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IN RE: :  
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PUBLIC HEARING ON :  
DECLINING PATIENT :  
POPULATION AT CLARKS :  
SUMMIT STATE HOSPITAL :  
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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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1 MR. MARION: Good evening. Welcome. My  
2 name is Dennis Marion, and I'm deputy secretary for  
3 the Office of Mental Health and Substance Abuse  
4 Services. I'm delighted to be here with you this  
5 evening on a special event. This is a special hearing  
6 related to some changes that are going on that affect  
7 Clarks Summit State Hospital and it's a hearing that  
8 is triggered by a change in population or a change in  
9 staffing patterns at the hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 So, again, the census back in December of  
4 '97, 268, and then with a staff complement of about  
5 530 individuals. And, again, as March 2014 we're  
6 looking at 218 individuals and a salaried complement  
7 of 423 individuals. And notice the 20 percent  
8 reduction. The 20 percent reduction is the trigger  
9 point that if the reduction in folks served at the  
10 facility or the staff complement moved at 20 percent,  
11 that was the trigger point for having the Fairchild  
12 Hearing. So that is the technical reason why the  
13 hearing has been scheduled for this evening.

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

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

25 Couple things. The monies that supported

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

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

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

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

1 state hospital placement.

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

7 In the '13/14 budget the CHIPPs beds  
8 funded in this hospital service area, we're looking at  
9 27 CHIPPs being supported.

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

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

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

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

15 Just to give you a sense of the overall  
16 -- remember I said the state hospital system is part  
17 of a large system of care. We serve in and around  
18 650,000 individuals each year with resources managed  
19 by OMHSAS, the Office of Mental Health and Substance  
20 Abuse Services. And in that we want to juxtapose that  
21 against the number of individuals served at the state  
22 hospital level. So at a given day in the state  
23 hospital census is 1500 and -- just over 1500 out of a  
24 total population being served of 650,000.

25 So it's an important piece. It meets the

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

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

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

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

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

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

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

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

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

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

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

12 UNIDENTIFIED SPEAKER: No.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 MR. MARION: Thank you, Julie.

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

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

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

1 name for the record.

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

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

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

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

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

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

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

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

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

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

10 MR. MARION: Terrence McCarthy?

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

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

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

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

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

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

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

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

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

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

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

12 In many cases the development of new and  
13 innovative services can be accomplished through a cash  
14 infusion into the county system. The obvious source  
15 for these funds is in the closure of the state  
16 hospital with an annual operating budget of nearly  
17 \$50 million.

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

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

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

8 Cecelia Luchi?

9 Marie Onukiavage?

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

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

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

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

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

25           Yes, with adequate effective systems and

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

9           Okay. I'm not finished.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MR. MARION: Thank you very much.

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

1 MS. ONUKIAVAGE: I gave --

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

5 MS. ONUKIAVAGE: Okay. Thank you.

6 MR. MARION: Next we have Helene Burgess.

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

9 UNIDENTIFIED SPEAKER: Use the  
10 microphone.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 MR. MARION: Thank you very much.

7 Robert Quinn?

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

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

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

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

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

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

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

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

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

7           Meanwhile, since the 1963 act about  
8 90 percent of beds have been cut at state hospitals  
9 according to Paul Appelbaum, a Columbia University  
10 psychiatry professor and expert in how the law affects  
11 the practice of medicine. Several mental health  
12 experts said in many cases that has left us nowhere  
13 for the sickest people to turn, so they end up  
14 homeless, abusing substances, or in prison.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 I did some research. At the end of 1964  
17 there were 24 mental health state hospitals and 8  
18 state run prisons. The first hospital closed in 1979,  
19 which began to switch the roles of how we as a  
20 community take care of the mentally ill. In the late  
21 '80s, early '90s, we started building more and more  
22 prisons because of an increase in population, many of  
23 those with a history of mental illness. Now there are  
24 27 state prisons and 6 mental hospitals currently in  
25 operation. I think our numbers speak for themselves.

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

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

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

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

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

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

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

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

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

12 While at White Haven Center during the  
13 '80s and '90s I saw many residents discharged, often  
14 against their family's will, and later sadly heard  
15 that several of them had died from such things as  
16 choking on a peanut butter sandwich, which we did not  
17 allow at the center. I also know of the 24/7 medical  
18 care and treatment, the recreational opportunities,  
19 and even membership in the Lions Club, that the  
20 residents at White Haven Center have had available to  
21 them. And I have decided that that isn't very  
22 restrictive at all.

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

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

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

25 I have been retired now for almost four

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

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

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

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

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

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

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

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

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

19 So we have Jeanne Yarmey followed by  
20 Jennifer Priestman.

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

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

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

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

13 MR. MARION: Jennifer Priestman?  
14 Judy Kirkendoll?

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

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

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

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

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

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

6 MR. MARION: Art Noldy? Art Noldy?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1           MR. BAKER: Hi. My name is Mike Baker,  
2 and I wanted to talk about some of the experiences we  
3 had with the closing of Allentown State Hospital in  
4 2010. We found out -- I work for the state and I'm  
5 also chairperson of my union chapter, SEIU Local 668,  
6 so I was involved with the opposition of that from day  
7 one.

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

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

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

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

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

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

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

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

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

17 In 1949 there were 27 state hospitals and  
18 6 state prisons. In a little over 60 years we now  
19 have 26 state prisons and currently 6 state hospitals  
20 spread across the state. Unfortunately I think we may  
21 end up having five because the problem is is that  
22 whenever there has been a Fairchild Hearing since 1999  
23 on a state hospital on a declining patient census, the  
24 hospital has been closed. So despite everybody saying  
25 this is not a hearing for closing, the fact of the

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

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

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

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

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

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

1 institution, but I can still see him every week.

2 Thank you very much.

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

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

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

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

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

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

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

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

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

15           So the CHIPP is a very serious process.  
16 So we expect any of the counties coming forward when  
17 they've identified a potential individual -- and those  
18 27 individuals, I think the number is, for Clarks  
19 Summit, each of those should have and will have a  
20 comprehensive plan that includes a match to a system  
21 of services on the community side. So that's an  
22 expectation we have within the department. That's an  
23 expectation we have on the county programs that are a  
24 critical partner in. It's also expected that the  
25 staff within the state hospital will be part of the

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

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

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

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

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

1 So --

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

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

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

8 MR. MARION: Yes.

9 UNIDENTIFIED SPEAKER: That would be  
10 valuable.

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

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

1 individuals that come out under CHIPP.

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

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

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

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

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

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

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

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

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

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

14 UNIDENTIFIED SPEAKER: Right. Exactly.

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

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

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

3 To answer your question about being a  
4 coincidence, from a technical perspective the  
5 reduction of six beds would have facilitated the need  
6 for this Fairchild Hearing. The fact that we're doing  
7 27 CHIPPs and only closing 14 is nothing coincidental.  
8 That was -- as Dennis said, throughout the entire  
9 state we went out and said to the counties would you  
10 like to engage with us in a CHIPP initiative in your  
11 catchment area. We got 97 requests for people to do  
12 that. We didn't ask for any targets. We didn't ask  
13 for any percentages. We didn't say, you know, what's  
14 wrong with you guys at Clarks Summit, why aren't you  
15 doing this. It was a true voluntary effort. So even  
16 if we would have only done 6 CHIPPs, we would have  
17 still been here tonight.

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

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

1 to say?

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

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

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

8 UNIDENTIFIED SPEAKER: It's already  
9 allotted, though.

10 UNIDENTIFIED SPEAKER: It's already  
11 allotted.

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

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

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

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

21 UNIDENTIFIED SPEAKER: What prison.

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

1 they want offered to be into the hearing?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 UNIDENTIFIED SPEAKER: All of the ones  
19 that are --

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

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

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

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

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

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

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

18 MR. MARION: For someone -- yes.

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

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

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

1 UNIDENTIFIED SPEAKER: That is not --

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

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

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

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

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

4 So related to this we've heard some stuff  
5 today about concerns about how individuals might  
6 become entangled in the criminal justice system. As a  
7 department. We meet regularly with Secretary Wetzels,  
8 who is secretary for the department of corrections.

9 We meet and sit on committees within the commission on  
10 crime and delinquency which includes judges, district  
11 attorneys, and other folks who share our concern,  
12 because some of the best advocates quite frankly for  
13 good mental health care are our partners in the mental  
14 health system. So if you talk to folks that are  
15 members of the district attorney's association, folks  
16 that sit within the various -- the justice-related  
17 committees within the commission on crime and  
18 delinquency, and Secretary Wetzels, if you've been --  
19 had any experience with Secretary Wetzels, we had an  
20 opportunity to share a podium this past week,  
21 absolutely committed to a shared effort to continue to  
22 improve how we meet the needs of our individuals.

23 Because we don't want them entering the corrections  
24 system either at the county or at the state level. So  
25 we're looking to develop better interventions that

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

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

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

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

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

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

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

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

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

20 Okay?

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

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

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

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

5 UNIDENTIFIED SPEAKER: Where are those  
6 people going to go?

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

23 UNIDENTIFIED SPEAKER: You're missing her  
24 point completely.

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

1 I'm doing my best here.

2 UNIDENTIFIED SPEAKER: How old is your  
3 son? 55?

4 UNIDENTIFIED SPEAKER: 55.

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

7 UNIDENTIFIED SPEAKER: Yeah.

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

10 (Simultaneous discussion.)

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

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

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

20 MR. MARION: Agreed.

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

23 UNIDENTIFIED SPEAKER: Where do they  
24 go --

25 (Simultaneous discussion.)

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

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

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

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

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

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

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

25 MR. MARION: Yes. It becomes part of the

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

4 UNIDENTIFIED SPEAKER: Based on the  
5 legislation.

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

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

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

15 UNIDENTIFIED SPEAKER: For the rest of  
16 their life they're going to get that hundred thousand  
17 --

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

1 600,000 individuals who are not currently eligible for  
2 medicaid. Remember, the bulk of our service delivery  
3 system is supported with those medicaid fundings,  
4 \$3.1 billion in funds come through medicaid under  
5 managed care in the Commonwealth. The Commonwealth  
6 has a well known and well acknowledged services of  
7 managed care supports for both drug and alcohol and  
8 mental health services, which is how we created  
9 innovation to build in a variety of services that  
10 historically weren't available in the community side.  
11 Recovery focused care, peer supports, a number of new  
12 initiatives are now part of our planning mix that  
13 weren't there ten years ago. So there is different  
14 ingredients in the overall approach that historically  
15 we did not have at our disposal, and we're continuing  
16 to add those services and supports as we move forward.

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

20 MR. MARION: Yes.

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

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

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

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

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

14 MR. MARION: Yeah, we're not closing all  
15 27 beds. We're closing 14 beds.

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

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

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

23 UNIDENTIFIED SPEAKER: Okay. Thank you.

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

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

3 UNIDENTIFIED SPEAKER: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

24 UNIDENTIFIED SPEAKER: Yes.

25 MR. MARION: It was a proration. When

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

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

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

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

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

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

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

25 UNIDENTIFIED SPEAKER: I just want to say

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

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

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

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

9 UNIDENTIFIED SPEAKER: I just want to  
10 know --

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

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

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

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

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

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

11  
12                           (Proceedings concluded at 8:28 p.m.)  
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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.

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Carrie A. Kaufman  
Registered Professional Reporter  
Notary Public

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