And what he told me was the one thing that turned the corner for him was learning Tai Chi, that if he did that every day, that helped him manage and keep his emotional levels at a place that he felt comfortable. And it's that approaching people holistically, respecting their voices, understanding when they say a medication's not working for them.

We have something which the Legislature passed a few years ago called Advanced Directives, so that if you think that you're going to go in and out of different levels of functions, you can write an Advanced Directive that says if I'm really acting poorly and I don't think --- and it looks like I'm a danger to myself, this is the doctor I want you to take me to. This is the doctor I don't want you to take me to and so forth. That's a really progressive thing, but it gives the power to the people and doesn't assume they're just a victim of their disease

any more than you're a victim of cancer or arthritis. You know, you learn to live with it and figure out what's going to keep you maximally healthy, even with a disabling condition.

REPRESENTATIVE REICHLEY:

Thank you. One of the reasons I was very enthusiastic about joining Representative Wheatley in doing this was because after the incident at Virginia Tech, I thought it was important that we try to be much more serious about improving --- or removing the stigma about seeking out services. Having said that, though, I'll give Representative Mundy a chance to get back up on her high horse.

You don't have to be in the legislature for 18 days before you learn that there are 254 different agendas. And there are lots of competing concerns and there are 254 different pet projects that people want to have funded. And the difficult situation we're all going to be in next spring, and I fully anticipate there'll be protests and people coming in, is much like your home budgets. You can't afford to do everything. And that's not to trivialize the necessity of improving mental health services or guaranteeing there is adequate treatment. But we are going to be in a significant financial detriment.

Just today, Virginia has laid off hundreds of employees, delaying a cost of living increase because they're $2 billion in the red. That's Virginia. We're doing pretty well. California needs a $7 billion loan to stay out of bankruptcy. We don't want to be in that situation. But we're going to have to look very, very hard and that's the reality of it.

MS. ONUKIAVAGE:

If I can say something? We all understand and we all appreciate that and we all are facing, you know, the same concerns at home. But the cost of mental illness left untreated properly is much greater than the cost of mental illness treated properly. And, you know, to be, you know, preventative --- and you're talking about cost savings, treating it properly is cost savings, or finding a way to treat it.

REPRESENTATIVE REICHLEY:

Thank you.

MS. LUCKENBILL:

One thing I know is that no matter how tight the budget is going to get, it's going to be very hard to close prisons or reduce prison populations. And right now we have 1 in 100 people in

the United States in prison. So at least within the juvenile justice system, we're working very, very hard to provide evidence-based practices. Some counties like Lackawanna and Judge Harhut are embracing it wholeheartedly. Other counties are not stepping up to the base. And as you know, there's one county near here where there's tremendous problems with the judge and accountability for the kind of services they were purchasing. So my only advice to you is that --- do you want me --- I'll tell you it later.

REPRESENTATIVE MUNDY:

It's my county.

MS. LUCKENBILL:

I just want to encourage you that we're using state monies to buy services. There should be accountability for their effectiveness. And no longer should we be buying things because the facility is operated by our brother-in-law.

REPRESENTATIVE SMITH:

Thank you. If I can come back to Kathy Wallace, Representative Wheatley touched on this earlier. You spoke of hospitalization for youth mental health hospitalization. And I know that here in northeastern Pennsylvania there's a real challenge. There are beds for them in Luzerne County, several,

but none in Lackawanna County. And that has been brought to my attention. How do we fix that, why and where are we going with this?

MS. WALLACE:

As an advocate --- and families, don't shoot me. But as an advocate, I really think that the more services and facilities we have, the more we will fill. And so I'm not a real advocate for increasing, especially residentials --- especially residentials. There are costly hospitalizations. I think it's very, very difficult, both adults and children --- even though we have adult hospitals here, sometimes they're maxed out or they're not accepting of some people, mostly drug and alcohol issues --- that children and adults have to go farther away and it really --- it not only affects the families, but it affects their treatment and discharge planning. Families can't visit. They can't be a part of the treatment. They can't be a resource, as far as discharge planning.

So I think that if you improve the community-based services, there may be less hospitalizations. I wouldn't say do away with hospitalizations, but everything that we talked about today about the high turnover of staff, I can't tell you how much that affects pushing children into more

use of extensive services that are only geared towards stabilization and not treatment. And so when you go into the hospital, many families think that they're going to get treatment, and it's not. It's just stabilization. And boom, they're back out and then you have people that don't know what to do with the children.

And so I certainly respect the concerns that our hospitals are not in Lackawanna, Susquehanna Counties. And I don't know the answer to that. Maybe smaller units, which would be nicer. Maybe a unit just like they have for adults instead of --- definitely not increasing any hospital, but maybe more units. But I just --- I'm more concerned with what brought the child to the hospitalization. And I think it's the system itself.

CHAIRMAN:

Thank you. Eddie?

REPRESENTATIVE PASHINSKI:

Thank you very much, Mr. Chairman. Thank all of you for being here today and your influence out there working under these very difficult conditions. I have a couple questions relative to --- first of all, to Kathy. Your peer group evidently is working very well; is that correct?

MS. WALLACE:

Excuse me? Our ---?

REPRESENTATIVE PASHINSKI:

Your peer advocate ---?

MS. WALLACE:

Yes. Yes. It's working very, very well.

REPRESENTATIVE PASHINSKI:

How many parents are involved and how many children or how many ---?

MS. WALLACE:

Not as many as we need. Parents have to be available during the day most of the time. They have to have transportation. And so a lot of our family peer advocates can help families over the phone even. And so we have right now three, one full time, two part time, and we're always looking for families that are willing to come and go through the training, support and make themselves available.

Children, it's difficult to say because some of our calls may be just a quick, you know, here's what you could do, here's what you could access. A lot of our calls are educational advocacy, and not necessarily children's mental health advocacy.

I also want to say that even for the high turnover of staff and the lack of experience that does

create problems, a family may call a family peer advocate but is told that I can't do this or I can't do that, that families are extremely appreciative to the people that work with their children. And they may acknowledge that they don't have maybe the best training in the world, but the people who work in children services are very passionate and very dedicated and very respectful. And that sometimes in itself is enough to help stop a crisis, that support that they get from staff. And so I don't want to give the impression that the staff is not worth --- or not helpful. They are.

But family peer advocacy really does help an awful lot of families by clearing up and diminishing their stress and the time that they spend trying to navigate this system. The system is very extensive, which a plus for Pennsylvania, because there's a high continuum of different services. But yet, it's also very difficult to understand, especially with staff that are new in the system themselves and really don't understand.

REPRESENTATIVE PASHINSKI:

Well, it's a very complicated and complex system. Obviously, we're dealing with the money, and I'm not sure anybody has a real grasp of that,

honestly. But I'm trying to establish something that's working. And, you know, the reason why I'm bringing this up is you've talked about all different levels of problems. You've talked about schools, and there you're dealing with a variety of conditions unlike that of an adult.

MS. WALLACE:

Yes.

REPRESENTATIVE PASHINSKI:

And I'm looking for programs that are effective, that have proven to be effective, because as the legislators here have indicated, we have to --- well, we're in charge of your dollar and we have to make sure every dollar allocated is going to be worth the expenditure. And what I'm trying to establish here from you --- and I don't know that you can do it exactly right now. But if you want to help your cause, I'm suggesting that you show us what programs are actually working. And when I say working, I'm talking about not just putting the band-aid on, but eliminating the recidivism and actually ---. And coming to Wendy, if I may call you Wendy ---.

MS. LUCKENBILL:

Absolutely.

REPRESENTATIVE PASHINSKI:

You know, your point about you want these people to be productive.

MS. LUCKENBILL:

Right.

REPRESENTATIVE PASHINSKI:

And then the question I have for you is, define for me productive. Because of the different levels of mental problems, productive might be just being able to go to the bathroom, okay, as opposed to actually doing a job and getting paid for it. So there is definitely plenty of legislators that want to help. And my fellow commentators indicated, it's just a myriad of things that we have to deal with. If you would be able to help this very worthwhile cause by showing what systems are working and why they're working.

MS. LUCKENBILL:

I think we can do that.

CHAIRMAN:

And before you begin, I'm just going to have to use my chairman prerogative. And people up here know that I'm a very talkative person and I love to have all the questions and answers back and forth, but I do want to respect that we have one more presenter who we told would be on at 5:30, and

probably would be finished by 6:00. And we're a little past that, so if you would just answer ---.

MS. LUCKENBILL:

Well, I'd be really happy to prepare additional information for you.

REPRESENTATIVE PASHINSKI:

I will give you my card. And Mr. Chairman, I didn't want them to give me a dissertation. But honestly, thank you very much for your testimony today, and I look forward to that.

CHAIRMAN:

I want to thank all the members. You see some members having to leave a little bit earlier, but again, they have very a tight time schedule and I do appreciate them showing. Our last but not least presenter, Sal Santoli, who is associate center director for Scranton Counseling Center.

MR. SANTOLI:

Thank you. Good evening.

CHAIRMAN:

Good evening.

MR. SANTOLI:

My name is Sal Santoli. I'm the associate center director for Scranton Counseling Center. Scranton Counseling Center is a comprehensive

mental health/mental retardation facility servicing over 7,00 Pennsylvania citizens. We work with children and adults with mental illness and intellectual disabilities. Scranton Counseling is dependent on public funding, with close to three-quarters of our revenue coming from the public dollar.

I'm here representing not only my agency but also the Pennsylvania Community Providers Association. The Pennsylvania Community Providers Association is a trade association representing nearly 200 community-based organizations that provide mental health, mental retardation, substance abuse, children's and other human services. Members cover all 67 counties in the Commonwealth and serve over one million Pennsylvanians each year.

We would like to first thank Representative Jake Wheatley and the members of the House Health and Human Services Committee for your leadership in bringing the future of the delivery of mental health and substance abuse services to the forefront. These are vital issues to all Pennsylvanians. On behalf of those of who we serve, I would like to extend our appreciation for your willingness to engage in this discussion regarding the ongoing stability and viability of the Pennsylvania

human service system.

I'd like to focus on a couple of areas that as my agency look towards the future, are the most pressing issues. There are some issues that I hope the Committee will help us all work towards making the delivery of mental health and substance abuse service the most effective and the highest quality possible. The citizens we serve deserve nothing less.

The community-based human service system was created by a change in state policy more than 40 years ago as an alternative to state institutions. This system, which provides mental health, mental retardation and drug and alcohol services, is the key for many to continuing a productive life in the community, including thousands of former residents of closed state hospitals and state centers.

The system has functioned for over 40 years and has proven to be an effective and efficient alternative to state institutionalization. Most communities have now have a range of services and supports available locally. The community-based system is dependent upon the state for sufficient resources to enable consumers to move successfully from the institutional settings and to maintain those

supports over time.

Every year, the provider community finds itself in a quandary where there is not enough money to operate. The cost of providing services continues to go up as rent, transportation, utilities, supplies, benefits, et cetera increase and staff salaries continue to fall further behind. The ultimate costs shift to the individuals we serve and the quality of workforce as we continue to try to do more with less. My colleagues and I are well aware of the budget challenges our statef faces as revenues have decreased. However, it has been said that the measure of a society is how it treats it most vulnerable citizens. These most vulnerable of our citizens should be a priority.

Failure to provide a regular cost of living increase in the state budget creates problems as the state has moved to close institutions. In order to assist the state in this commendable goal of returning people to more normalized settings, my agency stepped forward to develop services for individuals leaving state institutions. Now, less than three years later, those same consumers may, in the future, see some erosion in these services when faced with inadequate funding.

One of our biggest problems is the recruitment and retention of our staff. The success of our efforts is dependent upon our ability to train and retain qualified, competent and compassionate staff. In order to do this, we must be able to pay competitive wages. The salaries we are able to pay are highly dependent, and in some cases solely dependent, upon the money that the state places in the annual budget. The lack of an annual cost of living adjustment has had a significant impact upon mental health and D&A service delivery in Pennsylvania. The net result is that today, our wages are not competitive. And some of the best leave the field altogether because they can no longer stay and afford to stay.

I would urge the committee to support PCPA's efforts in this regard. Quality services requires quality staff with minimal turnover. A well-trained, highly-qualified staff translated directly to better results for our consumers. Much progress has been made since the early days of treating those with mental illness. We must not allow this progress to be lost.

Another important issue I'd like to bring to the Committee's attention is access to appropriate

behavioral health medication. My agency and many others report significant problems in accessing and maintaining needed medications. These problems seriously threaten the recovery of the consumer in need of services and come at a time when the Commonwealth is working hard to provide consumers a life in the community in the least restrictive environment possible.

One of the Office of Mental Health and Substance Abuser Services' three main objectives is the implementation of services and policy to support recovery and resiliency in the adult behavioral health system. Without appropriate medication, many individuals cannot experience life in the community. Pennsylvania is working hard to build and sustain recovery programs. Using the right medication at the right time increases the consumer's chance of recovery, and is in alignment with the recovery-focused program. In fact, it is the advent of and access to new medications that has made recovery possible for countless people. The lack of access, numerous continuity problems and clinically undesired medication switches make achieving and sustaining recovery difficult, if not impossible. This is an important issue that needs to be addressed in

Pennsylvania, and I urge the committee to support open access to appropriate mediation.

Some things that can be done to make this happen are primarily the use of a universal and consistent formulary for mental health and substance abuse medications. Additionally, a transparent prior authorization process is needed so consumers can get the medication that will allow them to function optimally in the community.

My agency's most important service areas include services to children and to seniors. Our senior services include geriatric case management, and we work in collaboration with the Lackawanna County Area Agency on Aging to address seniors' mental health needs. Our children's services include a school-based case management program in Scranton School District's elementary schools, intermediate schools and the two high schools. In addition, at Scranton High, we are designated as a satellite to provide outpatient care directly to the students of the school. These programs have more than proven themselves over time and have been tremendously successful at keeping troubled children in the school setting.

For Pennsylvania's children to maximize their potential and become productive citizens, the

school setting must provide the support and opportunity necessary. Schools have an important role in helping all children and young adults acquire these essential life skills. In short, schools are not just about academics. We support the establishment of productive partnerships between schools and community agencies to establish programs to strengthen, to support resiliency, intervention and prevention strategies for Pennsylvania's school children.

It's not just students with emotional disabilities that need programs. PCPA is working towards an expansion of School-Wide Positive Behavioral Support, or PBS, which is a research-based, highly effective approach to creating, teaching and reinforcing students' social, emotional and academic learning skills. These skills in turn improve and sustain academic achievement and mental and emotional well-being of all students. It is currently in use in a number of Pennsylvania schools in partnership with community agencies who have reported it to be very successful. PCPA is advocating for the expansion of this program.

Partnerships between schools and community agencies to establish programs in schools is an effective way to support strategies to make the

school setting as productive as possible for Pennsylvania's children.

Again, I would like to thank Representative Wheatley and the other members of the Health Subcommittee for your leadership in looking at the future of mental health and substance abuse services in Pennsylvania. On behalf of my agency and those we serve, thank you again for the opportunity.

CHAIRMAN:

Thank you. And I'm going to ask a couple of quick questions and then I'm going to let it go back to the Committee. One of the panelists from before, and I can't remember who and I apologize, mentioned that --- I think it was Mary (sic) who talked about Pennsylvania is second as it relates to the investment in mental health funding. You have very diligently pointed out in your presentation and testimony that certainly that there might be some funding needs that we need to improve upon. How do you match the two, meaning going back to Representative Reichley's perspective and point that he made earlier, we're going to be dealing with a possible $1 billion deficit. There are going to be a lot of great causes and great concerns on the table. There's a belief that we are funding second as it

relates to the state. I'm assuming that's what --- we're second as it relates to the other states in the amount that we're funding. Just keeping it at level funding would be a victory for you in some sense. So how would you --- what would your argument be to that statement?

MR. SANTOLI:

Well, we're very cognizant of the economic challenges facing the state and we understand the difficulties for the future. One of our concerns, if services are cut, I think that's something that previous panel members discussed, about the increase of inpatient psychiatric care, which is very expensive, an increase of emergency room visits, which is very expensive, and unfortunately, an increase of incarceration to our consumers. That's why we talked about the universal medication piece to our consumers to get well without having the difficulties of being denied and then reapplying and then hopefully getting approval for the medication. And truly, most of it is still on the physical health side when it comes to medication.

I know there's been discussion of moving the pharmacological over to behavioral health piece in OMHSAS. That might be a benefit to our consumers in

Pennsylvania. It's more streamlined to make it universal to everyone.

CHAIRMAN:

And I'm just starting to get acclimated to a lot of the research out there on this subject matter, but the World Health Organization just came out with a whole report talking about the --- their belief to increase more funding in the mental health area. In Pennsylvania, how do we integrate --- or do we integrate mental health and primary care?

MR. SANTOLI:

Well, I think in collaboration now, that's where some of a decrease in the cost comes from for the care of our mental health consumers. There is much more corporation and much more involvement. I think with managed care health choices coming into Pennsylvania, it's helped create the awareness of the need for us to partner up with our primary care physicians in our communities with our consumers. And now, on the federal level we're looking at making the combination of, you know, physical health and mental health in the same facility that is available to consumers at the same time. So you have the coordination and the care and continuity.

CHAIRMAN:

So are we doing it now? Are you saying we're already doing that or are we moving towards that?

MR. SANTOLI:

I think we're moving towards that. I think we're a long way from that. This is something that I think as a state we have to become more cognizant of and help push it in that direction. I think on local levels, you know, it depends on your primary care. In our area, there's different clinics that we work closely with because they see a lot of our same consumers, you know. And coordinating with the psychiatry piece and then the physical health piece.

CHAIRMAN:

Okay.

REPRESENTATIVE PASHINSKI:

Thank you, Mr. Santoli. Real quick. You indicated in your testimony that there were several schools that were using the PCPA very successfully. Do you know who those schools are? Who they are?

MR. SANTOLI:

Well, my counter --- Ann, where is she? Ann?

MS. LEISURE:

Yeah. Hi. I'm from PCPA. And I know several of our members are in partnership with some of these schools, and I can't tell you off the top of my head which ones they are.

MS. LUCKENBILL:

There are some on my website, but there's more coming. There's 30 schools. They're not all school district-wide implementations. I know around here Mount Pocono's doing it very effectively. I'd be happy to supply that list to you.

REPRESENTATIVE PASHINSKI:

I'm just saying that information is very important. That's one of the things that you're telling me that it's working. How long is --- how long has it been instituted?

MS. LUCKENBILL:

We're in year two.

REPRESENTATIVE PASHINSKI:

Year two.

MS. LUCKENBILL:

It's a three-year implementation. You implement at the universal level first, so you train everybody positive approaches to all children. Then you implement year two on how to effectively interact

with kids that are experiencing difficulty, the kind of kids we would normally give detention to or maybe a short suspension. And then in year three you implement at the tertiary level, which is the kids you would normally send out to a juvenile detention facility or alternative ed. And you'd be able to demonstrate within --- not in Pennsylvania yet because this is early dates, but in other states they have very strong data saying we keep kids in school using minimal kind of community mental health services for the kids that need them, but diverting a lot of that angst because you respond appropriately to kids early.

MR. SANTOLI:

We'll be happy to provide you with information. December 11th, there's a PBS summit between the Department of Public Welfare and the Department of Education just to help move forward in the State of Pennsylvania.

MS. LUCKENBILL:

We would love to have you there. Lucille Eber, who has been working with children's mental health for about 30 years, is coming to present on her evidence-based practice. She's the national leader, but it's also been adopted nationally by SAMSHA, which I talked about. So we would love to have some folks

in Harrisburg join us.

CHAIRMAN:

If you would supply us with the information, we'll make sure the members get it.

REPRESENTATIVE PASHINSKI:

Yes. I'd very much be interested in actually visiting the school and talking to the people.

MS. LUCKENBILL:

That sounds great.

REPRESENTATIVE PASHINSKI:

Could you make a statement as to --- do you believe that --- in the school systems that we have today, you have a PCPA system working? Would you care to venture a guess as to how many may not even be able to function in that, and may not be adaptable to a regular school system?

MS. LUCKENBILL:

I don't have that number off the top of my head, but I know it's remarkably different than the statistics we have now. I think it might be about 90 to 90 percent --- 90 to 99 percent of the kids that are staying within that school, but I'd be happy to get that data to you. And in fact, it might be in that plan at the end of my testimony, but I'll revamp

that and send that to you again.

REPRESENTATIVE PASHINSKI:

And that's ---.

MS. LUCKENBILL:

It's significantly different.

REPRESENTATIVE PASHINSKI:

That's very encouraging. The last question I have is, do you have any statistics relative to the status of that child relative to the family or lack thereof? In other words, is there an increase --- is there an increased problem of mental health due to the fact that the family circle is quite different today than it was ten years ago and 20 years ago and 30 years ago, et cetera?

MS. LUCKENBILL:

I could provide you with an answer to that.

MR. SANTOLI:

Well, certainly there are different pressures and stressors on families today. We talk about from an economic perspective. We talk about the difficulties of marriages sustaining and we talk about the difficulties just from children and what happens in their lives and in the school lives. I think one of the differences with that type of program is to

help increase the family unit and the insulation. And if we keep the child in the school environment where it's the healthiest for the child. And as we talked about previously, the placement or residential care, trying to reduce the other high cost programs, certainly from a family perspective, and maybe Marie can even answer that better than myself, is there'll be much more beneficial help for the family and then to the child in particular for their future growth.

REPRESENTATIVE PASHINSKI:

And the reason I bring that up to you is because, you know, you can be doing a great job in the school, but if the environment at home or lack thereof is not good, all your work is going down the proverbial tube. And that's where I was wanting to see whether you could piggyback with what the other testifier in the parent peer program and see if that could ---.

MS. LUCKENBILL:

We need to give you a list of the evidence-based practices that are in place. Like family group decision making has not been implemented by the Office of Children, Youth and Families, which significantly impacts the way we approach families in chaos and devise very new and evidence-based ways to

support keeping families and kids together. But absolutely when the family system falls apart, if you're not there with the programs and services that can help them, then the kids get placed in one place and the other ---.

REPRESENTATIVE PASHINSKI:

That's what I'm saying. You know, there's multiple holes ---.

MS. LUCKENBILL:

Absolutely.

REPRESENTATIVE PASHINSKI:

Thank you very much.

CHAIRMAN:

Well, once again, I want to thank all of the members of the subcommittee and others who have joined use today. This is the second of our hearings. We plan on doing two more --- actually, three more, Pittsburgh and Erie, Philadelphia tomorrow. Hopefully, we may add one back in Harrisburg. I think it is the one about the research and bring in the conversation around research-based and also evaluation of programs, because part of this is about looking at our system currently, what works, what's not working, how it all fits together and making sure that our limited resources are going to those areas that are

going to deliver the best results and provide the best services for folks.

So we would advise you --- I would encourage to you to stay connected to what we're doing. Hopefully if you can participate in other settings or hearings, please do so. If you have other opinions that were not able to be expressed here today, you can certainly submit them to me or to the chairman, Chairman Oliver's office, and we will get it as part of our official documentation.

Again, I want to thank you all, the presenters. I really learned a lot from you all around the table. For you folks in the audience, we do want to give you some chance. I think we still had allotted for some opportunity for some comments from the public, if you want to make some. Thank you, Mr. Santoli. And anyone from the audience who may want to say something on the official record? Thank you all. And with that --- you want ---? Say your name, please.

MS. REDMAN:

My name is Marybeth Redman. Can I sit?

CHAIRMAN:

Yeah, you can sit. Where are you from?

MS. REDMAN:

I'm a mom. I live in Gouldsboro, Wayne County. And I'm a consumer for my son. My son is 17 at this time. We started him in mental health services back when he was seven, so about ten years ago. We didn't get very far with mental health services. We dealt with Scranton Counseling, First Hospital, Kids Friendship House. We had family home based. We had a TSS. We had tons of things. We had psychological evaluations that showed disabilities.

Unfortunately, we even did the mentor program. It's voluntary foster care. We put him in voluntary foster care to see what we could do for him. Things were getting worse and worse. We weren't very supported through the whole event. Coming out of mentor program, we were actually left with no services at all. We had like a four-month gap of no services. So my son continued to be in crisis, and unfortunately, ended up in the juvenile justice system.

The day that he got to the juvenile justice system and he got to probation, he was taken that day. He was actually charged and taken that day and put into the juvenile system. He was in a private facility for two years. Then he was in RTF for a year and now he's back at a private facility, which is

extremely restrictive. He has no rights and privileges at this point, completely restrictive.

We're going four years of confinement for this child for his offense. For that entire four years, from day one, I explained to the probation department that he had a diagnosis of Asperger's, which you know is a form of autism. We already had documented mental health issues and we had documented that we were in services. Scranton Counseling, at that point, wanted to get a meeting together to implement what can we do. Probation would not hear anything about that. They wanted to do what they wanted to, and they felt at that time that they were the people who could best determine what facility would be great for my son.

I went on the Internet. I pulled off things about Asperger's. I gave them all the psych evals so that they would have a clear picture of what they were dealing with. It turns out, after four years of continually advocating for my son and hitting brick walls all the time, I keep hearing the same thing from probation, from the juvenile justice system. We deal with --- we're dealing with his criminal offense first. We don't care about his mental health situation. That's secondary.

It's wrong. I have fought and fought and fought for this child to get ---. Before he went to this restrictive placement, we asked for a second opinion. One person made the determination that he had to go somewhere more restrictive. I asked for a psychological evaluation and was denied. I asked for a different therapist. We were denied. I hear here today how a lot of these stories reflect everything that has happened to me as a consumer for my son. The idea that I have understood is mental health people --- children should be in a less restrictive area possible. My son has gone from restriction to less restriction to severe restriction, severe restriction.

Continuing to push and advocate for my son through MH/MR, which actually has not been help for us at all. They don't advocate for my son at all. They just keep closed mouths. While having a meeting with them, everyone was tired of hearing me, tired of me saying that my son has disabilities and they said, fine, we'll get a neuropsych eval. A neuropsych eval was done in early September and it came back with a true definitive diagnosis of Asperger's. Now we're dealing with a child who is mentally disabled, has all of these mental issues, and at this point four years through programs, probation isn't willing to

necessarily change his environment. I can partially understand why. He's doing fairly well where he is. We don't want to disrupt the apple cart again.

But my point is, and this is a clear, clear spot where this falls out, where we lose our children, if probation had listened from day one that my child was a mental health patient and had severe mental health disabilities, he may have been placed in an appropriate facility that could have facilitated him to learn properly the way he's supposed to learn, got all the help he needed to get and he would be out now and he would be a productive citizen. He's not. Not only isn't he productive, he has no life skills at all. Free time is sitting in a chair looking into his room. They took his guitar away, which was his --- he was self taught. No life, no liberties, nothing. That's where the fault is. There has to be mental health advocates with probation. Probation department is not trained in mental health. They're not, and they think they are. There's where the gap is.

CHAIRMAN:

And I appreciate you providing some testimony. We will have a chance to have a conversation with Department of Corrections. I'm not sure if parole is a part of that, but maybe we should

include them in that. Any of the advocates who are here today, can you speak to if this is a case of --- an isolated case that may have fallen through the cracks or is this systematic and indicative of a system? Because I'm not sure ---. Do you have advocates who are at the table when ---

MS. REDMAN:

Yes.

CHAIRMAN:

--- when someone comes up for ---?

MS. REDMAN:

That's when help started. As soon as I got --- first off, when you first --- as a mom when you first know that you need mental health services, it's very hard to open up the Yellow Pages and figure out where to go, very difficult. About a year before his placement, we got in touch with children advocacy and I've been involved with them off and on, and they have been very helpful and supportive to --- they're a huge support for me to be able to continue to advocate for my son.

REPRESENTATIVE SMITH:

Is your son in the Lackawanna County Juvenile System or ---?

MS. REDMAN:

Wayne County.

REPRESENTATIVE REICHLEY:

What was he adjudicated for?

MS. REDMAN:

Felony One, indecent sexual assault. I can also add that when that happened, I'm not a lawyer, but from what I know, his civil rights were not upheld. Nobody ever interviewed his victim, ever. So he was just --- my husband had the story. He told the story to me. I told the story to Scranton Counseling. Scranton Counseling said, call Children and Youth. I told the story to Children and Youth, who told it to the probation department. And then he was taken. So that's about six different people that the story went through. Really unfair. Really, it's an unfortunate situation.

MS. LUCKENBILL:

Can I just briefly say that I'm also involved with the McCarthy Models for Change Program in Pennsylvania, as I mentioned, and we have a mental health juvenile justice initiative as a part of that. And first of all, I'd like to help you by connecting you with some state people who can help you work with this issue and help you work with Wayne County Juvenile Probation, because this is not appropriate,

what's happened.

But when we started McCarthy's Models for Change in Pennsylvania five years ago, the prevailing sense of it was that about five percent of kids in the juvenile justice system had significantly enough mental health needs that they would need services, which is completely askew from the national average, which says it's between 75 and 90. We now consensus mostly in Pennsylvania that about 80 to 90 percent of the kids that are in the juvenile justice system need mental health treatment and they're not getting it. But we did not need to lock our kids up and this is also --- particularly around Asperger's, which is a very difficult and only most recently understood diagnosis, even though it's been around for a long time. It is autism. It's a neurological, perceptual disorder. Folks with that have trouble processing what's coming at them, and they have trouble responding correctly. In residential treatment facilities, psychiatric ones, about a third of the population has autism. We're locking up kids that we should be teaching.

CHAIRMAN:

And I thank you for your presentation. And Ken, did you have a question?

REPRESENTATIVE SMITH:

No. I just want to make sure --- you'll connect with her?

MS. LUCKENBILL:

Yes.

MS. REDMAN:

Thank you very much for listening.

CHAIRMAN:

And October 14th is the hearing that we will do Corrections and mental health, so maybe they'll be another one for you to be at as well.

Again, thank you all for being here. I want to thank the Dunmore Center for having us here. I want to thank Representative Smith for hosting us here tonight. And again we really appreciate your time. We look forward to working with you on this very critical issue. Thank you.

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HEARING CONCLUDED AT 7:05 P.M.

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