COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

JOINT PUBLIC HEARING
OF THE
EDUCATION COMMITTEE AND
HUMAN SERVICES COMMITTEE

STATE CAPITOL
HARRISBURG, PA

MAIN CAPITOL BUILDING
140 MAJORITY CAUCUS ROOM

MONDAY, MAY 24, 2021
10:03 A.M.

PRESENTATION ON
STUDENT MENTAL HEALTH SERVICES

BEFORE:
HONORABLE CURTIS G. SONNEY, MAJORITY CHAIRMAN,
EDUCATION COMMITTEE
HONORABLE VALERIE S. GAYDOS
HONORABLE MARK M. GILLEN
HONORABLE BARBARA GLEIM
HONORABLE DAVID S. HICKERNELL
HONORABLE ANDREW LEWIS
HONORABLE MILOU MACKENZIE
HONORABLE ROBERT W. MERCURI
HONORABLE MEGHAN SCHROEDER
HONORABLE CRAIG T. STAATS
HONORABLE JESSE TOPPER
HONORABLE TIM TWARDZIK
HONORABLE MARK LONGIETTI, DEMOCRATIC CHAIRMAN,
EDUCATION COMMITTEE
HONORABLE JOE CIRESI
HONORABLE CAROL HILL-EVANS

* * * * *

Debra B. Miller
dbmreporting@msn.com

BEFORE (continued):
HONORABLE MARYLOUISE ISAACSON
HONORABLE PATTY KIM
HONORABLE MAUREEN E. MADDEN
HONORABLE NAPOLEON J. NELSON
HONORABLE MIKE ZABEL

HONORABLE FRANK A. FARRY, MAJORITY CHAIRMAN,
HUMAN SERVICES COMMITTEE
HONORABLE MIKE ARMANINI
HONORABLE TIMOTHY R. BONNER
HONORABLE ANN FLOOD
HONORABLE SHELBY LABS
HONORABLE CARRIE LEWIS DELROSSO
HONORABLE MILOU MACKENZIE
HONORABLE NATALIE MIHALEK
HONORABLE MARCI MUSTELLO
HONORABLE F. TODD POLINCHOCK
HONORABLE JASON SILVIS
HONORABLE JAMES B. STRUZZI II
HONORABLE KATHLEEN C. TOMLINSON
HONORABLE TARAH TOOHIL
HONORABLE CRAIG WILLIAMS
HONORABLE STEPHEN KINSEY, ACTING DEMOCRATIC CHAIRMAN,
HUMAN SERVICES COMMITTEE
HONORABLE JESSICA BENHAM
HONORABLE ISABELLA V. FITZGERALD
HONORABLE NANCY GUENST
HONORABLE EMILY KINKEAD
HONORABLE MAUREEN E. MADDEN
HONORABLE DANIELLE FRIEL OTTEN
HONORABLE DAN K. WILLIAMS

COMMITTEE STAFF PRESENT:

CHRISTINE SEITZ
MAJORITY EXECUTIVE DIRECTOR,
EDUCATION COMMITTEE

DANIEL GLATFELTER
MAJORITY RESEARCH ANALYST, EDUCATION COMMITTEE

CHRISTINE CRONE
MAJORITY LEGISLATIVE ADMINISTRATIVE ASSISTANT II,
EDUCATION COMMITTEE

MITCHELL ROSENBERGER
MAJORITY RESEARCH ANALYST, EDUCATION COMMITTEE

ERIN DIXON
DEMOCRATIC EXECUTIVE DIRECTOR,
EDUCATION COMMITTEE

ALYCIA LAURETI
DEMOCRATIC SENIOR RESEARCH ANALYST,
EDUCATION COMMITTEE

CHRISTOPHER WAKELEY
DEMOCRATIC EDUCATION SPECIALIST,
EDUCATION COMMITTEE

BOB BROWNAWELL
DEMOCRATIC SENIOR LEGISLATIVE ASSISTANT,
EDUCATION COMMITTEE

MARLENA MILLER
DEMOCRATIC LEGISLATIVE ASSISTANT,
EDUCATION COMMITTEE

ERIN RAUB
MAJORITY EXECUTIVE DIRECTOR,
HUMAN SERVICES COMMITTEE

DAWN PELLETIER
MAJORITY LEGISLATIVE ADMINISTRATIVE ASSISTANT II,
HUMAN SERVICES COMMITTEE

CALEB SISAK
DEMOCRATIC EXECUTIVE DIRECTOR,
HUMAN SERVICES COMMITTEE

IMOGEN WRIGHT
DEMOCRATIC RESEARCH ANALYST,
HUMAN SERVICES COMMITTEE

I N D E X

TESTIFIERS

* * *

TESTIFIERS (continued):

SUBMITTED WRITTEN TESTIMONY

* * *

See submitted written testimony and handouts online under "Show:" at:

https://www.legis.State.pa.us/cfdocs/Legis/TR/Public/tr_finder_public_action.cfm?tr_doc_typ=T&billBody=&billTyp=&billNbr=&hearing_month=&hearing_day=&hearing_year=&NewCommittee=Education&subcommittee=&subject=&bill=&new_title=&new_salutation=&new_first_name=&new_middle_name=&new_last_name=&new_suffix=&hearing_loc=

P R O C E E D I N G S

* * *

MAJORITY EDUCATION CHAIRMAN SONNEY: Good morning, and welcome to this joint public hearing of the House Education and Human Services Committees.

I would like to remind everyone that this hearing is being recorded and livestreamed so the public may watch. If we experience any technical difficulties, we will recess the hearing until those technical difficulties can be addressed.

For the Members and testifiers participating virtually, please mute your microphones until it is your turn to speak. Additionally for Members who are participating virtually, if you want to be recognized for questions or comments, please use the "Raise Hand" function. After being recognized but prior to speaking, please turn on your camera and unmute your microphone. After you have completed your questions, please remember to mute your microphone.

For Members attending in person, please silence all of your electronic devices.

Each testifier has been asked to limit their testimony to the Committee to 3 minutes or less. If we could ask testifiers to not read their submitted testimony verbatim. Following, the presenter may be questioned by

Members of the Committee.

At this time, we will do introductions of those that are present in the room, and I will begin.

I'm Representative Curt Sonney. I represent the 4th Legislative District in Erie County.

And we'll go to my right.

MAJORITY HUMAN SERVICES CHAIRMAN FARRY: Representative Frank Farry, Chairman of the Human Services Committee from Bucks County.

MINORITY HUMAN SERVICES ACTING CHAIRMAN KINSEY: Good morning.

Representative Stephen Kinsey, Philadelphia County.

REPRESENTATIVE KIM: Good morning.

My name is Patty Kim, and I represent the 103rd District, the city of Harrisburg.

REPRESENTATIVE BENHAM: Representative Jessica Benham, the 36th District, Allegheny County.

REPRESENTATIVE MADDEN: Representative Maureen Madden, Monroe County, the 115th Legislative District.

REPRESENTATIVE KINKEAD: Emily Kinkead, the 20th District, Allegheny County.

REPRESENTATIVE ZABEL: Good morning.

Mike Zabel, the 163rd, Delaware County.

REPRESENTATIVE D. WILLIAMS: Good morning.

Dan Williams, the 74th, Chester County.

REPRESENTATIVE ISAACSON: Mary Isaacson, the 175th District, Philadelphia County.

REPRESENTATIVE HILL-EVANS: Good morning.

Carol Hill-Evans, the mighty 95th District in York County.

REPRESENTATIVE STAATS: Good morning, everyone.

Craig Staats, proudly representing the 145th District in Bucks County.

REPRESENTATIVE LEWIS: Andrew Lewis, representing the gorgeous 105th District, about 15 minutes away in Dauphin County.

REPRESENTATIVE TWARDZIK: Tim Twardzik, representing the 123rd, wonderful Schuylkill County, Pennsylvania.

MINORITY EDUCATION CHAIRMAN LONGIETTI: Good morning.

Mark Longietti. I represent the 7th District in Mercer County, and I serve as Minority Chair of the House Education Committee.

REPRESENTATIVE SCHROEDER: Representative Meghan Schroeder from the 29th District, from Bucks County.

REPRESENTATIVE POLINCHOCK: Representative Todd Polinchock from the 144th, the central part of Bucks

County.

REPRESENTATIVE STRUZZI: Jim Struzzi, the 62nd, Indiana County.

REPRESENTATIVE C. WILLIAMS: Representative Craig Williams, the 160th District, Delaware and Chester Counties.

REPRESENTATIVE MUSTELLO: Marci Mustello from Butler County's 11th District.

REPRESENTATIVE LABS: Representative Shelby Labs, the 143rd District, Bucks County.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

And those attending virtually are Representatives Gaydos, Ciresi, Mackenzie, Tomlinson, Flood, Fitzgerald, Guenst, and Toohil.

Today's joint public hearing is focused on mental health services and how they are provided to Pennsylvania's elementary and secondary school students.

The current pandemic has exasperated mental health issues among our elementary and secondary school students and increased the need that our students are provided access to mental health services. We look forward to learning more about how these services are provided and any areas for improvement.

I thank all of our testifiers in advance for taking the time to be here with us today, and I look

forward to hearing from you.

I would ask Chairman Farry if you have any opening comments?

MAJORITY HUMAN SERVICES CHAIRMAN FARRY: I join Chairman Sonney in his comments, and I think we just need to move forward to the testifiers.

MAJORITY EDUCATION CHAIRMAN SONNEY: Chairman Longietti.

MINORITY EDUCATION CHAIRMAN LONGIETTI: I just want to thank Chairman Sonney and Chairman Farry for calling this important hearing. We know that COVID has had significant impacts on mental health concerns for our students, and so we look forward to hearing from the testifiers today.

MAJORITY EDUCATION CHAIRMAN SONNEY: Chairman Cruz is unable to be here today, so acting in his place is Acting Chairman Kinsey.

MINORITY HUMAN SERVICES ACTING CHAIRMAN KINSEY: Thank you, Mr. Chairman, and I want to thank all the Chairmen also.

As we look at what has taken place in our society, the health pandemic as well as the impact of school closings, we think that this is a very important topic, and I'm just happy to be invited and participate.

So thank you again, Mr. Chairman.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

PANEL 1

PA DEPARTMENT OF EDUCATION AND

PA DEPARTMENT OF HUMAN SERVICES

MAJORITY EDUCATION CHAIRMAN SONNEY: Our first panel will consist of Dr. Sherri Smith, Special Advisor to the Deputy Secretary for the Office of Elementary and Secondary Education; Dr. Dana Milakovic, Mental Health/AOD Specialist, Office for Safe Schools, and Statewide Advisor for Trauma-Informed Practices.

And from the Department of Human Services, there will be Scott Talley, Director of the Bureau of Children's Behavioral Health Services, the Office of Mental Health and Substance Abuse Services; and Jason de Manincor, Director of the Division of Eastern Operations, the Office of Mental Health and Substance Abuse Services.

I would ask the first panel if you could please rise and raise your hand, or just raise your right hand so that you can be sworn in:

Do you swear and affirm that the testimony that you are about to give is true to the best of your knowledge, information, and belief? And if so, please indicate by saying "I do."

(Testifiers responded "I do.")

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Dr. Smith, you may begin.

DR. SMITH: Good morning, everyone.

So good morning, Chairman Sonney, Chairman Longietti, Chairman Farry, Acting Chairman Kinsey, and Members of the Education and Human Services Committees.

My name is Dr. Sherri Smith. I'm the Advisor to the Deputy Secretary for Elementary and Secondary Education and a former superintendent of the Lower Dauphin School District.

With me today is Dr. Dana Milakovic, Mental Health Specialist/Alcohol and Other Drugs Specialist and Trauma Lead at the Pennsylvania Department of Education.

Before joining the Department, Dr. Milakovic served for 15 years as a school psychologist, 2 years as a supervisor for psychological services at the Harrisburg Area School District, as well as having 15 years as an evaluator with community mental health agencies.

We want to thank you for inviting both of us today to discuss the critically important topic of student mental health.

Throughout the pandemic, PDE collaborated with the intermediate units of other interagency State partners

to provide universal supports for educators, families, and students. We expect there to be even greater needs next school year as students fully return to in-person instruction.

After 14 months of frequent transitions to remote learning for students across the Commonwealth, additional stressors and trauma have impacted student mental and physical well-being. During the pandemic, schools continued to focus on providing safe, supportive learning environments for all students; yet, students have lost the feeling of routine and safety that schools provide.

While mental health data from the pandemic continues to be collected, we know that prior to the pandemic, over 20 percent of the students were experiencing some level of mental health concerns, and that number has risen. We know from our schools and families that more students are being reported as chronically absent and more students report feeling disconnected from their school staff. Research and other experience tells us that chronic absenteeism and lack of connection to school staff negatively impacts students' mental health, as well as their academic and social success.

It is our collective responsibility as mental health professionals, educators, and policymakers to do everything within our power to help every student. It is

with this focus that we have taken several critical actions to assist schools.

As part of a larger roadmap for school leaders and communities, in the fall of 2020, PDE developed a *Staff and Student Wellness Guide* for schools. Then in April of this year, PDE released a new toolkit and professional learning series entitled *Accelerated Learning through an Integrated System of Support* to provide school leaders with research and a systemic process for addressing academic and emotional well-being of students in preparation for the upcoming school year.

In March, PDE received a $1 million Federal grant from the Institute of Education Sciences to study the impact of COVID-19 on K to 12 students. The findings from the research will help policymakers and educators in Pennsylvania understand the challenges faced by students most harmed by COVID-19, identify ways to respond to possible future epidemics, assess whether some remote-learning strategies are more effective than others, consider recruitment and retention strategies for teachers who may be most effective with disadvantaged students, and better identify students at risk of dropping out.

The Department will also be using the American Rescue Plan Elementary and Secondary School Emergency Relief, more commonly known as ARP ESSER, funds to address

the social-emotional and mental health needs of students and is encouraging schools also to use their ESSER funding for this purpose.

As part of our written testimony today, we provide a list of resources that are readily available to students and educators, highlight additional resources that have been developed, and future efforts and needs.

With nearly half of Pennsylvania's adult population fully vaccinated and students ages 12 and older approved to receive vaccinations, schools are expected to return to in-person instruction this fall. Students are eager to learn and will return to a sense of normalcy, but to do that, we must continue to develop partnerships and expand efforts to support and enhance the emotional and social wellness and mental health services provided to students and families through schools and communities.

In the interest of time, and if the Committee Chairs agree, we will submit the testimony as if read in its entirety and will move right into questions from the Members.

Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Dr. Milakovic, you can proceed.

We'll do questions after this panel has completed.

DR. MILAKOVIC: Thank you, Chairman.

Dr. Smith actually read both of our statements together so that we can make sure we are utilizing your time most effectively and be able to have time for questions.

MAJORITY EDUCATION CHAIRMAN SONNEY: Perfect.

Scott Talley.

MR. TALLEY: Good morning. And we will be doing the same. I will do the testimony for both myself and Jason.

Good morning, everybody.

Chairman Sonney, Chairman Longietti, Chairman Farry, Acting Chairman Kinsey, and the Members of the House Education and Human Services Committees, my name is Scott Talley, and I'm the Director of the Bureau of Children's Behavioral Health Services, which is housed in the Office of Mental Health and Substance Abuse Services, OMHSAS, within the Department of Human Services. It is my pleasure to appear before you to discuss mental health in schools.

I should note that Dr. Perri Rosen, who submitted our written testimony, was unable to testify this morning, so I am here in her place to represent OMHSAS.

This morning, I would like to highlight a few points from the testimony that I believe are important to

note for this hearing.

The COVID-19 pandemic has impacted every youth-serving system in unprecedented ways. School systems in particular have been struggling to address increasing concerns about student mental health, as well as stress, burnout, and mental health and wellness of teachers, administrators, and families. While we recognize these current realities and the need to address them, it is also critical to acknowledge that youth and families in our communities are resilient.

We do not yet have enough research or data on the impact of the pandemic on mental health in Pennsylvania or nationwide. However, we know trauma, mental health, and suicide were all significant concerns prior to the pandemic. These are not new issues for schools, although schools may be more directly confronted with these issues now.

OMHSAS and the Department of Education's Office for Safe Schools have partnered closely on several initiatives related to youth mental health and supporting schools to create safer learning environments and building infrastructure to better identify and refer students to needed support services.

One initiative I would like to highlight is Pennsylvania's Student Assistance Program, commonly

referred to as SAP, which is supported by a partnership between OMHSAS, our colleagues at the Department of Education, and our colleagues at the Department of Drug and Alcohol Programs and has been ongoing for over 30 years.

Leadership from our three agencies oversee SAP implementation, and the established process involves school teams partnering with behavioral health liaisons from community agencies to screen or assess students when there is a concern that a student may have an underlying mental health or drug and alcohol concern. SAP liaisons are knowledgeable about the range of services, supports, and resources available within a county and support school teams through consultation and by providing recommendations for student supports both in the school and in the community.

It should be noted that during the pandemic, many SAP liaison agencies reported utilizing telehealth to allow for continued support to school teams, students, and families.

Knowing that schools are where students spend a majority of their time, it is important to recognize the school setting as an important point of access to mental health supports and services. Schools are not alone in their efforts to support youth mental health, and establishing partnerships with mental health providers can

help schools feel more supported in their efforts.

There is a range of mental health services that may be provided within the school setting, such as psychiatric outpatient services and intensive behavioral health services, which include individual services, group services, and applied behavior analysis services.

In addition, family-based mental health services and mental health targeted case management may also be delivered at the school. Providers of these services are licensed by OMHSAS and credentialed by behavioral health managed care organizations. In reaching out to your county mental health office, schools can learn more about available services and how to establish these partnerships.

In concluding, I would like to recognize Mr. Jason de Manincor, who is the OMHSAS Director of Eastern Operations and joins me on this call to assist in answering any questions related to our licensed services that can be provided in schools.

And I would like to reiterate as well that this is highlights and not the complete testimony which we submitted.

Thank you again for the opportunity to speak.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

We have been joined in the meeting by

Representatives Topper, Nelson, and Mackenzie, and Representative Friel Otten.

I guess I'll start with the first question for Dr. Smith.

You talked a little bit about chronic absenteeism. Have you been able to identify just how great that was throughout this year of virtual learning?

DR. SMITH: Yeah. Thank you for that question, Chairman.

So with the data collection that comes in on our October 1 PIMS I think will be where we'll identify the number of chronic absenteeism issues for this year. So that's the typical data collection of that. Until then, we don't have clear data to establish that.

MAJORITY EDUCATION CHAIRMAN SONNEY: Do you think that the potential learning loss is going to have an extreme effect on the students' mental health?

DR. SMITH: So we definitely think that, you know, the lack of connections to schools will contribute to the mental health of our students. So reintroducing our students, as many of our schools are doing right now, to in-person instruction and getting our students back into school I think will assist us in assessing where our students are and getting them just used to being back in school, to be honest with you.

So it's a good start, a good kick-start for next year, and that's why the accelerated learning plan that we put into place to process culture and climate issues to begin with as a first tier for our schools coming back next year is making students feel comfortable back in the classroom environment.

MAJORITY EDUCATION CHAIRMAN SONNEY: And, Mr. Talley, you mentioned county services. Do you believe that all of our counties are able to provide those support services to our school districts?

MR. TALLEY: Jason, I'm going to have you answer that question, because you work more directly with the counties and the regions.

MR. DE MANINCOR: Yes. Good morning, everybody. This is Jason de Manincor.

I would say, yes, there is a full range of mental health treatment services available to children, and we are constantly speaking with our full array of stakeholders and, you know, addressing any issues, you know, that are identified when there is an issue with access. So at this point, yes.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Chairman Longietti.

MINORITY EDUCATION CHAIRMAN LONGIETTI: Thank you all.

So, you know, I think all of us are trying to find something positive that came out of COVID. And I noticed from the testimony, and I had heard this before on television, that suicide, it appears that suicides were down 5 to 6 percent amongst young people, and it seems like more folks were seeking mental health support, and I believe the one testimony indicates that the top issues that were reported by students were similar to the non-pandemic years. So it looks like more people are getting help.

I can't help but speculate or wonder whether parents and children being together in homes helped to get referrals for mental health services. But whatever it was, is there anything that we learned for the future so that we can get more children to have the mental health support that they need so that we can continue perhaps to see lower suicide rates?

Any thoughts on that?

MR. TALLEY: I think there's two points -- I was waiting to see if somebody else would talk first as well.

I think there's a couple of points that I would raise. One is, there is a lot -- it's more accessible to be able to reach out now. So we have the crisis text lines, and so kids who are, you know, really tech savvy and would rather use a text line can do that. But it's easier

to reach out.

And I think the other piece is, although it's not right for every family, is the telehealth piece of it. So people are able to access telehealth now. Sometimes they weren't able to do that in the past because of schedules and things like that, but they're able to do that now.

So I think those are two things that will be helpful moving forward, and I will turn it over to anybody else who has something to add, as we all unmuted at the same time.

DR. MILAKOVIC: And that's okay. Thank you.

And I'm going to add, I agree with what Scott said.

And then, Chairman, I think this is a great question, and I think one of the things that we have definitely seen in the school system and with families that we work with is that the stigma around mental health is becoming much less reduced.

So while there were concerns before with our administrators, with our staff, with our students, it wasn't as, I guess I would say okay to say that you needed help, to say that we have a mental health concern. We've been, you know, dealing with stigma around mental health for a very long time, and one of the things that the pandemic has definitely highlighted is that we can't do

things alone. Relationships matter, and we need to find ways to be able to create those relationships and support each other. So conversations around mental health, conversations around organizational self-care, around individual self-care, have become more prominent and they are okay to have, and it has been this huge focus on, we can do this in multiple ways.

Telehealth can be a support for families in our rural communities who can't access mental health. One of the things PDE has heard when we really talked around trauma-informed practices is, it's great if you are in a community where you can go down the road in order to get support, but if you are in a community where you have to drive an hour, an hour and a half in order to access mental health services and you don't have a car, how do we get our students those supports and how do we help integrate them into our schools.

So that work has really been happening for many years, and the availability of telehealth has really supported those initiatives for schools to be able to develop those partnerships and provide families and students more support.

MINORITY EDUCATION CHAIRMAN LONGIETTI: Anyone else?

All right. Well, thank you very much.

Thank you, Mr. Chairman.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Chairman Kinsey.

MINORITY HUMAN SERVICES ACTING CHAIRMAN KINSEY: Thank you. Thank you, Chairman.

Dr. Smith, I want to go back to your statement about students being chronically absent and disconnected from school.

In your report, can you tell us some of the reasons? I mean, is it -- I'm assuming there's a variety of reasons that we're seeing children chronically absent. But, you know, I represent the city of Philadelphia, and I know that there were reports that came out that technology was one of the concerns about it. In talking with some of the parents and students in my district, some of it seemed to be a mindset, like summer -- it's almost like the summer session and "school is out" type mentality.

And then other students reported personal responsibilities at home, and again what I mean by that is that students were now saying that they had to either care for a younger brother or a younger sister or there were more additional chores put on them by their parents. Is there something that you're seeing overall that is leading to the chronic, students being chronically absent and/or disconnected from school?

DR. SMITH: Yeah. That's a really great question, and I think all the things that you have mentioned are definitely impacts that caused some of the concerns with chronic absenteeism.

You know, when students are in a classroom in school, they are in front of their teachers and there's less stimulus around them that can interfere sometimes with their learning remotely. And, you know, one of the things I think we have learned is some students really thrive with remote learning and others struggle with that concept and really need that in-person type of instruction to stay connected to their education.

But that, on top of it all, as you indicated, you know, many times in the homes we had parents that were working, and they were trying to assist their students in staying engaged while they are also trying to complete their work in the home. So I think a lot of those things did that, I think the disconnect.

You know, the one thing I will say is that we, or one of the things that I think we tried to provide through the Department and through our intermediate unit partners and to our schools is to be creative in ways that you build relationships with the students and the parents if there wasn't a good connect with technology, and I know in many places that there was a lot of engagement with students in

building relationships.

We had a meeting with a group of students and the Department about 3 weeks ago, and actually some of the students that we engaged in indicated that they had stronger relationships with some of their teachers through the remote learning than they did actually in the classrooms.

So again, I think it's, you know, really based on the student, each student in their own home environment, and how they are, the type of learner they are and whether or not they were engaged or then moved to chronic absenteeism or not.

Dana, I don't know if you have anything you want to add to that.

DR. MILAKOVIC: I think I would just like to add that this is a trend we're seeing across the United States and what we have done with the Mental Health Technology Transfer Center, which is a national center out of SAMSHA, and they are seeing similar things.

And Pennsylvania has actually been highlighted in the work that we have been doing in terms of addressing chronic absenteeism and supporting schools, but we are still finding that we do see disproportionality based on where a student lives and the resources that they have available.

And the connectivity is something we have been working on throughout the pandemic and really what started the big relationship between PDE and our IUs and PDIS, so that we could access more students and be able to get in families' homes.

But it is a continued concern and something we are definitely addressing and using as much data as we can get through our interagency relationships to be able to support our families.

MINORITY HUMAN SERVICES ACTING CHAIRMAN KINSEY: Thank you both very much.

Thank you, Mr. Chairman.

MAJORITY EDUCATION CHAIRMAN SONNEY: Representative Isaacson.

REPRESENTATIVE ISAACSON: Thank you.

My question is about the resources that are available in our schools. I am glad to hear, and I would agree, I think there is slightly less stigma, but that means we are going to have a higher demand, or at least that's what we're seeing in my district, we're seeing a much greater demand. And I'm wondering if we have our arms around what are the mental health supports in our schools across the entire State and what does that look like, because what I hear is, it goes all the way from the nurse to a psychologist and/or psychiatrist. And schools have a

whole variety of difference, and I'm wondering if you have done that analysis to see where we have dramatic weaknesses across the State of Pennsylvania.

DR. MILAKOVIC: Thank you, Representative, for that question.

I think it's definitely something that's on our radar. One of the things that we have built into the accelerated learning plan that Dr. Smith talked about in the beginning is that idea of, how do we create positive learning environments?

When I reflect back on the testimony from OMHSAS and the discussion around resiliency, that's really what we are focusing on on a universal level. So how do we address at a universal level, for every single student that walks in our building, how do we address building a positive learning environment? How do we make them feel safe and secure so we can develop social-emotional skills and we really can focus on let's provide supports for everyone so that the children who are experiencing more mental health concerns, who are experiencing more trauma responses, rise to the top and we can individualize supports on them and be able to really look at how we support students. It's not possible to have a mental health professional for every single student in our school, and not every single student needs it, but if we focus on developing that equitable

trauma-informed State learning environment to begin with, then we'll be able to individualize those supports for other students.

Scott talked a lot about our Student Assistance Program, and that is present in every school and is supported by OMHSAS, the Department of Drug and Alcohol, and PDE. And we also have regional coordinators for every part of the State to be able to provide more support and really help them flesh out those services and get the supports they need.

It does very much differ on what district you're in. With being a local-control State, we have a wide variety. At PDE, we're really trying to focus on relationships so that educators understand you don't have to have a psychology degree in order to be a positive influence on a child's life and be able to create that mental health support. It's really about those relationships.

So in some of our districts, we have nurses who are on mental health teams, and they have those relationships. In other districts, it's the secretary. They walk in, and they're having that first positive interaction, and it really is about how do we develop that staff capacity. And that has been one of the major focuses we have in the accelerated learning, knowing that we would

love to have more mental health professionals in our schools, but be able to have that pipeline of staff and able to do the support and the funding. We want to make sure we utilize all the staff that we have.

DR. SMITH: And if I may add to that.

Additionally, with the ESSER III, the last round of ESSER dollars that came from USDE, the ARP ESSER, we have in there on the State set-aside the 5-percent learning loss. One of the things that we are recommending is that we have an opportunity or a grant opportunity for schools to increase the personnel for mental health needs in our schools.

So know that we are focusing that to provide additional supports to our schools in the area of mental health personnel.

MR. TALLEY: Yeah. If I could add one thing.

We're working very closely with Dana, and the Department of Education is and the State is doing this, we're trying to become trauma informed. And I think it's really important to note that all staff should be trauma informed. It's a big lift, and we're working on it. We're working on it in OMHSAS, I know they're working on it in PDE, and we're actually working together on it.

But I wanted to make sure that the Committees were aware that that's a big part, and it's a much

different approach to somebody when you ask them "what's happened to you" rather than "what's wrong with you." And so that's the outlook we have through our trauma approaches.

REPRESENTATIVE ISAACSON: Thank you.

I might just note that I believe in some other States, they have done some telemedicine right into the schools to help support that mental health. So I don't know if you have had a chance to look at that, but I would just submit that as an idea.

Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Representative Friel Otten.

REPRESENTATIVE OTTEN: Thank you, Chairman.

One of you just mentioned that you don't have to have a psychology degree to have positive relationships with kids, and just kind of spinning off of that, I am finding that the greatest concern that I'm hearing from parents, from teachers, from other folks in the community who are working with our kids who do need mental health services is the workforce issue, the lack of access. Even if you do have health insurance that will cover it, that there are no beds. There are 6-week wait times to get in to a provider.

And so, you know, as a parent, I guess my thought

is, what does a mom or a dad do if they have a child who is in crisis and who needs, who needs care and attention from a professional but that's not immediately available. Are there things that we're building in to our structures and our systems in the schools that support students and family members in kind of a DIY? Like, what do you do personally in the case of a mental health crisis?

I've had several constituents who have reached out to me because their children can't get access to a provider or to an inpatient facility when it's needed. And so I kind of feel like we're at a crisis moment in the workforce where we really need to be teaching our students, our faculty, our parents, our community members about how to handle these situations and get these kids by until they can get in to see who they need to see. And then in addition to that, we need to work on the workforce issue.

But any suggestions or thoughts? I know in our district, we have a program called Communities That Care where they do peer-to-peer programs. But what other things are available within the districts?

DR. MILAKOVIC: So one of the things that is available in the districts is the Student Assistance Program, and so this pairs educators in the school system with mental health professionals.

So I definitely hear your concern. I hear your

concern from working in the schools for so long. We still, you know, hear those concerns in the districts we're working with, and as a mom.

We are really trying to focus across the State in our partnership with OMHSAS and DDAP, one, how do we make Student Assistance Programs more widely known, because while all schools have them, not all parents know about them. And so not all parents know that they can call their school and they can get help and their student can get referred out for a mental health evaluation, a drug and alcohol evaluation.

The other thing that we are really focusing on in schools is, how do we support our mental health professionals to be able to free up their time to use their capacity for students who need it the most, like the students you are talking about. And I know from a personal perspective, you know, being in the schools, when we would see students who needed more support than we can give, it really is like a team's approach.

And Scott mentioned the relationship that we have together, and we work a lot together. And one of the things that we have been focusing on is, how do we take the multitiered system of support that is available in schools and really look at that tiered approach to individualize support and pair it with mental health? And we know that

schools need guidance around that, and we have really spent this last year working in a partnership with OMHSAS on being able to develop that guidance. I'm talking to schools across the State who are doing it well to, what lessons can we learn? How can we help other schools be able to do that in a faster way and not have to go through trial and error, so that we can give ideas on being able to provide those supports in a school when they are not available in the community.

I would have to rely on Scott to talk about the community aspect of it, but in the school setting, we really are thinking like about how do you do needs assessments. How do you teach resource mapping so that schools don't feel they have to do it on their own and they partner with their communities. And that is a huge part of our accelerated learning modules that we did, is really walking you through that needs assessment and resource mapping to be able to help schools develop those relationships that they may have not historically had.

MR. DE MANINCOR: This is Jason at the Office of Mental Health and Substance Abuse Services.

And I would like to say that our county mental health programs and the Medicaid behavioral health primary contractors, the managed care organizations, have been working very hard over the last number of years with

community-based providers to ensure additional access to mental health treatment services in schools.

If you have a few minutes, I would love to provide an overview of really what the landscape of mental health services for children looks like in Pennsylvania.

So we have a variety of facility-based services, such as psychiatric outpatient clinic services, where a child can go to see a psychiatrist or a therapist, much like they would go and see their PCP. We have a lot of outpatient clinic satellites that are located in schools.

Another facility-based service is partial hospitalization programs. This is where a child can attend a program with other children to work on mental health concerns in primarily group settings with some individual sessions or time with the psychiatrist as needed. And very much like outpatient, there are partial hospitalization programs located in schools.

We have inpatient psychiatric units that are part of acute care hospitals, as well as private psychiatric hospitals, that provide short-term treatment to stabilize a youth and discharge them back home where they are linked to lower levels of mental health treatment.

Other services are more mobile in nature and can occur in a variety of settings, so such as the home, the school, or the community, depending on where the child

needs the service. So intensive behavioral health services, or IBHS, includes three main categories of service -- individual service, group service, and applied behavior analysis, or ABA -- as well as a provision for evidence-based treatment, which can occur in any of the three main IBHS service categories.

There is also what is called family-based mental health services that are delivered by a team of therapists who work with the youth and their family with a focus on structural family therapy, really getting at the dysfunction within the family, how to improve that to improve the child's mental health overall.

We also have mental health targeted case management services that can assist children and their families in gaining access to needed medical, social, educational, and treatment services.

Someone mentioned crisis intervention. We do license service mental health crisis intervention that are available to children experiencing a mental health crisis. And I did want to note that telephone crisis services and mobile crisis services are available in every county.

Sometimes children do need to be placed outside of their home for a time to receive needed mental health treatment. Some of these services include things like Community Residential Rehabilitation Host Home Services, or

what we call CRR Host Homes, where the child gets placed with a treatment family who has received special training to work with children with mental health challenges.

Another out-of-home treatment placement is residential treatment facilities for children. These are facility-based levels of care that can provide longer term mental health treatment in a setting that is really highly supervised and highly structured for those that need it.

I did also want to mention that more recently, Pennsylvania has made some additional services available to youth 14 and older, including psychiatric rehabilitation services. Now, these are facility-based or mobile services that provide emotional, cognitive, and social skills development for the individual served, including youth.

And then as someone else mentioned, we do license peer support services, and these are provided to individuals, including adolescents 14 and older, by someone with that shared experience of having a mental illness. This service can provide shared experience and assisting with navigating the mental health system from someone who has actually been there.

And as previously mentioned, I really do think that one of the things that really has improved access during the pandemic is the use of telehealth. So during the public health emergency, many of our mental health

treatment services have been provided either wholly or in part through telehealth.

Now, the services I just talked about are those that are licensed by OMHSAS. There are additional mental health treatment services available that we don't license, and these are services through various individual practitioners, so psychiatrists, psychologists, and other clinicians like licensed social workers, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed behavior specialists, and certified music and art therapists. Group practices that are made up of individually licensed practitioners don't need to be licensed by OMHSAS, but there are many of them that provide mental health treatment services to youths.

There are also programs like was already mentioned earlier, which is the Student Assistance Program in schools, which is really a team process that identifies and helps students to overcome barriers to learning, such as mental illness and substance abuse, and they can make referrals to treatment and other support services.

But I did just want to let folks know that programs that are licensed by OMHSAS are available on the DHS website on the Human Services provider directory, and I can certainly provide that link.

Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Members, so that we have enough time to be able to get through the other remaining two panels, Representative Schroeder is going to have the last question for this panel. So if any of the Members have questions that they would like to have answered from this panel, please submit them to either Chairman Farry or myself, and we will submit them for those answers.

Representative Schroeder.

REPRESENTATIVE SCHROEDER: Thank you, Chairman. I'll be quick.

I think it's, I guess Dr. Smith, if you would want to answer this. It has to do with the Institute of Education Sciences, the $1 million grant. I guess it's over a 2-year period that the research will take place.

So I was just wondering, with the collection of data and everything happening, is it including student surveys? Are you actually interviewing students and talking directly to the students?

DR. SMITH: So, yes. The IES is comprehensive where we get lots of stakeholder -- teachers, students, parents -- a lot of input into the whole process.

Additionally, one of the things that I think is really important to note is with, you know, the

requirements from USDE on a lot of the learning loss and those types of things. There's a lot of data collection that is occurring for all these grants and stuff that will provide, I think, a lot of information for us on how our students are doing and provide opportunities for student input.

Certainly, you know, hearing directly from our students, we can learn a lot from that, and I think it's an important part of the whole data collection, no matter if it's through the IES grant or through our own collections at the State level.

REPRESENTATIVE SCHROEDER: Okay.

And just, I wanted to say like even the impacts of the extracurriculars and things through the past year that, you know, I have heard from many parents and even grandparents that their student athlete, who was really outgoing, no longer is that person right now, and they are really nervous about that going forward. But the music, the sports, you know, obviously the academics and afterschool activities, are a really important impact, I think, that had on student life, so I just wanted to make sure that we're doing that.

But I'll conclude there and let us keep moving on. I know there's a lot of questions today. Thank you very much for being here.

DR. SMITH: You're welcome. Thank you for the opportunity.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

MR. TALLEY: Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Now we're going to move on to the second panel. I would like to thank all of you that just completed your testimony. And I hope that some of you might be able to stay on in case there's additional questions, but we're going to move to the second panel.

PANEL 2

SCHOOL ENTITIES

MAJORITY EDUCATION CHAIRMAN SONNEY: On the second panel, we're going to be hearing from our school entities. We'll be hearing from Jason McMillen, the Director of Business Programs and Services for Appalachia Intermediate Unit 8; Dr. Titina Brown, President of the Association of School Psychologists of Pennsylvania; Nicolle Hutchinson, Executive Director and Instructional Coach, Gillingham Charter School; Melissa Myers, Principal, Wilkes-Barre Area School District; and Charles Michael, Principal at South Allegheny School District.

If I could ask all of you to please raise your

right hand to be sworn in:

Do you swear or affirm that the testimony you are about to give is true to the best of your knowledge, information, and belief? And if so, please indicate by saying "I do."

(Testifiers responded "I do.")

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

And Mr. McMillen, if you would like to begin.

MR. McMILLEN: Good morning.

On behalf of the Pennsylvania Association of School Business Officials, thank you for the invitation. My name is Jason McMillen, and I'm the Director of Business Programs and Services at Appalachia Intermediate Unit 8, and it's my pleasure to talk about the topic of mental health today and specifically the purpose or the impact that a School Based Access Program can have on mental health and how it works. I have written testimony for your reference.

A school-based mental health program is specifically for students with a disability as defined by an education program. SBAP funds cannot be used for students that do not have an individualized education program, or IEP, and can only be used for services that are

defined in that IEP.

These psychiatric services often are more physical ailments, such as physical therapy, occupational therapy, nursing aide and personal-care aides. But more importantly, any services defined in the IEP must have a duration and a frequency, so it can't be provided as needed, and once it is defined in the IEP, it has to be provided to ensure that is being met.

So the limits of the SBAP funds are significant to mostly students that have, if you have significant psychiatric needs, you can use those. But for what would be a less than significant mental health need, it's difficult to use the School Based Access funds.

There has been already talk about what schools are currently doing. The SBAP program is in every school. It does make referrals, and schools are providing other associations with other programs such as Communities in Schools, the Association of Clinical Research Professionals, Victims' Services, and they use a variety of ways to pay for these, such as just local funds or maybe a State and Federal grant or a local grant.

And then we talked about, earlier the panel talked about guidance counselors, social workers, psychologists, almost any school employee has been involved in or could be involved in, and depending on your school,

to provide services.

This is allowed due to the limited resources that schools have. I think a lot of schools realize that there is a gap that needs to be filled, and they are just filling it with the people they have, because it's difficult to find other professionals or it's, you know, financially difficult to get those professionals.

At IU 8 this year, we have had openings for social workers and psychologists the entire year. We had schools ask us to provide services for social workers, though when we couldn't provide them, we didn't have the capacity, they actually hired a social worker that was once our employee. So we had a resignation and they had a hire, which didn't actually change any of the capacity that was available in the area, it just, you know, moved around who was paying for that capacity.

IU 8 additionally, though, has received a grant from the Pennsylvania Crime and Delinquency for trauma-informed training. So we have been working, through that grant, to train to become more trauma informed.

So with that, I will allow any questions and refer you also to my written testimony.

Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Dr. Brown.

DR. BROWN: Thank you so much for inviting ASPP here today, and thank you to the other panelists who are here to promote best practices in student mental health.

You have our testimony and some handouts that was provided, so I just want to highlight some areas.

The first that I would like to highlight are some of the statistics from our national association that indicate only one out of every six children who need it receive any mental health services, and 80 percent of that occurs in a school setting. Students with mental health needs have only a 40-percent graduation rate.

So those numbers are sobering, but there's also many real-world examples of how school psychologists help to provide services to students in need. So we may support high school students to remove barriers to learning, including symptoms of ADHD, or with elementary students who may be having behavioral issues, refusing to go to school. Or we might provide risk assessments for students who are feeling that they may harm themselves, and we connect them to community providers. We communicate with families, community agencies. And we also provide telehealth services. That has been something that we have developed significant resources for across the State in response to COVID.

As you can see by the graphic provided, those

real-world examples only scratch the surface of our practice model. We bridge the gap between academics and mental health as school psychologists.

So COVID-19 has brought concerns with student mental health to the forefront. Evidence of student need can be found from the U.S. Centers for Disease Control, which cited a recent rise in calls to help centers, or several journal articles that have been published indicating a rise in reports of depression, anxiety, and difficulty accessing services, including those for addiction.

Nationally, there's a shortage of school psychologists, so some of the members have also talked about the difficulty of accessing services. This includes PA. So COVID has magnified the disparities between communities, and that includes the large gap in ratios in some districts. The average across Pennsylvania for school psychologists is 1 to 1500. The national recommendation is 1 to 500. So what we're looking to is to improve those ratios so that students and families and staff have access to those mental health providers.

So an example from a colleague who went from 1 to 1500 to 1 to 600 indicates that when that ratio was improved, she was able to improve services across our practice model, but also direct services to students. She

went from serving 7 students in 4 years directly to 35 students in 1 year. Improving those ratios creates a system that is proactive, focuses on the whole child, and promotes best practices in early identification.

One solution comes from Ohio. It addresses its shortages by including a line item in their annual budget that funds the final year of graduate training for students who are placed in the school setting. That statement is based on a starting teacher's salary, and it makes entering the field of school psychology not only more attractive to graduate students but also allows them to focus on the demands of their final year, which includes a full year of full-time work in a school setting.

So COVID has taught us a lot that we cannot wait to address student mental health needs, and so I really appreciate this opportunity to work together to remove the barriers of services. So thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

We have been joined virtually by Representatives Gillen and Silvis.

And next will be Nicolle Hutchinson.

MS. HUTCHINSON: Good morning.

I'm Nicolle Hutchinson, Executive Director of Gillingham Charter School, the first and only public Charlotte Mason School in the U.S., and we proudly serve

250 students in Schuylkill County, which is located in the anthracite coal region and is known for some of the highest rates of alcoholism in the nation.

Seventy percent of our students qualify for free and reduced meals, and we see mental illness affecting our students. We have low levels of serotonin and dopamine neurotransmitters, which affects their moods and motivation, and their brain's frontal lobe is greatly altered. This part runs our executive functioning skills, and many don't really realize that. Just like students with attention deficit disorder, or ADD, students with mental illness are impulsive, disorganized, and unmotivated, and unless they are really interested, they struggle to pay attention. In the end, they can't remember as much and they struggle to control their emotions.

They didn't bring these issues upon themselves, and they cannot change the physical makeup of their executive functioning brain. It's like my eyesight. I was not happy when I turned 40 and needed glasses. I can't will myself to see better; I have to wear these. But people with ADD and mental illness cannot will their brains to be better and they aren't happy about their struggles, and they actually have very low self-esteem and get more depressed. I mean, if they can't fit us, then we need to fit them. We must provide the "glasses" to enable these

"smart but scattered" human beings to learn successfully.

So at Gillingham, we do that in two ways:

First, our entire program is carefully structured to create a positive learning environment for all. Atmosphere is key. We create a sense of home and belonging to create "relaxed alertness" for the brain to learn at full capacity.

So we are intentionally a small school with small class sizes, so everyone knows your name.

Our school building is not institutional but beautiful and orderly.

Our teachers teach the same students for 2 to 4 years. They loop. And they eat daily with their students.

And we are constantly recognizing our students' successes using the Nurtured Heart Approach instead of focusing on the negative, and Restorative Practices daily build community and belonging.

And we learn, eat, and play outside, boosting physical health and serotonin and dopamine.

And phones are not allowed in classrooms, so less distractions and less chances of bullying.

And our method of instruction provides interesting books and hands-on activities to keep the mind highly engaged and attentive.

And students narrate. They ask the questions, and they talk about the ideas, so their thoughts matter.

And all of our students don't have a choice; they have to learn art, Shakespeare, Spanish, Latin, and music. They play an instrument, take nature walks, play sports, and internships to use the right side of the brain to support the left side and to boost the serotonin and dopamine.

And on top of all of that, we have additional supports just for those with mental illness. Our staff are trauma informed. We have an expert executive function deficit trainer. We have a positive point system to provide outward motivation. And since these students don't work well alone and get unmotivated, we give every student a Chromebook and Internet services using the ESSER grants so that we can have 3 hours of live lessons every day during remote learning this year. And we offer student study group with adult coaches during the afternoon asynchronous learning to keep the students on track and to keep them from being lonely.

We found that we can't afford alternative ed programs all the time, so we have designed our own self-contained classrooms to coach executive functioning, and we have a social worker, a student coach, and a student assistance program and a reflection room to cool off and to

cope. And it's working. Our parents are saying, my child is no longer depressed; my child would not get up for school, but now she gets up every day with a smile; and, my child would never have graduated. And I've heard students say, I finally discovered that I have a future.

And you can help us. I appreciate that you guys asked how you could. And charter schools don't profit off the backs of special needs kids, as some would like to say we do. Actually, many students come to Gillingham because they weren't served or even identified. And charter schools need more access to the mental health services offered at intermediate units.

In Schuylkill County, our families say that they just need more TSS workers, and I had a family tell me that there's not one therapist in our county who focuses on attachment disorders. And teachers, even special ed teachers, we just don't know enough about executive functioning deficits, so we need more professional development and instruction in teacher colleges.

And finally, I would just ask that we just don't cut the spending to charter schools. No student or parent should have to fear that the school they love be closed due to funding cuts, so that the funding for their special education services will be slashed.

So, I mean, if you'd like to get a tour of our

little school, please let me know, and I'm happy to answer any of your questions.

Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Melissa Myers.

MS. MYERS: Good morning, and it is such a pleasure to be with you all and testifying on behalf of the importance of mental health and the care for our students and overall well-being within our public school system.

I am the Principal of Heights-Murray Elementary School in the Wilkes-Barre Area School District. Our school hosts approximately 900 children who attend kindergarten through sixth grades, 93 percent or more of whom are economically disadvantaged.

Our students represent a very diverse background and a variety of cultures and languages. In a traditional school year, pre-pandemic, about 700 of our students walk to and from school each day to the location of our school within the community, as it is close access to their homes.

Typically, we have about 40 to 50 students who participate in our school-based behavioral health program, which is located right within our building on site. This particular program is facilitated by the Children's Service Center of the Wyoming Valley.

Prior to the pandemic, the center has also

facilitated in-person monthly counseling sessions, group therapy sessions for children, and on-site medication management, during which parents and guardians were able to come to school for their child's medication management. Our school is closer and more accessible to the home environments than the center and many other mental health agencies, especially when a family does not have a personal vehicle to travel. This, you know, close location enables and empowers not only the children to get the help that they need but also to better accommodate the parents.

In addition, we have multiple children and families who utilize different mental health agencies for different services such as outpatient counseling, family-based therapy, trauma counseling, medication management, and more. Particularly, the Children's Service Center of the Wyoming Valley has been an extreme support system for our children in crises as well.

Unfortunately, due to the pandemic, we have had multiple recent crisis referrals in elementary-aged children K to 6, again, the population that my building services. The children have notably experienced significant depression, unfortunately suicidal thoughts, and have even began abusing drugs or alcohol due to the more frequent exposure to these elements while being home during the pandemic.

The pandemic has intensified the need for the available mental health services that are available due to increased social anxiety and our students' unfortunate domestic situations, exposure to inappropriate online interaction with peers and possibly adults that may not be brought to light immediately, and increased exposure as well to criminal activity in poverty-stricken homes. All of this has initiated more immediate care for mental health, traumatic events, and more.

Our students must have access to mental health services, as they do now, but the pandemic has intensified the barriers for many parents and students reaching that level of support that they so desperately need.

As we know, mental health services at a young age is critical to develop their coping skills through the mental health disorder or life experiences that the child is working through. By having immediate or planned access to services, children and families are enabled to acquire long-term skills and improved mental health in order to become well-functioning, successful adults and contribute to our society.

The early recognition of mental health in our children is vital. By having the mental health care professionals available in our schools, much beyond a school-based behavioral health team on-site, we are able to

establish a rapport with parents and guardians to build their understanding and cooperation to help their own children, thereby implementing proper mental health care in the young stages of children's lives.

The pandemic, unfortunately, as we know, has significantly impacted how we systematically address mental health in our schools since we have been limited to provide in-person services on school site due to following the CDC's guidelines and recommendations for health and safety in the school setting. Unfortunately, many parents and guardians don't have a personal vehicle, as I mentioned prior, making it difficult for them to coordinate their visits to these different centers and agencies for services.

Although virtual appointments are accessible and have occurred, the effectiveness of the level of support has been noted to be a major challenge, since as we know, Internet connectivity may be a barrier and not always functioning properly, thereby compromising the integrity of the service provided.

We anticipate there will be a significant increase in mental health concerns for our youth once all students return to in-person learning. Currently here in Wilkes-Barre at Heights Elementary, we only have 220 students out of 900 that are here in person learning

due to a parent's option to take advantage of that in-person learning during the pandemic. All other students are virtual and have been since the beginning of the school year, thereby not having that face-to-face interaction with their staff or peers much at all since March of 2020 when the pandemic began. We must be prepared to address and handle the mental health issues that will be presented to us post-pandemic when all students return to school.

Our parents here at Heights see our school as a community center where they come for support, referrals for assistance, and engage in the SAP team and process involved with that, a sense of care and teamwork for their children. In order to strengthen our community overall, providing access to mental health care for students on site is and has been found to be the most effective.

Through the help of the additional funding that our district will receive for post-pandemic relief, we plan to purchase resources to successfully implement a social-emotional curriculum to equip particularly our sixth through eighth grade students with the skills to identify important social-emotional issues that they are experiencing and how to navigate through them. Our hope is that this curriculum will hopefully infuse to all levels, K to 12, over the next few years, as it is so desperately needed.

Providing mental health within the schools not only increases availability to services but works to decrease the stigma through psycho-education. Not only is it able to increase the education for those who are coping directly with the need but also those around them, including professional development for our teachers, staff, and the students' peers.

Viewing mental health access as a prerequisite to overall wellness and the ability to function in the educational and home environment will ultimately increase a child's ability to focus upon academics as well as in the long-term perspective working to overcome poverty, reduce incarceration, decrease substance abuse, and increase physical well-being.

While most programs have a family component, there is the alternate side to this that we must not ignore in which guardians or parents are resistant to become involved with treatment for their children. Many of us, as I have listened, have testified to the importance and the recent growth in reducing the stigma. However, the stigma does still exist, especially at the elementary level when their children are very young.

This by no means decreases the child's present need. By having mental health services available and provided within the school setting on site, the barrier of

uninvolved guardians and parents is significantly reduced, allowing for treatment to be provided and reducing the likelihood of a child's mental health needs being overlooked and untreated.

In closing, a great deal of on-site mental health care is primarily focused in our elementary schools, but we must not overlook all school levels, K to 12.

Thank you, and my testimony has been provided for reference.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Charles Michael.

MR. MICHAEL: Yes. I would like to thank everyone for inviting me today.

I am Chuck Michael. I'm Principal at South Allegheny School District, which is in the suburbs of Pittsburgh, and I'm going to talk about some of the things we have been doing and some of the things we have seen that are working when it comes to mental health, some of the things that aren't working, and our plans for the future.

Going into this school year, we had a behavior therapist that we contracted through a local agency, and we had school-based therapists for our students. We also hired this summer a social worker that would be contracted through an agency and work with our students.

The social worker was very positive. It was someone that would reach out to our families. They would do home visits. They would call home. They would email. They made a lot of connections with our families.

The behavior therapist was an issue for us because of the high turnover. We had four people fill that spot in one year, which did not allow us or allow them to make connections with our families. That's why we're actually moving to another agency, to hopefully keep that consistence.

The behavior therapist and the school-based used telehealth during the school year. We were here; we were not here. We were virtual; we were in-person. We were hybrid. Since February, we have been 4 days in-person. We were only getting about 30 percent of our students here in the school.

We are providing the students with laptops. We are providing them with hotspots. Our tech support team has a 24-hour hotline that gets back to students and parents within about 12 hours with any types of issues. So we are providing the services via telecommunications and in person.

Some of the issues we are running into is the environments of the families. There have been numerous times when I have had to call home and speak about the

background noise or people in the background or things that weren't conducive to an educational environment. That, I think, is one of our biggest challenges of students being at home. The other challenge was, and probably it happened today on this call, is people, kids having their cameras off and maybe being present but not engaged. That's one of our biggest challenges, whether we talk about academics or even mental health, is they may be online, but are they engaged in that, in the therapy or in the academic situation. That's why we're pushing for in-person, especially next year when we want to bring all our kids back.

Like I said before, the main things that worked for us was anytime you had a positive connection. Anytime you knew, we would reach out to staff and say, do you have a connection with this student, or this student. Emails; phone calls. Even we did a lot of home visits, especially early on when we were 100-percent virtual. And if the staff, even if it was somebody that had the kid 4 or 5 years ago, if they had a positive connection with the kid, that would work and help us help that child with their mental health and providing them those services.

That high turnover in that behavioral health therapist position did hurt us. Hopefully, we'll remedy that for next year.

Some things that we want to do moving forward is we want to educate our community: one, you know, why we provide mental health; why their children should take advantage of that mental health. We want to make sure that we have a plan for in-person and if a child would need virtual and how that plan would be carried out. We are adding more mental health services with the different grants we have and partnering with different agencies.

The thing that we're trying to stay away from is having too many agencies involved. We're trying to narrow it down so then we have a clear path when a child needs assistance, whether that be through a psychiatrist or TSS or whatever those agencies have. But right now, we have a bunch of different agencies, a variety of different agencies in our schools, and we're trying to narrow that path so we can provide consistency.

I think also the PAYS data that we're going to be collecting here next fall will really be able to support, we'll be able to look at that data and support our kids with their answers on that data if we can, you know, get it done and get our kids in the building.

I would answer any questions. I wanted to keep it short. My testimony, my written testimony, is, well, bullet points, so I didn't have a very long, drawn-out testimony. But I think what I want people to take away

from me today is that it is, you know, and I have said this to many people, COVID is a blessing and a curse. We were able to provide our students with laptops. Every student had a laptop. If students needed it, they had hotspots. We were able to provide them asynchronous instruction, whether they were here or not. And we were able to provide them with that mental health therapy, whether they were at home or in the building.

I think now it's that education, educating parents and educating the community on why these services are important and making sure that we are able to provide those services, especially when kids come back a hundred percent in person and help them with that transition back, because it's going to be a tough one.

Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

The first question is from Representative Topper.

REPRESENTATIVE TOPPER: Thank you, Mr. Chairman.

I have heard now here on a couple of panels discussion surrounding the accelerated learning programs that are being developed, both, you know, PDE has developed and I think local school districts are developing as well, and hiring more staff. And just so that we are on the same page, you know, the 20 percent of money from the Feds that are designated specifically for the learning loss, I

believe it lasts for 2 years. Is that your understanding as well? For anybody.

MR. McMILLEN: Yes, that's my understanding.

REPRESENTATIVE TOPPER: So just making sure, and I'm sure we are, that our plans for the added staff, have that in the consideration. In other words, that we do have a timeframe that we are dealing with in terms of having this plan for accelerated learning, additional staff come on, you know, and then in 3 and 4 years that money runs out. Do we feel comfortable that the plans that we are developing in regards to learning loss and mental health, trying to make sure that our students are back on track, is 2 years enough time for that, in your opinion?

DR. BROWN: If I may address that.

One of the things that we had a discussion as a State association is the difficulty with hiring personnel when it is time-limited. And so that's why one of the things we highlighted was just how Ohio dealt with its lack of individuals in the pipeline. And I think you heard from some other panelists, the difficulty for many educational entities across the State is budget and finding personnel. And so if we limit that to 2 years through essentially a grant, that is unlikely to encourage people to have the long-term personnel that is needed to make the long-term changes for student mental health.

So when we think about that, again, the idea of being time-limited I think limits the entity's ability to add staff, particularly staff that can support students individually, families, and other educational professionals.

REPRESENTATIVE TOPPER: But we recognize that as of right now, it is time-limited as far as the Federal dollars. So you think we'll have a difficult time in terms of the additional staff that will be required to meet the plans that are being set forth by both PDE and local districts, or are we on track to meet those?

The summer will go quickly, correct? And we'll be back in school before we know it.

MR. MICHAEL: It is a---

DR. BROWN: Yeah. I don't know if any of the other panelists want to address this, but particularly if you're talking about school psychology, one of the issues is we don't have individuals in the pipeline to fill the gap. So that is one of the reasons we want to make it attractive to graduate students to come to the field, is we just need to have the people available. So whether it's the staff to actually hire once the positions are there, or whether we're talking community-based providers. I have heard the same thing in our geographic area from parents and students, is the waiting list, and those will not go

away over the summer.

So again, I'm not sure that we'll be able to address it in such a short amount of time.

REPRESENTATIVE TOPPER: Okay. Well, then I think it's probably incumbent upon us then to help with that in terms of creating plans that we feel we can accomplish in that amount of time, and maybe over the next few weeks those discussions will take place here and we can help with that.

Does anybody else want to add anything? I'm done. Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Representative Nelson.

REPRESENTATIVE NELSON: Thank you.

I appreciate all of you in your testimony as well as the panel ahead of you. I think we are in this era where trauma-informed instruction is critical. And for you all, ensuring that you have a staff that is well trained in trauma-informed behaviors and supports is critical.

My concern is, to what degree are you being informed of student trauma? My understanding is that for most, you all are informed of student trauma effectively through internal discovery or self-reporting. How comprehensive do you feel that is, and is there additional supports that we could provide to ensure a better flow of

support and information to you from partner networks as opposed to you referring outward to partner networks?

MS. MYERS: I can comment on that, Representative.

I would like to just commend the State for adopting the Safe2Say app and link, et cetera. That has done a tremendous amount of help and helps us to be informed when you reference "trauma-informed" and whether we as a staff are or are not.

It has been fantastic. We have been able to get the local law enforcement agencies involved pretty quickly. Even after school hours, through the night if something does come through, a tip, to share that information with the authorities and make sure that children and families are being, you know, addressed and taken care of if there is a self-harm or a depressive situation that is going on. So that is one element that I do need to commend the State on and hope to see that continue.

In addition, I know that our school district here at Wilkes-Barre is starting to partner with our local Wilkes-Barre City Police in what is known as Handle With Care. That is something, if we are all not familiar with that, where it is, again, another initiative that I believe is being implemented or hopes to be implemented across the State where the local law enforcement agencies are able to

basically tip off, similar to Safe2Say, with the school district representatives, with situations that may involve criminal activity or a traumatic event where law enforcement is involved and they are able to determine the child's school, you know, age of child. And then in turn we are notified administratively so that we have our team ready to go first thing in the morning to receive that child in the school, and then in turn take the necessary steps to address that child's situation and provide care.

MS. HUTCHINSON: I'll try to answer a little bit of what you're saying.

I think that what we have found is that there just isn't enough outside supports in our county. Our families often come to us and say that they have tried. It just takes forever to find some support, to find services.

I know this was mentioned by some panelists earlier, which I totally concur with. In our county, we are so, I guess what many would consider remote. If a student does have extreme issues, they have to go all the way down to Philadelphia, 2 hours' drive for a family, and there aren't enough beds. I would say that it has been difficult to find even alternative education placements for students, and then are they approved by the State? Will we be reimbursed, because then we have to pay for transportation and all of these other things.

So I would say that there just needs to be more, of course, outside the schools for the students. That's what I would recommend.

MAJORITY EDUCATION CHAIRMAN SONNEY: Chairman Longietti.

MINORITY EDUCATION CHAIRMAN LONGIETTI: Thank you, Chairman Sonney.

So, you know, it seems like one of the big challenges is there's a need for additional mental health professionals with schools, but budgets are tight. The pipeline is limited. We have talked a little bit about American Rescue Plan dollars being one-time dollars. So what's the best use? Is it professional development of existing staff? Some of you have talked about trauma-informed education. Some have talked about executive decision, making professional development. Is that the best use of the funds, or what do you think the one-time funds ought to be used to address?

DR. BROWN: I do believe those could be extremely helpful with professional development. I believe another panelist mentioned different research-based programs that could be used to address the entire student body and really looking at a tiered approach. So whether it's trauma-informed care, which I know we have been doing. Locally, some school psychologists are part of that

Train the Trainer's program, and they're out there and they're training other school staff. Or it's looking at things like training high schools in Check & Connect, which is another research-based program.

So just giving districts and personnel money and time. So sometimes it requires some additional training hours and maybe some materials. That certainly would be a great use of those funds, is encouraging a system-wide look at current resources, personnel, and how you could kind of increase capacity through some of those research-based programs.

MS. HUTCHINSON: I was just going to say that I really appreciate that principals and leaders of schools are required to get training and that Pennsylvania is offering the PILs, which uses the NISL program, and it's research based and it's wonderful.

And I was thinking, I think that if it's possible that schools would, just as she had mentioned talking about research-based programs that build community and build relationship building within the classrooms, I think schools could learn more about those kind of programs, like Restorative Practices. And these things help build that community so that kids have that sense of belonging and connect with their teachers more. Those programs teach teachers how to do those things. So more time, as she's

saying, for learning them, and then promoting those kinds of programs.

It's not just one that fits all, right? There's all kinds out there that can build the school's capacity to be more relational and help kids with that social-emotional learning and relationship building.

MINORITY EDUCATION CHAIRMAN LONGIETTI: Great.

Well, thank you for that input and those ideas.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

And I would like to thank the panel for your testimony. We're going to move on to the final panel.

PANEL 3

MENTAL HEALTH SERVICE PROVIDERS

MAJORITY EDUCATION CHAIRMAN SONNEY: So for our last panel, we'll be receiving testimony from mental health service providers. We have Amy Tielemans, Legislative Chair of the Pennsylvania Association of Marriage and Family Therapy; Michael Hopkins, President of Children's Service Center; Michael Quinn, CEO of Chestnut Ridge Counseling Services; and Andy Kind-Rubin, Chief Clinical Officer, Child Guidance Resource Centers.

I would like to thank you for joining us. If you could all raise your right hand and be sworn:

Do you swear or affirm that the testimony you are about to give is true to the best of your knowledge, information, and belief? If so, please indicate by saying "I do."

(Testifiers responded "I do.")

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

And Amy, would you like to begin?

MS. TIELEMANS: Good morning, Chairman Sonney, Chairman Farry, and the esteemed Members of the House Education and House Human Services Committees.

My name is Amy Tielemans, and I am the Legislative Chairperson and the Past President for the Pennsylvania Association of Marriage and Family Therapists, otherwise referred to as PAMFT.

Seated next to me is Dr. Matthew Mutchler, the current Chair-elect for PAMFT, and also our Executive Director, Suzanne Morano, is with us as well.

PAMFT is the professional association for marriage and family therapists. We represent the interests of our LMFTs, our licensed marriage and family therapists, students, and also our pre-licensed marriage and family therapists within the Commonwealth.

MFTs are licensed by the State of Pennsylvania

and must hold a master's or doctorate degree in marriage and family therapy. We have extensive postgraduate clinical experience in the field and, of course, pass rigorous exams to demonstrate the professional competency and the highest ethical standards necessary to practice mental health.

We are specifically trained in systemic therapy to identify the behavioral, emotional, or mental health illnesses for individuals, groups, and families all within the context of the relationships which they are a part of. Relationships, we know, impact a person's mental well-being, their behavior, and their emotional stability.

LMFTs provide therapy through private practice, through courts, through private schools, health institutions, and a host of other organizations in order to assess, diagnose, and treat to improve mental and emotional disorders; again, within the context of the family or the larger social system.

Like other States in this nation, the Commonwealth is facing a major mental health crisis, and unfortunately, our schools are facing the brunt of the issues. We know that the fallout from the COVID pandemic has compounded the crisis and continues to present challenges to our schools, our educators, our parents, and our students.

Today we have heard alarming statistics, none of which tell you the reality of sitting across from real live teenagers, teenagers that are suffering with anxiety or depression, managing grief, or any of the multitude of challenges faced by children and teens today. But the bottom line is that students often spend more time in school and more face-to-face time with their teachers than with their parents and their families.

School personnel is likely to be the first to notice signs of change in behavior, emotional status, or psychological changes in a student.

Currently, rather than developing a comprehensive school clinical mental health provider education specialist certification for all mental health care providers to assess, evaluate, diagnose, and treat mental health and behavioral issues in school, the Administration and the Department of Education have been focused on hiring more social workers, more guidance counselors, to address the mental health needs of the students in the Commonwealth.

School social workers are viewed as experts about community resources for mental health services, food programs, government resources. They know how to do the paperwork to fully assist families in accessing the community and government resources that are necessary. By simply continuing to hire more school social workers and

guidance counselors who are not specifically trained or licensed as clinical mental health providers in schools could actually potentially cause more harm.

I would like to take a moment just to clarify that in Pennsylvania, all licensed clinical mental health providers at the master's and doctorate levels are able to assess, diagnose, and treat a full range of behavioral, mental, and emotional disorders. The title of "social work" seems to have become kind of a catchall phrase that means mental health clinician. But unless the school social workers are licensed as clinical social workers and the guidance counselors are licensed as professional counselors, neither are trained or have the statutorily defined clinical education, training, and expertise to assess, evaluate, diagnose, and treat mental health issues anywhere in this Commonwealth, including schools.

Often that designation of "social work" is used in documentation for employment when a licensed clinical mental health professional is required for the mental health evaluations, diagnosis, and treatment. We are urging the General Assembly to implement sound public policies to ensure our Commonwealth students get the best possible care from licensed clinical mental health care providers to promote early intervention, care integration, and while ensuring that our students get the services that

they need when they actually need them.

To illustrate for you the depth of the mental health issues for students, I would like to share my own experience as one of those contracted mental health providers in one of our public schools.

I began my career about 18 years ago as a marriage and family therapist, and as a recent graduate, I had provided therapy with families in their homes, like we had spoken of, and in outpatient settings with families that were managing substance abuse in a small agency.

The agency was contracted to provide what they were going to refer to as a "crisis counselor" and asked me to become that person. I could never have imagined what it was like walking into that school the first day, but I still talk about my experiences, what I learned, my experience with the students and the range of care I provided, and the appreciation I received from students, parents, guidance counselors, and even eventually the administration.

On my first day as "crisis counselor," a young lady, not quite 16 years old, came into my office and told me the list of substances she had ingested the night before and again that morning. They included MDMA, marijuana, painkillers, and alcohol. She realized she had ingested too much and in too short of a time and was scared and she

was angry. She had been unable to sleep from depression and anxiety and could not find someone to talk to the night before. She self-medicated.

The following week, a two-story window came crashing down due to a 17-year-old boy's jealousy and anger outburst over a girlfriend. As I started to meet with individual identified students, word spread that I was there to talk through issues and emotions they simply did not have the experience to manage.

One morning, 21 students were lined up outside my office door at 7:30 a.m., all hoping to talk that day. Those 14- to 18-year-old girls and boys, they came to talk about being sexually abused. They were bullied and scared to go home. They had parents who were alcoholics, siblings with severe mental illnesses and disabilities. They faced issues such as substance abuse, as expected, but these kids came to talk because of the dysfunctional relationships within the systems they lived in each day.

The expectation was that they had to succeed in their school system despite dysfunctional family issues, anxiety, depression, manic episodes, inability to sleep, fears of failure and fears of what happened if they were not successful or perfect, fear if they dropped the ball on the football field or if they missed the basket at the end of the basketball game. They were bullied, struggling with

identity issues around their own sexuality, managing their parents' divorce, incarceration, grief, death, abusive dating relationships, foster families, and struggling with undiagnosed ADHD, anxiety, and depression.

Now as an LMFT in private practice, I can attest that these are the same issues still faced by adolescents each day. This school had amazing guidance counselors who were committed to these students and focused on securing their place in either college, the military, a trade school, or a job where they could begin to support themselves for the future.

I was able to make interventions to educate the faculty on managing mental health issues students were facing, connect students and their families together to address and seek continued therapy. I was able to convince the school principal to be a bit more aware when he would say over the announcements in the morning, hey, high school is the best time in your life. Can you imagine how the adolescents I spoke with each day felt when they heard him say that?

I am sharing this with you not to suggest that schools should become the mental health agencies, but my experience does, however, speak to the need for specific, well-trained, licensed mental health providers to be present in schools to work together with parents and

faculty to remove those barriers to learning and together to raise happy, successful adults.

In closing, clinical mental health professionals in schools reduce the stigma of mental health illness, normalizing the need and the importance for mental health wellness. PAMFT believes that by addressing the relationship dysfunctions and their impact on the mental health of children and adolescents early in the child's development leads to improved school attendance, academic performance and success, improved family interactions and involvement, a reduction in substance use and abuse, and a decrease in psychiatric symptoms such as anxiety and depression.

PAMFT is respectfully requesting the enactment of legislation to require the Pennsylvania Department of Education to develop a comprehensive school clinical mental health care provider education specialist certification so licensed clinical health-care providers can legally assess, evaluate, diagnose, and treat mental health disorders and can be hired by and provide clinical mental health care service to our Commonwealth school students in the schools. To this end, we respectfully submit the legislative draft proposal in Attachment A along with our written testimony for your consideration.

Thank you for inviting us to share our views, and

we're happy to answer any questions as well.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Michael Hopkins.

MR. HOPKINS: Thank you for allowing me to be here today, and I appreciate the opportunity.

You received my testimony, so I'll try and avoid repeating myself. One of the beauties of going last is some of the things that I was going to talk about have already been mentioned, and if I was here any longer, I would have rewrote this three times after hearing the earlier testimony. So it's good to -- and it's also lunchtime, so I'll try to keep it brief.

Scott and Jason mentioned, as well as Amy, as well as Melissa, basically CSC offers a great deal of support to the schools that we are involved in and we are embedded in. We have our outpatient license extended to the schools that we are in providing services, so every service that we can provide in our outpatient clinic we can provide in the schools, which is an important step, but only for the managed care companies. Private insurance is a different challenge, and they don't recognize that license being moved to the schools, which is a problem, because not all of our kids -- 87 percent of our kids are on Medical Assistance. However, not all of the kids that we would see either have Medical Assistance or are on

private insurance, so that is one of the barriers that you'll see.

We offer 24-hour support to children and families with mental health needs. We are available for crisis support at home. We bring medication management into the schools. So basically if you think about it, a nurse practitioner, if you have a child who lives, say, 30 minutes from our outpatient clinic, you would have to go pick that child up to come in for a 15-minute med check. You would have to leave work. You would have to go to school, pick the child up, and bring them to the clinic. Once that appointment was over -- you may have to wait 15, 20 minutes if the practitioner is running late -- you would have to get that child back to the school again and then get back to work. For a 15-minute med check, you might lose 3 hours of work time. That's a huge challenge for our families.

So what we have done is taken the outpatient practitioner, whether it be an outpatient therapist, whether it be a medication management, a nurse practitioner, and moved that practice for that day into the school. So if they were going to see eight clients that day in the clinic, we can have them see eight clients in that school, and they just adjust their schedule to do that.

Your sure rate is a lot higher. The children are getting the services that they need. It's easier for the families to receive those services. It's easier for the practitioner, and a lot of our practitioners are paid on an incentive model, so the more clients they see, the more money they make. So it's a win-win-win all the way around.

So that's what we have been able to do, and I think that's a model that is something that we should be taking a closer look at to see if it's practical for other areas.

Of course I went off the script, so I'll have to find where I was on this.

There is a holistic approach to mental health services being embedded within the schools, and hopefully the future will look like that. We're a long way from that. We're fortunate that we serve 10,000 clients a year, both adult and children. I think children and adolescents, about 6,000 a year throughout northeastern and north-central Pennsylvania. So, you know, we have been around, as my testimony would say, 158 years, 159 years now. So we have the good fortune of being around and having done this for a long time.

There's lots of mom-and-pop organizations that really do a good job but don't have the resources that other providers have. So I think the reimbursement model

is important that we look at, and I'll touch on that, too.

If the focus is just putting a social worker in the schools, as Amy mentioned, I think there's problems with that. Who is going to supervise the social worker? What work are they going to be able to do? Who is working with the children at night? I mean, there's trauma that's happening in the evenings. They may be able to do a lot of great work with the kids during the day, but then they're going back to the same situation at night. So if it's not a holistic approach in working with the family, and the siblings of those children, then there's holes in that system. And I'd hate to see us -- you know, I used to say all the time that today's solution is tomorrow's problem. I would hate to see us create more problems by fixing what we think is fixing a solution today and creating three more problems tomorrow. So again, any legislation I think needs to address that and look at the whole situation.

You know, in moving clinical services to the schools, youth easily receive the services. Parents get to participate in those services. It helps with work. It helps with transportation. It helps with child care. All those things are improved by moving services into the school.

Some of the challenges that you're going to see is workforce. It's not just in behavioral health, it's

across. It's restaurants. It's movie theaters. It's everything. You know, everything right now is having a very difficult time recruiting and retaining staff. It was mentioned in one of the testimonies earlier, that is a problem.

And our reimbursement system for our services, there's low pay, low reimbursement. Eighty-seven percent of our business comes through the behavioral health managed care system. So every year, we request rate increases. It's not like a restaurant where you can charge an extra 50 cents if your costs go up. If our costs go up, we have to go to somebody else and say, we need more money. That sometimes gets approved, sometimes it doesn't. We could go years without any rate adjustments or rate increases.

The whole push for $15 an hour pay has really had an impact on us, because everybody thinks they should be getting 15. McDonald's is 17, 20 now. You know, a lot of people are going for that. We have a lot of, you know, Chewy factories and warehouses and stuff that are paying 17, 18 bucks an hour. Workforce is an issue in our business.

Space in the schools is an issue. A lot of the schools are older. They don't have the space for clinical services to be moved into the schools. So again, it's something else to think about.

And mental health stigma was mentioned before as well, and I think it has improved, but it's nowhere near where it should be. We opened up, as Amy mentioned, we opened up a school-based team in a high school in Mount Carmel, and it was great. I mean, the numbers grew, but the numbers grew because somebody who came for services mentioned to their friend that, I was getting help, and then the next thing you know, like Amy said, there was a line.

So I think that's an indication that there is improvement with stigma, that people don't, you know, students don't feel as upset now, at least at the high school level, about getting help. I still think that's going to be an issue in your elementary and your grade school levels.

I would ask that each of you think big. Focus on collaboration between schools. Any legislation should focus on collaboration and incentivizing collaboration between your schools and your providers and looking at outcomes in that area: What can you do together to get to a place where it's going to benefit the kids and families we serve?

I would focus on fixing existing problems. SAP was mentioned earlier. Yes, there's a SAP system in place. It probably could be stronger.

Look at reimbursement models, again, to ensure proper funding. Encourage collaboration wherever possible.

And again, I thank you for your time, and thank you for allowing me to testify.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Michael Quinn.

MR. QUINN: Thank you.

Thank you to all the Chairs, Committee Members, and panelists.

Boy, it's tough going at this part of the process. Michael said a lot of things that I was going to say. But I'm the CEO of Chestnut Ridge Counseling Services in Uniontown. We're a large mental health program.

Some statistics from the Pennsylvania Youth Survey: 13 percent of youth planned suicide. Thirty-eight percent felt bad most days of the past year. Now, if the Penguins lose tomorrow, I'm going to feel bad, but 4 out of 10 children feel bad every day? And 16 percent considered suicide.

The scary part: That was 2019. Wait till we get to 2020 and '21.

For Chestnut Ridge, our crisis team is seeing 30 percent more people than we did before. Our crisis follow-ups are up 500 percent. That is our staff asking our crisis team to check on Billy over the weekend, or

tonight, for example. And we have sent 25 percent more children to psychiatric emergency rooms.

Every morning, I get together with our crisis team and we go over all the activity from the day before. This weekend alone, 3 hours ago, we reviewed four children with distinct suicidality that we were able to intervene with. But that's some real boots-on-the-ground information.

Related to schools:

As Michael alluded to, we are licensed satellites for all the schools in Fayette County. That works and it doesn't work. It sounds like Michael's group is a little bit more consolidated. The issue there is, it's truly a fee-for-service basis. Our therapist has to be busy, has to be billable, has to have a child in front of themselves. That's really hard when you're jumping from school to school to school. So it's a good model. It's cost effective for the school districts. As a mental health business model, that can be tweaked, but it's a little bit tougher.

The other option that we have come up with is what we call a mental health resource specialist, and these are social workers of ours, as has been alluded to by some of the other presenters, that are in the schools but can concentrate on the areas that the schools would like or

that need to be concentrated on -- home visits, truancy, staff education, early identification. And some of the services may be billable, but one of the nice parts of that arrangement is that the child doesn't necessarily need to be diagnosed to receive those services. On an outpatient clinic model, they have to have a mental health diagnosis to be able to bill for those services.

That's a good model. It is a cost to the school district. Because of that, we have also come up with hybrid models, which is kind of a school-based therapist. It's also a mental health resource specialist and, you know, kind of put the puzzle together that way.

One of the other things that we put together, just outpatient services in general, is we went to an urgent care open access model. So literally if a child needs seen today at 12 o'clock, they can come right in and see a therapist for an assessment with no appointment. And with the way that we schedule our clinical staff, particularly the medical staff, and at least for us right now, you could see a child now as a psychiatrist within a couple of weeks. So, you know, changing some of our operations has helped that. I know access has been mentioned a couple of times.

There is still, as Michael alluded to and others, there are still workforce issues, the payment issues that

Michael said so eloquently.

So basically just some considerations moving forward. Not to say too much that Michael already did, but we need to look at parity in mental health funding and reimbursement as related to physical health as well. Blended and braided funding for the school district staff is an example of that. There are probably other opportunities to be more creative to get wellness initiatives into the schools as well, things like mental health first aid training being required for all school personnel; again, an evidence-based process that would train school employees to be sensitized to mental health issues. And if we can get to the children sooner, we can be so much more productive and with better outcomes.

I think that paraphrased most of what I wanted to cover. I'm available for questions and appreciate the opportunity.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Lastly, we have Andy Kind-Rubin, and I have got to tell you, we are running out of time. We have about 2 minutes. So cover whatever you think hasn't been covered.

DR. KIND-RUBIN: Well, good morning. I don't know that I can do this in 2 minutes, so I'm hoping you'll give me a little bit longer. It's hard to be last.

But I am Andy Kind-Rubin. I am a child and community psychologist. I live in Doylestown, Pennsylvania, Bucks County, and I have served as the Chief Clinical Officer at Child Guidance Resource Centers.

Child Guidance is a 64-year-old community behavioral health center serving children, youth, adults, and families. We have approximately 500 employees, and we serve about 9,000 clients each year. And we provide services in Delaware, Philadelphia, Chester, and Montgomery Counties through a vast array of programs.

I was asked to speak about the integration of education and behavioral health services, and we have three different programs that do that. One is a K through 8 special education school that we run for kids with social and emotional difficulties, and these students are referred by their school districts because the districts feel they can no longer meet their educational needs.

The second are school-based programs that people have talked about where the school districts contract with Child Guidance for a variety of things -- psychiatry, one-on-one, individual and group therapy -- and they employ both bachelor's and master's level staff.

The third is a model that people have talked about, licensed outpatient offices within school buildings. From my perspective, this is a win-win. The schools

provide the space and then Child Guidance provides the staff, and it is funded through Medical Assistance. It reduces stigma and increases access. I think it is a great model.

As I said, I think it is a no-brainer. It meets children and families where they're at, and in the case of school, 5 days a week. It gives us an increased opportunity to educate people about mental illness or emotional and behavioral difficulties, thus reducing the stigma associated with mental illness and therapy. And most importantly, it provides us with the opportunity to focus on prevention, on aspects of good mental health, hopefully resulting in a decrease in mental illness and all of the potential difficulties associated with this.

Okay. So this is a model that you have heard about and that is throughout the State, but there are barriers, and I was asked to speak about that.

One is, in order for this to be successful, the necessary administrators, the building principal, pupil personnel and special education directors, guidance counselors, must support this initiative and do what it takes to keep it working and vibrant. Without this, the services will languish and die. As with all systems, there are insiders and outsiders. Without this support, we remain as outsiders within the school buildings, subject to

arbitrary rules, suspicion, and neglect.

Related to this is a change of administration. When administrators change, so do changes in priorities and budgets. Over the years, we have had a number of contracts end due to this.

Again related to this first point are turf issues. On a number of occasions, we have had guidance counselors resistant to using our services, refusing to make referrals, because they see this as their responsibility or are concerned that we may make their positions unnecessary. As mentioned, without strong leadership, this attitude can remain and grow.

The regulations that oversee education and behavioral health are different, and these at times run counter to each other. That is that the expectations of the school district may not be possible, causing misunderstanding and tension.

And finally, in order to do this, you need consent of the county and of the MCO, and we have had a number of occasions in which the schools have lobbied for these clinics but the county and the MCO have refused, stating that the needs of the students can adequately be met by already existing offices.

These barriers are not insurmountable but require strong leadership and commitment on both sides.

Finally, I would be remiss if I do not emphasize one last point. I have worked in the field for over 40 years, and I have never been so concerned and worried about the state of behavioral health services in the State and its ability to meet the needs of children and families as I am now.

The behavioral health system in PA, though rich, has been underfunded for years. This underfunding has led to a severe shortage in staffing across the Commonwealth of behavioral health staff at all levels. Why? Because at the rates at which services are reimbursed, providers are forced to pay low salaries, salaries that a family of three cannot live on. What we then have are individuals with master's degrees asked to perform very difficult work, helping clients with complex and traumatic problems, often in people's homes and in the evenings, for less than a living wage. No wonder we have fewer and fewer individuals who elect to go into this field.

Prior to COVID, there were significant cracks in the system. Then comes COVID, and the needs become far greater. As people said, suicidal ideation and behavior, depression and anxiety, have all increased significantly, yet the system in place to meet these needs has diminished, leading to far greater difficulty accessing services for those in need.

We have all been touched by mental illness or substance abuse, either through friends, family members, neighbors, or personally. Now is the time to step up and support the Pennsylvania behavioral health system through legislation and funding, and I guarantee you, an investment in accessible, available behavioral health care, both community and clinic-based, is an investment in our future and the economic, social, and community health of our State.

Thank you.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

Chairman Farry, briefly.

MAJORITY HUMAN SERVICES CHAIRMAN FARRY: Thank you.

And this is more so for the first panel. Two of our colleagues that had to leave had questions/comments. So for the first panelists, again, not looking for a response, but I'm just going to make sure this is on the record.

One was referring to children being turned into, her term, "screened zombies." Now that students are back in school, there is still a push for them to be using devices. Homework and the lot is more geared towards how remote learning went and just, you know, ensuring that student learning is broad based.

The second one, a comment, was from Representative Williams, you know, that every child has been affected by this, even if they are not showing the impacts, and going back to classroom learning now on an accelerated basis is adding additional stress to students and driving more students that have problems. So the programming plans need to also recognize that as the learning has been accelerated to make up for any deficiencies that happened during remote learning.

MAJORITY EDUCATION CHAIRMAN SONNEY: Thank you.

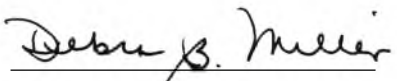
I would like to apologize that we are out of time. I would hope that you would all be receptive to any Members' questions that we might submit to you. I very much appreciate you being here. It's so nice to see people here in person.

And I would like to thank all of the panelists who joined us today. Your testimony provided our Committee with valuable insights on how mental health services are provided to our elementary and secondary school students.

This joint public hearing of the House Education and Human Services Committees is now adjourned.

(At 12:03 p.m., the joint public hearing adjourned.)

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



Debra B. Miller

Transcriptionist

dbmreporting@msn.com