COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HUMAN SERVICES
COMMITTEE HEARING

STATE CAPITOL
HARRISBURG, PA

MAIN CAPITOL BUILDING
ROOM 60 EAST WING

THURSDAY, MARCH 14, 2013
10:02 A.M.

PRESENTATION ON
MENTAL ILLNESS AND VIOLENCE

BEFORE:
HONORABLE GENE DiGIROLAMO, MAJORITY CHAIRMAN
HONORABLE JOSEPH T. HACKETT
HONORABLE C. ADAM HARRIS
HONORABLE STEVEN C. MENTZER
HONORABLE THOMAS P. MURT
HONORABLE MARCY TOEPEL
HONORABLE PAMELA A. DeLISSIO
HONORABLE STEPHEN KINSEY
HONORABLE WILLIAM C. KORTZ II

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania

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MAJORITY EXECUTIVE DIRECTOR

PAMELA HUSS
MAJORITY ADMINISTRATIVE ASSISTANT

ASHLEY McCAHAN
DEMOCRATIC EXECUTIVE DIRECTOR

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P R O C E E D I N G S

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MAJORITY CHAIRMAN DiGIROLAMO: Welcome to Harrisburg, and I certainly thank you all for being here today.

I'd like to call the meeting of the Human Services Committee to order, and for our first order of business, I ask everyone to stand for the Pledge of Allegiance to the flag.

(The Pledge of Allegiance was recited.)

MAJORITY CHAIRMAN DiGIROLAMO: Okay. I thought maybe to begin with I would go around the room and let the Members just say hello and let you know where they come from.

Representative Mentzer, if you want to start out.

REPRESENTATIVE MENTZER: I'm Steve Mentzer. I'm from the 97th District, which is Lancaster County and southern York City.

REPRESENTATIVE HARRIS: Adam Harris. I'm new to the Committee. I represent Juniata, Mifflin, and Snyder Counties.

REPRESENTATIVE HACKETT: Good morning.

Joe Hackett, Delaware County, the 161st District.

REPRESENTATIVE TOEPEL: Good morning. I'm new to the Committee as well.

Marcy Toepel from the 147th District, Montgomery County.

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

REPRESENTATIVE MURT: Tom Murt, Montgomery County and Philadelphia County.

REPRESENTATIVE DeLISSIO: Pam DeLissio, the 194th, representing parts of Philadelphia and Montgomery Counties.

REPRESENTATIVE KORTZ: Good morning, everyone.

My name is Bill Kortz. I'm from Allegheny County. I represent the 38th District.

REPRESENTATIVE KINSEY: Good morning.

My name is Stephen Kinsey. I represent Philadelphia County.

MAJORITY CHAIRMAN DiGIROLAMO: Okay. And I would also like to announce that the Democratic Chairman, Representative Angel Cruz from Philadelphia, is not able to be here today, and in his absence, Representative DeLissio will be the Chairman for the Democratic purposes of today.

I would also like to recognize Melanie Brown, who is the Executive Director of the Human Services Committee, and she's getting a lot of smiles and hi's. Melanie just

did a great job of putting this hearing together and does a great job on behalf of Human Services all the time, and Pam Huss, who is my Administrative Assistant on the Committee.

With that, I just want to lay a couple of ground rules. The cameras are on, so we are being recorded. So the testimony today will be recorded, so we are live.

Also, we have a very, very ambitious schedule. I'm going to ask the Members to defer from asking questions until after the hearing. I know some of you testify early. If you have to leave, you know, so be it. But we'd like to get through, since you traveled a long time, we would like to get through the testimony first to make sure everybody has an opportunity to testify before we start asking questions. So we're going to leave questions until the end of the hearing.

And, you know, this is a terribly important, critically important issue, the issue of mental health around the Commonwealth. And, you know, whether it comes to legislation or funding, I know those of you who provide these services around the State struggle with trying to take care of our most vulnerable citizens.

So I first want to thank everybody that's going to testify today. Thank you for the good work that you do each and every year, each and every day here in

Pennsylvania. I mean, this is an illness and a disease that touches virtually every family in this Commonwealth -- every family.

With that, I would like to turn the meeting over to the Chairman, or the Co-Chair of the Mental Health Subcommittee for Human Services, and that is Representative Tom Murt, and I'm going to let Tom run the hearing today. So, Tom, if you want to take over and you have an opening statement, and maybe give Representative DeLissio an opportunity, if she would like, to make an opening statement also.

REPRESENTATIVE MURT: Thank you, Mr. Chairman.

Good morning, and welcome to our Human Services Committee hearing on mental health in our Commonwealth. The tragedy in Newtown, Connecticut, has spurred a great deal of conversation around mental health issues nationally. Because we received so many requests to discuss the state of mental health in Pennsylvania and ways to keep our community safe, we decided to call this hearing to better understand these issues.

Pennsylvania has always been a national and even a global leader in innovative and evidence-based mental health services. Unfortunately, over the past few difficult budget years, human services, including behavioral health, have suffered cuts to their system.

Before we propose any policy changes, we wish to collect as much information as we possibly can and, as such, have invited a diverse group of speakers to testify on this issue. We hope this will help us to draft policy proposals that will be effective in both affording protection of our citizens in the Commonwealth from gun violence and in respecting and treating the mental health needs of our constituents who face mental health challenges.

We'd like to make clear at the beginning of this hearing that we are in no way trying to communicate that people with mental health conditions are more violent than the general population. We realize that this stigma can prevent people from seeking treatment, and the statement is simply not accurate. In fact, people with mental health conditions are more likely to be victims of violence than perpetrators of violence. People with schizophrenia, bipolar disorder, or psychosis are two-and-a-half times more likely to be attacked, raped, or assaulted than the general population.

Unfortunately, much of the public is unaware of this. A recent poll by the New England Journal of Medicine found that 46 percent of respondents said they believe that those with serious mental illnesses are more dangerous than others, 71 percent said they wouldn't want to work closely

with a person with a mental illness, and 67 percent said they wouldn't want a neighbor with a mental illness. These attitudes create barriers to people seeking treatment, and we want to be sure that we do not perpetuate this harmful stigma.

We know that when people are able to receive the necessary supports within their community, our communities are healthier and safer, and we strive to create a Commonwealth where this is possible. We're fortunate to have a wide and diverse array of speakers with us today to share their areas of expertise.

As Representative DiGirolamo mentioned, we do have a lengthy agenda, so we respectfully ask that each speaker stick with their allotted time interval to allow time for every testifier. Thank you to all of our speakers for taking the time to be with us today and to share your various areas of knowledge and interests.

Thank you.

REPRESENTATIVE DeLISSIO: Thank you, Representative Murt, for this opportunity and for all of us to be here today.

Last Thursday, interestingly enough, the Southeast Delegation convened a roundtable on this issue as well, on mental health and its interplay with both illegal and legal gun ownership. I think it's the goal of all of

my colleagues in the House to educate ourselves as to what the nuances are of these discussions in order to come up with the best public policy.

Personally, I am very intrigued with sort of that chicken-and-egg discussion. Very often I think treatment may be prescribed based on what's covered versus is that the best treatment that's out there, that's documented in the literature that we know of. So for myself, I'm hoping that the information gleaned that will influence public policy includes whether or not -- what parts of the system need to be revamped, particularly letting treatment, the best known and best practices among treatment, drive the rest of the discussion and not the other way around.

REPRESENTATIVE MURT: Thank you, Representative DeLissio.

At this time, we'd like to call our first testifier forward: Mr. Dennis Marion, the Deputy Secretary of the Department of Public Welfare, the Office of Mental Health and Substance Abuse Services.

Secretary Marion, thank you for being with us today.

DEPUTY SECRETARY MARION: It's a pleasure to be with you this morning.

Again, Mr. Chairman, Members of the Committee, it is an honor to be with you and have this opportunity to

talk with you about this important topic, and my goal today is to provide you with a brief overview of the consumers we serve, the resources we use, and the results we strive to achieve at OMHSAS and within the Department of Public Welfare.

One in four people in the U.S. experience a mental illness each year. We as a department are actively engaged in a focus on prevention, early intervention, and community-based treatment. We're also committed to reducing stigma and other factors, as you've mentioned, that prevent individuals from seeking help.

We know that people with behavioral health disorders can and do recover. DPW is committed to ensuring that individuals served by the mental health and substance abuse service system will have the opportunity for growth, recovery, and inclusion in our communities, have access to culturally competent services and supports of their choice, and in the end, enjoy a quality of life that includes family members and friends.

Our guiding principles are simple and direct: provide quality services and supports that facilitate recovery for adults, including older adults, and resiliency for children. There's an emphasis and a focus on prevention and early intervention and an assurance of collaboration with our stakeholders, community agencies,

and county service systems. OMHSAS underwrites an array of community-based services that build on natural and community supports unique to each individual and family.

Regarding our service to youth:

OMHSAS is working to transform the children's behavioral health system into a system that is family driven and youth guided. OMHSAS funds services and supports for over 200,000 youth, comprising an estimated 40 percent of our consumer base. Children's services are guided by principles which promote child-centeredness, family-focused, community-based, and culturally-competent systems. Pennsylvania supports the development of an array of services, including Multisystemic Therapy, Functional Family Therapy, and Parent-Child Interaction Therapy.

Pennsylvania also is engaged in the System of Care Cooperative Agreement. Pennsylvania is in the midst of implementing a 6-year grant funded by SAMHSA, the Substance Abuse and Mental Health Services Administration, to develop a Pennsylvania System of Care Partnership. The partnership is working to transform the way that categorical services at the State and county levels serve youth and families who have complex needs, particularly those involved with both mental health and child welfare or juvenile justice systems.

Over the grant period, the partnership will work

with 15 counties chosen through an application process. Each partner county will build a system that includes something referred to as "High Fidelity Wraparound," an evidence-based practice model, to serve at least 25 youth annually from the population that is the focus of the grant. The System of Care Partnership will build on other cross-system efforts that have been underway for several years to both integrate and more effectively serve our youth.

Serving adults:

We work to address the behavioral health needs of over 400,000 adult consumers each year in the least restrictive settings possible. Our services include an array of evidence-based practices, such as assertive community treatment, supported employment, plus traditional treatment models such as case management and outpatient services. We also work to target the distinctive needs of veterans, justice-involved individuals, and other underserved populations.

Serving older adults:

OMHSAS funding reaches an estimated 30,000 older adults each year. Data suggests, though, that older adults tend to under-use behavioral health services for many reasons, including stigma, ageism, transportation challenges, costs, and misconceptions about aging and

behavioral health.

Many older adults have rooted views that behavioral health disorders and treatment are shameful, insignificant, untreatable, and believe that services are designed for younger populations. OMHSAS collaborates with the Department of Aging to provide support and involvement to assure that behavioral health services and supports recognize and accommodate the unique needs of older adults. Identified priorities include local collaboration, advocacy, training, and service development to improve access to care for older adults.

Funding:

OMHSAS administers over $3.9 billion to support behavioral health care in Pennsylvania. Examples of our funding include $2.8 billion for the HealthChoices Behavioral Health Managed Care Program; over $56 million for the Behavioral Health Services Initiative, as well as funds for drug and alcohol Act 152 funding; over $2 million to go towards the Special Pharmaceutical Benefits Program, which provides antipsychotic medications to eligible individuals.

The HealthChoices Behavioral Managed Care Program, which was built in partnership with our local county programs and local government, ensures mental health and drug and alcohol services to eligible Pennsylvanians.

There are three key goals for the program: one, to assure greater access to services by unifying service development and financial resources at the local level closest to the people served; to improve quality for those services; and to manage costs.

As of January 1, 2013, 1.8 million people were enrolled in HealthChoices Behavioral Health. Over its 15-year history, approximately $500 million of the HealthChoices funding has been reinvested into the expansion of service options in the community. Reinvestment has been used for startup funds to develop services targeted for special populations such as persons with autism, the Latino population, intellectually disabled individuals, and persons who are deaf or hard of hearing.

Pennsylvania also has a State hospital system. Pennsylvania operates six mental health hospitals and one restoration center. There are currently 1,527 people served in these centers. With hospital closures and our shift to community-based services through efforts such as the Community Hospital Integration Projects Program, CHIPP, and our commitment to Olmstead, our census has decreased from 2,928 patients in the year 2000 to the current number.

CHIPP, as I referenced, creates services to support persons with a long-term history of hospitalization or other complex needs so that they can live successfully

in the community. CHIPP funds are used to pay for services and supports that are not Medicaid eligible such as housing and nonclinical support services or for services for people who are not Medicaid eligible through a unified systems approach. HealthChoices and CHIPP also include funding for diversionary services for people who may be at risk of State hospital admission.

The South Mountain Restoration Center provides licensed skilled nursing and intermediate long-term care services to 139 older adults with special needs whose needs cannot be met by their community nursing facilities. The center was recognized as one of the top State nursing homes in the country by U.S. News & World Report.

Housing for individuals with behavioral health disorders is also a critical component of assuring our commitment to community integration. Fifty-three counties have made reinvestment resources available as part of the OMHSAS Permanent Supportive Housing Initiative. The goals of the initiative are to create affordable housing for people with disabilities, specifically our OMHSAS/DPW target populations; to utilize the HealthChoices reinvestment funds; CHIPPS or base funding to access and leverage mainstream housing resources; and to create partnerships with State and local housing and community development entities.

Pennsylvania is considered a national leader in recovery. Our spending exceeds $3.9 billion in State and Federal tax dollars to support positive behavioral health. DPW and OMHSAS oversees the provision of behavioral health services throughout the Commonwealth and is responsible for administering the Federal Mental Health Services Block Grant funds and other State appropriations to the local community mental health programs.

Moving to a different and new piece for this year: Mental Health Matters.

To build public awareness of Pennsylvania's extensive commitment to behavioral health services and to educate all Pennsylvanians about the stigma and signs and the symptoms of mental illness, OMHSAS is kicking off a new initiative called Mental Health Matters. A core component of Mental Health Matters is to partner with local counties and communities to support education about mental health while encouraging all community members to get involved by becoming educated.

Families and communities are the front line of defense, and through a gatekeeper approach, we can promote early detection and interventions for loved ones, family members, friends, and fellow citizens. Studies show that most people with mental illness become well and many completely recover, but first, they must seek help.

Reaching out to veterans:

Pennsylvania has 1.1 million veterans, which is the fourth largest veteran population in the country. We rank second in suicide among veterans. We must strengthen the full continuum of care for behavioral health services offered to service members, veterans, and their families. Through a collaborative partnership, we are working to promote a system of support that better informs service men and women and their families of services and resources that ensure targeted training on military culture and behavioral health issues, including suicide prevention.

Planning and collaboration is my final point here this morning:

Of important note is our Mental Health Planning Council that is comprised of three committees: older adults, the adult population at large, and children. The membership includes individuals representing the interests of family members, persons in recovery from substance abuse disorders, and transition youth as well. The council is charged with advising our office on the implementation of services and policies that support recovery and resiliency for individuals in the Commonwealth's behavioral health system.

In conclusion, I join my colleagues, stakeholders, individuals in recovery, family members, in

strengthening our system through a person-centered approach to ensure that together, we recognize that every individual served in our system has the ability and right to live in our communities through a supported approach, and I do thank you for the opportunity to speak with you this morning.

REPRESENTATIVE MURT: Thank you, Secretary Marion. I appreciate you being here today.

Our second testifier is Dr. Arthur Evans, the Commissioner of the Department of Behavioral Health and Intellectual disAbility Services from the city of Philadelphia.

Good morning, Dr. Evans, and thank you for being with us today.

DR. EVANS: Good morning, Chairman DiGirolamo; Chairman Angel Cruz; in his absence, Representative Murt; all of the guests and friends here. I'm Dr. Arthur C. Evans, Commissioner for the Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

Rather than reading testimony which you have before you, I thought the best use of my time would be to just simply talk to you about my experiences as Commissioner for the Department of Behavioral Health and Intellectual disAbility Services. It is one of the largest behavioral health systems in the country, and I think this

issue is really welcomed by me and my colleagues around the country as we have tried to have a national discussion about mental health and its impact on the community.

The first thing that I want to say is that I think it's really important for the public to know where we stand today in terms of our treatment of people with serious mental illness. As you just heard, 25 percent of the population will experience a mental health problem in the course of a year. Most of those people have milder forms of mental illness, but some of them have very significant kinds of mental illnesses like schizophrenia and bipolar illness.

The reality is that the public's perception is that those individuals are not going to get well, and as you just heard from the Deputy Secretary, most people with serious mental illness actually will recover. What the research says is that for people with even schizophrenia, bipolar illness, about a third, over time -- and these are longitudinal studies that have shown this -- will be asymptomatic after a significant period of time. Another third will be symptomatic. That means they'll have some residual symptoms, but they will be functioning pretty well. There are only about a third of the people with those very serious mental illnesses that we haven't figured out a technology and developed the treatments that have

been really effective at helping them to fully recover, but we continue to work on that. I think that's very important, because the public has to understand that the country's mental health system is effective at treating, again, the majority of people if people have the right resources, if people have the right services and supports to help them.

That brings me to another issue which I think is really important. What we know and what systems in Philadelphia, our system in Philadelphia and systems around the country have begun to do is to transform around the idea that our goal should be to help people to recover. Most of our systems have been set up to, quote, "maintain" people, to "stabilize" people, but not really to focus on the idea of long-term recovery, and let me give you an example.

I talked to a woman who had an adult son who lived in her basement, watched TV all day, smoked cigarettes, drank coffee, and that was his life. He had been discharged from a State hospital. In our traditional system, he would be considered a success. What she said was, he wants more for his life and I want more for his life. What she said was and what I think is important is that our system would consider him a success because he's not in a State hospital, he's not in jail, he's not

bothering anyone, he's in a home, he has stable housing, but that's not what he wanted, that's not what his parents wanted, that's not what we would want if we were in that situation.

So the goal of a recovery-oriented system of care really is, how do we help people have the kind of life that they want to have in the community? And systems around the country, all of the States have adopted this as a framework for how they want to operate their systems, and systems are struggling to try to figure out what that actually means. But we've had a lot of success in Pennsylvania, in Philadelphia, and other places around the country.

One of the most important things that we found is that by incorporating people with lived experience, peer specialists who can model and be an inspiration for other people, that that has had a tremendous impact on people's belief that they can actually recover, that they can see someone else who has the illness that they have who has recovered. So in Philadelphia we've trained over 580 people who have had schizophrenia, who have had other kinds of behavioral health conditions, to work in our system, and it has had a tremendous impact on people moving from that "maintenance" kind of state that I talked about to really engaging in life, engaging in the community, giving back to the community.

And I think the policy implication of that is that we need, as behavioral health systems, to have the kind of funding flexibility that allows us to support and pay for those services that people need beyond treatment. Ninety-seven percent of my budget is dedicated to treatment. Treatment is only one aspect, and like I said, the gentleman who was living in the basement had good treatment, but he didn't have the other kinds of supports that he needed to be successful in life. That's what we need, because when we know that people are engaged in life, have jobs, who are engaged in the community, it actually reduces recidivism. It actually has implications and impact on treatment outcomes.

So you hear the term "recovery" a lot and you may not really understand what that means, but it's really important to understand, number one, that it's possible, and number two, with the right kinds of policies, that we can actually help more people to recover and have that kind of life that any of us would want.

Given the recent events around Sandy Hook, I wanted to mention another really important policy issue that is related to this issue of people who, in the public's mind, are mentally ill and who are violent and talk about what I see as sort of the crux of the problem.

I recently wrote an op-ed that was published in

the Philadelphia Inquirer. It was entitled the "Great Gray Area," and it in what I tried to argue, and I did argue, is that the issue for mental health systems is that we have systems that are designed to treat people after they are ill. So for people who recognize that they're ill and voluntarily go into treatment, we, as I said, can be pretty successful in helping to treat them. For people who are at a point where they are a danger to themselves or a danger to other people, we have laws that allow us to involuntarily commit those people and get the help that they want.

The challenge for systems is people who fall in this gray area: people who are what we would call at high clinical risk. That is, they're beginning to have symptoms, but they don't reach that threshold for dangerousness nor do they have the insight that they need help. Those are the folks that often get into difficulty, and often what you hear in the aftermath of situations like Newtown is that we knew something was wrong but we didn't really know what to do; we didn't know how to access help. That is a huge challenge for systems, and what I believe and I think my colleagues around the country believe is that we have to have more of our resources that are dedicated to early intervention, to prevention, to education. If 97 percent of my budget is in treatment,

that's after the fact. Three percent is for those kinds of things that allow us to create services that can do outreach into the community, that can help prevent mental illness, early intervention kinds of programs, and programs that can help educate the public about how to intervene, so if you are a family member, you know what to do.

One of the most successful programs, and you heard this in the President's recommendations about what needed to happen in the aftermath of Sandy Hook, is something called Mental Health First Aid. We have a huge initiative in Philadelphia where people learn how to recognize signs and symptoms of mental illness, learn how to support people and how to connect people to treatment. We think it's a very important resource, a very important kind of program, because it's the kind of thing that I think will help the community to really know how to deal with those issues.

The last thing that I'll mention is that health-care reform, we believe, is a very positive thing for people with mental illness. For one thing, the Medicaid expansion would allow more people to have coverage. We think that that's essential. Right now you have a system that is a bifurcated system. If you have an entitlement like Medicaid, you have access to all of the services that you need. If you are uninsured, you don't

have access to those services or you have much more limited, and those are the services, frankly, that have been cut over the last several years. The grant dollars, the State-only dollars, that's where systems around the country, $2 billion over the last several years during the economic downturn, have been taken out of the country's mental health system. Those were those State-only dollars that allow States to provide services to the uninsured and to provide those kinds of flexible services that I mentioned.

So there are two reasons why I believe Medicaid expansion is really important. Number one is, it covers people who don't have insurance and allows them to have access to treatment, but the other thing that is really important is that as States expand Medicaid, it frees up their State-only dollars for those recovery support services that I was talking about. It frees up dollars for those early intervention programs that I was talking about. And what I would really urge this Committee to think about is as Medicaid expansion goes forward -- and I'm hopeful that it will happen in Pennsylvania as it is happening around the country -- that those dollars are protected and that counties around the country, around the State, have the ability to use those resources for the kinds of flexible services that we need.

I said that was the last point. I do have one other point that I think is really important. Pennsylvania has the best, I believe and many people believe, behavioral health program in the country. The HealthChoices Program that gives the counties the behavioral health dollars and allows county governments to manage the behavioral health benefit is really a national model. People look to Pennsylvania on this issue because it is the best, again, widely considered the best behavioral health carveout in the country.

It is a very important policy decision that the Legislature has made, and I'll just give you one quick example. Because we've used managed-care principles and we are a government that has an incentive to make sure that people have services and not to drive the bottom line, we have over the last 5 years, since 2008 to 2011, we actually spent less money in 2011 than we spent in 2008, and we're serving more people. We are providing a broader range of services. Because our incentive was to take those reinvestment dollars that the Deputy Secretary talked about and invest them in things like evidence-based practices, trauma treatments, those kinds of things, we've been able to drive down recidivism, which has freed up dollars for us to serve more people with less resources. So that I don't believe would have happened in a privatized system. And

the county governments across the State, I am quite sure if you ask those governments about how this program has helped them to make sure that their child welfare services, their criminal justice services are getting the kind of support that they need in order to accomplish their work, I think that they would tell you that.

So I thank you for your time. I appreciate very much the opportunity to talk with you, and I hope my comments have been helpful.

REPRESENTATIVE MURT: Thank you, Dr. Evans. I appreciate your testimony.

Our next testifier is Christine Flowers. Christine, thank you for being with us today.

MS. FLOWERS: Good morning.

Thank you, Chairman DiGirolamo and Chairman Murt and Members of the Committee. I very much appreciate the invitation to speak to you today and also to have the opportunity to listen to the other honored speakers. My comments will be relatively brief.

A hearing like this has particular relevance in the wake of some highly publicized tragedies that our country has experienced over the past several months. We gather here under the immediate shadow of Newtown, but the names of other towns and the faces of other victims are before us. From a courageous Congresswoman in Arizona, to

moviegoers in Colorado, to subway commuters in New York, innocent people have lost their lives, in part because some sick and troubled individuals have been left untreated, homeless, and were either able to obtain firearms, other weapons, or simply employ their own untreated delusions to hurt them.

Others here will talk about the need for expanded medical resources and social resources to address the concerns of the mentally ill, and that is as it should be. I will leave to them, the experts, the discussion and debate about what is necessary and appropriate to improve our mental health system from a therapeutic standpoint. My comments will be limited to how we can diminish the probability that the afflicted will pose a threat to the well-being of the general public.

In the wake of the massacre in Newtown, I published a column in the Philadelphia Daily News in which I wrote the following:

"Assault weapons should be banned; no private citizen needs to keep a military-style arsenal in his home, regardless of how people will tell you that bans are ineffective. The mentally suspect should not be roaming the streets simply because we don't want to infringe on their ACLU-fabricated right to pose a public danger. The homeless man who attacked me last month should have been in

either a hospital bed or a jail cell, not loitering at Broad and Walnut" in Philadelphia.

Those words pleased no one, as I anticipated. Second Amendment activists were unpersuaded by my calls for a ban on any particular weapon, and civil libertarians, including the spokeswoman for our local chapter of the ACLU who reached out to me in an e-mail to scold me for unfairly characterizing the work of that group, viewed this as much of a "rights" issue as their opponents in the pro-Second Amendment lobby.

I believe that I fall in that vast middle ground between both extremes, along with millions of other Pennsylvanians. We respect the Second Amendment. We understand that it is an individual right under *Heller*, but we are unwilling to view it in a vacuum that fails to factor in social considerations such as the effect straw purchases have on the communities like those in Philadelphia that are already wracked by violence.

On the other hand, and as referenced by Dr. Evans in his previous remarks, we do not think it should be as difficult as it currently is to involuntarily commit someone who demonstrates a propensity for violence, especially when our laws as currently constituted essentially require that individual to first commit the violence we are seeking to prevent before we can even find

him or her sufficiently dangerous under the statutory standard.

As an attorney with some grounding in constitutional law and more specifically in the area of privacy rights, I am cognizant of that extremely narrow line between liberty and safety. We must be extremely careful not to revert to a previous dark and uninformed time when mental illness was not treated as an organic disease but rather as a moral spiritual failing. Our laws have been developed over the past 40-some years in Pennsylvania to emphasize the therapeutic over the punitive. That is as it should be.

Nonetheless, as I noted in my article in the Daily News, the pendulum seems to have swung too far in the opposite direction where we are now hesitant to take any remedial or preemptive action unless it's absolutely clear that the subject poses a direct threat to himself or others. Under Section 302 of the Mental Health Code, the prerequisite for involuntary commitment is, quote, "severe mental disability based upon clear and present danger to self or others. Overt behaviors or threats with acts to further the threats occurring within 30 days."

"Clear and present danger" means obvious and immediate. Unfortunately, that standard, which is deceptively simple when written in a statute, is extremely

difficult to implement in real life, particularly when there is a reluctance to deprive someone of his or her liberty interest. In the case of *In re Chiumento*, our Superior Court held that, quote, "It is well settled PA law that involuntary civil commitment of mentally ill persons constitutes deprivation of liberty and may only be accomplished in accordance with due process requirements." That is, of course, as it should be as well. No one wants us to revert to a time when people could be committed without legitimate cause or where the commitment process could be manipulated by those who had something other than a good-faith interest in obtaining treatment for the afflicted.

The law, dating back to 1976, was enacted in part to prevent family members from being able to have their relatives committed to mental institutions when this could result in a financial windfall or other gain for that family member. But we cannot at the same time lose sight of the fact that requiring such a high standard as "clear and convincing danger" to oneself or others and imposing a preponderance of the evidence burden on such a finding can expose innocent people to unnecessary dangers as we have seen in Arizona, in Colorado, in Connecticut, in New York, and even in Pennsylvania where in 2007 a troubled young man fatally stabbed his twin 11-year-old stepbrothers, even

though the family had sought help from Western Psychiatric Institute the day before. Because that 18-year-old was not considered a "clear and present danger," the family was told to simply watch and observe him, with obvious tragic results.

It is thus with the greatest respect that I ask you in your deliberations to please consider the rights of all Pennsylvanians when attempting to craft measures to address the mentally ill.

Thank you very much for your time.

REPRESENTATIVE MURT: Thank you, Christine, for your testimony.

I'd like to ask District Attorney Seth Williams from the city of Philadelphia to please come forward. District Attorney Williams, thank you for being with us today.

MR. WILLIAMS: Thank you very much.

Good morning, Mr. Chairman, Members of the House Human Services Committee.

As Representative Murt just stated, my name is Seth Williams, and I have the honor and distinction of serving the citizens of Philadelphia as the District Attorney. I sincerely appreciate the opportunity to speak with you this morning about such a very important public health and public safety issue.

I first want to just start by saying -- I'd ask, of course, if you could accept my written testimony into your records. I won't read through all of it. I learned from a previous boss of mine, I'll keep my comments as brief as possible no matter how long it takes me.

But in all sincerity, you've heard from Mr. Marion; you've heard from Dr. Evans. They're experts in this area. I am not an expert. I, unfortunately -- I'm an expert when we do not have accessible behavioral health and accessible mental health services. I'm an expert in what happens when we don't have those services, because we see that every day. Unfortunately, as you heard from Ms. Flowers, we see that every day on the streets of the city of Philadelphia.

The need to address mental health issues was critical before the tragedy at Sandy Hook and remains critical now. Unfortunately, Sandy Hook demonstrated to many people what can happen when those with significant mental health issues are not adequately treated. The bottom line is that we need to make mental health and behavioral health treatment as accessible as handguns.

I am from Philadelphia, and in Philadelphia, as you know, we have a significant problem related to gun violence. More than 300 people per year are shot and killed. In 2012 we had 334 homicides; 85 percent of them

were committed with handguns. We have an additional 1,200 to 1,400 people every year that are shot, but thankfully survive.

There is an unfortunate nexus between mental health issues and gun violence. That is why I am incredibly pleased that our State Police have begun to send Pennsylvania's mental health records to the Federal Bureau of Investigation to be submitted to the NICS system. I also hope that there is bipartisan legislation in Washington to require universal background checks and the sharing of that information to all 50 States.

I hope that we can work together to identify other ways of keeping firearms out of the hands of individuals with serious mental illness. Doing so will save lives. But there is much more to talk about. I fervently believe that public safety is improved if we are smart on crime, and being smart on crime includes finding ways of reducing recidivism. Incarceration is a key component, but it is not the exclusive means of achieving this goal. Appropriate diversion, better treatment, and linking offenders to the services that they need when they are released will make Pennsylvania safer.

Mr. Chairman, you along with my friend and former colleague Gary Tennis have led the efforts to make robust, effective drug and alcohol treatment a reality in

Pennsylvania, and I simply want to thank you. We must now re-double our efforts and provide the same intense dedication and focus on our mental health system.

I do not want to leave here today and leave this hearing with people fearing those with mental illness issues. The vast majority of individuals with serious mental illness are nonviolent and do not pose a threat to society. Millions of Americans are afflicted with serious mental illness. The American population, I have been told, about 1 out of every 17 Americans suffers from a severe mental illness. These people are particularly vulnerable and in need of our protection, as they are often the victims of crimes. We must remain mindful of these facts when crafting policy.

But the reality also is that we have to make, again, we have to make mental health and behavioral health accessible to the public. I believe in the eighties these treatment facilities that were more community based were more accessible to the public, but in the eighties, a lot of that funding went away.

But we don't just spend less money now on mental health, it's where do we spend the money? Do we spend it on the front end or are we spending it on the back end? And I've been led to believe, maybe just anecdotally, that the number-one provider of mental health and behavioral

health treatment in the United States is the Los Angeles County prison system. The number two is the New York City prison system. Number three is the Cook County, Illinois, prison system, home of Chicago. And I'm very sure if you were to speak with Secretary Wetzel that the corrections system in Pennsylvania is the largest provider for mental health and behavioral health treatment, which I think is absurd. We need to be providing services on the front end as opposed to waiting for these individuals with health issues to act out and for us then to incarcerate them to provide these services.

There is, however, a direct correlation between unrelated serious mental illness and increased risk of violence -- I mean, untreated serious mental illness and increased risk of violence. A review of 22 studies published between 1990 and 2004 concluded that major mental disorders are associated with higher risk for personal violence and can account for between 5 and 15 percent of community violence and between 5 and 10 percent of homicides in the United States.

The MacArthur Foundation went on and found that individuals with serious mental illness committed twice as many acts of violence when they did not receive treatment as they did after being hospitalized. This same study showed a 50-percent reduction in rate of violence among

those treated for their illness.

The prevalence of co-occurring substance abuse and mental health disorders presents an additional challenge for public officials. A co-occurring disorder is when an individual has both a mental health disorder and a substance abuse disorder. About 4 million Americans have co-occurring disorders and about half receive no treatment for either issue.

In Philadelphia, our statistics estimate that 16 percent of the prison population is mentally ill. Seven thousand of our 85,000 total criminal cases in Philadelphia are referred for potential mental health issues. As a result, we have taken steps to address offenders with mental health and behavioral health issues. Again, I do not pretend to have all the answers, but I do believe it is our duty to think critically about the research and the empirical evidence that is necessary in order to develop reasonable solutions.

We should continue our emphasis on Mental Health Courts. I am an avid proponent of specialty courts. These courts target specific groups of offenders who have unique needs and develop judicially supervised, community-based treatment plans aimed to keeping participants from reoffending.

Philadelphia's Mental Health Court is one such

program. Serious mental health problems who have an open criminal case related to their mental health issue are given such help. Any such offender is eligible for the program, provided that there is a case that can be fairly and properly resolved with a county sentence. Eligible offenders are offered plea deals to a negotiated sentence with the caveat that they must participate and abide by the conditions of the Mental Health Court. Once in the program, a team of individuals works with the offenders and their families to gradually reintegrate these offenders back into society.

This reintegration is vitally important. We know from experience that transitioning from incarceration or hospitalization back to independent living is precarious. These offenders need a support network to ensure that they do not ultimately reoffend and end up back in the criminal justice system. To that end, participants are assigned a caseworker who monitors their progress, sometimes visiting them multiple times a day to ensure they have treatment, housing, medication, and community support.

I also believe this type of reintegration ought to be provided to mentally ill offenders who are under State supervision. Currently, Mental Health Court is limited to relatively low-level offenders. The program cannot be expanded to include offenders whose cases entail

a State sentence, because the county court loses jurisdiction over those offenders once they receive a State sentence.

During his budget testimony, Secretary Wetzel said that he was going to work on improving how the Department of Corrections addresses mental health issues. I have tremendous confidence in Secretary Wetzel, and I expect that any work he and his staff do to address these issues will have a positive, a very positive impact.

I hope that mentally ill offenders have a good transition and good transitional plans and are appropriately reintegrated into the community. It is critical that housing be secured and that the offenders be given access to a caseworker, community-based programs, resources, treatment, and medication, because without any or all of those elements coming together, we are merely setting the individual up for failure.

We must also discuss options for the mentally ill offender who cannot be safely reintegrated into the community. Currently, the only options for such an offender are long-term incarceration or hospitalization. With only six State mental health hospitals, it is not uncommon for offenders to spend long periods of time on a waiting list, only to reach their maximum incarceration date and be released prior to receiving any mental health

treatment, and without treatment, this scenario only repeats itself.

We must develop residential treatment options for these individuals that are separate and apart from the State mental health hospitals. To be sure, this proposal is one that will require considerable financial investment, and that's a real challenge in these times of scarce economic resources. While requiring funds upfront, it is one that will return the investment many times over.

Now, you've already heard testimony from Dr. Evans and Ms. Flowers that will be much more eloquent than mine when they were discussing Section 302 and involuntary commitments. Well, I just want to emphasize that again. We need to discuss the standard for involuntary commitments of individuals with a mental health illness who do not voluntarily seek treatment. This issue is controversial. I believe there are individuals who should be eligible for involuntary commitment who do not meet the existing standards.

The existing standard does not allow for consideration of other relevant factors such as a prior history of violence or harm, treatment history, and whether the individual is currently complying with treatment options. On the other hand, resources are scarce, and involuntarily committing more individuals may only dilute

the scarce resources and limited facilities that currently exist, but we need to discuss this issue and look to other States for best practices.

So on a very personal note, a very close, personal friend of mine who is known to everyone that has a television in Philadelphia reached out to me because he wanted his child, an adult, to receive behavioral health treatment. She was acting out. She's a professional, though, and many people and judges knew of her and know of her, but we couldn't get her treatment because she wouldn't submit to it voluntarily and she didn't meet the standard. And he tried, and I had members of my staff, lawyers and detectives, look into it, recording all the crazy, nonsensical things she was putting on Twitter and Facebook and how she was behaving in public, and it made him cry. But it took her acting out and assaulting a police officer, which could have led to much more violence and her possible death, it led to that for her now to be receiving the treatment that she should have been receiving for a long time.

So the stakes are high here. If someone slips through the cracks, there is a significant risk that he or she will commit a crime, meaning that there will be a new victim. Those who commit crimes must be held accountable, even if they are drug addicted or mentally ill. Once they

enter the criminal justice system because they have committed a crime, I believe that the treatment, services, and process of building connections with the community must be robust. Otherwise, this cycle will continue.

Finally, my belief is that all the systems, State and local, criminal and civil, mental health and drug treatment, must work together, not in silos, and better integrate our work, knowledge, best practices, and data.

So again, I'm very thankful for the opportunity to be here. I love the drive on the turnpike. But I'm very thankful to have had the opportunity. I mean, this is very, very important and we have to do something. We have to find solutions that will serve the mentally ill, will help prevent them from being re-victimized, will help them from being re-incarcerated over and over and over, and will help save the lives of victims like Ms. Flowers and all the others from Sandy Hook to the shores of North Philly.

Now, unfortunately, I'll have to return now to Philadelphia, but I leave here experts that know this area much better than I: Mr. Greg Rowe, who is the Chief of my Legislation and Policy Unit, and Assistant District Attorney Kate Thurston, who is really responsible for the majority of my testimony today. But again, my office, the District Attorney's Office of Philadelphia, and on behalf of the Pennsylvania District Attorneys Association, we're

here to work with you and your staffs to resolve this very serious crisis.

Thank you very much.

REPRESENTATIVE MURT: Thank you, District Attorney Williams. We appreciate your testimony.

At this time I would like to ask Mr. James Jordan, the Executive Director of the National Alliance on Mental Illness Pennsylvania, to please come forward.

Mr. Jordan, thank you for joining us today.

MR. JORDAN: Thank you very much.

Representative Murt, Chairman DiGirolamo, thank you for providing this opportunity to meet with you and the Committee Members.

I'm Jim Jordan, and I am the Executive Director of NAMI Pennsylvania. NAMI stands for "National Alliance on Mental Illness." We are the largest membership-based family and consumer organization on mental illness in Pennsylvania.

I'm not going to read every comment in my testimony, but I'll hit on the salient points. The testimony today is intended to present a perspective for this Committee's consideration regarding service gaps. I also think it's important to make a few comments regarding the subject of violence and mental illness. This subject is receiving a great deal of attention, and so I would like

to posit these concepts for your consideration.

Mental illnesses are biological brain disorders. They are diseases, and like other diseases, mental illness can be treated and treatment works.

Mental illness is the only disease that defines a person. For example, if you have diabetes, I've never heard someone say "There's a diabetes person" or "There's a cancer person"; they always separate the person from the disease and they say "There's a person with cancer" or "There's a person with diabetes." But when it comes to mental illness, as soon as you hear the word "mental illness" or "crazy," that brings about a full understanding of what people perceive that person to be.

We'd like to change the thinking you may have regarding individuals with mental illness and get you to separate the person from the illness. Think about the human being and think about the illness separately. It requires conscious effort on your part, because all of us have been trained to think in a very different way.

Concerning violence, we live in a violent society. More people are killed each year by violent crime in this country than most other Western countries combined. People use violence as a tool to handle problems. The FBI estimates that -- and this is according to the National Journal -- that 96 percent of violent crimes are committed

by people who do not have a mental illness. That means that 4 percent of the population has a mental illness committing these violent crimes; there's 96 percent of the rest of the population engaged in this activity.

People with mental illness are less likely to commit a violent crime than, quote, "normal" persons in the community. The key is access to treatment and sustained access to support, medication, supportive employment, safe and affordable housing, and I think you've heard speakers already, like Dr. Evans, indicate that there is a need for an ability to treat people and to buy into the concept of recovery. We're not talking about maintenance here; we're talking about enabling people to have quality lives and to be contributing members of society.

Now, from time to time a person with a severe mental illness commits a murder that makes headlines, as the tragic slaughter of children and teachers in Newtown points out. Sometimes the call to improve mental health policy and practice comes from politicians, journalists, and advocates who sincerely believe that addressing the mental health issue could reduce mass murders in the United States. Again I ask you that you separate the person from the illness and separate the use of violence as a tool from the person and from the illness. The solution to mass murders and a reduction in violence is complex and will

require a comprehensive approach which addresses not only mental illness but other significant factors.

Next, I want to recognize the serious fiscal challenges facing the State and the desire on the part of policymakers to protect our fragile safety net for the most in need. We believe community mental health services are an important part of that safety net to prevent and eliminate the need for more costly treatment settings.

Over the years, treatment has moved from care provided in institutional settings to a less restrictive community setting. This has been reflected in Pennsylvania with the closing of a number of hospitals in our State hospital system. However, deinstitutionalization doesn't mean the need for care is reduced or goes away. As care shifts from institutional settings, the need for a community support structure has dramatically increased.

State hospitals have been closed without a comprehensive plan which assures stability and access to services. This has created major problems in the mental health system and, if allowed to continue, will further exacerbate this situation. NAMI Pennsylvania supports an organized comprehensive implementation of a mental health plan, and we believe that plan has to go beyond a discussion by the mental health community. The others that need to be involved in this planning include the Department

of Corrections, the department of the Board of Probation and Parole, the mental health department, and all those affected by mental illness, substance abuse, co-occurring disorders, and the treatment of and support of the recovery principles.

Next, we strongly oppose a reduction in funding for mental health services. In the past, State hospitals were closed and 50 percent or more of the funds allocated to the State hospital system were diverted to non-mental health programs. That's a good savings on the front end, but you end up paying for it in services provided through prisons and jails and other programs as well that are not specifically designed to treat mental illness or co-occurring disorder.

Next, I've listed systems gaps. I've got a whole host of systems gaps here. I'm not going to read them to you -- all -- but I want to point out a few that I think require discussion:

- A lack of funding to adequately support movement into community services for persons with mental illness and maintenance of services in the community.
- Shift of operational responsibility of the mental health system to counties, which we think is a good thing. But we also believe

that there's a need to provide funding for those services and not put counties in the position of having to raise local taxes.

- There's an increasing possibility of uneven services for persons with mental illness, and we'd like to see consistent service across the State.
- County and municipal hospitals, by default, are being forced to provide care and shelter to persons with mental illness. Their operational costs have increased the financial burden of these hospitals and forced these facilities to provide services never intended.
- There's a severe need for housing.
- Also, and this is absolutely critical, there is an increase in the number of persons with a mental illness in the State and county prisons and jails. In 2001 when I joined NAMI, the total number of offenders with mental illness in the State and county prisons and jails was a little over 13 percent. Today, it is 20 percent. In California, they attempted to close the psychiatric hospitals, and by default, as was mentioned just by the previous speaker, the Los Angeles County Jail is now the

largest treatment facility in the country. The National Alliance on Mental Illness believes that having a mental illness does not mean a person is a criminal. The criminalization of the mentally ill is unacceptable. We are a better society than that and a better society than we're reflecting in our actions.

- County and city police departments face increasing challenges in dealing with individuals who are on the street, off medications, and without care and support.
- There's a need for better coordination of funding for treatment of persons with co-occurring disorders.
- State and county municipal judges have problems when trying to find placement for persons in need of treatment.
- One unintended outcome of the State hospital closures has been a growing trend to incarcerate the mentally ill in jails and prisons.
- The impact on the State corrections system is tremendous. There are currently 51,000 offenders in the State corrections system; 10,000 of these offenders are classified as

having a "mental illness." That makes the State Department of Corrections our biggest institutional treatment program in the State for people with mental illness.

- State prisons and county jails find themselves in a position where they have to develop treatment programs to handle the additional demands placed on them by a system that is shifting consumers from one institution to another.
- Sometimes, patients are moved out of their service area. For example, Harrisburg State Hospital was closed. There are large numbers of patients at Danville and in Wernersville and families find it difficult to visit and support the treatment that is going on in those hospitals.
- The number of homeless have increased as well.

Now I'll move through, and I ask you to read all of the service gaps I've identified, but I want to move to the access restrictions.

I want to just mention one thing. We're concerned with policies that restrict access to effective pharmaceutical treatments, which not only increase the

paperwork and red tape for the health-care providers but require children and adults to "fail first" on cheaper drugs before being able to access new drugs that might have fewer side effects or be effective. We believe this is especially cruel and inhumane for children. Studies indicate that every time a patient fails on a drug, there can be permanent cognitive damage, and it is the taxpayer who pays for the long-term care.

Additionally, if a person is forced to "fail" and has a psychotic episode, there can be a serious consequence or serious consequences. We believe that the treating provider and the consumer are the most appropriate to determine care. We support open access to psychotropic medications. Further, we believe that real savings can be realized by allowing the psychiatrist to work with the consumer to better identify what works.

I've already mentioned the increase in homelessness, the incarceration, and so on. I'll just point out a couple of recommendations that we have.

We believe that there should be a review of the current budget and develop a plan that meets funding requirements of a comprehensive plan. There is a need for a comprehensive State plan which will help ensure standardization of services. This plan would ensure that current utilization of resources is appropriate. This plan

would also provide for consistent services to be available statewide and would help to ensure sustainability of services.

The final thing that I want to talk about is the possibility of a creative use for State hospital grounds. We'd like to see the State hospital grounds become -- be developed. We'd like to see the State not give away this property, but if the State leases or sells this property, we want those resources to come back into the mental health system. But we'd like to see mental health communities that are not ghettos. We'd like to see communities that integrate the full community -- businesses, hotels, recreation centers, treatment for the mentally ill -- people develop right on the hospital grounds in cities where they exist, providing for better integration of those individuals and to the community.

I have other recommendations. I encourage you to read those. But I thank you for this opportunity to speak to you today.

REPRESENTATIVE MURT: Jim, thank you for your testimony.

MR. JORDAN: Thank you.

REPRESENTATIVE MURT: I'd ask Jim MacMillan, the Director of the Gun Crisis Reporting Project, to please come forward. Joining Jim MacMillan

will be Eric Larson, Peer Support Coordinator, and David Dan, a social worker and also a Fellow at Drexel University's Center for Nonviolence and Social Justice.

Thank you very much for coming today.

MR. LARSON: Thank you very much.

My name is Eric Larson. I'm a person in recovery, and I'm a person who lived in my parents' basement. My mother assured me that if I wanted to remain in her good graces that I would refer to it as the "downstairs," however.

I'm happy to hear so much universal talk about people with mental health challenges. One of the things that I think is really becoming even more clear to me is that if we're really talking about recovery and rehabilitation and we're not talking about seclusion and institutionalization, we're having a different kind of conversation, and what we're talking about is community inclusion. And if I look back over the tapestry of my recovery path, which is very individual for every person, I really see that there was a very clear intervention that made the difference in having my recovery story be successful, and these were really having a family that did not give up on me and made a very clear decision to not enter me into the State hospital system, despite recommendations of the psychiatrists.

That, I think, is a pivotal difference, that when we're talking about community inclusion, we're talking about recovery success; we're not talking about institutionalization and secluding people. What we're talking about is a universal looking at people, encouraging them with progressive things that bring us into the community and allow us to not isolate. It allows us to really look at being encouraged, to be active citizens, and I learned this basically through a family that did not give up on me, despite having very significant challenges -- loss of hope, hearing voices, and having a major mental health diagnosis. Despite that diagnosis, I think it's all of our challenge as human beings to work towards mental health wellness.

Some very instrumental community programs helped me to bridge the gap between staying in my parents' basement and becoming an active community member. These programs included the Compeer Program, which is a program that helps mentor and create friendships for people in recovery to prevent isolation; the Wellness Recovery Action Plan, which is actually a consumer-based originated program that allows people to take a look at their well-being and create action plans for staying well in the community; and finally, the Peer Specialist education, which was provided to me by the Institute for Recovery and Community

Integration. This peer support education gave me a life's passion to really share my story of recovery and what I learned in that and really give it back to the community of people and how they can learn about themselves and really move self-care to the forefront rather than the peripheries of their lives.

So I really just want to highlight those programs, and now working for Resources for Human Development as a Peer Support Coordinator, I can really give back the lived experience and the things that I learned to the community. And I think that I am certain without these types of key supports in our community and a family that did not give up on me, I would not be the contributing member of society that I am today.

And I just thank you for your time and your partnership and working to support people in mental health recovery.

REPRESENTATIVE MURT: Thank you, Eric.

MR. DAN: Good morning.

Mr. Chairman, Honorable Members, it's a privilege to be here. I really appreciate the opportunity.

My name is David Dan. I work with Resources for Human Development, and I just want to share some observations, some of which will echo what Representative Murt said, what Dr. Evans said, what Mr. Jordan said.

I just want to share the observation that in the wake of trauma, a national tragedy such as Newtown and other incidents, it's normal for people to look for answers, for explanations, for reasons, because if we have reasons, if we have explanations, we believe we're better able to predict and control.

Unfortunately, the argument over gun control, gun control advocates, gun ownership advocates, is so polarized in this country that it's really tempting to find middle ground with other kinds of issues, and I believe that's part of what happens in the correlation between mental illness and gun violence, which the President himself, whom I respect greatly, made that correlation three times in the third Presidential debate. It's a public perception. It's not accurate.

I have, at Melanie's suggestion, I have distributed to you a factsheet which lists eight research citations, all of which concur that the incidence of connecting gun violence and mental illness is between 3 and 5 percent.

David Sirota in a somewhat facetious, rhetorical article mentions that if we want to look at risk factors, we could look at young men who are Caucasian, but we would never base public policy on that because we know too many fine, young White men. That is not going to stick as a

basis for public policy. But the correlation between mental illness and gun violence is no less untrue.

And it's very important, and I really respect the work you do and I respect a democracy where a diversity of opinions can come forth, but it's really important that we base public policy on reality, not perceptions. And I think the danger at this time, if we don't really understand the research and the reality and the fact that 96 percent, as I think Mr. Jordan said, 96 percent of people with mental illness live in communities without incident unless they, of course, unfortunately are victims of violence, we have a danger to drive public policy in two very wrong directions.

One is a direction toward reinstitutionalization, which I understand there is advocacy in Connecticut and actually the Newtown community to reopen a State hospital. That would be destructive, regressive, expensive. One of the great accomplishments of our society in the past 50 years has been the humane medical-considered treatment of people with mental illness.

And the other danger is that we increase stigma and shame and really enlarge the gray area that Dr. Evans talked about, where people who may need treatment won't want the label, because the label is associated in the public mind with something really undesirable, dangerous,

stigmatized, et cetera. So I think it's very important that we continue to articulate the lack of correlation between gun violence and mental illness as a cause. And again, I think we're reaching for explanations.

I do, on a positive note, again picking up on what Dr. Evans said about HealthChoices, Pennsylvania is a national leader -- as well as in recovery and some other areas -- Pennsylvania is a national leader in providing mental health services in schools. The vision of Community Behavioral Health, which serves Philadelphia, and Community Care Behavioral Health, which serves, I believe, 40 counties in Philadelphia, has supported teams of mental health professionals onsite in schools where they have been able to identify young people at risk, identify people in need of treatment, engage families, and also make a very positive contribution to school climate and help teachers and other staff develop pro-social, nonviolent strategies for problem solving, and this, I think, is just something that Pennsylvania should be very proud of and something that I really want to advocate for the continued support of.

Thank you.

MR. MacMILLAN: Good morning.

My name is Jim MacMillan, and I am the Editor of the Gun Crisis Reporting Project in Philadelphia. I'd like

to thank the Chairman, Representative Murt, and the Committee for this great opportunity.

The Gun Crisis Reporting Project is a solutions-oriented independent news organization now residing in the incubator at Resources for Human Development. I also covered gun violence directly for 17 years as a photographer at the Philadelphia Daily News.

Nearly 10,000 people have been murdered in Philadelphia over the last 25 years, and more than four out of five of them have been killed with a gun. More people have been shot to death in Philadelphia since September 11 than the total number of victims killed by terrorists on that date, and during the Iraq War, more Americans were shot to death in Philadelphia than were killed by enemy forces in Iraq.

These senseless urban killings are not the result of deranged individuals. Police Commissioner Charles Ramsey put it very simply to the Philadelphia Tribune last summer when he said, "Much of the violence is sparked by arguments over nonsense."

Contrary to media portrayals and public perception, research has shown that no more than 4 or 5 percent of violent crimes are perpetuated by people with mental illness. At GunCrisis.org, we look at urban violence as a public health threat, an epidemic similar to

plagues such as cholera and smallpox, and we believe violence, too, can be eradicated.

Residents of cities beset by war or terrorist attacks are never blamed for the violence surrounding them, so it is a mistake to blame members of any urban U.S. neighborhood or any other community for the epidemic of shootings that has been imposed upon them. Certain socioeconomic factors make some communities more vulnerable to epidemic violence; for instance, the lack of opportunity, the lack of jobs, and the lack of good schools, coupled with an abundant supply of guns and illegal drugs.

There are many strategies for reducing gun violence, but perpetuating the stigmas and stereotypes of mental illness is not one of them.

Thank you.

REPRESENTATIVE MURT: Thank you, Jim, Eric, and David. I appreciate your testimony. Thank you.

Our next testifier is Joseph Rogers, the Chief Advocacy Officer for the Mental Health Association of Southeastern Pennsylvania.

Mr. Rogers, thank you for joining us today.

MR. ROGERS: Thank you.

I want to thank the Committee for having this hearing and really taking the time to really think about

these issues. I do a lot of work on a national basis in addition to the work I do in southeastern Pennsylvania. I'm involved in the development of a consumer movement, a mental health consumer movement. I'm a person with a diagnosis of bipolar disorder myself and, as a result of my mental illness, have been hospitalized and been homeless.

And I've watched around the country as people, you know, tackle the issue of mental health that has come out of the Sandy Hook tragedy, and I'm not seeing a lot of good, rational discussions. And I really want to thank the Chairpersons of this Committee, because I think we're going about it the right way. We're trying to find out real issues, real solutions to the issues.

My testimony I've sent to Ms. Brown, and so it's available to the Committee. So I won't read it, but there are six points, you know, if you read the testimony there are six strategies that we think we have unprecedented opportunities here in Pennsylvania to invest in our behavioral health system. We need to turn around our taking-away money from our county behavioral health systems. We have one of the best behavioral health systems in the country, and the funding that the State puts in to the mental health system is the money that really allows for the flexibility. You heard about the Peer Specialist Program. The money we put in, the State puts in, allows

for the Peer Specialist Program -- the training, the development of peer specialists, which is a unique program that Pennsylvania is one of the leaders in, where people in recovery for mental health issues are now activated and providing support to other people in recovery.

We hear about the people in the basement. Well, peer specialists go into the basement and say, "I've been there, too. I've been in the basement. Hey, come on; there's a group down the street." You know, kind of like the Alcoholics Anonymous movement, the AA 12-step where people can sponsor each other? That's what's happening as a result of the funding that we have, and that's State dollars.

But for the most part, crisis intervention programs, we're talking about trying to prevent tragedies. Well, crisis intervention is key to trying to prevent tragedies. Most of the tragedies you see in mental health are where people hurt themselves -- a huge amount of, unfortunately, suicide among young people, among veterans, among older people. Mostly that can be prevented and is prevented.

On a daily basis, our behavioral health system, county-based system, local control, locally developed, locally planned, consumers and families and providers coming together and planning on a county-by-county basis --

each county has a plan -- provides crisis intervention services that prevents thousands of suicides and other tragedies. That system is funded with State dollars for the most part. Medicaid dollars can't fund that. That system for the most part is coming because the Commonwealth has had the foresight, unlike many States, to put money into a community mental health system, to resource a community mental health system.

As we close our State hospitals, we move the resources from the State hospital into the community mental health system almost dollar for dollar -- more than dollar for dollar. So we have that capacity. So we need to continue to invest in that county-based, local, well-planned mental health system.

Medicaid plays a vital role. We need to expand Medicaid. Many of the young people that we're talking about that can get into crisis, that have dual-diagnosed problems, end up in the streets, end up in jails, end up, unfortunately, involved in incidents that might be prevented, that could be prevented. Those young people are not insured. If they're poor, if they're not working, if they're working and below a certain income because they're, you know -- you know young people; they get jobs at Burger King. They get jobs at McDonalds. You know, when I came out of school, I was working on a bachelor's degree, and

most of the time I worked at carpet installing, and those jobs don't have insurance and you can be working below the poverty, 125 percent or whatever the poverty, and Medicaid, if we expand it, will cover those young people and they can get behavioral health services they can't get now. We need to expand Medicaid.

We need to create standards. As we create the new mental health benefit, unfortunately, Pennsylvania to date -- this can change -- has opted out of being part of the health exchange program, creating that health exchange. The Federal Government is going to create it for us. Well, we at least in the advocacy community are going to get involved. We're going to teleconference with the Federal Government, and we're going to tell them, you know, as citizens of Pennsylvania, while you're going to start a health exchange for us in Pennsylvania, maybe our government isn't going to help you with it but us citizens want to help you with it, and we want to make sure that there's mental health and behavioral health covered in a vigorous way when we see that program get established. So we want to create standards for mental health benefits.

We need to integrate mental health care better with primary care, primary health care. Most people -- you may not know this -- most people with a diagnosis of mental health get their treatment, which is usually medication,

you know, especially when you start talking about major depressions and things like that, get their treatment from their primary-care physician. Most people, when they begin to have a substance abuse problem, it's usually a primary-care physician who kind of recognizes it and, you know, sees the problems, because there are a lot of health problems if you're using alcohol wrongly or overuse of it. So primary-care physicians need to be better integrated. We need to co-locate programs. We need to have behavioral health specialists within our health-care system, and that's something the State can encourage. Again, when we look at the county dollars, those county dollars can help encourage and help these big hospitals, these big health-payer programs, to have behavioral health specialists in their health-care program.

And we need to increase funding flexibility. Dr. Evans talked about the gray area. You know, I think this is an important discussion, and we've just sort of begun to think about it because of Dr. Evans' op-ed piece. But it really kind of struck me, yes, we now have the technology and knowledge to identify people with potential issues, serious mental health issues, at pretty young ages.

Now, we don't want to start labeling people. We don't necessarily want to create a career path into being a mental patient. I always talk about I have a career path,

and that's being a very good mental patient. Well, we don't want to create those career paths; we want to divert people. But if we can find people as young -- and some of the evidence shows that as young as in middle school and even late elementary school, we can see problems and we can address those problems. There are technologies, but we don't have the funding for that. We don't have the flexibility of funding.

Again, the State investment in the county mental health programs could be used and are used in many cases to do things like school outreach and school education, things that Medicaid aren't quite funding. Or we need to advocate, all come together and advocate more flexibility in the Medicaid funding so we can reach out to young people before they have their first break, or definitely after their first psychiatric incident, more aggressively, more, you know, assertively so that they can get the help they need.

And we need to involve families. We need to create a system of care that really respects the role of families. Throughout the age group, our population is aging. I just turned 61, never thought I'd make it to 61. I feel blessed. But, you know, I'm looking down the road; what's going to happen for me? I have a psychiatric illness and there is some profile there that things could

not go so well as I get older. So not only for people with psychiatric diagnoses, as they age things change and problems arise, but for all older people we see problems that impact the brain and mental health issues. Are we prepared for that, the baby boomers as they're getting old? We need families involved in that. We need young people.

We just recently, my mother-in-law, we were dealing with her, you know, dementia, and as a family we were trying to -- and, you know, I work in the mental health field, I'm an advocate, but there wasn't a lot of resources. There wasn't a lot of information. We need to help families be able to cope with those kinds of situations better.

So thank you for being here. Thank you for caring. Thank you for your work, both of you. You're both great and wonderful advocates for us, and we appreciate it. Thank you so much.

REPRESENTATIVE MURT: Thank you, Mr. Rogers.

Our next testifier is Dr. Guy Diamond, the Director of the Center for Family Intervention Science, also an Associate Professor at the University of Pennsylvania School of Medicine.

Dr. Diamond, thank you for joining us today.

DR. DIAMOND: Thank you for having me.

I work at the University of Pennsylvania. I run

a research center developing empirically supported treatments and trying to disseminate them. I know what those challenges look like.

But I'm here today to talk a little bit -- I have a great segue from the last speaker to talk about a project that we've been involved in in screening for suicide and violence in primary care, which I think is a very important problem in our community, and we have some interesting solutions that we'd like to bring to your attention.

So let me just emphasis things you may already know. Suicide is the third leading cause of death in adolescents nationally as well as in the State of Pennsylvania. People don't realize that, but it's after homicide and vehicular problems. It's the main reason adolescents are dying over many illnesses. So it's a serious problem.

In addition to that, many more kids attempt suicide, and this is what is filling up our emergency rooms. Certainly the major reason for being admitted into an inpatient unit is for a suicide attempt or suicide-related behavior. So it's a high cost to society as well as in terms of using up resources.

The three top methods of suicide are firearms, suffocation, and poisoning, and those are particularly, with boys using firearms more often, having access to a gun

more often than girls. It's an interesting variation.

What do we know about suicide risk behavior? How could we try to identify these kids? We know that 60 percent of kids who attempt suicide have a history of depression. We know substance use is often involved. A history of sexual abuse is a high-risk factor for suicide behavior; family conflict; previous suicide in the family is an unfortunate risk factor as well; and obviously, previous attempts. That's the strongest predictor of a future attempt, someone who has tried in the past before.

There's an interesting parallel to some of the sort of mass violence that we've been seeing, the mass shootings that we're all concerned about, that kids who have been known to bring guns into schools, into movie theaters and other environments also tend to have, those kids have a history of certain kinds of mental distress. Many of them have a history of violence, a history of trauma, come from chaotic home environments. They've been bullied, the strong history of these kids being bullied a lot, and tend to be more socially isolated kids, and this is somehow their, quote, sort of "acting out" behavior.

There is also an interesting link between suicide and these kids. A lot of these kids write suicide notes before going on these shooting sprees, end up killing themselves as part of these shooting sprees. So the

element of suicidal behavior or thoughts as a precursor to some of these events is something I think is worth us trying to think about.

So the real challenge is, what do we do? And nationally, the conversation is multifaceted. A common recommendation is, how could we strengthen the mental health community to try to help as one component of preventing some of this violence?

We've heard a number of testimonies today about a lot of things that can be done, very important things. One of the things that we're particularly interested in is the idea of increasing screening, early identification and prevention, and the national conversation around this is about doing it in primary care.

Does everyone have my slides? Good. I'm going through this quickly.

The Association of Pediatrics, psychiatry associations, the Joint Commission on hospital accreditation, the Affordable Care Act -- all of these organizations are putting forth positions saying we need to increase our attention to behavioral health concerns in the medical community. This is a very good place to identify kids. Seventy percent of kids go see their primary-care doctor once a year. It's an amazing opportunity for screening, for behavioral health assessment. It's

certainly recommended to be done at a well visit, but is it done, is it paid for, and is there enough time become challenges.

Kids also like talking to their pediatrician more than they like talking to us, you know, psychiatric doctors and things. There's less stigma in your medical office. You've known this person for years, if you're lucky enough to be in a health-care environment like that. So there's a tremendous opportunity to evaluate and understand mental health problems in the context of primary care or emergency room settings as well.

There are a lot of challenges in that area. Doctors say "I don't have the time"; "I don't have the training"; "I don't have a place to send people." Those are the three complaints: "I wasn't trained to do this"; you know, "How am I going to talk to these kids about it?"; and "If I identify them, where do they go?"

The recommendations that we've come up with, and we've had a number of grants from SAMHSA, NIDA, NIMH, even some of the Pennsylvania tobacco dollars, have been to develop the Behavioral Health-Works Program. So this is a program we've developed in Philadelphia. We started it at Children's Hospital, at CHOP, where I work. We've had grants, particularly with OMHSAS. We have a collaboration with them for a large suicide-dissemination project. And

it tries to say if you just introduce screening, it's not going to be successful. Screening needs to involve education upfront, then screening tools, and then an enhanced system for making referrals, and that's what our sort of program is packaged together to do.

We go in and work with doctors. We have Web-based training programs. We know doctors don't have a lot of time. These are short interventions during lunch. They sit around having a sandwich while they watch some training tapes on how to talk to kids about suicide, how to talk to them about substance use, depression; how to talk to parents about these problems once they're identified, because parents take kids to services, kids don't go on their own.

The center part -- actually, I'm going a little faster than I want. There's a slide here that shows the counties that we're in with the current projects that we have. We started in Luzerne, Lackawanna, and Schuylkill. Those three counties have the highest suicide rates in the State, but with this second grant that we've gotten, we've been able to expand to the five counties around the Philadelphia region, and we're out in Allegheny and Westmoreland.

The centerpiece of the work has been our Web-based screening tool. Lots of screening tools that are

being used today are two questions about depression. Depression seems to be the leading theme that pediatricians feel comfortable evaluating. They see a lot of it, and therefore, they're interested in that.

Our view is, screening really requires a much more broad-based evaluation, and you can see on one of the slides here that our screening covers school problems, families, safety, substance use, sexuality, anxiety, depression, suicidality, psychosis, trauma, and bullying. It's a Web-based tool. Because it's Web-based, you can program in skip-out logic. Things can move pretty quickly. It takes about 5 to 7 minutes to complete the whole tool. When the kid is done, he hits a button. The report summarizes itself, generates a report for the pediatrician, and downloads a PDF for the electronic medical records. So we've tried to sort of streamline the screening process to make it more effective and fit into the workflow for the busy pediatrician.

We've been up and running on a suicide grant for about 3 years. CHOP has been running this in their emergency room for about 7 years now. JCo came, saw the tool running, and said, this is exactly what JCo is recommending in terms of how hospitals could do more attention to safety and suicide prevention.

Let me show you a little bit of the outcomes on

one of the cohorts that we had in our first grant of about 1,500 kids. The highlight of it is we screened and we found about 5 percent of the kids reported high suicide, current suicide risk. I should say that this population has some interesting details. Some doctors want to screen universally: Every kid who walks in the door, I'm going to give them a tool, because a lot of kids suffer in silence and I don't know that they're upset. A lot of doctors say, well, when I'm worried about a kid, that's who I'm going to screen, sort of what we call indicated screening. Most of these kids are indicated screening, so the rates are a little high. But still, this is what is showing up in medical practices across Pennsylvania.

So about 5 percent have pretty severe suicide ideation, ideation that would require immediate attention: This is a kid who says "yes" to a couple of questions; I need to activate crisis services and refer him now. A lot of those kids, what we found in CHOP is a lot of those kids would have been missed had we not been using the screening tool and they would have just gone home. At CHOP, in the emergency room, it's being used on all kids presenting, so they come in for a scratched knee, they do this questionnaire, and we're finding out that there are a number of kids that we're able to pick up and refer for services.

About 28 percent have pretty severe depression, and about 40 percent report some pretty severe exposure to violence. These are all risk behaviors for suicide as well as for some of the mass shooting things.

One thing we found is when we do ask a question about whether you have access to a gun in your home, when a kid indicates severe risk behavior, that question pops up because that's a severe risk factor for further violence. And what we found is 16 percent of the kids who reported severe suicide ideation said they did have access to a gun in their home. So that's a very high-risk population, and this creates a very important learning moment for the physician who should be well trained in how to talk to families about gun safety, and this would be the time to activate some of those learning modules. But if we didn't ask these questions, most doctors do not ask these kinds of things on a routine basis. So it's a nice indication of the kind of opportunity that could come through screenings like this.

At CHOP, the last slide, we've shown an increase in mental health identification -- 2 percent to 10 percent. Ten percent of the kids coming into the ED for a nonpsychiatric problem are presenting with psychiatric problems if they were screened appropriately. A lot of those kids are getting referrals, and a lot of those kids

are getting assessments.

So our recommendation, as you try to figure out how to move forward, is to support this general integration of behavioral health and primary care. It's a unique opportunity to try to solve a lot of problems. There's a lot of national interest in that. Pennsylvania is one of the leaders in developing a program like this. Our SAMHSA grant is a national model for what SAMHSA is trying to promote around the country.

We would like to develop the program so it could expand to all of the counties in the Commonwealth. We would obviously need more resources to do that. But right now we do training, we do screening, and we do triage. A lot of the States have also added a sort of a telephone, a telemedicine consult service that really helps the physicians engage in this project and field more resource, so it's an important thing.

The benefits, obviously, are early identification -- identifying kids when they're having problems early on so that we can get them treatment and services -- and trying to reduce referrals to the emergency room and psychiatric hospitals.

We estimate the current program we have, or a rough estimate would probably be about $2 million a year to try to expand it across the Commonwealth. That's about a

dollar per child in the State of Pennsylvania to create a prevention program that would really enhance services and spur a whole new kind of conversation. If we were able to add some of the consultation services like Massachusetts has, it's probably more like $2 a child. That's how they factor it, so about a $5-million-a-year project.

Essential: Even if you don't fund the project, which I'm not assuming you will, but an essential component that you could enact quite easily is encouraging reimbursement for screening. Right now, doctors don't get a penny for doing all this additional behavioral health work, and believe me, I'm out in the trench every day. They say, I get paid for everything I do and this is the most complicated thing you're asking me to do; if I got paid, it would just help fit into my workflow a little bit better.

Massachusetts introduced reimbursement for screening. Medicaid pays $10, private insurance pays $15, screening went up 60 percent. So it's a small intervention to put that -- actually, there's a code on the pay scale in Medicaid. We've been talking with them for 3 years, but they just have not been willing to activate that for this kind of screening at this time. It would be a small gesture that could have a huge impact on increasing early identification rates.

Also, finally, there are a number of groups involved with this. The Pennsylvania Providers Association I believe is going to talk today. They have pulled together a learning community. All the major State medical associations, all the major psychiatric and psychological associations come to the table on a bimonthly basis talking about how to support these activities and moving things along. That would be another organization to try to reach out to and support our work in trying to do this.

So I hope that helps with your deliberating about some ideas that you might do to try to move early identification and prevention forward. Thank you.

REPRESENTATIVE MURT: Thank you, Dr. Diamond, for your testimony.

Our next testifier is Lloyd Wertz, the Vice President for Policy and Program Development, the Family Training and Advocacy Center for serious mental illness.

Mr. Wertz, thank you for joining us today.

MR. WERTZ: Thank you for having us. Thank you to Representative DiGirolamo, Representative Murt, Representative DeLissio, for holding this important hearing.

And I suspect you know this, but your staff is truly competent and just excellent in arranging these

things, and perhaps the only thing that exceeds their competence is their commitment to this topic, and we are consistently impressed with that and thankful for that.

I did some testimony -- I'm going to be loud. My prayer last night was that I wouldn't follow Joe Rogers. Apparently I prayed for the wrong thing. Some prayers don't get answered.

I do note that there are some new faces around this table, and I do note then that you probably have some catching up to do, especially when I read your Committee listing, and I will certainly hope that God blesses you in that pursuit because this is an important topic to all of us.

My name is Lloyd Wertz. I'm employed by PMHCC of Philadelphia. We work with family advocacy and training. We also convened the Pennsylvania Psychiatric Leadership Council. More importantly, though, for this topic, I had a father who suffered from mental illness for years before his premature death.

In the context of last year's budget cuts, which your body enacted, we began a process of seeking real-life stories from individuals in the community, people who have lost services, people who have lost incomes, people who have lost the lives that they had begun to reconstruct on their roads to recovery.

I included in your packet a safety net pyramid. We went out and tried to create what services are really included in this safety net. We don't act as if that's the entire say-all and be-all about safety nets, but it gives you some idea about what you might refer to.

As part of this process, we received some letters, a number of letters from folks in the community about those services. I'm going to read to you brief excerpts from two of them and then refer them back to that safety net that you have hopefully in front of you.

The first one starts off with:

"To whom it may concern:

"I was in a horrific car accident in 2008. I was in the ICU and I wasn't expected to live. Since then I have had 8 surgeries to repair my skull, face, spine, and knee and I have been unable to work. Afterwards I had fallen into a deep depression."

At that time this gentleman was introduced to case management and he was referred to services. With these resources, he was able to maintain a "normal" living while awaiting for determination on his Social Security claim.

Now, of course, cuts in benefits have affected him in various ways. He no longer has the money to meet copays to doctors. He ends up in credit collections, and

he has accrued bills with pharmacies.

After the six-prescription limit that was enacted under Act 22, he has been working with physicians to write exceptions for that six-medication rule and has not been terribly successful with that.

"Currently I..." live "in a residential program that provides for my basic needs. However, this situation is temporary and due to not having any income whatsoever, I do not meet the requirements to obtain even the lowest of income housing. I am faced with imminent homeless, knowing that shelter...in Dauphin County is also limited. I do not have family support and I do not meet the homelessness requirements...for long term shelter housing. Without Cash Assistance, I will be unable to provide for my very basic needs such as hygiene supplies and...clothes once I leave this residential program.

"The changes to the General Assistance Program has changed my life in dramatic ways and although I am independent, strong willed, hardworking, and bright, I do not know what my future holds for me without this type of assistance."

Now, the General Assistance funds that are paid to people that were applying for Social Security disability get paid back. They were paid back to the General Assistance Fund once those disability benefits were

secured. We don't have that option anymore, and these folks literally don't know where they'll be living. They don't know whether a house will be over their head during that time.

The next story comes from a young woman who aspires to be a neurologist. She faced significant symptoms of mental illness in her adolescence, requiring a brief acute inpatient psychiatric admission and outpatient treatment in a program affiliated with her school district:

"When you cut budgets, and possibly close our school, you're not simply saving money. You are affecting our lives and futures, leaving us in the dark. So if you're considering closing our school, please think of us first. We need this program. We are the future. We're not...a group of...misfits and we aren't severely disabled. We lead normal, functionary lives with proper help. Don't look at us as...numbers in a budget. Look at us as people who need a little more help. You have the power to control our future, for better or for worse."

The lost potential of this woman and many like her focuses on the significant costs of these "cost saving" measures. How much future taxable income have we lost? How many illnesses will not be successfully treated? How much more of our future safety net -- our children -- are we willing to risk to save potentially and reasonably small

portions of our current State budget expenses?

Briefly, as to the relationship between gun violence and mental illness, you have all heard this many times before, but there is clearly a connection, and that connection is, people who are victims of mental illness are far more likely to be victims of gun violence.

The research, though, has also indicated that the increased likelihood of individuals with behavioral health issues to commit acts of violence occurs at far higher levels when symptoms begin to worsen. This "ramping up" of severe depression and hallucinations and delusions has been found to have some association with gun violence, as has the co-involvement of substance abuse services. When we deplete community mental health treatment resources, we leave those with mental illness who live in the community with fewer options when they find themselves in most need of care.

This year's budget, near as I can tell, has no increase for community services. We see an increase in the line item for people coming out of State mental hospitals. Last year, we experienced a 10-percent decrease, and on the way down here I heard that we have a 2-percent inflation for this country for this year. So we're down 12 percent versus 2 years ago. How long can we continue that and really act as if it's the same?

People in your constituencies, they know that when you cut back on services, bad things happen. You know that, right? We need to do something different to make that change.

You heard Dr. Evans mention Mental Health First Aid. He actually provided treatment that I participated in, so now I'm a Mental Health First Aid certified trainer, and I'd like to offer to this Committee the opportunity to engage in Mental Health First Aid training. We would be more than happy to come here with a co-trainer and provide the training to folks on this Committee to help you to recognize the early-on symptoms of mental illness and prevent them before they become the costly and potentially dangerous symptoms that we see on occasion here. That invitation is open, and we'd be more than happy to do that.

Finally, the Commonwealth has a Mental Health Procedures Act which was written with the intention of allowing for involuntary inpatient and outpatient treatment in our communities. Some counties use the procedures on a regular basis for outpatient involuntary care and have found them to be effective. Others have not. Before we are led to the point of considering scarce resources in the community being reduced, shouldn't we think about the act that we currently have?

All indications at this time are that during this

legislative session you'll be asked to pass a law which will specifically direct involuntary commitment for outpatient treatment. It will undoubtedly require that a set of guidelines be developed, new staff hired and trained, reporting requirements to judicial branches of local government, and costly implementation of monitoring systems to effect procedures that are already available in our current statute. We strongly urge that you consider other alternatives before you move along that path.

Thank you so very much for this time. We appreciate it.

REPRESENTATIVE MURT: Thank you, Mr. Wertz, for your testimony.

Our next testifier is Mark Murphy, the CEO of the Disability Rights Network of Pennsylvania.

Good morning, Mr. Murphy. Thank you for joining us.

MR. MURPHY: Thank you for the invitation, and I echo Lloyd's comment about the great work that your staff does, and I appreciate very much the leadership that Representative DiGirolamo, Representative Murt, and Representative DeLissio have given on this issue.

My name is Mark Murphy. I am the Chief Executive Officer of the Disability Rights Network of Pennsylvania, which is a statewide, nonprofit organization that provides

advocacy and other services on behalf of people with disabilities, including people with mental illness and their families.

Thank you very much for the opportunity to make these brief comments. I also will try to be as loud as possible. Maybe we can have a sing-along or something.

What I want to talk about are just a few issues and hopefully, like others, not use all of our time, but let me make a few brief comments about the mental health system in Pennsylvania as it currently operates.

Recent horrible events in several parts of the country, which have already been referenced, have brought to greater prominence the issue of how to improve our mental health services system. In many ways this is unfortunate, not only because of the personal tragedies involved but also because policy responses to such events often can be skewed by the understandable impulse to try to fix some sort of problem that is identified that may or may not exist or otherwise to just do something, anything, about an issue, and I think we all have to be careful that the policy decisions are not overly driven by reactions to these admittedly terrible events.

So my first request is simply this: As Legislators and policymakers, please do not view the issues related to the mental health system solely or even mostly

through the lens of "violence prevention." Instead, what should be driving the policy discussion is the fact that when provided with an array of appropriate, well-funded community services, people with mental illness can and do recover.

For some people with mental illness, symptoms may disappear once appropriate treatment is found. For others, recovery means living a full and meaningful life while still experiencing such symptoms. Regardless of the situation, however, in order to facilitate recovery, the service system must ensure that the unique needs and strengths of each individual are identified and that an array of community services that meets these needs is funded, developed, and delivered, including a stable living environment when that is required.

Moreover, it is imperative that stigma and false assumptions about the potential of individuals with mental illness not drive these services and opportunities. Rather, it is the voice of the consumers themselves that must inform this discussion. We have to listen to consumers, ask for input from families, and learn from the individual successes brought about by prior initiatives, including closures of some of the State hospitals.

Most importantly, if the General Assembly is serious about improving Pennsylvania's mental health

system, then it must make a real and lasting commitment to provide the resources necessary to make and sustain these improvements. Unfortunately, in recent years there has been no such commitment, and indeed the trend has been in the wrong direction, and instead, community mental health services have sustained large cuts, including 10 percent in last year's State budget as part of, at least what we consider the ill-fated -- not ill-fated, ill-considered, rather, block grant and the elimination of the General Assistance Program, which has had a very negative impact on many people with mental illness.

In a recent survey conducted by the Pennsylvania Association of County Administrators of Mental Health and Developmental Services, 89 percent of the responding counties had reduced program and service capacity at the local level and 63 percent eliminated one or more programs or services. Despite this problem, the proposed budget now under consideration for FY '13-14 provides only a small amount for community services, and that funding is only in the context of moving approximately 90 people from State hospitals. While such movement is a good thing, the funds provided do not come close to making up for recent reductions in funding and services and certainly come nowhere near what is necessary to get the service system where it needs to be.

In essence, without funding, we could talk all day long about a lot of these great ideas, and the Legislature and the Governor have to get together and figure out a way to make that type of financial commitment. One way to do it or to help with it, of course, is the Medicaid expansion now being offered to Pennsylvania as part of the Affordable Care Act. This is literally a once-in-a-lifetime opportunity to grow and strengthen the community mental health system.

By some estimates, as many as 40 percent of the people who will be eligible under the Medicaid expansion nationally are people with mental illness. Many of these people in Pennsylvania currently are receiving services that are funded entirely with State dollars, and what Medicaid expansion will do is have significant amounts of Federal dollars being used to help pay for these services, which will enable the State dollars to then be used to strengthen and grow the behavioral health system. And so the State dollars can be used to strengthen, to add services, to otherwise fund services that may not be funded now because the Federal dollar will be taking care of what 100 percent State-funded services are doing now, and this includes helping to restore money that has been cut in recent years. So the quickest path to restoring that 10 percent, to restoring some of these other cuts, is

through the Medicaid expansion.

And we have examples here in Pennsylvania, of course, of programs that help people with mental illness, including people with severe mental illness, so we're not starting from scratch. We've helped them recover. In recent months, and again, in light of some of these recent tragedies, one has often heard arguments made in favor of increasing long-term hospitalization and imposing other restrictive treatment measures. The outcome for individuals with mental illness following the closures of Philadelphia, Harrisburg, and Mayview State Hospitals, however, contradicts many of the often-stated assumptions about homelessness and criminal activity involving people with mental illness.

For example, the closure of Mayview State Hospital resulted in a five-county service area developing a comprehensive array of services, including housing, crisis services, and assertive community treatment teams. None of the 275 people discharged as part of the closure are homeless. Very few individuals discharged have been involved with the criminal justice system since the hospital closed.

In my written comments I refer the Committee to a couple of different reports that have been done about the group that came out of Mayview State Hospital, and I refer

you to those documents and reports for further information about this.

What's important to note, however, is once funding is provided and once services start, reducing or otherwise cutting those services could have particularly disastrous results. People can't maintain recovery without the services that help support their success.

In addition, the success achieved by discharged individuals and those diverted from State hospitals as part of a thoughtfully planned community services system also can result in significant cost savings. It is clear that when we plan State hospital closures carefully and develop good community services that match the needs of the people served, both the individuals with mental illness and the taxpayers win.

There are, of course, many issues that have to be addressed if we are to make our mental health system as good as it can be, so by all means, let's have that discussion and include all the stakeholders involved. But let's have facts, not assumptions, stigma, and stereotypes drive that discussion, and the facts tell us that when people with mental illness receive an array of services that are tailored to meet their needs and when such services are provided in a properly funded, well-planned, community-based system, people can and do recover and lead

meaningful lives.

Thank you again for the opportunity to present these brief comments.

REPRESENTATIVE MURT: Thank you, Mr. Murphy, for your testimony.

MAJORITY CHAIRMAN DiGIROLAMO: I would like to apologize for the music outside. It's a bunch of young people that have traveled a long distance to be here today, and they've kind of had this planned for a long time. I'm going to try to ask them to tone it down or maybe take a little break. But we might have to work in between the drums and the horns. So again, I apologize.

REPRESENTATIVE MURT: Our next testifier is Dr. Andrew Clark, a child and adolescent psychiatrist and also the Medical Director at KidsPeace Children's Hospital and Residential Services.

Good afternoon, Dr. Clark. Thank you for joining us.

DR. CLARK: Good morning, Mr. Chairman and Members of the Committee.

I'm Dr. Andrew Clark. I'm Medical Director for KidsPeace Children's Hospital and Residential Services. I'm a board-certified child and adolescent psychiatrist and a native of northeastern Pennsylvania.

On behalf of KidsPeace and our clinical staff,

please let me express my sincere gratitude to the Pennsylvania House of Representatives Human Services Committee for allowing me to be a part of this important hearing.

KidsPeace is a 130-year-old children's mental health organization that was first established as an orphanage in the Lehigh Valley. Through the years, KidsPeace has grown in size and scope to operate programs in 10 States and Washington, DC.

KidsPeace is one of Pennsylvania's largest providers of child and adolescent behavioral health care, including a 96-bed child and adolescent inpatient psychiatric hospital, a residential-care program that averaged a daily census of 227 kids last year, educational services, therapeutic foster care, community-based outpatient services, prevention, and public education programs.

In 2012 KidsPeace served more than 10,500 clients in our programs, including 2,300 youth that were admitted to the KidsPeace Children's Hospital in Orefield, Pennsylvania. We treat kids with a range of needs from disruptive behavior disorders, including ADHD, to anxiety disorders such as post-traumatic stress disorder, to the most severe psychiatric disorders such as bipolar disorder and early-onset schizophrenia. In addition, KidsPeace

provides specific programming for developmentally challenged children with autistic spectrum disorders and intellectual disabilities.

KidsPeace considers advocacy for our kids a priority in meeting our mission. What I hope to convey to you all today is the necessity of supporting providers who care for children with severe mental illness. Awareness, funding, and access to mental health treatment are critical. Nearly one in four youth have shown signs of a mental health disorder in the past year, according to the most recent community-based prevalence studies. Anxiety disorders are by far the most frequent psychiatric diagnosis in children, followed by disruptive behavior disorders, mood disorders, and substance-use disorders. But sadly, despite having treatments that work, fewer than half of youth with mental health disorders receive specialty treatment and far fewer obtain properly disseminated evidence-based treatments.

Nowhere else is the lack of access more disheartening than when a teenager commits suicide. According to the Centers for Disease Control, suicide is the third leading cause of death, behind accidents and homicides, for 15- to 24-year-old individuals. Even sadder, suicide is the fourth leading cause of death for children between the ages of 10 and 14.

Overall, teen suicidal behaviors are increasing. The attempted suicide rate among teens has increased by 20 percent between 2009 and 2011. To better grasp this data, visualize a high school classroom with about 24 kids in it. According to the most recent Youth Risk Behavior Survey by the CDC, four of these students have seriously considered suicide and two have attempted it.

In order to address these challenges, providers need your help. A number of factors have reduced the amount of time and resources available for children with mental health needs. Workforce shortages, redundant and outdated regulatory burdens, and strict managed-care requirements have created barriers for child and adolescent clients. Provider reimbursement rates have not increased for many years, but added external expectations have.

Given these factors, it is no wonder that caregiver burnout and organizational financial pressures are at an all-time high. While the average approved hospital stay has declined by half, the rate of short-stay inpatient hospitalizations rose by 81 percent among children and 42 percent among adolescents from 1996 to 2007, according to the National Center for Health Statistics. Shortening the inpatient length of stay and denying residential care has served only to increase readmission rates.

Attempts to minimize the inpatient and residential levels of care can compromise the treatment available to the most severe mental health clients. Due to the recent trend of limiting approvals for residential treatment, our hospital has had to expand its number of beds to accommodate the numerous readmissions of children failing community-based services. Many of these children would have had earlier approval for residential treatment in the past. Therefore, the adolescents now referred for residential treatment programs are more severely ill.

Countless studies support that early identification and treatment of youth can reduce mental health costs down the road. Unfortunately, the most evidence-based treatments, such as Parent-Child Interaction Therapy, which you heard earlier, and Multisystemic Therapy, which you've heard as well, have significant funding barriers while the costly, poorly evidenced alphabet soup of outdated Pennsylvania wraparound services remain in place.

Behavioral health-care costs continue to climb, but dollars are not spent efficiently. The number of individuals seeking access to care in the past 4 years has risen dramatically, according to the Health Care Cost Institute, but it has become increasingly difficult for providers to be considered compliant and receive

reimbursement in an era of managed care. While we realize regulations are created in the best interests of the youth, these external demands are so constant that they compromise our ability to deploy the administrative resources to implement evidence-based systems of care.

At KidsPeace, the compliance and utilization management departments now begin to rival the cost of delivering professional services. The demands of the system are steering precious resources away from direct care. The four Medicaid managed-care organizations for behavioral health in Pennsylvania all have very different business, regulatory, and utilization practices, which adds significant complexity for providers.

The Pennsylvania children and youth welfare systems do also need further support and modernization to increase access to care and support children who are experiencing abuse, neglect, and abandonment. Recent large population-based studies on child welfare systems in both Canada and Sweden have supported that children with mental health disorders who receive care in these systems have dramatically less likelihood of death by suicide, suicide attempts, and psychiatric hospitalizations than those who are not able to receive services in the children and youth welfare systems.

Unfortunately, the limited ability for the

Department of Children and Youth to fulfill its mandate of placing a child in need has often prevented psychiatrically stabilized youth in the inpatient hospital from moving to a less restrictive level of care. While waiting for appropriate disposition plans, hospital resources are pressured by the system to develop less ideal "interim plans" to return clients to the same environments that have precipitated their crisis.

In addition, laws such as Act 147 provide extensive confidentiality and treatment rights to minors as young as 14 years old in all mental health settings, which sometimes undermine their best interests for family support. Although intended to facilitate treatment with providers, these barriers to communication with parents often do more harm than good.

In one recent example, a 16-year-old client we had, who blames her mom for allowing her stepfather to abuse her, refused to sign releases of information to children and youth caseworkers, her mother, or outside providers, halting her treatment progress and leaving her mother heartbroken as she watches her daughter struggle.

While there are a myriad of challenges when providing direct care to children and adolescents at the hospital and residential levels of care, those of us working in the trenches are acutely aware of the workforce

shortages in child and adolescent psychiatry. As an example, certified registered nurse practitioners work daily in acute medical-care hospitals in a wide variety of disciplines as valued team members under the regulation of the Department of Health. However, the outdated regulations for behavioral health do not acknowledge the current Pennsylvania vocational standards of a psychiatric certified registered nurse practitioner or physician assistant working in the acute psychiatric hospital and residential levels of care.

Despite limitations on training resources, our mental health technicians, which provide our most direct care to these children at these levels of care, must maintain near heroic vigilance with tight staffing patterns in the face of sometimes assaultive behavior from clients for very low wages, which consequently leads to poor retention for the providers.

There are approximately 7,000 board-certified child and adolescent psychiatrists in the U.S., and the estimated need has been projected to be 12,600 to meet the demand. An anticipated 30-percent increase to about 8,300 can only be expected if current funding for training and recruitment remains stable. Certified nurse practitioners and physician assistants responsibly utilized and supervised can help to fill this gap.

It is time we take a closer look at updating the mental health system to better serve children in need in Pennsylvania. Last year's tragedies in Newtown, Connecticut, and Denver, Colorado, have shed light on the need for early identification, prevention, and comprehensive treatment in the mental health system. How many tragedies this year will point to the same?

The Pennsylvania public health message should be that psychiatric illnesses are "brain-based" physiological disorders akin to diabetes and hypertension, with the goal of further reducing the stigma attached to mental illness. Notice how communities rally around impairing diseases that you can see but never the devastating brain-based psychiatric diseases that you cannot.

Finally, our leaders must support ending the unfair advantage toward procedural reimbursements over comprehensive care for chronic illnesses, including psychiatric illnesses. KidsPeace looks forward to partnering with you to ensure mental health treatment services are accessible and providing them is affordable. Every child deserves a chance to have access to treatments that work, and providers need your support to deliver them.

Thank you very much.

REPRESENTATIVE MURT: Thank you, Dr. Clark.

Just as an aside, I visited KidsPeace last year

up in Orefield.

Our next testifier is Jon Evans, the CEO of Safe Harbor Behavioral Health. Mr. Evans will be testifying on behalf of the Pennsylvania Community Providers Association.

Good afternoon, Mr. Evans.

MR. EVANS: Good afternoon.

And Representative DiGirolamo and the Committee, I would like to thank you very much for this opportunity, and Representative DiGirolamo, especially for your leadership in this area. You've really been in the forefront of highlighting the need for this.

And I am going to talk to you from a perspective of both the Pennsylvania Community Providers Association, who are over 200 very committed agencies strong, as the current President of their board, and as the CEO of Safe Harbor Behavioral Health, a provider agency in Erie, Pennsylvania.

And if you would, I would like to ask you to read my testimony, and I'll talk more freehand because I think I can be more meaningful to you. I also had a neuropsych professor long ago tell me it's not a good thing to read to very well educated, bright people, and I think this Committee clearly is an example of that.

So I'd like to focus on three issues, all of which are initiatives that we have as the Pennsylvania

Community Providers Association put forward to the department as examples of where, from our knowledge, the community on the forefront of providing service could actually improve care and save the Commonwealth tax dollars. The need to do that would be able to take the long run in the budget cycle and be able to look beyond one budget cycle and look at the long haul.

The first example is in regard to outpatient treatment. Outpatient really does represent the safety net in this community, and from an example I can speak to you of is being fortunate enough to be the founding CEO of Safe Harbor in 1993 during one of the first CHIPP initiatives. We were asked to set up an intensive outpatient clinic to welcome back individuals who lived in Erie County that had been housed at Warren State Hospital. Their average length of stay was 8 to 10 years, with the consumer with the longest length of stay being 40 years. We welcomed 177 individuals into that project over a number of years, and I'm really pleased to tell you that that project worked well beyond any of our expectations. We've only had two individuals have to return to the State hospital in 20 years. It's an example of when services can be appropriately funded and supported that treatment truly works.

And I would like to thank Mr. Larson, if he's

still here. Mr. Larson, your testimony may have been the most meaningful here today. You're an excellent example of what recovery means, and I thank you for your courage to testify. It was truly meaningful.

Now, Mr. Larson is a good example of many consumers that we have at our clinic who have been able to live meaningful lives. However, since that time, since that initiation in '93 and '94, there has been no cost of living in that primary CHIPP budget. In fact, last year, those funds were cut.

We have a board president who is a former executive VP from PNC Bank and now a financial advisor, and he says we're the best case managers he has ever known, because as a result of the fee-for-service system, we actually lose money on every unit of care we deliver and, like most other outpatient clinics, have to have other services that will backfill that or really work closely with our county administrators to find some way to backfill those dollars. So we have put forward an initiative to properly fund outpatient services and provided the department with some data to support that.

We have actually grown in outpatient from an average of 2,400 individuals active in care 3 years ago. The demand is unprecedented. We now have 6,300 active individuals and are welcoming 200 new patients every month

from various numbers of sources. We don't advertise or market. These are people that come to us. And to my knowledge, most outpatient clinics are finding that demand at the front door.

We take that on as our challenge and welcome it with a certain degree of passion, but at some point, if the structure of funding outpatient doesn't change, we will not be able to accept new individuals into our clinics. Many of the outpatient clinics, according to our survey, have either had to restrict access or some have closed doors and even had to send individuals elsewhere for care in Pennsylvania.

The other example that I would like to share with you is a paper that we put forth to the department with regard to psychopharmacology. As we talk about serious mental illness, it is, all we all know, a biologically-based disorder that responds well to the proper type of medication in support of care. In fact, there is significant research that is quite redundant that supports that. Fortunately, new medications have become available that don't have the very noxious side effects where individuals can actually take them and not feel like they have to stop taking them.

The prior authorization process, that has not only been implemented but actually recently has been

ratcheted up, costs significant dollars to the Commonwealth. It costs significant dollars in staff time. I have three nurses in our clinic that do nothing but sit on the phone and argue with parents about what medication a psychiatrist can prescribe who has just met with that individual patient for an hour.

We've had studies that are fairly significant, the State of Ohio being one, that demonstrate that prior authorization actually costs more money to the Commonwealth. We have put forth a proposal that would ask that the Commonwealth allow community-based mental health clinics and psychiatrists practicing in them to have a waiver from that prior authorization while keeping the prior authorization in place for primary-care physicians that probably should refer those individuals to us. Unfortunately, we have not been able to get any traction on that.

Our final initiative was in regard to the regulations for the entire system. Many of the regulations were written in the 1970s and are not germane any longer. An example I can give you of that is one just in regard to the necessity of having a psychiatrist review a treatment plan. Psychiatrists are very busy, and they are our most expensive employees, as they should be. Psychiatrists are required to review treatment plans on every single

individual we see, even those who are only in therapy but not under their care. This costs a tremendous amount of hours of physicians sitting and reading treatment plans where we would prefer to have them see individuals.

And in fact in medical school now, most psychiatrists are not even trained in therapy. They're trained in pharmacology and biology, so they can do their part of the treatment modality. And in fact psychiatrists don't have time to do therapy anymore, so one real easy waiver of one regulation would be to not have psychiatrists sign treatment plans of patients that are in therapy only. We would increase psychiatric hours to see patients in the clinic and reduce costs significantly.

There are a number of similar examples of regulatory reform that we would very much want to be active partners with the department in working on to save money, and that is kind of the fundamental point I wanted to make, is in regard to the initiatives that we put forward, we are eager partners that want to work with the department to improve care and lower costs, and we feel we have opportunities. We would like to have that opportunity to do this.

The one final comment I think I'd like to make is just in regard to a previous speaker who spoke about the Mental Health Procedures Act and commitment laws. And

certainly the tragedies that we heard about are horrific and touch us all, but I would say they are not good examples of what happens with individuals with mental illness. You've heard other speakers say that people with mental illness are more often victims of crime. And if we actually use data, we all have a much better chance, based on data, of being done in by our spouse than by someone with a random act of mental illness. And frankly, depending on the given day, I think my wife of 37 years might want to come here and testify to that fact, but she's a good enough person, hopefully she won't do that. But I would suggest that we need to be very careful in looking at the Mental Health Procedures Act because it could be a very slippery slope.

We do have laws in place that I think pretty adequately take care of that. In fact, we have a crisis unit that does involuntary commitments every day, and again, with the proper funding, we do have staff that can go out and make sure that people are safe and get them the care they need.

I want to thank the Committee for your attention, and I appreciate your work.

REPRESENTATIVE MURT: Thank you, Mr. Evans, for your testimony.

Our next testifier is Dr. David Lewis, the Chair

of the Department of Psychiatry at the University of Pittsburgh and also the Medical Director at the Western Psychiatric Institute and Clinic.

Good afternoon, Dr. Lewis.

DR. LEWIS: Good afternoon.

Thank you very much for this opportunity to speak with you today on behalf of the academic and clinical leadership of the University of Pittsburgh's Department of Psychiatry and Western Psychiatric Institute and Clinic.

Having been at Pitt and WPIC for the past 25 years, I want to extend our thanks to this Committee and to the leadership of the Commonwealth for your help and support in enabling us to become the internationally recognized leaders in psychiatric clinical care, research, and education that we are.

I've been asked to speak with you today about the relationship between mental health and violence. In addressing this question, I think I'm going to reinforce a number of the comments that you've already heard, three points that will characterize my testimony.

First, people with mental illness are much more likely to be the victims than the perpetrators of violence. Second, effective treatments are available for people with mental illness that will reduce the risk of violence. And third, the future for individuals with mental health

disorders and the safety of our communities can be improved through new models of care, improved regulation, and additional research.

Now, I'd like to place my perspective on mental illness to you to begin with. It's a broad term. It describes a wide range of brain disorders, most of which are the result of a complex interplay between genetic liabilities and environmental risk factors.

Advances in neuroscience research are revealing how these factors alter the brain's circuitry and lead to impairments in thinking, the regulation of emotion, and behaviors that characterize psychiatric disorders.

Mental illnesses are common. About one in four of us in this room today will have a diagnosable mental illness, but predicting who, when they are ill, will become violent is extremely difficult.

As you've heard, the reality is that most mentally ill people are not violent and most violent people are not mentally ill. In fact, the vast majority of violent crimes, 95 percent, are committed by people who do not have a diagnosable mental illness.

Mass shootings are also not strongly related to mental illness. The majority of individuals who commit mass murders do not have an identifiable mental disorder, but it is true that violence does occur. Violent acts are

committed by people with mental illnesses, and that's why it's so important to recognize that effective treatments for these illnesses are available and these treatments are associated with a reduced risk of violence, both to the individual who has the illness as well as to those around them.

But approximately two-thirds of people with mental illness do not seek treatment. This is often as a result of the stigma associated with having a psychiatric diagnosis. It's due to access problems: People just can't get to the help they need. It's due to insurance or payment issues: If they can find the help, they can't find a way to pay for it. And in some cases it's due to the belief, maybe as a result of the illness itself, that they don't need treatment. So for these reasons we think the idea of a registry of individuals with mental disorders will only further discourage them from seeking treatment and may actually increase rather than reduce the risk of violent acts.

So instead, I would like to suggest to you three practical strategies that can promote safety and the engagement in treatment for individuals with mental illness. These include improving access to services; second, implementing appropriate regulatory reform; and third, addressing the public health concern regarding

access to weapons.

So first, access to services. Our nation's systems of mental health care and drug abuse treatment suffer from serious fragmentation and underfunding. Since the push for deinstitutionalization in the 1960s, the inadequate funding for community-based programs has left millions of individuals with inadequate treatment, resulting in increasing numbers of individuals with mental illness living on the streets or, as you heard earlier, residing in prisons. So our strongest recommendation is to look for ways to improve the capacity of community-based programs to meet the needs of individuals with mental illnesses.

I'd like to briefly mention two examples of innovative programs that are addressing this need. In partnership with Allegheny County, we developed the first fully comprehensive resolve crisis network that provides 24 hours a day, 7 days a week, 365 days a year, the opportunity for an individual to call in, to have a mobile team sent out, to drop in, to spend up to 7 days living in our facility. This is available to anyone, anywhere in the county, in any type of crisis. This award-winning program helps resolve crises before they become emergencies. It reduces burdens on law enforcement and hospital emergency rooms, and it facilitates the engagement of the individual

in crisis and appropriate followup that will reduce the likelihood of future crises.

Second: Now, we have a live two-way video psychiatry program that brings our psychiatrists at Western Psychiatric Institute and Clinic to individuals with mental illness, especially children and adolescents to seven rural counties of the Commonwealth that lack expertise in this area. And for both of these programs we are able and interested to bring these types of expertise to all the counties in the Commonwealth.

Secondly, there's the issue of regulatory reform. Although psychiatric emergencies might carry a risk of violence in a small percentage of individuals with mental illness, our ability to handle these emergencies is, frankly, far from optimal in Pennsylvania. Think about a medical emergency. Your spouse has the sudden onset of crushing chest pain. You pick up the phone; you call 9-1-1. A medical team scrambles out. They assess the situation, they stabilize the individual, and if necessary, they immediately transport them to an emergency department.

This efficiency for handling medical emergencies contrasts sharply with psychiatric emergencies, especially when involuntary commitment is needed. That process involves filing petitions, adhering to strict criteria, applying for approvals from appropriate regulatory agents,

waiting for those approvals, and on and on. We think part of the problem is Pennsylvania's Mental Health Procedures Act, which dates from 1976 and, consequently, is not fully informed by the tremendous advances in knowledge that have occurred during the past 37 years.

A focus of the act was to, quote, "consistently apply principles of due process to make voluntary and involuntary treatment available where the need is great and where the absence of treatment could result in serious harm to the mentally ill person or to others," end quote. Ironically, though, current legal standards frequently result in families having to sit back and watch their loved ones deteriorate to the point of seriously threatening or committing dangerous acts before the family or a clinician, if involved, can actually seek emergency treatment.

So our recommendation would be that the process for providing emergency psychiatric response be reevaluated with input from a multidisciplinary task force that includes individuals with mental illness and with their families. We think we need new standards that take into account illness severity and ability to adhere to treatment and that allow for emergency treatment in advance of an individual exhibiting dangerous acts, and we believe this could be done while still maintaining due process and respecting everyone's rights.

The third point I wanted to address is public health concerns regarding access to weapons. Firearm deaths by homicide and suicide are highly correlated with high per capita rates of gun ownership, especially in young people. The United States leads all high-income countries in both rates of firearm deaths and gun ownership per capita.

Homicide is a significant public health problem across the country, but suicide is even more common. In fact, it is suicide, not homicide, that is most strongly associated with mental illness. Approximately 90 percent of suicides are committed by individuals with mental illness compared to only 5 percent of homicides, and death by suicide is strongly related to the availability of lethal means such as firearms.

So we support and we encourage you to support Federal initiatives that would ensure firearm availability is appropriately regulated in a manner that prior studies, existing research, has demonstrated decreases the risk of suicide, homicide, and mass shootings.

We also encourage you to support research that will further or advance our ability to understand mental illnesses as diseases of brain circuits with the goal of improving our ability at early identification and early treatment.

In my own area of expertise, schizophrenia, the National Institute of Mental Health estimates that approximately 100,000 people, mostly 16- to 25-year-olds, will become newly psychotic each year, and it is during and even before the first episode of psychosis that these individuals have an increased risk for violent acts, but with treatment, the risk of violence is reduced 15-fold.

So in conclusion, I want to again thank you for the opportunity to speak with you today. The issues and recommendations that I have highlighted require collaboration by government, health-care providers, scientists, law enforcement, and families in order to improve the life experience of individuals with mental illness and to reduce violence in our communities.

We are committed to working with you on these and related initiatives in any way that we can be of help. Thank you.

REPRESENTATIVE MURT: Thank you, Dr. Lewis, for your testimony.

We appreciate everybody hanging in. Our final testifier today is Lt. Col. Scott Snyder from the Pennsylvania State Police.

Good afternoon, Colonel Snyder. Thank you for being with us today.

LIEUTENANT COLONEL SNYDER: Good afternoon, and thank you.

As you said, I'm Lt. Col. Scott Snyder. I'm the Deputy Commissioner of Staff with the Pennsylvania State Police, and I'd like to thank you for this opportunity to present testimony at today's hearing.

Late last week we were invited to offer some comments regarding mental health commitments as they relate to prohibitions against possession of firearms, and as a public safety measure, Federal and State statutes prohibit the purchase and possession of firearms by certain persons. Background checks on persons purchasing firearms from licensed dealers have been required under Federal law since March 1, 1994, when the Brady Handgun Violence Prevention Act took effect.

The Brady Act established the National Instant Background Check System, or NICS. The NICS is a national computerized background check system that queries records of persons to determine if they are prohibited from receiving firearms by either State or Federal law. Most of the records in the databases checked by NICS originate with States, which are not required to submit records to NICS but do so voluntarily for public safety or other law enforcement purposes.

Each State is free to determine the extent of its

involvement in the NICS. Pennsylvania chose to implement its own background check system as a point-of-contact State. Now, the Pennsylvania Uniform Firearms Act was amended to require the Pennsylvania State Police to establish, maintain, and operate an instantaneous firearm background check system. In 1998 the Pennsylvania Instant Check System, or PICS, became operational and provides licensed firearm dealers, county sheriffs, and the Chief of Police of the city of the first class immediate access to a background check on individuals who attempt to purchase or transfer a firearm or apply for a license to carry a firearm. When PICS receives a call, multiple sources are checked, including both Federal and State databases.

Persons are prohibited from possessing firearms under Federal law if they, among other things, have been convicted of a felony, have been involuntarily committed to a mental institution, or are unlawful users of or addicted to any controlled substance.

Under the Pennsylvania Uniform Firearms Act, there are similar disqualifiers, including a person who has been adjudicated as an incompetent or who has been involuntarily committed to a mental institution for inpatient care and treatment under Sections 302, 303, or 304 of the provisions of the Mental Health Procedures Act.

Pennsylvania law provides for mandatory

notification of prohibiting mental health commitments to the State Police for compliance with Pennsylvania's mental health prohibition relating to firearms and to the county sheriff for revoking licenses to carry.

Our agency is statutorily tasked with maintaining a mental health records database for purposes of firearms background checks. Notification of Mental Health Commitment forms are completed by the counties and forwarded to State Police by U.S. Mail or fax. Until recently, the State Police maintained these records solely at the State level. However, a 2008 amendment to the Uniform Firearms Act allowed the State Police to disclose to the U.S. Attorney General, or his designee, records relevant under Federal law.

As of January 2013, State Police has submitted all of its historical records and is submitting the mental health records we continue to receive to NICS for inclusion into the NICS Index. The data is manually entered into the State Police database within 48 hours of receipt and the information is uploaded to NICS daily. We receive approximately 3,200 mental records per month. As of February 2013, over 650,000 records have been submitted.

In 2007 the Federal NICS Improvement Amendments Act was enacted to, among other things, provide incentives for States to make more records available for use during

firearm-related background checks, particularly mental health records. The act also permits States to establish a program that allows individuals who have been prohibited from possessing firearms due to a mental health-related adjudication or commitment to seek relief from the associated Federal firearms prohibition.

Pennsylvania law currently provides for mental health relief for firearms disabilities. Now, the State Police, through its Firearms Division, defends the interests of the Commonwealth in these hearings, which are normally held in the petitioner's county of residence.

Currently, the Bureau of Alcohol, Tobacco, Firearms and Explosives does not recognize Pennsylvania's State relief as removing a person's Federal mental health prohibition for firearms. The process itself is in compliance; however, Pennsylvania law must require the judge to consider specific evidence and make specific findings as required by the NICS Improvement Act before the ATF will certify our mental health relief process.

These minor deficiencies could be remedied by amending the Pennsylvania Uniform Firearms Act with federally acceptable language, which would qualify that process to be federally certified by the ATF. This amendment would benefit our citizens by providing recognized Federal relief, codifying already existing

practices related to the process, and would give Pennsylvania access to grant funds which require a certified relief program to be in place. We would welcome the opportunity to work with the Legislature regarding this matter.

Once again, thank you for inviting us, and we'll be happy to answer any questions at the time.

REPRESENTATIVE MURT: Thank you, Colonel Snyder.

At this time, I would ask if any of the Members would have questions of any of our testifiers? We do have to vacate this room by 1 o'clock, so.

I have a question, and I think I might direct this to Dr. Diamond or to Dr. Evans, if you don't mind. The question is, is there a genetic or a biological predisposition for a child to attempt suicide because a parent did, or is it the fact that a child observed or found out about a parent who had tried suicide? I think you mentioned that in your testimony in passing, and I'm just curious whether or not there is a genetic predisposition for that.

DR. EVANS: I'd like to get Dr. Diamond's take on this. My take would be this: that there's not necessarily a genetic predisposition to suicide. There is a genetic predisposition to the mental illnesses that are related to suicide. So, for example, people who have a history of

family depression are also going to have a higher propensity for having depression themselves. Schizophrenia has a clear genetic component. So the issue isn't necessarily related to suicidality and genetics; it really is the connection between genetics and the mental illnesses that are related to it.

DR. DIAMOND: Yeah; I think that's a good answer. There has not been enough research to show a genetic direct transmission. Certainly, as I said, if a family member commits suicide, a kid is more likely at risk, but it's hard to know how much that's exposure and a kind of family process on how that plays out.

But I think the point is right. Kids who attempt suicide often have all kinds of vulnerabilities, psychiatric vulnerabilities, and then the kind of environment they live in either activates those vulnerabilities and drives a kid to that act or helps buffer against the kinds of stresses of adolescent life.

So it's a complicated thing. We're still trying to learn more about it.

REPRESENTATIVE MURT: Thank you.

Representative Toepel.

REPRESENTATIVE TOEPEL: Thank you, Mr. Chair.

I know that DA Seth Williams left, but I was wondering if any of his representatives could answer a

question about the Mental Health Court.

Thanks, Greg. I put you in the hot seat.

Just a quick question. I know that Philadelphia has been using the Mental Health Court and other counties have used it as well. I think it's a great idea. People who are mentally ill or commit crimes, if we throw them in jail or prison, it doesn't help the situation.

Do you have any data on the recidivism? Is it helping? I don't know how long you've had the Mental Health Court. Have you been able to assess how it's working?

MR. ROWE: Right. I don't have the recidivism numbers in front of me. I do know -- and often in Mental Health Courts in Pennsylvania, the Allegheny County model is cited as almost the gold standard of Mental Health Courts.

I was reading a study last night. I think they've estimated their recidivism rate at in the teens. And I don't know the exact calculus or the period of time, but certainly the numbers are far lower. As you know, the Department of Corrections released a recidivism study at a rate of about 62 percent of people leaving State prison are re-arrested within 3 years.

I can tell you that in Philadelphia and in the other Mental Health Courts, the numbers are certainly

lower. Whether they're 40 percent or 30 percent, I can't answer that. We can follow up with you. But the numbers are absolutely lower because of the connection with services and the oversight by the courts and the prosecutors and the defense attorneys.

REPRESENTATIVE TOEPEL: Those are wonderful numbers, the reduction in the recidivism. And is this program being expanded into other counties? I mean, if you say Allegheny has the model, are you noticing other counties who are implementing the courts?

MR. ROWE: Yes. Many other counties have Mental Health Courts, not all of the counties. I believe the number is between -- you know, more than a dozen counties have Mental Health Courts, but certainly not every one. More counties have Drug Courts than Mental Health Courts. That's sort of the first specialty court that you saw. But that is -- I know PCCD for years has been working on trying to take, reducing the pot of money that they get and trying to move them into establishing new treatment courts.

REPRESENTATIVE TOEPEL: Okay. Thank you. Sorry to put you on one of the questions without the data---

MR. ROWE: No; my pleasure. My pleasure.

REPRESENTATIVE TOEPEL: ---but that's good news. Thank you.

REPRESENTATIVE MURT: Representative DeLissio.

REPRESENTATIVE DeLISSIO: Just a couple of quick both questions and comments. I don't know if Deputy Secretary Marion is still here? Yes.

Do you happen to know, Deputy Secretary, if the census for the State hospitals has gone up at all? It cites a statistic that there are currently 1,527 folks hospitalized. Do you know if that census has been static over the last 2 to 3 years? if it has gone up? if it has decreased?

DEPUTY SECRETARY MARION: It has been working downwards.

REPRESENTATIVE DeLISSIO: It has gone down.

DEPUTY SECRETARY MARION: [inaudible.] But it is lower. I can give you more detailed, I can submit more detailed information to the Committee along those lines so you can see how that's trending.

REPRESENTATIVE DeLISSIO: Okay. And one other question for you, sir.

The Mental Health Matters Program, and I think the public -- there are a lot of things that are key here. This is definitely a complex, complicated event, and we need to consider all of these variables to move forward. So is the money for that Mental Health Matters Program appropriated? Is that a program that is happening now? What are the mediums? Is it radio? TV? print?

DEPUTY SECRETARY MARION: The exact methodology will be worked out with all of the local communities where programs may be in place already. The money for this next year, you know, any approval, is a reallocation of funding that was not utilized in prior -- a program did not get far enough along at this point in time. So it's not moving away from another service base, but it's one-time only going into this next year.

REPRESENTATIVE DeLISSIO: One-time only.

DEPUTY SECRETARY MARION: The idea is to team up with the efforts underway at each of our global communities where you have a program, as has been testified, in Philadelphia, for instance, regarding Mental Health First Aid. We don't want to come in and try to supplant or replace; we'd rather just alter. And so we know there are those kinds of good programming going on throughout the Commonwealth. We want to match up with those, you know, at least with a small allocation of funding.

REPRESENTATIVE DeLISSIO: Thank you, sir.

REPRESENTATIVE MURT: Representative Hackett.

REPRESENTATIVE HACKETT: Thank you, Mr. Chairman, and thank you, Sub Chairman Murt, also for putting today's hearing together.

I thought it was appropriate, as the Lieutenant Colonel was finishing up our testifying, that the

background music, our background orchestra, was playing "What a Wonderful World." And it certainly is a wonderful world here today that we could get some folks together to all sit around a roundtable, just like my coworker, Pam DeLissio, put together a roundtable recently. Thank you for your efforts there, Pam.

I did take note that about nine of our testifiers were asking for funding. Ladies and gentlemen, funding is a big issue in the State of Pennsylvania for many issues, but keep in mind that the group that's here tonight is fighting for you. We're all fighting very hard for you, and we believe it is a priority. We've been backed against a corner on many issues, but we still stand strong for you guys.

I have a list of questions. I've been educated today. I thank you for that. My questions I won't ask today. I'll get to everyone individually, and I'll hopefully get the answers. As a 26-year veteran of law enforcement, I can tell you how it was on the streets trying to handle those with mental disabilities, and it's not easy. But it made me smile today. We have some great knowledge in this room, and I hope we can put it together and move some procedures forward that will truly help the Commonwealth of Pennsylvania.

Thank you all for attending today and testifying.

REPRESENTATIVE MURT: Representative Kinsey.

REPRESENTATIVE KINSEY: Thank you, Mr. Chair.

My initial question was for Dr. Evans, but I see that he left, so I'm going to just move on to, I believe Dr. Clark?

Dr. Clark, my question, as we talked, I think as you mentioned screening or prescreening for some of the youth, I know in the days in which I worked with folks in the mental health field, the DSM, I believe, DSM-IV, was the book, so to speak, that we used for the diagnosis. Is that the same book that's used for children as well in regard to diagnoses and then looking at early prevention programs, or is there a different type of measurement that's used for the adolescents as opposed to adults?

DR. CLARK: The DSM-IV has been, for a long time, our standard diagnostic manual. The DSM-5 now has just been published which will change the shape of the system somewhat. We are anticipating over a year's time there will be a number of adaptations to sort of bring DSM-5 up to speed within the delivery system.

I think that, you know, certainly diagnostic integrity is really paramount in child adolescent psychiatry and throughout psychiatry. It is difficult in child adolescent psychiatry; it's more of a moving target, is how I like to describe it, in that the diagnostic

system, the DSM, is built on what is called nosology, which is a classification system of meeting criteria that is sort of fixed. It really does serve research quite well for consistency and integrity.

In clinical care, though, there can be, you know, added benefits to having a high-quality formulation and other sorts of avenues of really describing predisposition factors and perpetuating factors that exist to make a more accurate assessment. But certainly screening tools exist and incredibly efficient diagnostic structured tools exist which could all be deployed through probably even more sophisticated IT-based systems.

Unfortunately, behavioral health has been lagged by the disincentive for electronic health records, which was not a part of the initial Federal incentive acts for health care to get onboard with EHR. So single mental health providers were never incentivized for those systems, and most have very outdated IT support.

REPRESENTATIVE KINSEY: Thank you, Dr. Clark.

Thank you, Mr. Chair.

REPRESENTATIVE MURT: And Representative DeLissio.

REPRESENTATIVE DeLISSIO: Just a general comment.

And I, too, have learned a lot. Last week I learned a tremendous amount. This week I think it's

government's role to sort of get out of the way sometimes or get those impediments out of the way that prevent you from doing the jobs that you do.

And we know that we spend about $34,000 per year for anybody who's incarcerated, and for that percentage of the population that has mental illness, those dollars would, I'm sure, cover a lot of treatment outside of the penal system than they do here.

So I think we have to find ways to be extremely proactive about this as opposed to reactive, and it's the reactive that appears to have contributed to the situation that we're in now. So I think that's kind of a bit of a policy decision as well, and I'm not sure legislatively how we can help that and support that. But certainly my commitment is there to continue to listen, learn, and to do that.

Thank you.

REPRESENTATIVE MURT: I don't think there are any more questions.

I just want to thank all the Members that attended today. Also, a special thanks to Melanie Brown, Liz Yarnell, and Pam for putting together our hearing.

Also, gratitude to our Chairman for your indulgence, and also thank you very much to our testifiers, especially to all the advocates that have been so generous

with your time and your expertise, helping us to shape policy and to educating us. We took a lot of notes today -- I know I did -- and there are a lot of things that we will follow up on, a lot of suggestions for policy changes in legislation. So thank you very much.

Mr. Chairman.

MAJORITY CHAIRMAN DiGIROLAMO: Yeah; what a great hearing. In the 18 years I've been here, almost 19 years, I mean, I don't think I've ever been at a hearing that has been more informative, more interesting, and more organized.

And I want to thank Tom Murt and Melanie for putting this together. I mean, we got a lot of really good information. Thank you from the bottom of my heart for the good work, as I said at the beginning, you do each and every day.

And just two quick points. Eric Larson, you said you had a family that didn't give up, and, I mean, I think that's really, really important for us to hear. And, you know, whether it's mental health or drug and alcohol or a disability, in every way family is so really important. Thank you for your heartfelt testimony.

And I think what I heard is that treatment works; if we can get you the resources and the funding to do the things that you do best, that treatment works. And you've

got this Committee, my commitment and this Committee's commitment that we're going to do everything that we can possibly do, whether it's legislatively or in the budget, to make sure that you have the resources and the funding to do what you do best.

So thank you, God bless you, and have a safe trip home.

(The hearing concluded at 12:56 p.m.)

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

Debra B. Miller
Committee Hearing Coordinator/
Legislative Reporter
Notary Public