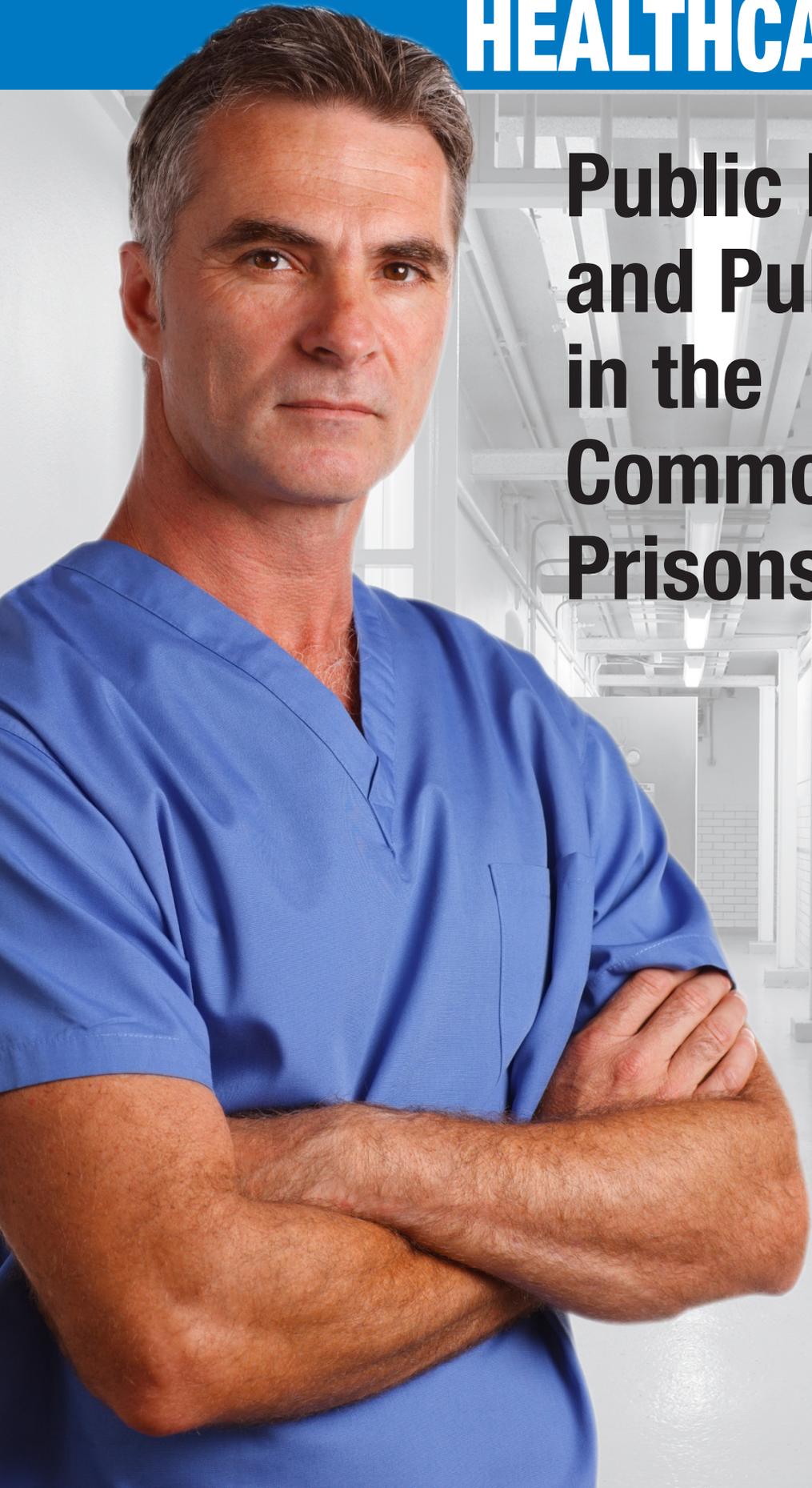


DEPARTMENT OF CORRECTIONS HEALTHCARE

A man with short, graying hair and a serious expression stands in a prison hallway. He is wearing blue medical scrubs and has his arms crossed. The hallway is long and brightly lit, with white walls and a white floor. On the right side of the hallway, there are rows of white metal prison cells with bars. The perspective is from the end of the hallway, looking down its length.

**Public Health
and Public Safety
in the
Commonwealth's
Prisons**

Executive Summary

IN SEPTEMBER 2011, the Commonwealth requested bids to greatly expand the current private healthcare services within the Department of Corrections (DOC). The history of contracted prison healthcare both in Pennsylvania and across the country is a history of unrealized cost savings, lawsuits, and diminished care. Expanding the scope of privatized healthcare will likely result in more of the same for the DOC.

Corrections is a core responsibility of state government that directly impacts the safety and health of Pennsylvania communities. Putting more of our Corrections system into the hands of for-profit, private companies opens our state up to a whole host of potential problems.

Proponents of privatization promise to fix budget woes by saving the government money. But numerous examples in a variety of sectors show that projected savings don't always materialize. Cost overruns combined with hidden and indirect costs, such as contract monitoring and administration, can make privatization more expensive than in-house services for governments.

The Commonwealth currently subcontracts certain medical, psychiatric, and pharmacy services in state prisons. Nursing care is not subcontracted, though private sector staffing agencies are used to fill nurse shortages in DOC facilities. Many of the problems DOC staff encounter working with these agency nurses would exist with nurses employed by a contracted for-profit company.

In 2009, Jeffrey Beard, the former DOC Secretary acknowledged the essential role DOC nurses have in maintaining quality health services in the current multiple contractor arrangement. According to Mr. Beard, *“Critical to the success of managing this new multiple-vendor system is a strong central office staff and well-trained on-site correctional healthcare administrators and **nurses who are state employees.**”*

Before the Commonwealth embarks on a potentially expensive and dangerous decision to expand subcontracted prison healthcare, legislators and the public have a right to know about the performance of the current subcontracted services and how the Commonwealth expects to operate with potentially expanded subcontracting. Answers to the following questions must be provided before taking any steps to further subcontract:

- Will all subcontracted healthcare staff have the same level of security training as current DOC nurses?
- Will the Commonwealth guarantee the same level of nurse staffing if it decides to subcontract?
- Where does the Commonwealth expect to find savings while providing the same level of service?
- How does the Commonwealth expect to provide oversight without Commonwealth nurses?
- Over the past 5 years, what has been the yearly estimate of the cost of the current healthcare contracting agreement and final yearly cost of the agreement, including amendments to the agreement?
- Over the past 5 years, what are all the deficiencies in PHS/Corizon-run clinics and penalties assigned?
- Over the past 5 years, how



many times has the Commonwealth found PHS/Corizon out of compliance in its PHS/Corizon-run clinics?

- What are the estimated and actual savings with the PHS/Corizon implementation of the Catalyst SM electronic health record system?
- Are there any financial or performance audits pertaining to the current contracting Agreement?

When the above questions are answered it will be clear that pursuing further outsourcing of healthcare services in Pennsylvania's prison is not good for the Commonwealth or its citizens. Outsourcing could diminish safety and security within state prisons, expose the public to increased health risks, and there is no guaranteed cost savings to the Commonwealth. We urge the Pennsylvania legislature, the Department of Corrections and Governor Corbett to abandon any plans to put this core responsibility of government into the hands of any for-profit contractor.

Public Health and Public Safety in the Commonwealth's Prisons

CORRECTIONS IS A CORE GOVERNMENT SERVICE necessary to protect Commonwealth citizens from dangerous criminals, safeguard the employees who work in prisons, and protect the health of communities when prisoners return home after serving their sentences.

In September 2011, the Commonwealth requested bids to greatly expand the current private healthcare services within the Department of Corrections (DOC). The history of contracted prison healthcare both in Pennsylvania and across the country is a history of unrealized cost savings, lawsuits, and diminished care. Expanding the scope of privatized healthcare will likely result in more of the same for the DOC and undermine DOC's ability to guarantee the safety and security of both employees and the public.

Before the Commonwealth decides to subcontract more corrections healthcare, the state should look deeper into the record of subcontracting in prisons and make sure it can guarantee the health and safety of our communities.

Prison Healthcare

Prior to federal courts intervening in numerous states, prison healthcare was often poor and limited. Many prison officials considered healthcare a privilege and withheld it as punishment. Prisoners and prison-rights advocates filed numerous lawsuits related to inadequate medical care and in 1976, the Supreme Court ruled that "deliberate indifference" to a prisoner's serious health problem violates the Eighth Amendment prohibition of cruel and unusual punishment. The court established the right to "reasonably adequate medical care."¹

The vagueness of what is reasonable is still debated and has led to many legal proceedings around

healthcare. Medical care is the most litigated issue involving prisons² and has contributed to dangerous prison incidents.

In 1989, prisoners at SCI Camp Hill rioted for four days before being brought under control. In the class action complaint that eventually led to the "Austin Agreement," plaintiffs cited the failure of the Department of Corrections and its contractors to provide adequate routine and emergency medical care as one of the causes of the riot. The complaint specifically cited high RN and LPN vacancies.³

Unhealthy Prisoners

It is important to provide prison healthcare because prisoners suffer disproportionately from many dangerous diseases and the vast majority will return to their communities. Prisoners have very high rates of HIV, Hepatitis C, Tuberculosis and have elevated risk of chronic diseases such as diabetes and other conditions because of smoking, heavy alcohol consumption, and poor nutrition.⁴ Effective prison healthcare includes both treatment where appropriate, and more importantly, education to help inmates manage their conditions and protect communities from infection.

Privatizing Prison Services

When the government decides to vest its power over prisoners in a for-profit corporation, the state is transferring a substantial amount of public authority to a subcontractor, but the liabilities largely stay with the state. It is one thing to transfer the authority to operate concessions in the Capitol building, it's quite another to cede power over the care of prisoners who have a constitutional right to adequate healthcare.

Why the Push to Subcontract?

Governor Corbett's privatization taskforce is charged with examining government services to see where

privatization could be a benefit to taxpayers.

Proponents of privatization promise to fix budget woes by saving the government money. However, the record of subcontracting in general and prison health services specifically, is not one of regular savings. Numerous examples in a variety of sectors show that projected savings don't always materialize. Cost overruns combined with hidden and indirect costs, such as contract monitoring and administration, can make privatization more expensive than in-house services for governments. In fact, the Government Finance Officers Association estimates that hidden and indirect costs can add up to 25% to the contract price.⁵

The Government Accountability Office has found that methods by which agencies and privatization consultants conduct projections and report contract costs can make cost savings appear greater than they actually are.⁶ According to a 2007 survey by the International City/County Management Association, 52% of governments that brought services back in-house reported that the primary reason was insufficient cost savings.⁷

In 2001, a U.S. Bureau of Justice Assistance-backed study on prison privatization concluded that private prisons offered only 1% cost savings on average, primarily achieved through lower labor costs. There also was “no evidence found that the existence of private prisons will have a dramatic effect on how non-private prisons operate.”⁸

A trail of evidence,⁹ scandals,¹⁰ canceled contracts,¹¹ costly lawsuits,¹² and public records¹³ makes clear to legislators their imperative to assess the costs and benefits in their particular circumstances.

Recent Examples of Privatization Failing to Save Money

In Maine, a 2011 report by the Legislature's Office of Program Evaluation and Accountability (OPEGA) concluded that the company (Corizon) that provides medical services to Maine's prison inmates failed to adequately fulfill many of its contractual obligations. The report stated that 50% of the contractor's medical records were in error and that records could not be found for nearly 10% of the prisoners treated.¹⁴

In 2011, Florida's Jackson Health System announced it is reversing course and will not outsource inmate healthcare. Executives last year were so convinced that outsourcing would save money that they placed the estimated \$8 million savings in the budget for this fiscal year, which ends Sept. 30. When Jackson's new chief executive, Carlos Migoya, arrived in May, he reviewed the program, which covers 6,000 Miami-Dade County inmates. After the second set of final bids came in, he decided the proposals were “notably higher” than what his team thought it would cost Jackson to perform the same service, he said. “There was a big difference,” he said. Chief Financial Officer Mark Knight said the lower of the two bids was \$60.5 million. Executives now believe Jackson can provide the same services for no more than \$58 million—and perhaps considerably less next year with reduced labor costs.¹⁵

Recent studies by the Arizona Department of Corrections found that, despite a state law mandating private prisons must create “cost savings,” inmates in private prisons can cost up to \$1,600 more per year while often housing only relatively healthy inmates.¹⁶

In 2000, the South Carolina General Assembly conducted a review of the state's use of subcontracted healthcare in its prisons. The report documents the experience with subcontracted healthcare in the SC prison system was rife with problems that ranged from very poor medical care to cost over-runs and substantial funds spent on services that were never provided.¹⁷

Subcontracting Prison Health Jeopardizes Public Health

As mentioned above, prison populations suffer from disproportionately high rates of infectious diseases, mental illness, and substance abuse. These challenges pose not just a threat to the prison population, but can be devastating to communities that typically receive former inmates once they are released. Nationwide, thousands of offenders are released daily from prison.¹⁸ Incidentally, Governor Corbett has proposed increasing the amount of prisoners released as part of his 2012-2013 budget proposal.

Any proposals to further subcontract Pennsylvania prison health must bear this increasing release rate in

mind. Prison healthcare companies promise to reduce healthcare costs, but many articles and reports show that companies cut costs by creating obstacles to care, hiring too few staff, employing inexperienced staff, and skimping on medication.¹⁹

Recent Examples of Prison Healthcare Subcontracting Putting Communities at Risk

Since 2005, a leading prison healthcare contractor has lost contracts or failed to win renewals with prison systems in four states, each with seven to 24 prisons: Vermont (2005), Alabama (2007), Delaware (2010) and Maryland (2010). Additionally, the company also lost contracts at individual county jails in Galveston County, Texas (2007), Pima County, Ariz. (2008), and Monroe County, N.Y. (2010).

In almost every case, the contract losses followed allegations by correctional or county officials that the company failed to provide adequate health care. Pima County officials withheld \$1.3 million in payments over staffing and healthcare problems.²⁰

Over 12 months ending in June 2011, Idaho fined a prison healthcare contractor more than \$270,000 for a wide range of medical and mental healthcare shortfalls, including staffing shortages. Public documents released to the Associated Press said the contractor was supposed to fill vacancies within 60 days, but left the South Boise Women's Correctional Center without an Ob/Gyn for more than two years and left another maximum-security prison without a staff psychologist for more than eight months.²¹

In 2006, an 18-year old woman with bipolar disorder and clinical depression hanged herself while incarcerated in solitary confinement in a Florida prison. In 2011, her family settled a \$500,000 lawsuit over her death with the Florida Department of Corrections as well as private companies contracted to provide medical and mental health services.²²

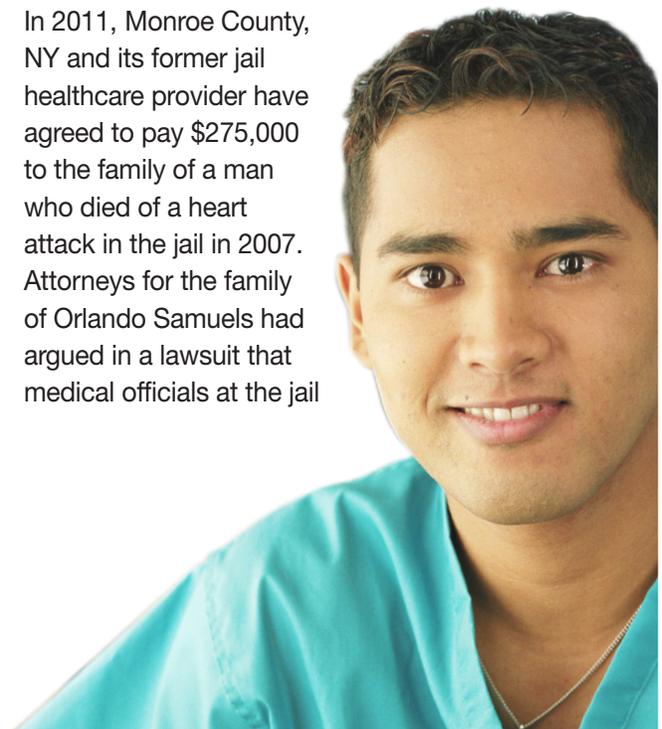
In 2009, the American Civil Liberties Union filed a wrongful death lawsuit over the death of a jail inmate in St. Louis, claiming he did not get proper care for a heart condition. 32-year-old Courtland Lucas died at the St. Louis City Justice Center in May 2009, five

days after he was jailed on a probation violation. The ACLU says Lucas had chronic heart disease and was wearing a pacemaker when taken into custody. The suit contends the private healthcare subcontractor failed to provide proper medications or care for Lucas.²³

In 2010, Delaware replaced the company that provided medical care in the state's prisons after five years of criticism and turmoil over the quality of inmate healthcare. The change was a result of frustration with the subcontractor and a 2005 investigation by The News Journal. The newspaper's series brought to light problems with high inmate death rates, especially from AIDS and suicide. It also pointed out neglect of sick inmates who were in filthy infirmaries that sometimes lacked beds. Following the series, a federal monitor was appointed by the U.S. Justice Department to oversee prison healthcare.²⁴

In 2010, Maryland state officials decided to extend the current contract for six months while searching for a new company to oversee medical care for Maryland prisoners. A 2007 state audit found "several significant areas of noncompliance," and a state auditors' review of those findings released in April 2010 found that there were still problems. At that time, the whole system, serving some 23,000 inmates at a cost of about \$150 million per year, had only one medical doctor. Even inmate deaths could not be properly reviewed.²⁵

In 2011, Monroe County, NY and its former jail healthcare provider have agreed to pay \$275,000 to the family of a man who died of a heart attack in the jail in 2007. Attorneys for the family of Orlando Samuels had argued in a lawsuit that medical officials at the jail



ignored Samuels' heart condition, causing his death in May 2007. The county no longer contracts with the healthcare contractor and last year sued the company, seeking \$2 million in contractual restitution for alleged staffing shortages while CMS ran jail medical care.²⁶

In 2007, The Michigan Department of Corrections (MDOC) conducted a thorough review of its corrections healthcare. MDOC used a private contractor for physicians and physician assistants. Nurses, dentists, and support staff are MDOC employees. The findings include:

- Contracting out providers leads to organizational problems.
- It is not always clear who is in charge and how change can be made.
- Providers don't feel a need to correct problems as they are not employees of MDOC.²⁷

In 2006, to save money on its contract with the New Mexico state corrections department, a contractor cut costs and provided poor healthcare to inmates. In the wake of Wexford Health Sources' cost-cutting,

“chronically sick inmates were routinely refused off-site specialty visits. Other inmates waited for days, even weeks, to receive critical prescription drug renewals. Still other inmates were forced to lie in their own feces because basic supplies, like bed sheets, were in such short order.” In addition, staffing was a problem in prison medical units due to the contractor not filling vacant positions as yet another means of cost-cutting. In the end, people ranging from “Wexford’s top medical officers in New Mexico to nurses and administrative employees” resigned as a result of the effect of the company’s belt-tightening on their ability to help patients.²⁸

According to an investigation of one prison healthcare contractor, as a matter of formal policy, the contractor discourages treatment for hepatitis—which is epidemic in prisons—and the onerous protocol pathway is just a way of making it harder for prisoners to demand it.²⁹

In 2009, a Virginia jury awarded \$1.5 million to be paid by a prison health services contractor to settle a lawsuit filed by the widow of a mentally ill man who died of pneumonia and dehydration six days after he was jailed on a misdemeanor charge.³⁰

WHY CONTRACTING OUT NURSING SERVICES IS WRONG FOR PENNSYLVANIA

Corrections is a core responsibility of state government that directly impacts the safety and health of Pennsylvania communities. Putting more of our Corrections system into the hands of for-profit, private companies opens our state up to a whole host of potential problems.

The Commonwealth currently subcontracts certain medical, psychiatric, and pharmacy services in state prisons. Nursing care is not subcontracted, though private sector staffing agencies are used to fill nurse shortages in DOC facilities. Many of the problems DOC staff encounter working with these agency nurses would exist with nurses employed by a contracted for-profit company.

For example, DOC nurses and corrections officers frequently express their unease at working alongside agency nurses who are not committed to security. Agency nurses do not have the same training and experience in security protocols that DOC nurses have. Inmates are acutely aware of that lack of training and often look to take advantage of inexperienced staff. Agency nurses do not view themselves as part of the security team and place an extra strain on DOC staff because they often insist on being accompanied by corrections officers whenever they work with inmates.

Moreover, agency nurses do not have the same level of commitment to educating inmates about managing their conditions and diseases for their eventual return to the community. Health education is an involved process that takes time and requires establishing a rapport with the patient. A more transient workforce will be less effective at education than a stable, dedicated workforce.

DOC Nurses are Critical for Oversight

In 2009, Jeffrey Beard, the former DOC Secretary acknowledged the essential role DOC nurses have in maintaining quality health services in the current multiple contractor arrangement. According to Mr. Beard, *“Critical to the success of managing this new multiple-vendor system is a strong central office staff and well-*

*trained on-site correctional healthcare administrators and nurses who are state employees.”*³²

Commonwealth nurses have two concerns when they go to work every day—maintain safety and provide needed care. They are the on-the-ground oversight of the current medical vendors and take seriously their role of guardians of the Commonwealth budget. In conversations with DOC nurses and nurse supervisors, many expressed concerns over waste and lack of oversight of the currently contracted services.

There are structural barriers to effective governmental monitoring of private prison contractors.³² When a government agency contracts for services in other areas such as constructing a public road, taxpayers can easily see the results. Prisons, on the other hand, are closed institutions where the public has almost no ability to evaluate the quality of services purchased with taxpayer money. In addition, when an agency such as DOC has selected a contractor, the agency may be reluctant to publicize failures on the part of the contractor for fear that it may reflect poorly on the agency.

DOC’s Nurses are Trained, Experienced and Effective

DOC nurses are more than just caregivers. They are integral to the state corrections system and are front line workers necessary for the security of staff, inmates, and the community. DOC staff’s principal duties are “Care, Custody, and Control” and DOC nurses are charged with all three. Their workplace is typically in the bowels of a prison and they are often called on to enter prison cells in emergency situations.

Beyond the dramatically different work environment, DOC nurses also don’t treat the same patients as a typical nurse. They treat dangerous criminals, many of whom are infected with serious infectious diseases such as HIV, Hepatitis, and Tuberculosis.

In addition, DOC nurses are treating more and more criminals with severe mental health issues as the Commonwealth closes more State Hospitals and the former residents end up in our prison system.³³

If services are subcontracted, the vast bulk of current, well trained staff could be lost, thanks to the lower pay,

poorer conditions, and fewer benefits. If a contractor doesn't work out, as is frequently the case, the staff who left can't just be re-hired as they will likely have moved on to new jobs. A new staff would have to be built from scratch.

Protectors of Public Health

Most inmates that enter the state corrections system eventually return to the community. DOC nurses help cure inmates of infectious diseases before they are released. If the disease is incurable, they ensure that inmates know how to manage and prevent the spread of their diseases before they return to their families and communities. Without DOC nurses providing this critical education to inmates, we would see increases in HIV, Hepatitis and other serious diseases in our communities.

Training

Prior to entering the corrections system, DOC nurses undergo rigorous training at the DOC Training Academy where they learn the full spectrum of security protocols needed to work in a dangerous setting and to keep the entire facility safe. In addition, DOC nurses participate in yearly refresher courses on inmate security protocols and self defense.

Relationship with Corrections Officers

Within a corrections facility, every inmate, including patients, are considered potentially dangerous and every employee is responsible for security. Nurses and corrections officers work as a team when inmates are in a healthcare setting. Typically, DOC nurses work with inmate patients with a corrections officer nearby but not guarding individual inmates. Nurses rely on their training and experience to maintain security while corrections officers trust that nurses can react to potential situations and alert officers as needed.

DOC Healthcare Subcontracting— More Questions Than Answers

Before the Commonwealth embarks on a potentially expensive and dangerous decision to expand subcontracted prison healthcare, legislators and the public have a right to know about the performance of the current subcontracted services and how the Commonwealth expects to operate with potentially expanded subcontracting. Answers to the following

questions must be provided before taking any steps to further subcontract:

- Will all subcontracted healthcare staff have the same level of security training as current DOC nurses?
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- Over the past 5 years, how many times has the Commonwealth found PHS/Corizon out of compliance in its PHS/Corizon-run clinics?
- What are the estimated and actual savings with the PHS/Corizon implementation of the Catalyst SM electronic health record system?
- Are there any financial or performance audits pertaining to the Agreement?

Ultimately, we believe that when the above questions are answered, it will be clear that pursuing further outsourcing of healthcare services in Pennsylvania's prison is not good for the Commonwealth or its citizens. Further outsourcing could diminish safety and security within state prisons, expose the public to increased health risks, and there is no guaranteed cost savings to the Commonwealth. We urge the Pennsylvania legislature, the Department of Corrections and Governor Corbett to abandon any plans to put this core responsibility of government into the hands of any for-profit contractor.

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