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PUBLIC HEARING

Taken at the University of Scranton, Loyola Science Center, 20 Monroe Avenue, Scranton, Pennsylvania, on Tuesday, March 25, 2014, commencing at 6:31 p.m., before Carrie A. Kaufman, Registered Professional Reporter.

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MR. MARION: Good evening. Welcome. My name is Dennis Marion, and I'm deputy secretary for the Office of Mental Health and Substance Abuse Services. I'm delighted to be here with you this evening on a special event. This is a special hearing related to some changes that are going on that affect Clarks Summit State Hospital and it's a hearing that is triggered by a change in population or a change in staffing patterns at the hospitals.

It's my understanding that over time Clarks Summit is the last of the hospitals across the Commonwealth to have such a hearing. But it's really triggered by changes that began years ago as the nature of how we handle mental health services across the Commonwealth have evolved with a growing focus on community-based and person-centered care. Wherein the state hospital still provides an important role in the whole continuum of care, but as you see -- you'll see in some information we present over the next couple of minutes, you'll see how that has evolved over the past number of years and will continue into the future.

But for tonight it really is to talk specifically about the information that was reported in the press and talk about what we foresee with Clarks Summit going forward and to hear from you. So

our presentation is very short and then we will begin hearing testimony from those in attendance.

We've laid out a strategy for the evening to allow for five minutes to each speaker. And in order to give everybody fair opportunity to come forward and be heard, we're going to ask that you cooperate in that. I will be monitoring and moderating the process and so -- keeping -- watching the clock. So we will give you a four-minute warning as you get to the end of the time allotment for your own comments.

We will accept -- if time does not allow you to get all of your content presented and it's in written form, we will take that and make it part of our record. Okay? A number of folks have already submitted their testimony to us and it becomes part of our record of this hearing. Okay? So the focus is hearing from you tonight.

But we just want to provide a little bit of an overview to provide a context for the conversation that's going to take place.

So if I might -- again, a Fairchild Hearing is a very special hearing. It is actually one of many hearings we've been conducting. We've been going around the Commonwealth in public forums talking

with interested individuals about the nature of mental health services across the Commonwealth now and into the future. So we've held a dozen forums -- not Fairchild Hearings, but forums -- that have involved over 500 folks. And so we really have asked anyone with an -- we've been at CSP meetings, regional meetings, we have been in -- with our county administrative teams, and we've just had open forums in -- up here in the northeast. One was held up at the 911 center up in Jessup and similar forums like that, and we've had 500 folks participate in them. We're now beginning a second round.

But tonight is -- fulfills a couple things. It gives us an opportunity to talk about the hospital, the role of the hospital specifically, and also to satisfy the requirement that's known as the Fairchild Hearing.

Up in front of you this chart just kind of shows what's been going on with hospital population at Clarks Summit since 1997 through 2013. And you can see that back in '97 we were just above the 250 range. At this point in time we're looking at a population I believe the current capacity is at 208. So the evolution in terms of Clarks Summit Hospital particularly has been a slow evolution in terms of

looking for opportunities to bring folks out and give them opportunities to succeed and work through their recovery in community-based settings.

There was a time when the hospital was a dominant methodology of approaching treatment going back when in the heyday, the largest time, state hospital had 40, 50,000 folks. It was a very different era in terms of mental health care. But in recent times we've gotten much better in terms of having targeted therapies that work effectively, new medications, just -- and a broader infrastructure or broader array of community-based programs to help folks succeed. So we've come a long way since the -- over the decades. But as you can see there's been a movement downward in recent years and that will continue in small measures.

We last year in the budget had provisions for a CHIPP, and what that -- the CHIPP is a special funding strategy to help folks come out of hospital by taking part of the funding that would have supported an individual in the state hospital system and invest that in community-based services and supports. So we'll show you the kind of dollars that have gone in that direction. But the key point is converting resources so that there is an adequate infrastructure,

array of services in the community, that help support folks in their recovery journey.

So, again, the census back in December of '97, 268, and then with a staff complement of about 530 individuals. And, again, as March 2014 we're looking at 218 individuals and a salaried complement of 423 individuals. And notice the 20 percent reduction. The 20 percent reduction is the trigger point that if the reduction in folks served at the facility or the staff complement moved at 20 percent, that was the trigger point for having the Fairchild Hearing. So that is the technical reason why the hearing has been scheduled for this evening.

And then post this current round of CHIPPs, we're going to look at a population at the hospital of 208.

The Community Hospital Integration Project Program, CHIPP, began back in '91, '92, and was part of a concerted effort to look to build up the array of services and supports in the community and help folks find their way out of state hospital to succeed in the community base. And along with that we had a transfer of funding that went along into the community following the individual.

Couple things. The monies that supported

individuals as they came out of the hospitals helped serve that individual's needs for his or her lifetime but then into the future provided an infrastructure that allowed resources to continue to operate in the community to allow folks to be served without ever having to move up to the state hospital level of care.

And to date, commonwealth-wide, CHIPPs have supported the closure of over 3100 beds, transferring $249 million into the community infrastructure for mental health services, the noninstitutional side of our service system. And through that same process 3100 individuals have moved from state hospital services into community-based supports. And those kinds of supports have allowed us to develop new levels of services, new approaches.

In my own experience as a county administrator in Cumberland-Perry what we were able to do is develop resources through an extended acute, another piece of the service continuum that really had not existed in prior decades. So it has become a new and important part of how we approach services for individuals.

And in the same time window with these CHIPP investments we've looked at over 15,000 individuals being successfully diverted away from

state hospital placement.

So, again, it's a two-part process, helping individuals come out successfully and helping provide a structure in the community that helps prevent folks ever having to move up to a state hospital level of care.

In the '13/14 budget the CHIPPs beds funded in this hospital service area, we're looking at 27 CHIPPs being supported.

We went around the Commonwealth and asked county administrators to look within their service population that would be in any of the state hospitals and try to identify individuals that have reached a point in their recovery where they could make the transition if we provided the community-based resources.

And so in the budget last year we had 90 CHIPPs targeted. They were not targeted to a particular facility. We went to counties at large and said rather than pick a single hospital and say we want them to come out of one hospital, we wanted really to look at individuals and give all counties, rural and urban, an opportunity to think about creating these opportunities for folks to come out. And as a result of that we had over 90 proposals

submitted, I think 96 was the actual number, submitted from counties across the entire Commonwealth. And, again, not targeting any given facility.

So the numbers that have been identified for Clarks Summit really are just the result of counties who are served by that hospital looking within their client population and saying these are individuals that based on where they're at in their recovery they could make a move with a CHIPP. And so it just so happened that within Clarks Summit this is how it added up. And you notice that they are distributed amongst counties. So it was counties looking through their own populations that they know and work with and identify those individuals.

Just to give you a sense of the overall -- remember I said the state hospital system is part of a large system of care. We serve in and around 650,000 individuals each year with resources managed by OMHSAS, the Office of Mental Health and Substance Abuse Services. And in that we want to juxtapose that against the number of individuals served at the state hospital level. So at a given day in the state hospital census is 1500 and -- just over 1500 out of a total population being served of 650,000.

So it's an important piece. It meets the

needs of individuals at a particular point in their illness and provides a form of care that allows it to run longer than might be available in the community-based side, but, again, it's part of a larger continuum of care.

The dollars going into services and supports for individuals is now -- we're in -- for the budget -- the governor's proposed budget we're looking at just over $4 billion of resources of which three quarters comes through Health Choices, the medicaid managed care program for behavioral health services. So the lion's share of the funding that supports OMHSAS services comes through medicaid and Health Choices. But then that combines with a couple of other resources.

So we have $597 million which are dollars that go to the traditional county programs, combinations of state and federal dollars. You can see the kinds of subcategories that are in there. State hospitals budgets are just over $400 million. We are then looking at specialized services for BHSI-D&A and Act 152, that's a line item that supports substance abuse services, at $39.1 million, and then the medicaids then, which is a combination of fee for service, that the lion's share is in the Health

Choices program, and that's the $3.1 billion that provides a substantial portion of the community-based services for individuals with mental illness and substance abuse services. And then we do have a special pharmaceuticals program of $1.5 million.

Again, the point here is just to give you a sense of the broad scale both in terms of services, variety of services, and the amount of dollars invested in the system at large.

And, again, this is to address graphic format. The pac man like shape there is -- represents the Health Choices component, the medicaid funding that supports mental health service in the Commonwealth.

And at this point in time I'm going to introduce Monica Bradbury, CEO of Clarks Summit State Hospital, to provide a little more context for what the hospital provides for the community.

MS. BRADBURY: Thank you for joining us this evening. Just a few words about Clarks Summit State Hospital and its role -- and its role in the continuing of the care in the community today. Is this better? No. Okay. How about I'll just talk louder. Would that be good? Okay. Clarks Summit State Hospital, role is recovery. Our mission really

is to assist the individuals to get back to the community. That is accomplished really in the framework of the treatment team, community support, and the community support plan. Through a treatment team and contact with the individual, if a person in treatment has --

UNIDENTIFIED SPEAKER: I'm sorry. We can't hear you. Hold the mic closer to your mouth, please.

MS. BRADBURY: All right. Is this working now? Okay. Everybody has a behavior --

UNIDENTIFIED SPEAKER: No.

MS. BRADBURY: Okay. Better? Is that working now over there? Okay. Anyway, the hospital's mission is really to assist the individual to get back to the community. As I said, every individual with their treatment team has a treatment plan. It is based in behavior with specific goals, and those goals are recovery oriented. Everybody -- given some of our programs and our structured activities, there are multiple opportunities also to go into the community to practice the skills that have been acquired.

We're also very fortunate as a hospital to have a large number of volunteers and community groups and students who frequently donate their time

to come in and work with the individuals, socializing, and providing some recreation. Also, again, the community connection.

In addition to that, as Mr. Marion has indicated, there are a lot of new medications. There are also innovative treatments out there, two of which are CogRem, which is cognitive remediation, and dialectical behavior therapy. Both of them are used at the hospital.

The CHIPP initiative will make available the development of a special needs unit which will allow us to target some complex needs, but that's still in development.

The circle of treatment. Clearly all of these things come to bear when somebody is trying to recover. We have a great number of clinicians that bring their academic experience to the team. Some of these folks that you can see here -- I'll start really with medicine and psychiatry. We have dentists. We have a podiatrist. We have an on-call physician. So physician access is 24/7. Our nursing department RNs, LPNs, psychiatric aids, 24/7. Programs are conducted seven days a week. Additional disciplines that are represented there, vocational adjustment services, infection control, dietary, psychology, therapeutic

rec, pharmacy, physical therapy, social services. We also have certified peer specialists, we have spiritual supports, and we have external advocates. So there's a tremendous team of people there to assist the individual to recover.

Not on the slide, but certainly we need to mention, our infrastructure requires a lot of support. Some of those departments, not all, are fire marshal, safety, security, facility plan operations, ground facilities, trainings, library, information services, medical records, performance improvement, business management.

So there's a tremendous amount of work and energy dedicated to try to get the individual well and back into the community.

That brings us to the transition piece, community support planning, which really involves the individual at the beginning of their admission and it evolves over the course of their treatment. It's the individual with whatever supports, family, friends, whomever they would like to be a part of that team, the treatment team, the community, the community providers, certified peer specialists, external advocates, everybody pulls together, tries to identify together the supports and services that are going to

be needed and design that to fortify success in the community. And then we're to the community piece of it.

So I would like to introduce Ms. Julie Barley, and she'll give you some more information about the community development. Thank you.

MS. BARLEY: Thank you, everyone, for coming this evening. It's really exciting to see the interest that we have in our communities regarding services to persons who have behavior health needs.

One of the things that has really been critical in terms of community service development has been the role that recovery has had, recovery principles, the -- looking at how we can find better ways to serve individuals in their home and community.

One of the things that really impacted the northeast region, the area that we're in tonight, has been the implementation of the Health Choices program, which began in 2006 and 2007 in the northeast. Today we have about 139,000 persons covered through our public behavioral health managed care program called Health Choices. And in addition to that there has been a lot of expansion of services built on the use of improved medications as well as more effective treatment approaches. And we have

taken the concepts that Monica touched on, the consumer support plans, and moved them into the community so that we have a continuity of care and that both sides of our system are working together to serve the individual.

Health Choices improved the access and the availability of additional services and programs. Additional outpatient therapists were able to be enrolled through the process of enrolling practitioners and additional clinic services. In addition to that, we had new evidence-based practices and services such as the assertive community treatment teams, psych rehab services, certified peer support services. Right now we have a new ACT program at Northeast Counseling Services and at Scranton Counseling. In addition recently there was the opening of a crisis residential program in Wilkes-Barre that has the capacity to serve eight individuals at a time. And we have also experienced in this area some additional funding, perhaps to a more limited degree, but through past CHIPPs projects in these counties.

With this development we have been able to bring folks together tonight, and that's one of the reasons we're here, to talk about -- to hear from you

as we move forward in terms of expanding the CHIPP initiative here in the northeast.

And at this point I will turn the program back over to Mr. Marion, who will be our moderator for the testimony that we're about to hear.

MR. MARION: Thank you, Julie.

A number of folks have preregistered for -- to provide testimony this evening. And, again, we're going to ask your cooperation in keeping testimony within the five-minute window. So the game plan is we will use the microphones so that other folks in the audience can hear. We're going to ask you to project as well as you can because we are taking a transcript of the evening and recording the contents so we can refer back to it. So I'm asking you just to be mindful of that to be heard both for the folks taking notes on the meeting but also for all your -- other individuals who have been kind enough to attend here tonight.

So what we have first on the list is Kevin Bennett.

So we're going to ask you just to restate your name and if you want to identify an affiliation, feel free to do that, either geographically or by association, but at least we would like to hear your

name for the record.

MR. BENNETT: Hi. My name is Kevin Bennett, and I'm a registered nurse. I've worked in the nursing home field a time when Danville State started getting some of the people out and we ended up picking up a few of them and they had a lot of behaviors in the nursing home, a lot of disruption.

Also I work every other weekend, or used to, in the prison system, and we've seen a lot of revolving door, the ones on the mental health that were coming in there, get back out, and then back again.

I have a lot of social workers that are in there that just kind of threw up their arms and just said we don't know what to do with them, and the judges don't know what to do with them.

And also I've been dealing with another nurse that worked in the same field, same place, and had the same outcome.

I've also worked with the office of long term living under the waiver system and I've worked with -- across the state with a lot of the people and a lot of the complex cases, and sometimes they don't know what to do with them. We sit in a group that are professionals that are across the state trying to find

a place to put some of these patients, consumers, whether it's mental health, whether it's brain injury, and they have a difficult time placing them and they don't know what to do with them.

I have a daughter that works for children and youth down in Union County, been there for a number of years, also to the point where she's the supervisor, and she works with a lot of the judges and a lot of the police there and sometimes they have a lot of revolving door. She told me the other day they have a patient in there that the police picked up on an ongoing basis, gets his shot of lithium, and then he's fine for a while, back in trouble again, cops pick him up, put him in jail, give him another shot of lithium, back out again. And it's a revolving door that -- and a lot of times patients in the jail system, they don't take their meds. They're back out, they don't take their meds, same problems, get back in, back on the meds again.

So it's a big revolving door, and I think there is a lot of work that needs to be done that -- I think there just needs a lot more work that needs to be done out there to just -- there's a gap.

I know a couple coworkers that work in where I'm at when they actually let out the ones out

of Harrisburg State Hospital there was no place for them to go, some were homeless, some have been in jails, and it's -- there just needs to be a lot more follow up, if you want to call it that, to make sure these people are taking their meds and services are available to them and get them there because a lot of times once they get out they don't take them. They don't take their meds and everything. So -- I think I'm done.

MR. MARION: Terrence McCarthy?

MR. McCARTHY: If I speak loud enough, can you hear me? Because I'm going to be reading and it's hard to hold and read.

Good evening. My name is Terry McCarthy, and I'm the Mental Health Team Leader at the Disability Rights Network of Pennsylvania. I am grateful for the opportunity to address this forum regarding the decrease in the census at Clarks Summit State Hospital. DRN functions under federal statutes which allows my teams to monitor institutions and have access to individuals in state hospitals.

It is DRN's position that a state hospital should not be used as a place to nurse -- excuse me, to house people and that individuals are better served in community settings with adequate

mental health treatment and supports that further their recovery. I'm here to ask DPW to consider the census and staff reduction at Clarks Summit State Hospital and the impact of moving the funding into community mental health services.

The closure would offer the individuals being served in the hospital as well as the service area counties the opportunity to access increased community-based mental health services. This increase in community services would not only benefit individuals discharged from the state hospital but also individuals currently in the community who use or will have future use of mental health services.

As previously mentioned, DRN monitors state hospitals. In the course of my work I have spoken to hundreds of individuals. Many individuals have reported being routinely penalized for small infractions of hospital rules. In most cases there is zero tolerance policies for infractions, resulting in a further loss of freedom for the individual and less opportunity to make choices. Choice and decision making are not encouraged in an institutional setting.

To a great extent those of us in the community have the right to control our lives and the directions our lives take is the result of those

choices, and we take these choices for granted. The lack of choice and resulting lack of control over their lives gives many individuals in state hospitals a feeling of hopelessness. People living in institutional settings simply do not have the opportunity or supports to exercise their rights to make better and informed choices for themselves. This is a fact of institutional life.

State hospitals have been and continue to be used as residential settings where individuals linger for years. This is not to say that individuals in our state hospitals are not in need of treatment. However, with new medications and the appropriate services and supports, most people's stay should be time limited. Unfortunately cuts in the community mental health budget have resulted in a lack of community services and individuals staying in state hospitals much longer than necessary. Many individuals ready to be discharged have nowhere to go.

Continuity of treatment requires service development that meets the specific needs of the individual. A major tool in the identification of the service needs is the community support planning process developed during the Harrisburg State Hospital closure. The CSP is the result of preferred and

needed services identified through consumer, family, and clinical assessments. One of the guiding principles of the process is that by incorporating the individual's preferences in community services the individual will have a better chance for successful community integration following discharge. Supported housing, mobile medication teams, assertive community treatment teams, and better crisis services as well as recovery services including drop-in centers, clubhouse, are examples of services developed as a result of the CSP process.

In many cases the development of new and innovative services can be accomplished through a cash infusion into the county system. The obvious source for these funds is in the closure of the state hospital with an annual operating budget of nearly $50 million.

If DPW truly wants a healthy PA, then it has an opportunity and the responsibility to develop robust treatment and support services in community with monies currently being used to fund state hospital operations. When the opportunity comes along it should be seized, as there is no service offered in the institution that cannot be developed in the community.

I want to thank DPW for giving me the opportunity to give this testimony and meet my responsibility to all individuals being served in this state hospital by requesting Clarks Summit State Hospital be closed. Thank you.

MR. MARION: Next up we have Martin Schofield? Martin Schofield?

Cecelia Luchi?

Marie Onukiavage?

MS. ONUKIAVAGE: Hello. This one works. My name is Marie Onukiavage. I'm the executive director of NAMI PA Scranton. It's -- we're an affiliate of The National Alliance on Mental Illness. I would like to thank everybody for taking the time to listen to us tonight.

NAMI's mission and identity statement is: NAMI recognizes that the key concepts of recovery, resilience, and support are essential to improving the wellness and quality of life of all persons affected by mental illness. Mental illnesses should not be an obstacle to a full and meaningful life for persons who live with them. NAMI will advocate at all levels to ensure that all persons affected by mental illness receive the services that they need and deserve, in a timely fashion.

In the past many people with mental illness lived without hope. We benefitted from advances in treatment and in the use and development of new medications. Our understanding of recovery and an individual's potential to recover from a mental illness has inspired much hope. Many people with a mental illness are able to lead productive lives and to raise -- and to work and to raise families.

We support any activity that will help to continue improvement in the quality of lives of those who have a mental illness. We believe a person's recovery is enhanced and supported by the least restrictive environment of care within his or her own community and NAMI Scranton recognizes the need and value of the state hospital as a component of this environment of care.

History illustrates that eliminating hospital bells -- beds, I'm sorry, when there are insufficient appropriate community alternatives is irresponsible and cruel public policy that inevitably leads to shifting of costs to our criminal justice systems, first responders, and emergency departments. Pennsylvania must not step over a dollar to pick up a dime on the back of our loved ones.

Yes, with adequate effective systems and

supports there is always a reduced need for hospitalizations, but the crisis component must still be effectively addressed and we believe that the reality is that some beds will always be needed for individuals requiring intermediate or long term care. State operated hospitals meet a need for a safety net of service when all else has failed. Don't take that safety net away.

Okay. I'm not finished.

And transferring those with the greatest of needs to another hospital doesn't meet the geographic needs of our families.

The three largest behavioral health providers in the nation are the Cook County Jail in Illinois, Los Angeles County Jail, and Rikers Island. Untreated and inadequately treated mental illnesses can and does put persons at risk for committing crimes that can result in incarceration. Once incarcerated they have a harder time following the rules of the institution and they are much less likely to qualify for early release or parole, therefore maxing out and being released with little or no supervision.

The Council of State Governments Justice Center website cites a study of more than 20,000 individuals entering five local jails. Researchers

documented serious mental illnesses in 14.5 percent of the men and 31 percent of the women. Taken together, that compromises 16.9 percent of those studied. NAMI believes that number can be as high as 24 percent.

Nationwide, state spending on correctional systems has increased 350 percent in the past 20 years, contributing significantly to state budget crises. According to the Department of Justice the costs of incarcerating persons with mental illness are enormous, ranging from $80 per day to house regular inmates to $130 per day for an inmate with mental illness. The Council of State Governments Criminal Justice/Mental Health Census Project states that Pennsylvania estimates the cost to be approximately $60 more per day.

As in many areas, Lackawanna County Prison is the largest single consumer of county tax dollars. Prison capacity is about 1100 people and the number of inmates with mental illness is estimated to be about 240.

So persons with untreated or inadequately treated mental illnesses are at risk to become entwined in the criminal justice system. They find themselves in the prison system longer, costing more to treat in the prison than out, and then can be

released without adequate supervision, increasing the likelihood they will commit -- they will recommit, starting the cycle again and stepping over that dollar to pick up the dime yet again. And this doesn't even begin to address the cost to law enforcement, first responders, and emergency departments, stepping over more dollars.

NAMI recognizes the link between untreated mental illness and involvement in the criminal justice system. Locally and across the country NAMI affiliates are involved with efforts aimed at diverting persons with mental illness from the criminal justice system into the mental health system. We fear that if the behavioral health system cannot meet the varied needs of all individuals, from the least restrictive to the most restrictive, then our prison will become the de facto behavioral health institution.

In 2007 the Clarks Summit State Hospital census was 225. In the seven years that have lapsed since then efforts to reduce this census have been aggressive. Needs have been identified. Diversion efforts are exhausted prior to admittance -- prior to even admittance to the hospital. There are evidence-based programs at the hospital and innovative

supports within the community. And despite these aggressive efforts the current census is 218, the equivalent of one bed reduction per year since then. It is evident that we cannot meet the intensive needs of 218 persons in a short period outside of the hospital without making cuts elsewhere.

Due to limited time I will not be able to address the problems of homelessness, the barriers to treatment a closure will create for veterans, among a lot of other concerns that NAMI has.

I would like to briefly address the barriers that state --

MR. MARION: I'm sorry. We're at our limit.

MS. ONUKIAVAGE: Well, I mean basically hospital transfers would put a great hardship on family members, really reducing the likelihood of families being able to visit and support and participate in their loved one's treatment and recovery.

MR. MARION: Thank you very much.

For folks whose content goes beyond the limit, I'm giving some latitude on the back end, but we will take the full testimony if that is an extra copy.

MS. ONUKIAVAGE: I gave --

MR. MARION: Okay. That will go in our record. So we will take the full testimony as part of the official record.

MS. ONUKIAVAGE: Okay. Thank you.

MR. MARION: Next we have Helene Burgess.

MS. BURGESS: My name is Helene Burgess, and I'm here this evening --

UNIDENTIFIED SPEAKER: Use the microphone.

MS. BURGESS: My name is Helene Burgess, and I'm here really tonight thanks to my sister who came from Jersey to drive me up here. I'm from Hawley.

I want to thank all the board members and everyone who is here this evening.

It's good when community treatment of patients is successful for the majority, but it doesn't always pan out for a few. Hospital treatment is their safety net.

My adult son I believe is one of the few. He's been challenged since he was 23 with being schizophrenic. He's 55 now and a patient at Clarks Summit for about the third time. For many years he handled his illness quite well. The last few years

have been a different story. He's had many ups and downs. One of the ups is -- we're grateful for is his treatment at Clarks Summit State Hospital. He basically seems to go along with the programs. He especially likes his job at the Novice Work Shop. He does not respond well to community treatment. He won't go to the programming and he won't let nurses or counselors into his home and only goes to the doctor to get his medicine. He eventually stops taking his meds and then doesn't even see the doctor. Each episode leaves him dealing less with reality.

It would be wonderful if he would live in his home and make use of all the local community help available. His history proves that it is not beneficial to him, not to his wellbeing, because he won't take part in it. We feel he's been around this block at least 20 times. It's like a revolving door with no good exit.

Thus begins the difficult road to get him readmitted to the proper hospital. For our son as we see it Clarks Summit is the proper hospital. Our son has even asked to be at Clarks Summit. He doesn't always feel the same. Sometimes he says take me home. Other times he says he wants to live at Clarks Summit. All in all we believe somewhere deep inside him he

knows he's receiving the help he needs there and it's a safe place.

Community treatment doesn't work for everyone. Our son is so paranoid he will only take certain meds. At times I feel that he's his own worst enemy. We are grateful for all the caring staff of Clarks Summit, who with their expertise, help, and encouragement, they encourage our loved one. We are grateful he has a safe place to be. We are grateful for the other patients who offer friendship. We are grateful for the programs the hospital offers and the staff, technicians, social workers, nurses, financial staff, volunteers, who run all these programs. We are grateful for the trips that they go into town sometimes. One hospital he was in he never even got to go outside for almost a year. He never even got a breath of fresh air. Because they had no proper treatment for someone with mental illness.

We would love if our son would be able to live a contented life in his home. And I realize I can't speak for my son, as I don't live in his head. I only see what's going on on the outside and what he chooses to share with me from his thoughts.

Mental illness is an illness that robs people of their lives and brings heartache to them and

their families. My prayer is everyone afflicted with this illness receive the best form of treatment for them and community treatment, hospital treatment, be used to give the individual patient the best lives they can lead. The very best gift would be of course a cure.

I realize the state and community are always looking for ways to cut costs, but eliminating hospital care for needy patients may be a costlier road to travel in many ways.

After many -- sharing many thoughts with my sister, we decided there was more to tell regarding the treatment of a beloved family member suffering with mental illness. It is definitely a family affair.

Our son's father and myself are no longer young. We will be 76 in May. And his dad is not well. Our concern is what happens to him when we're no longer able to advocate for him. Where will he find shelter and safe haven? On one occasion in a hospital in Scranton they discharged him. That's where they sent him, to the hospital in Scranton. We were never notified of his discharge. And you know the privacy act, which is so inappropriate for this sector, as they are often out of touch with reality,

as is our son with his delusions and paranoia associated with schizophrenia. After his discharge the police picked him up walking barefoot, and when I wrote this originally I thought it was winter, however it was summer, much to the credit of the hospital, if you want to call it credit, but they discharged him. And we only found out through a process of elimination. Through a policeman who picked him up and their keen vigilance and compassion he was saved from walking out on the street and consequences of the unknown. They returned him to the hospital. So much better than being on the streets. Kudos to them. They have our heartfelt thanks. Unfortunately, though, this is not the first time our son has been taken to a hospital which is so poorly equipped to handle the needs of the mentally ill, and the inadequacies of such a hospital is glaringly apparent.

Our forever fear is that upon a future discharge our son is arrested for a misdemeanor, incarcerated, and lost in the system, as so many have been. The jails are no place for the mentally ill. I can't stress strongly enough that there is a population that will forever need lifetime shelter and therapy under your professional supervision. Our son's father and I are not the final answer to his

wellbeing and safety. Society and your professional expertise provide the care that our son and each one with mental illness deserve.

Thank you, public board members and everyone here, for listening to a family's concerns.

MR. MARION: Thank you very much.

Robert Quinn?

MR. QUINN: Good evening, everybody. Could you hear me? I'm not going to use the mic because I have to look down.

Mr. Marion -- Mr. Marion, before I go on the clock I want to ask you a question. I was trying to call the state hospital to get on to testify tonight and it took me about -- well, I was calling your agency and it took me almost four hours to get on there. When I got -- I didn't get on there, so I sent an e-mail. The following day I called up again after hours and I got online and I asked them if they received the e-mail, and they says yeah. I says, good, I says, what time will I speak, when will I speak. They says, you can't, you got to send your testimony up.

Now, I've been to hundreds of public hearings literally in my lifetime, and this is the first time anybody has ever asked me to send my

testimony up beforehand. I don't know the reason.

Well, anyways, good evening. My name is Bob Quinn. They call me Ozzie Quinn.

The Federal Housing Act of 1949 was the funding mechanism for urban renewal in our city. It turned out to be a paradox. Social scientists advocate from 1960s to 1985 urban renewal agencies demolished over one million single room occupancy housing units. These are where people live, their apartments, one room.

My testimony tonight will attempt to explain how the elimination of these housing units and mental health laws and policy through the years are repeating history.

The 1960 national community health act proposed to build 1,500 treatment centers to eliminate half the patients institutionalized. The act was anticipating moving people with serious mental illness from a hospital treatment setting into a community-based treatment. Does that sound familiar to you? However, it was never fully funded. In other words, it turned out to be a political football. This was the beginning of deinstitutionalizing patients. In 1965 hospital deinstitutionalization accelerated with the adoption of Medicaid.

In the 1980s the Reagan administration transferred the federal mental health block grant to states. Later, unfortunately, the laws were changed in every state to limit involuntary hospitalization so people can't be committed without their consent unless there is a danger of hurting themselves or others.

Meanwhile, since the 1963 act about 90 percent of beds have been cut at state hospitals according to Paul Appelbaum, a Columbia University psychiatry professor and expert in how the law affects the practice of medicine. Several mental health experts said in many cases that has left us nowhere for the sickest people to turn, so they end up homeless, abusing substances, or in prison.

The three largest mental health providers in the nation today, as you heard your representative from NAMI say, are the Cook County Jail, okay, in Illinois, Los Angeles County, and Rikers Island in New York.

Last month it was reported that nationwide in America more than three times as many mentally ill people are housed in prisons and jails as in hospitals. According to a 2010 study by the national sheriff's association and the treatment advocate center this exists.

Case in point. Last week. The death of the ex-marine who died in Rikers Island last week. He actually was baked. He was baked. Mentally ill.

In summary, the national alliance to end mental -- to end homelessness reports people with untreated psychiatric illnesses comprise one-third or a quarter million of the estimated 744,000 homeless population. The quality of life for these individuals is hopeless. Many are victimized regularly. One study found that 28 percent of homeless people with previous psychiatric hospitalizations obtained some food from garbage cans and 8 percent used garbage cans as their primary food source. Also NAMI reports that the poor veterans -- poor veterans make up as much as one-third of the nation's population of homeless people.

Governor Corbett has included in his budget, 2014/2015 budget, $4 million for the community hospital integration project program, CHIPP, for individuals currently in state hospitals, enabling the transition of 90 clients from state hospitals, mental hospitals, to bring progressive mental health treatments in home-like settings.

Robert Drake, a professor of psychiatry and community and family medicine at Dartmouth

College, said some states have tried to provide good community health care. But it's been very hard for them to sustain that because when the state budget crunches come -- when the state budget crunches come, listen to that -- it's easiest to defund mental health programs because the state legislature gets little -- relatively little little little pushback. Services are at a very low level right now. It's really kind of a disaster in most states. Unquote.

Rhetorically, is the CHIPP about to repeat history? Is the state legislation going to turn funding the mentally ill into a political football? As politics did in the past, I think it is.

I used to serve on the planning commission. I know how hard it is for zoning to approve group homes. I know how difficult it is. They have a hard task to try to implement this CHIPP program. People just do not want to accept them. They got the backyard syndrome.

Now, the governor would be better off using that money for research because actually in mental medicine, mental care, the doctors are rolling the dice. If the medicine works, it works. If it don't, it don't. You know? And economic development in Lackawanna County will suffer so much. And I see

that Commissioner O'Malley is here tonight, and he might comment on how much it will suffer. We're so low right now, unemployed, it will suffer more. You know? It is just terrible, if you let this happen and the politics get ahold of it, nobody is going to win. We're going to be -- these people are going to be homeless like they are right now. And that isn't Ozzie Quinn saying it. That is fact. Quotes by doctors and experts across the country. Thank you.

MR. MARION: Next we have Vicki Fenton followed by Sharon Korba.

MS. FENTON: Hi. My name is Vicki Fenton. I have been an employee for 21 years at Clarks Summit State Hospital. I can say I've seen many changes over the years for the good and the bad. It saddens me, though, through information that appeared in the paper had some false truths. Our patients, yes, do have better medications while at the hospital, stabilize them and makes them well. Once they leave our care it's a different story. Many of them stop taking the medications because they believe they don't need them or problems with insurance for payment for these medications. Also community doctors change their medications from what stabilized them during our care, usually causing a relapse. In any of

these situations our clients return to the hospital and usually in worse shape than what they were previous admissions. Notice I said admissions.

The community settings are also mentioned to exist, however for many of our patients placement is difficult due to past history while in the community. Housing is unable to meet their needs, like activities or helping them find work, and with usually no family support our patients end up trouble -- in trouble. They will end up in three places, one, a community hospital that holds them maybe 48 hours and then back out on the street, two, prison for some petty crime which now adds to the prison population, or, three, homeless because they just don't have anywhere to go.

I did some research. At the end of 1964 there were 24 mental health state hospitals and 8 state run prisons. The first hospital closed in 1979, which began to switch the roles of how we as a community take care of the mentally ill. In the late '80s, early '90s, we started building more and more prisons because of an increase in population, many of those with a history of mental illness. Now there are 27 state prisons and 6 mental hospitals currently in operation. I think our numbers speak for themselves.

Each time there is a mass shooting or an unexplained traumatic event happens mental illness is always to blame. Questions are always asked why can't we help these people. I just think I explained that early. We now have 27 prisons and 6 mental hospitals.

These people don't belong in prison. They belong where they can receive treatment and education on how to learn their illness in social settings. Clarks Summit State Hospital can provide that.

Thank you for your time and hopefully you will think of the direction you need to take for our future.

MR. MARION: Next we have Sharon Korba followed by Jeanne Yarmey.

MS. KORBA: I don't think I'll need the microphone. Can everybody hear me?

My name is Sharon Korba, and I'm a retired DPW employee, a sibling of an individual with schizophrenia, and a good friend and listed next of kin for an individual who currently resides at Clarks Summit State Hospital.

I was an adult education teacher, a residential services supervisor, and an assistant unit manager at White Haven Center for 21 years and the

vocational director at Clarks Summit State Hospital for 14 years. As such, my entire working career has been with people who have been mentally compromised in one way or another and it has always been in an institutional setting.

Over these many years I have had conflicting opinions of institutionalization versus the least restrictive environment. Although my heart has always told me that every individual has the right to live a normal life in the least restrictive setting possible, I have seen the benefits and risks of both.

While at White Haven Center during the '80s and '90s I saw many residents discharged, often against their family's will, and later sadly heard that several of them had died from such things as choking on a peanut butter sandwich, which we did not allow at the center. I also know of the 24/7 medical care and treatment, the recreational opportunities, and even membership in the Lions Club, that the residents at White Haven Center have had available to them. And I have decided that that isn't very restrictive at all.

While working at Clarks Summit State Hospital I visited several group homes for individuals with severe and persistent mental illness and they all

looked very nice. However, as one of the employees at the hospital who personally conducted the state mandated CSP meetings, I learned that there were far too few of these nice looking group homes or community residence for the people that needed them. I lost count of how many CSP meetings I held for individuals, especially from Luzerne County, who, despite the psychiatrists' recommendation for discharge, we were told time and time again that there just were no community placements available for them.

About five years ago I personally experienced a very brief and disappointing discharge for my friend from CSSH who I'll refer to as Dee. After many years at the hospital she was finally discharged to a small group home in Luzerne County which indeed looked very nice. I visited her frequently at this home and made my resources available to the staff. However, after barely two weeks she was returned to CSSH due to behavioral issues. At the hospital staff deal with serious behavioral issues daily, but the community staff did not appear equipped or willing to deal with any behaviors that those with severe and persistent mental illness often exhibit.

I have been retired now for almost four

years and so possibly these community shortcomings have decreased since then. However, I experienced an even more frustrating community shortcoming just a year ago when Dee was again discharged, this time to a personal care home that was very close to my home. And I was very pleased. I quickly made myself known to the staff, visited frequently, and again offered advice. The staff were nice. They liked Dee and she liked it there.

Unfortunately her long time psychiatric medication had to be discontinued due to irregular bloodwork. This wasn't her fault. It did have a negative effect on her behavior, however. But I continued to support her and work with the personal care home staff, but she was very soon committed to First Hospital where there seems to be a revolving door. She was committed there by the Luzerne/Wyoming County mental health staff. And when I visited her the very first day that I was allowed to, which was only two days, I believe, after she had been there, she certainly didn't appear to be a danger to herself or others to me, and employees at First Hospital also agreed and said the same thing.

This began a cycle of three commitments to First Hospital in three and a half months. She was

never even given a chance to recover before being admitted again. Each time she was committed straight from her day program where she had an assigned community-based psychiatrist. On the outside she had her own psychiatrist, but she had to be put in a hospital to get psychiatric services. And she only had the clothes on her back, there for a week and a half, two weeks at a time, with only the clothes on her back. No staff from the community ever took her anything. I went to the personal care home and got belongings and took them. She didn't even have her glasses one time.

While visiting her there I saw several other former patients who also would have had these community-based psychiatrists assigned to them. So I could only assume that these psychiatrists were unable to provide sufficient care to prevent rehospitalization.

Dee was then committed back to Clarks Summit State Hospital and in far much worse shape than when she left, which was corroborated by everyone who knew her, which is many people that are sitting here tonight.

For all of these reasons and others that I don't have the time to mention, I don't believe that

community mental health services currently available in many counties are adequate to provide for the multitude of needs that individuals with serious and mental -- serious and persistent mental illness have. Much additional planning and community resources are needed before services at Clarks Summit State Hospital should be further reduced or discontinued altogether such as in a closure or disaster will certainly occur for some of Pennsylvania's most vulnerable citizens. And as other people said, they're going to be homeless. They're going to be in prisons. Is that what we want? I certainly hope not. Thank you.

MR. MARION: We have four more scheduled folks on the schedule but then we will provide opportunities for folks to come this evening, so as we get through the scheduled presenters we'll then manage the other individuals that may want to provide testimony.

So we have Jeanne Yarmey followed by Jennifer Priestman.

MS. YARMEY: My name is Jeanne Yarmey. I live in the Clarks Summit area.

I understand that there is a declining enrollment, but I ask that the state look at the beautiful pristine complex that is there and think of

other ways to use it, maybe for more community sites for people to go, maybe for expanding it, using it so that rather than closing it, rather than losing that space, think outside the box. These people need help, more people need help, and I hate to tell you, the baby boomers are coming. Please do not take a short-sided stance.

I also deal with the issues of trying to place senior citizens in housing. It just doesn't exist. It's very very hard. Waiting lists are long. And, again, people who have special needs deserve special help. Thank you.

MR. MARION: Jennifer Priestman?

Judy Kirkendoll?

MS. KIRKENDOLL: Hi. My letter is a little bit different. Before I read my letter I just want to say that Clarks Summit State Hospital is a very good place to be. The employees are very very good. The care there is excellent. I visit my son every week and I am pleased every week with the nurses, with the aides, with everybody. I am very pleased with his doctor. He couldn't have a better doctor. But for some people being released from a state hospital is not the answer. And you will see as I read my letter why I believe this.

The state hospital is there for people that need a place to be. It might only be a small group of people, but being released for them is not going to work, and we need to care about these people. I believe that they are worth it.

My name is Judy Kirkendoll. I'm the mother of Fred Kirkendoll. It is my request that Fred Kirkendoll never be released from Clarks Summit State Hospital.

June 11th, 1995, he murdered his grandfather in cold blood, critically injured his father. These tragedies occurred while on a day pass from Clarks Summit State Hospital. These murders were thought out and planned while being treated as an inpatient in the hospital. He lived at the hospital for years under the care of psychiatric doctors planning these actions. His plans to kill were so well hidden in his mind that not one doctor or staff member had a vague idea of his intentions. His grandmother was able to get the gun from Fred. If she hadn't, only God knows how many more people would have died that day.

Our entire family fears for their safety if he is released. In all honesty I fear for my neighbors and for the general community. He also has

a sexual obsession for his sister, who lives by me. She has a three-year-old son, and I fear for their safety. I'm trying to prevent another tragedy. Please listen to the pleas of a mother's heart and of a family that is truly afraid.

MR. MARION: Art Noldy? Art Noldy?

At this point we will, again, take additional testimony, and what we'll do this -- what I would suggest we do, and we've done this in other hearings, is, if we would just create lines here and we'll provide an opportunity.

MR. O'MALLEY: Ladies and gentlemen, my name is Patrick O'Malley. I'm commissioner of Lackawanna County. I don't know about anybody else in this room, but I never heard anything really good about a Fairchild Hearing. I don't know about anybody else here. I've heard that it's always been the beginning of the end or the beginning of reduction. So I'm here to talk about -- give a few comments and some of my own thoughts.

I'm a former corrections officer. I have a business in the private sector, and, like I said, I'm the commissioner of Lackawanna County.

As a corrections officer I've seen what happens with the mental health needs of the community.

And for those of you that are here today who have family members that are at Clarks Summit State Hospital, which I think does a fabulous job, if they were to close or do reductions there, they would eventually, some of these people that are not able to be kept by their families, they would be -- end up in the streets. And if they do end up in the streets, they will end up in a county prison. And if they end up in a county prison, it's horrible to say, there's a food chain at the county prison, in state prison, or federal prison, and the food chain is people with mental illnesses are the ones that get fed upon, and that's just the way it is. And anybody who is in corrections will tell you that's the truth.

Also, I'm very concerned with the fact of all my friends that I know that are psychiatrists and counselors and doctors that told me that there is an absolute need for our facility. Those 200 and some beds are a necessity to the people of Lackawanna County. We absolutely need them.

Listen, I wish that we lived in rainbow land where there's going to be a miracle pill that's going to make everybody better, we can all be on the street and everybody can get along. That's just not going to happen. So we do need the state hospital.

My other concern is the 400 and some employees. This is a big part of Lackawanna County, Wyoming, Wayne, Monroe, Luzerne, where all these people live and they're all employed at the state hospital. That would be an incredible impact on the community at large, especially Lackawanna County.

I just feel that the state hospital is a necessity and has served our community very well for decades and decades.

My grandfather was a patient at the state hospital. Years ago when it was a different type of hospital my grandfather had a stroke and he spent a lot of time there because they didn't have an Allied Services. But the hospital evolved into different facets and I just believe that Clarks Summit State Hospital is an absolute plus for our community.

And to those people that are here tonight, thank you for doing a fine job at the jobs that you do.

And to the administration that's here, keep our state hospital open and keep our people safe and in their beds and keep the people that are in this room employed. Thank you very much.

MR. BUFFTON: My name is Bill Buffton and I'm a psychologist at Clarks Summit State Hospital. A

little bit about my background, I started out working in the Rap House, and we had a lot of frequent flyers who would circulate into the community, out of the community, to the hospital, back into the community, like a revolving door.

What happens to these people when the system fails? I'll tell you what happens. They get raped. They starve to death. They die under bridges. They die in garbage cans and refrigerator boxes. They get beaten. They get abused. And we don't even see it. Look under the bridge. That's where you'll see them.

The idea that anything that a hospital can do can be done out in the community is just flat not true. You cannot provide in the community a psychiatrist that with one phone call you'll have them there in five minutes to change someone's medication if they need it changed. Doesn't happen in the community. The myth that the community is out there with open arms just waiting for our patients is exactly that. It is a myth. The community doesn't have a lot of money. You've seen people who talk about dollars and no sense all the time cutting and cutting and cutting and cutting from the most vulnerable people we have. The fact of the matter is

some people require that sort of protection. The term asylum means a safe place. And I'll give you one name to think about when people are talking about the great job that community services do. David Hinkley [ph]. Thank you.

MR. WYANT: My name is Byron Wyant. I'm a licensed social worker with the State of Pennsylvania.

I'd like to applaud this gentleman in the second row. That took courage to do what you did, standing up for what you think.

The young lady from NAMI is the only one that came up here with any outcomes. I ask you folks from the state, if these are great programs, where is your outcome measures? Show me where your successes are. You're telling me you've treated 52,000 people. Where are they at? How are they doing? How come -- if it was such a great thing, you'd have slide after slide of how great they're doing, how they haven't had to go back to treatment, how this is working out so good, but you don't. The only person with outcome measures is the young lady who come in on her own time.

Keep the hospital open. The community can't support the people.

MR. BAKER: Hi. My name is Mike Baker, and I wanted to talk about some of the experiences we had with the closing of Allentown State Hospital in 2010. We found out -- I work for the state and I'm also chairperson of my union chapter, SEIU Local 668, so I was involved with the opposition of that from day one.

Many people that have spoken here have spoken about the problems that a state hospital can experience when it closes or a community can experience, and that's what happened in Allentown. In Allentown they talked about having community resources available. There was one group home with openings and you can't have more than 16 people in a group home and there were about 160 patients left in the state hospital. Because there was no community resources for them to move into, many of the patients had to be transferred to other state hospitals such as Norristown State Hospital and Wernersville State Hospital and maybe even a few to Clarks Summit State Hospital. That made it more difficult for the families to visit the patients when they were now at least 55 miles away from Allentown or Easton.

Beyond that, the community services, mental health services, in Allentown have been deluged

with patients that have been released and been in the community and been able to stay in the community. They don't have enough staff to handle the number of people that are coming in for their services. And they certainly find it very difficult to commit somebody because you have to make arrangements to transport them even if they're in a local hospital for two days.

The problem I think with any of these proposals when there is a patient census reduction is that they have pie in the sky estimates of what's available in the community. There is not the resources available in the community. I saw that Luzerne County in the one story was willing to take ten patients from Clarks Summit State Hospital. Now, you know that there is probably a lot more patients than ten from Luzerne County in Clarks Summit State Hospital. So that probably tells me that there might be one group home with ten slots available.

You don't get the level of care you get in the community as you do in the state hospital.

In Allentown one of the things that disturbed me the most was that the state artificially reduced the census of patients there in order to justify its closing. I say that because their -- they

saved $34 million in closing the state hospital. The money did not come back into the community. It went to reduce the budget for the office of mental health. The money did not come back for group homes, it did not come back for mental health services.

And I say it was artificially reduced, the census, because there was a waiting list for patients at Allentown State Hospital. And the state was simply not allowing them to be admitted, reducing the census. And I had psychiatrists and psychologists complaining to me that they could not get their patients in the state hospital and that's where they felt they needed to be, that the resources were there, not in community mental health situations.

So I speak out against the closing of Clarks Summit State Hospital.

In 1949 there were 27 state hospitals and 6 state prisons. In a little over 60 years we now have 26 state prisons and currently 6 state hospitals spread across the state. Unfortunately I think we may end up having five because the problem is is that whenever there has been a Fairchild Hearing since 1999 on a state hospital on a declining patient census, the hospital has been closed. So despite everybody saying this is not a hearing for closing, the fact of the

matter is there has never been one where the hospital has not been closed.

So I urge you, the workers and the community and the families and friends of patients, to oppose this closing and take action to not allow this place to be closed. Thank you.

MR. SOMOGA: My name is Mike Somoga, and my son is a patient at Clarks Summit State Hospital. And I have to thank the Clarks Summit State Hospital because right now I think that my son would not be alive if it wasn't for Clarks Summit State Hospital.

My son had a mental illness since the age of nine. He is bipolar and schizophrenia. My son is -- he always flees. He always takes off and he has a tendency to run in front of vehicles. This occurred just only a year ago when he was home on TL. He came home, he was only home for ten minutes, when he chose to run on us, but before that he threatened us and damaged our vehicles.

If my son was to be put out into the cities again in a community that cannot help him, I'm afraid that the ultimate thing that's going to happen he will not be alive.

I'd like to thank Clarks Summit for your help and to keep my son alive. He may be in an

institution, but I can still see him every week. Thank you very much.

MR. WELBY: My name is Thom Welby. I work for Representative Marty Flynn. And Marty couldn't be here tonight, but I can express to you his feelings about the fears and the concerns that we all have, and that is about the possibility of closing short term or long term Clarks Summit State Hospital, and I know that I speak also for the rest of the delegation in northeastern Pennsylvania and it will be fought to the end.

But I appreciate -- I spoke briefly with Deputy Secretary Marion, and I appreciate your candor in saying that that is not the intention of this hearing, is not the intention of the department. And we appreciate your saying that. However, there is -- as was stated here with testimony, there is a concern and a paranoia, and I'm sure you can appreciate what you heard tonight and what was expressed by people that have family members that are affected through the services of Clarks Summit State Hospital and any of the other institutions in the state, my gosh, my heart just cries for you and my heart just applauds the wonderful work that's done by the staff at the hospital. It's just absolutely incredible.

And I'm sickened by the thought that with all due respect, and I don't mean to be partisan, but that the current administration can increase the budget for corrections to $2 billion. $2 billion is the forecast for the corrections budget. Yet for our social services and for our facilities the budgets are cut and cut and cut and they continue to look at ways to cut that funding and in this case to perhaps reduce the number of beds and increase the number of people in our community.

And within Representative Flynn's office, which is in West Scranton, within a quarter mile of the office there are multiple multiple facilities, residences, and we see every day how many of these people are doing well, and truly many of them are doing well. We also see where some of them are victims. We also know -- I volunteer for a lot of different organizations, and I know that a lot of these people that -- what we used to call being mainstreamed are living homeless and are going into our prison system. And once they get into that prison system they don't get out. They make mistakes and it's not mistakes that they want to make or deliberately make. They just make mistakes and they fall into that prison system and they don't get out.

And I ask if Deputy Secretary Marion, if you and the department would consider going back to the administration, ask them to relook at the budget and relook at the spending that they are doing and increase the funding to the areas suggested by so many of the people giving testimony, and I'm sure that you heard that testimony, like testimony, all around the state, and we feel very strongly about it.

MR. MARION: And If I may just -- thank you very much. The one thing I think is important to share with you is I met with Secretary Mackereth this morning. I meet with her regularly to share the perspective on how our planning is going for services across the continuum. And what's important to know is in the governor's proposed budget actually there is an increase in support for overall mental health services. And I would invite you to just compare our numbers to our sister states, who typically we find ourselves on the top end of support for community-based care, which includes then also the inclusion of the state hospital as a part of a larger continuum of care.

So, again, many folks have expressed concerns about the prospects of closure. I come into this room with you as deputy secretary working with a

team of folks within OMHSAS that we are focused on person-centered care. And we recognize that some individuals may be at a point in their illness that a state hospital level of care is what is needed at that point in time. And each person needs to be explored separately and distinctly.

When we talk about a CHIPP, there is a requirement that a comprehensive plan be built around the needs of the individual who is being considered for coming out under a CHIPP. So it is not done casually, it is not done without an extensive amount of planning, and it is not done without having services lined up before the person leaves the hospital.

So the CHIPP is a very serious process. So we expect any of the counties coming forward when they've identified a potential individual -- and those 27 individuals, I think the number is, for Clarks Summit, each of those should have and will have a comprehensive plan that includes a match to a system of services on the community side. So that's an expectation we have within the department. That's an expectation we have on the county programs that are a critical partner in. It's also expected that the staff within the state hospital will be part of the

comprehensive planning process. So there is a lot that goes into each and every one of these decisions.

So the decision is not based on an arbitrary setting of a limited number of beds at the hospital. This really emerged, the number of folks that are coming out of the state hospital were identified by county programs who said who do they know that is at the state hospital level of care who is at a point in their recovery that they're ready to make the transition.

So I just want to distinguish this is a very person-centered analysis that is not based on the global budget. It is not based on a target number that we're going to eliminate X number of beds or staff at Clarks Summit. The persons identified came through a person by person review by all the counties.

So we've heard clearly the message and we value the message of family members of individuals that have been served through the system. All the staff at the hospital, you provide a critical function within our continuum of care.

So as the representative and the commissioner have spoken, we are taking this input back in. It does go into our planning process. And it is not in our plan to close that hospital. Okay.

So --

UNIDENTIFIED SPEAKER: Would you include follow up as part of that plan?

MR. MARION: Which follow up are you referring to, please?

UNIDENTIFIED SPEAKER: As each individual gets their prescription as what they're going to do.

MR. MARION: Yes.

UNIDENTIFIED SPEAKER: That would be valuable.

MR. MARION: My experience both through a closure process and through a CHIPP processes is that when I -- I worked at Cumberland-Perry, so each county is configured somewhat differently, but we follow a core set of principles about community-based care. It's my expectation when I was administrator that we would be monitoring very very closely individuals that come out of the hospital and make sure that we have a system of services and supports that follow them carefully going through when they come out, particularly under CHIPPs and particularly under closure scenarios.

So my experience may be different than what experiences other folks have had, but we do want to have an enhanced array of focus and supports around

individuals that come out under CHIPP.

UNIDENTIFIED SPEAKER: What happens when they get out on that CHIPP and they stumble and that CHIPPs bed is gone at that state hospital. Are they allowed to go back in for those services that they need?

MR. MARION: Well, a couple things happen. The avenue back into care typically comes through the acute care setting on the community side.

Now, in some instances we've added new features that were not part of earlier discharges, so the experiences of a decade ago don't take into effect that many communities have now begun to develop an extended acute, which is another level of care between the short term acute and the state hospital. So depending on where you're located, where this individual might be, the package of services available to support that individual may be a little bit different. But, yes, there is a pathway back into treatment. And our goal, though, is to provide supports in such a way, have the plan work in such a way, that that individual has a heightened opportunity and chance to succeed in the community side of the equation. So -- and monitoring med use and all that is part of that package.

UNIDENTIFIED SPEAKER: When you implement CHIPPs is there a certain percentage that you're encouraging hospitals to meet reduction for?

MR. MARION: No, this is person-centered planning. We ask counties as planning for the CHIPP to look at the folks they knew were in the state hospital level of care. And counties do monitor their folks that are in the state hospital. And so each county was meant to consult with the hospital staff and with their experience with their individual and identify those folks that may have reached a point in their recovery that they're ready to make the transition back to the community.

UNIDENTIFIED SPEAKER: What happens when they don't -- there aren't any who are ready to fill that -- to go into CHIPPs. Is that a possibility?

MR. MARION: We had 90 approved in the budget and so we put out a blanket invitation to all counties to look at who they had in state hospitals and consider who would be ready to make the transition out. And people do come out of the state hospital. People have come out of the hospital in a normal course of business. But what we're looking for is for the folks that needed a little bit more to make that transition out. The idea of the CHIPP is we allocate

funding to follow that individual at the county level, to build a little extra supports around -- or sometimes significant amounts of supports around that individual coming out.

So we did not set a target for any county. We did not set a target for any hospitals. We really just invited folks to explore who they knew was there and who was at a point in recovery that they could make the transition to community. And that is how this 90 person CHIPP was selected.

UNIDENTIFIED SPEAKER: And it's just a coincidence that that got you down to the 20 percent to have this hearing.

UNIDENTIFIED SPEAKER: Right. Exactly.

MR. MARION: People won't believe it's a coincidence, but it's a coincidence. What we know is that when we do -- I did not know that a Fairchild Hearing was even out there. I've just completed my first year in the role of deputy. I spent 30 plus years on the community side, on the county side.

MR. MADER: I don't need that. I don't think I'll need that. But I just want to point out just for clarification purposes -- my name is Phil Mader. I'm the director of the bureau of community and hospital operations. And in that role I'm

fortunate enough to work as part of the team for all the state hospitals.

To answer your question about being a coincidence, from a technical perspective the reduction of six beds would have facilitated the need for this Fairchild Hearing. The fact that we're doing 27 CHIPPs and only closing 14 is nothing coincidental. That was -- as Dennis said, throughout the entire state we went out and said to the counties would you like to engage with us in a CHIPP initiative in your catchment area. We got 97 requests for people to do that. We didn't ask for any targets. We didn't ask for any percentages. We didn't say, you know, what's wrong with you guys at Clarks Summit, why aren't you doing this. It was a true voluntary effort. So even if we would have only done 6 CHIPPs, we would have still been here tonight.

So I don't want you to misunderstand that we made the number higher artificially in order to do this.

UNIDENTIFIED SPEAKER: I don't know anything about politics, but I'm not stupid. Okay. When you go to the county and you go, Hey, if you identify some people to take out of state hospital, we'll give you money, what do you think they're going

to say?

UNIDENTIFIED SPEAKER: Why have a public hearing after the fact.

MR. MADER: Sir, we haven't closed any beds yet.

MR. MARION: We haven't closed any beds yet.

UNIDENTIFIED SPEAKER: It's already allotted, though.

UNIDENTIFIED SPEAKER: It's already allotted.

UNIDENTIFIED SPEAKER: They're already up there on the street.

UNIDENTIFIED SPEAKER: I was just curious. There is 90 beds. You're taking 27 from Clarks Summit. Where are the other beds?

MR. MARION: They are spread out among the other hospitals.

UNIDENTIFIED SPEAKER: How many -- which and where, do you know?

UNIDENTIFIED SPEAKER: What prison.

MR. MARION: Before we go any further I want to make sure we get any testimony on the record and then we can spend some time just trying to address questions, but does anybody have particular testimony

they want offered to be into the hearing?

UNIDENTIFIED SPEAKER: That dollar amount, that was the correct dollar amount for CHIPP bed and what is allotted for the people to go out into the community?

MR. MARION: Well, actually it varied. We didn't actually tell folks what the exact number was going to be. In a couple of instances, particularly rural communities -- I started my career serving -- working up in Susquehanna and Wayne Counties long ago, but -- most of my career has been down at Cumberland-Perry, but what we were concerned about is a county that only had a number or a handful of folks at the hospital, if they wanted to bring an individual back home the typical amount we would allocate for a CHIPP would not be enough to create a new residence or a new specialized program.

So we actually found a number of counties in the northwestern part of the Commonwealth, got together, and said, look, I've got a person here, you've got a person, and another county here within the five-county region has a person, if we pool our strategy together we will be able to afford supports that make sense for each of them and as a group were able to bring individuals out that previously they

were not able to because they would only have one or two persons maybe ready to come out.

So we really allowed the most flexibility as we possibly could for local communities to think this through and come up with a strategy that made sense in that community.

So it has played itself out differently from county to county across the Commonwealth. And that was probably the upside of this process, this is the broad scale process, but it is the first CHIPP process I've been involved with since my -- in my tenure on the state side.

Remember, I started and spent my career on the county side of operations with oversight on human services for Cumberland County. So when we've done CHIPPs we had a very thoughtful process. We would have a consumer advocate who spent a lot of time with each individual talking with that person -- remember, it's a person-centered plan. We do not force people out under CHIPP.

UNIDENTIFIED SPEAKER: If it was a person-centered plan you wouldn't be taking the beds away --

MR. MARION: No, actually remember what happened here, we are not closing all those beds.

Part of what we needed to do here is think through the level and the variety of care even available within the state hospital.

So one of the interesting things that's happened at the same time -- we'll go back to coincidence. At the same time we have three hospitals that identify that during the CHIPP process we may be able to reorganize what we're doing in some of our units in such a way that we can provide a specialized unit that focused on certain behaviors. That was not typically thought of as part of the overall planning process. So it's been very intriguing that in this instance we are not doing a person for person closure of beds. So we are looking at the creation of some specialty units among various hospitals that -- so then for folks that have particularized needs -- we've heard some reference here that when folks haven't had their individual needs effectively addressed that it can be a rocky road coming out and may not be a successful journey out. So what we've talked about is what's the state of the art in therapy, what do we think is going to be best practice or better practice. And rather than having individuals who have particular needs spread out throughout the whole hospital population, we are going to be exploring creating

specialty units that may be much more -- may be more therapeutically effective for those individuals. And hopefully that will positively influence their recovery in the hospital setting.

So the individuals that come out under CHIPP are folks that are part of a voluntary process. We don't force people out through CHIPP. So the individual needs to be ready, the folks and the supports for the individual need to be ready, in order for us to move that forward.

UNIDENTIFIED SPEAKER: Okay. So it still sounds like with all the hospitals that have closed, there's been Fairchild Hearings, none of them have resulted in hospitals staying open.

MR. MARION: Well, I don't think that's true, because all the other hospitals that are currently open have had Fairchild Hearings.

UNIDENTIFIED SPEAKER: All of the ones that are --

MR. MARION: Yes. This is the last area, this is the last hospital, to have gone through a Fairchild Hearing.

UNIDENTIFIED SPEAKER: Because I think what the concern seems to be is that you take these 27 beds, you close the hospital. How about those 181

people that don't have that money that's going along with them. The community can't support the people. So what about those --

MR. MARION: Well, in the normal course of business --

UNIDENTIFIED SPEAKER: -- all those other people that don't have that funding following them.

MR. MARION: Don't forget, CHIPP is really focused on particularly folks that don't come out in the normal course. People discharge from the hospital all the time. Not through CHIPP, but just because in the course of their recovery journey they have reached a point of stability that they are ready to come back out. If you look at the number of individuals -- we just ran new data --

UNIDENTIFIED SPEAKER: But the bed is still there for someone else.

MR. MARION: For someone -- yes.

UNIDENTIFIED SPEAKER: But now you take the beds away --

MR. MARION: Well, we're also creating alternative programming that does the same thing on the community-based side.

UNIDENTIFIED SPEAKER: Not for that dollar amount you're not.

UNIDENTIFIED SPEAKER: That is not --

UNIDENTIFIED SPEAKER: -- with that dollar amount. That's not right. Yeah, right.

UNIDENTIFIED SPEAKER: There's a waiting list for patients who need the hospital, and you're playing the numbers game because you can add beds or take beds away. There's got to be a hundred people that need to get in here -- into Clarks Summit and can't get in here and you're going to turn the numbers around and say that there is no need for us. And as the old Irishman said, don't piss on your leg and tell me it's raining.

MR. MARION: Again, I think the goal here for us this evening, and if you've been a participant in any of the other forums, we've been trying to be very mindful of what we've heard from the individuals, be they family members, prior consumers, individuals that work either within the hospital system or on the community side of the equation, people from the criminal justice system. We are paying particular time and attention to talking and engaging with folks.

Again, we've been on a tour of the Commonwealth making a point of being out within each region of the Commonwealth, and meeting with individuals, talking about what they see about the

strengths and weaknesses of their local system. And that has led us to prioritize the development of certain types of services.

So related to this we've heard some stuff today about concerns about how individuals might become entangled in the criminal justice system. As a department. We meet regularly with Secretary Wetzel, who is secretary for the department of corrections. We meet and sit on committees within the commission on crime and delinquency which includes judges, district attorneys, and other folks who share our concern, because some of the best advocates quite frankly for good mental health care are our partners in the mental health system. So if you talk to folks that are members of the district attorney's association, folks that sit within the various -- the justice-related committees within the commission on crime and delinquency, and Secretary Wetzel, if you've been -- had any experience with Secretary Wetzel, we had an opportunity to share a podium this past week, absolutely committed to a shared effort to continue to improve how we meet the needs of our individuals. Because we don't want them entering the corrections system either at the county or at the state level. So we're looking to develop better interventions that

occur earlier before illness gets out of control and then warrants very heavy interventions and hospitalizations.

So this -- these conversations all amount to identify opportunities for us to engage with folks earlier in the progression of their illness to try and have effective interventions and connections to treatment early in the progression so that we begin to intercede before the illness and the symptoms of the illness get out of control. And before all the support system collapses. So that's one of the other important pieces, is getting timely connections with folks as their symptoms emerge, ideally at first break, getting connected while there are still other resources that are willing to contribute while family is still connected, before all these bridges are burned.

So we have a strategy that is about earlier interventions. The state hospital will continue to play a role in the overall continuum of care. But part of what we want to do is have a community-based system that connects with people at an earlier stage of the progression of their illness. Sometimes that will not happen. But we have to have a balance system and that's what we're working towards.

We are going to continue meeting like this. The Fairchild Hearing is a technical requirement, but that isn't going to stop the hearing process. We are out in public forums.

Lynn, are we -- are we back up in this area -- we just had one --

MS. PATRONE: We just had one here. We'll be back in the fall.

MR. MARION: We will be back up in this area as part of the continuing conversation. And for folks that say what results there are, go to PArecovery.org. We publish a lot of information about the services that are out there. So PArecovery.org, which is our website that contains a lot of the information that people have alluded to. We have lots of information about what happens with the service delivery system, what we purchase on behalf of individuals with $4 billion dollars a year. That is a significant amount of spending. We're looking particularly to make sure that we line that up as well as we can. But, again, we need to support a continuum of care that meets people as their need emerges and get them before their circumstances get to the point where they require high level acute care. But when they do, we want a system of care at that level that

is well trained, well prepared, and ready to go. And that's what we're looking for is a balance in that system. But the vision is that for most folks they are going to see a pathway back to the community at some point. And we want that to be a smooth journey as well. So the needs of the housing, safe housing that's supportive of recovery, are all things that we share an interest in I think.

So what I've heard is some important things for us to have considered in our planning, and I can commit to you that in cooperation with Secretary Mackereth we will attempt to do that. And part of that will be the continuing presence back up here and other sectors around the Commonwealth having open forums, talking about where the service delivery system is. And we will share back both to the elected officials and the anyone that inquires about how we're doing with the dollars, what are the results we're seeing, as a result of the investment being made. Okay?

So what I want to do is thank you for the time you've taken to be with us tonight. Yes. Hold on one second.

UNIDENTIFIED SPEAKER: Does your plan -- does it fit in the population of people that will

never fit into your system that will need forever long-term acute care?

MR. MARION: We know there are folks that are just going to have --

UNIDENTIFIED SPEAKER: Where are those people going to go?

MR. MARION: Well, like I said, we're not closing the hospital. But we still do need to understand that there are folks that enter the hospital in an acute state that now are in their 70s and 80s. So our service delivery system meets folks from age 2 to 92 and probably beyond 92. So we work with folks throughout the whole life span. And what we need to do at each stage of that continuum of aging is somewhat different. So we are very mindful of that and what we know is that we have folks who are beyond their active stage of mental health symptoms but they are now in basically long-term supported care. So we look at it by age. We look at it by diagnosis. We look at it by behavioral needs. So there is a lot that goes into our planning about how to build a system of care that works.

UNIDENTIFIED SPEAKER: You're missing her point completely.

MR. MARION: Well, maybe I am. That's --

I'm doing my best here.

UNIDENTIFIED SPEAKER: How old is your son? 55?

UNIDENTIFIED SPEAKER: 55.

UNIDENTIFIED SPEAKER: He's got a long life ahead of him.

UNIDENTIFIED SPEAKER: Yeah.

UNIDENTIFIED SPEAKER: And he's been in and out of the hospital --

(Simultaneous discussion.)

MR. MARION: I think the important part is -- we have folks trying to record it.

In this person-centered care I can't give a blanket answer because there are dynamics that will be specific to the individual each one of you are thinking of.

UNIDENTIFIED SPEAKER: But that's not an individual thing. There are a lot of people like my son. There are a lot of --

MR. MARION: Agreed.

UNIDENTIFIED SPEAKER: The beds will be gone. They'll take the beds away.

UNIDENTIFIED SPEAKER: Where do they go --

(Simultaneous discussion.)

UNIDENTIFIED SPEAKER: Can I ask a question, sir? Maybe you could --

MR. MARION: Hold on. Hold on. We've got folks trying to -- we're going to go back to a structured approach. I can't deal with just random questions. We have to -- because there are folks trying to keep track of the record for this hearing. So we need to go --

UNIDENTIFIED SPEAKER: I think maybe if you could answer what makes Clarks Summit different than the hospitals that have closed, maybe the Allentown and Harrisburg, and maybe we would have a better understanding of -- I think there is an apprehension that we're going to close. Whatever you say, we're not going to close. But what makes Clarks Summit different than those hospitals that did close. Maybe if you can explain that then you can ease the tension.

MR. MARION: I don't think I'm in a position to explain the decisions that have been made at prior points. I wasn't part of those decisions on those prior closures. What I can tell you is we're planning capacity needs for the population we know of. Clarks Summit remains part of our plan as part of our service continuum.

UNIDENTIFIED SPEAKER: Did you not say that you were part of a closure at one time?

MR. MARION: I was at Harrisburg, but, again, I was on the county side of that equation. So my responsibility in that is to think through all the pieces that would need to be in place, housing, outpatient support, peer support, a whole array of services that would be needed to meet the needs of those individuals for them to succeed when they came out. So my experience was on bringing people out. It's my first time in this role on the state side of the equation as having oversight responsibility for the state side of the operation. But we have a great team of people that have developed experience over time. We want good outcomes for all the folks in our service system. That's our shared goal. We want good results for all the folks we encounter in our service delivery system.

UNIDENTIFIED SPEAKER: You mentioned that the money follows the patient. Say I have a patient who is discharged as a CHIPP discharge and say I get a hundred thousand dollars in my account for all the services that I need in the community. Next year would I get another hundred thousand?

MR. MARION: Yes. It becomes part of the

-- what we call infrastructure, which it sounds like a horribly technical term, but the idea is the dollar basis is retained year to year going forward.

UNIDENTIFIED SPEAKER: Based on the legislation.

MR. MARION: Based on the annual budget process, yes.

UNIDENTIFIED SPEAKER: Based on the legislation, but they could say no.

MR. MARION: I think if you look at the historical basis, that's been pretty solid over time because don't forget we've been doing this for more than a couple years. This has been a long-standing process.

UNIDENTIFIED SPEAKER: For the rest of their life they're going to get that hundred thousand --

MR. MARION: Well, don't forget, another thing that happens when people come out, if they become eligible -- this is another phenomenon at work now that is different than prior years is in our -- the needs of individuals that are out there to be served with the governor's proposal for coverage for newly eligibles, so we're talking about having coverage, health benefit coverage, for the next 500 to

600,000 individuals who are not currently eligible for medicaid. Remember, the bulk of our service delivery system is supported with those medicaid fundings, $3.1 billion in funds come through medicaid under managed care in the Commonwealth. The Commonwealth has a well known and well acknowledged services of managed care supports for both drug and alcohol and mental health services, which is how we created innovation to build in a variety of services that historically weren't available in the community side. Recovery focused care, peer supports, a number of new initiatives are now part of our planning mix that weren't there ten years ago. So there is different ingredients in the overall approach that historically we did not have at our disposal, and we're continuing to add those services and supports as we move forward.

UNIDENTIFIED SPEAKER: Deputy Secretary, the 27 consumers that the counties identified, do their families have any input in this process?

MR. MARION: Yes.

MR. MADER: As part of the CSP process, family involved in that, yes.

MR. MARION: Yes. I'm looking for the folks that actually work in and have direct responsibility. I've got experts here, so I don't

want to have to speak for them. But, yes, the expectation is all the significant folks that are involved in that individuals' lives are tempted to be brought into the planning process. So it should not -- it shouldn't -- our success is not going to be very good if we just try to deal in isolation not thinking through all the other supports that are going to make for a successful transition.

UNIDENTIFIED SPEAKER: Sir, after Clarks Summit loses the 27 beds to the CHIPPs program, is the state considering opening a special care unit at Clarks Summit State?

MR. MADER: We're only closing 14 of 27.

MR. MARION: Yeah, we're not closing all 27 beds. We're closing 14 beds.

UNIDENTIFIED SPEAKER: But are they considering opening a special --

MR. MADER: The remaining 13 beds will be used for the special needs unit.

MR. MARION: As Phil is describing here, the 13 beds that are staying -- that open we're looking to use those to create a specialty unit.

UNIDENTIFIED SPEAKER: Okay. Thank you.

MR. MARION: The specifics are still in conversation about, you know, what that mix would look

like, but that's part of the next evolution of what expect might be within the state hospital operations.

UNIDENTIFIED SPEAKER: Okay. Thank you.

MR. MARION: Let me go to this -- be mindful of time. We have about 10 minutes, 10 more minutes, 15 minutes. Yes.

UNIDENTIFIED SPEAKER: I sat here listening tonight and we have all these coincidences. I work for the state prison. I guess it's a coincidence that we're just adding another ward for the mental health. We're filling your family. We're bringing them in. We're going to keep doing that.

MR. MARION: Well, I just want to make -- I think I can speak for Secretary Wetzel on this when we talk about it. Within the context of DOC, we know there are individuals -- and there has always been individuals that bring in with them their chronic mental illness as part of who they are as a person. They are in our community, they are in our family, they are in potentially this room. So with the number of individuals that have some diagnosable condition, you would expect to find any large group of individuals that bring those diagnosis with them. It may not have been causable -- cause for why they were arrested, but what Secretary Wetzel is committed to is

the infusion of peer supports, the creation of specialty units, so rather than having folks with illness spread out throughout the whole correctional system, that they be put together in a therapeutic environment that better meets their needs as an individual with an illness. Nobody wants them in a jail environment, but while there what we're trying to do is provide the necessary care that meets their needs while they're incarcerated and then also have a plan that when they come to discharge, even though they're coming out of the correctional system rather than the state hospital, that there is a transition plan that includes community-based care.

UNIDENTIFIED SPEAKER: I did say it was a coincidence -- this is a coincidence that you're talking about possibly closing.

MR. MARION: No, we're not talking about possibly closing.

UNIDENTIFIED SPEAKER: People are thinking we could be closing. But we're opening a facility right now. We already putting mental health facility in our state prison.

MR. MARION: Yeah, and I think you're going to find that's not adding capacity. I think that's realigning capacity within DOC, if I understand

what the secretary had said. Because he wants to have units that better meet the needs of folks while they're incarcerated. Remember, these are folks that were deemed competent to be tried for their behaviors. So these are not folks that -- these folks had to go through a process of having been deemed competent.

But, again, we're here to talk about primarily the transition that's occurring at Clarks Summit. We are seeing that there are these beds closing, but it is only a part of the total number of folks being discharged under CHIPP.

This hearing was a technical requirement and this is the last hearings across the Commonwealth associated with reduction in size. I just want to remind folks of why we're here tonight. This is not a precursor to closure. This is to talk about the transition for these number of individuals. We're going to go back over here.

UNIDENTIFIED SPEAKER: In the projected budget it has the patients of Clarks Summit Hospital at 159.

MR. MARION: That's in the original blue book proposal?

UNIDENTIFIED SPEAKER: Yes.

MR. MARION: It was a proration. When

the number got put in the budget, there was an estimate made. It wasn't -- we have not even talked with counties yet as to the exact strategy for the next round of 90 beds. So we don't have a preconceived plan nor do we have identified any hospital or any individuals under the new proposed 90 bed CHIPP. Okay?

UNIDENTIFIED STRATEGY: Where did that number come from where it says 159?

MR. MARION: They just looked and prorate it by relative bed size. I'm not exactly sure how they projected it, but I can tell you as the individual in the office responsible for that we do not have -- we haven't even sat down with counties yet under the proposed budget numbers to talk about how that would look and how that would work.

UNIDENTIFIED SPEAKER: I just want to make a comment as someone who has worked in the medical field, registered nurse for 40 years, and as a family member who has someone with, you know, diagnosis of mental illness. Our community is very very -- we don't have enough resources. We don't have enough psychiatrists currently to take care of people that are out there now in the community. It's in our demographic especially and across all the states. On

top of that we don't have enough therapists that can work with these people. And they don't get enough intensive treatment, what they need, what they really need, and therefore it is -- it's almost like setting them up to fail unfortunately.

MR. MARION: Well, a couple pieces with that. If you look at the proposed budget, we're also talking about a broader strategy on healthy PA, so we're working in concert with other state agencies, including the department of health, and one of the things that we're attempting to do is try to create incentives that would attract additional psychiatrists and other medical professionals to be part of the continuum, and that's a continuing struggle, it's a continuing effort, we need to sustain. Some areas of the Commonwealth are strained a little bit more in terms of their access to doctor time, but we do know that that is an issue and it is -- that's part of our overall planning as well. We want the resources in place so that we have the kinds of therapists and the kinds of professionals, the kinds of doctors, we need to meet the needs of the individuals we serve.

I'm going to go back to this side and then --

UNIDENTIFIED SPEAKER: I just want to say

for the record that from -- if you look at acute care hospitals, which may be the door to Clarks Summit State Hospital behavioral health, that considering closing beds at Clarks Summit State Hospital with right now some patients will stay in an acute care facility up to 90 days waiting to get in to Clarks Summit State Hospital. So, you know, just to decrease the numbers to await an available bed, I really think that that has to be taken into consideration because when it's emergent and an urgent resource for behavioral health and right now they're ill equipped to therapeutically -- therapeutic environment for them long term, which I consider 90 days to be long term, and I'm afraid that may make it longer.

MR. MARION: Well, one of the other things we want to do is rather than constantly build the back end of the system, I think another part that we have to look at at the same time is earlier points where we would have been able to connect with that individual. Just like any other medical conditions that an acute care hospital might encounter, the earlier intervention, the earlier recognition, can make for an entirety different experience for the individual in terms of what they go through in terms of their illness and what it takes as a system of care

to provide a response to it. So concurrent with our thinking about what we need to do at the acute care and the state hospital level, we are looking at what can be done for more effective, more timely, earlier interventions, sort of a primary secondary prevention approach.

So time for a couple more. We will be here for -- after this, but --

UNIDENTIFIED SPEAKER: I just want to know --

MR. MARION: 8:30 the interpreters are done with their time with us, so that's what we have scheduled for, so we'll take -- I got three minutes.

UNIDENTIFIED SPEAKER: When our next democratic governor is elected, will these rumors of closing go away.

MR. MARION: You got to understand that the philosophy of care and our approach, community centered, has been in place for three administrations, so this has -- runs back for over a decade, our movement in this direction and the movement of the field. This is not just a Pennsylvania phenomena. If you go online, you will look that our sister states are exploring the very same challenges we are.

Okay. So if I may at this point in time,

we do need to bring this -- the formal process to a close. I just want to reaffirm how important it is for you as family members, as employees of our service delivery system, as elected officials, to be heard. We're here to listen and take this content back and add it into our thinking about what to do next.

So I want to thank you for all the time you've taken tonight, I do appreciate it, and I appreciate the vigor which you advocated your positions. Thank you.

(Proceedings concluded at 8:28 p.m.)

C E R T I F I C A T E

I HEREBY CERTIFY that the proceedings and evidence are contained fully and accurately, to the best of my ability, in the notes taken by me at the proceedings in the above matter, and that this is a true and correct transcript thereof.

_____

Carrie A. Kaufman
Registered Professional Reporter
Notary Public

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