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HOUSE OF REPRESENTATIVES
COMMONWEALTH *of* PENNSYLVANIA

House Democratic Policy Committee Roundtable
Mental Health in High Schools

Tuesday, March 3, 2021 | 11 a.m.

Hosted by state Representative Nick Pisciottano

ROUNDTABLE DISCUSSION PARTICIPANTS

Keith Elders
Pennsylvania Peer Support Coalition

Michael Fiore, School Social Worker/Home and School Visitor
Council Rock School District

Dr. Mike Ghilani, Superintendent
West Jefferson Hills School District

Shalawn James
Pennsylvania Mental Health Consumers Association

Laverne Krill, Guidance Counselor
West Mifflin Area Sch. District

Christina Paternoster, Project Director
Pennsylvania Parent & Family Alliance

Dr. Perri Rosen, Consulting Psychologist
Bureau of Children's Behavioral Health Services
Office of Mental Health and Substance Abuse Services, Department of Human Services

Valerie Zanotti
Pennsylvania Association of Nurses and Practitioners

PaPSC
PENNSYLVANIA PEER SUPPORT COALITION

03-03-2021

Good Morning,

Representative Ryan Bizzarro, Chairman Carla Walker, Leadership Research Analyst James Stanton, and Committee Members. I would like to thank you on behalf of the Pennsylvania Peer Support Coalition (PaPSC), as well as our partner organizations, The Pennsylvania Mental Health Consumers Association (PMHCA) and YouthMove PA, for giving me the opportunity to share my testimony.

My name is Keith Elders and I live in Johnstown, PA. I have been working with youth and young adults in the mental health field for 9 years now. I am an individual living in long term recovery. What that means for me is that for the last 3,565 days (9 years, 9 months, and 26 days) I have not found it necessary to take any mood- or mind-altering substances and that my mental health has been stable. I began working as a Certified Peer Specialist in Cambria County in 2012. I hold skills in youth engagement and leadership, forensics, crisis, older adults, and substance use. I have also worked as a peer-based supervisor and Director/Mental Health Professional. With my training and unique lived experience as a youth and young adult, I am now employed by Pennsylvania Peer Support Coalition (PaPSC) as their Grant and Project Coordinator. In this role design training curricula that is geared specifically towards peer-based professionals, including those who work with youth and young adults. Additionally, I write and manage grants for PaPSC where our most recent award was through The Appalachian Regional Commission (ARC) P.O.W.E.R. + Initiative. This $1 million dollar award titled *Building a Peer Support Workforce in PA* will focus on workforce development and recovery ecosystem creation for peer-based professionals. Additionally, youth leadership and engagement will be the sole focus of our Call for Change and Youth Coordinator.

My wife Shelly and I just recently got married on February 14th. We are raising my two beautiful daughters, Quinn and Althea, as well as Shelly's two children, Des and Gabriel. Shelly and I, like everyone else, are coping with the struggles of the COVID-19 pandemic. This past year has certainly brought challenges in my personal life due to COVID-19. Having four children participating virtually in school while both my wife and I having to maintain fulltime

employment virtually has added stressors to our life that no one could have predicted just one year ago. Furthermore, two of our children are engaged in mental health treatment with both reporting a drop in effectiveness since the rise of COVID-19. Both also cite a decrease in their natural supports such as friends and teachers since going virtual.

Over the past year, COVID-19 has brought forth unforeseen challenges that children attending school would never have expected. Changes at school and isolation from friends and family have taken a toll on the children. Add in the challenges parents are facing with working virtually, being laid off, losing their jobs completely, or having to go on unemployment, an already overburdened mental health system has been even more exacerbated.

The number of teens seeking and reporting help for anxiety and depression has continued to rise. Human beings are social in nature and certainly benefit from reaching out when dealing with symptoms of mental health issues. While social distancing has proven to be effective against the spreading of the virus, it has had devasting effects on our mental health, and particularly devastating for youth. Children, including my own, are unable to visit friends and family members, or even attend school in a normal fashion. They are dealing with issues at home caused by COVID that are out of their control. Parents are having to help their children with virtual learning which has made an already stressful situation even worse. The inconsistency of going back and forth from virtual learning to attending school in person can be confusing. Parents are having to figure out childcare situations, kids are seeing others around them struggle, and all these issues contribute to the rise in children reporting the need for help with symptoms of mental health.

I do understand that the Covid-19 pandemic has brought forth unprecedented times. The need for telehealth services is higher than ever before. Many children and teens have fallen, and continue to fall, through the cracks of the mental health system which, in my eyes, is unacceptable. We need to do more! Engaging these children and teens does not fall solely on the youth. This is a two-way relationship. Engagement and best practices trainings are vital to success in this area of engaging young people in services. Things we need to be doing more of:

- Checking in routinely with children and teens
- Listening and validating
- Helping children and teens focus on what they can control

One peer reviewed, evidence-based way to ensure that we can do the above listed bullet points is to have embedded Youth & Young Adult Certified Peer Specialists working within school districts. In fact, the whole premise of Peer Support is to engage those we serve in treatment and help them to develop and maintain natural supports within their communities. Peer Support within the schools is a logical step, especially given the new times we are living in with the pandemic.

Lack of resources, stigma, overcoming trust, and willingness to seek help are just of few of the barriers we have noticed at the state level that prevent youth from seeking out mental health services. I currently work for PaPSC, and maintain close working partnerships with PMHCA, and Youth Move PA. All of whom are statewide organizations within the Commonwealth of Pennsylvania that were created to ensure relevant policies are implemented that enhance the systems of care. In my partnership with Youth Move PA we have created many trainings addressing these very topics. The following trainings offered are ones that the youth and young adult demographic can participate in.

- Communication & Active Listening
- Etiquette
- Youth Engagement – for Peer Based Practitioners
- Social Media – What is it? Pros and Cons.
- Leadership Development
- Young Adult Roadmap
- Trauma Talk for Teens
- Trauma Talk for Adults
- Stigma Workshop/Training

Youth Move PA also offers a virtual support group called "Thrive for Hope" on the Zoom platform every Thursday from 2:30pm to 3:30pm. This support group is for youth, run by youth. This support group offers a safe space for young people to share their experience, strength, and hope. All these trainings and groups can be accessed here: @ Youth MOVE PA - Home (wildapricot.org). Furthermore, PaPSC and PMHCA facilitate a variety of trainings for peer-based professionals including Certified Peer Specialists, Certified Recovery Specialists, and Certified Family Recovery Specialists.

Making more resources available both inside and outside the school setting would be beneficial. Educating youth on all aspects of mental health will go a long way in reducing the stigma associated with having a mental health diagnosis. This, in turn, would allow more

children and teens to get the help they need without the fear of being judged or stigmatized. Information on treatment options needs to be more easily and readily available. Access to treatment depends on access to information. In talking to some of my friends and colleagues, I know the COVID-19 Relief Bill has allowed schools to put some, but limited mental health services into the schools across the Commonwealth of Pennsylvania.

There has been a rise in success recently with youth obtaining support from Youth and Young Adult Certified Peer Specialists. Given this, I believe there would be positive outcomes from placing peer-based professionals in schools so youth could speak to someone who has lived experience with mental health and/or substance use conditions. The benefits of peer-based professionals have proven to be a successful process. Peer-based professionals are called upon to share their personal experiences surrounding behavioral health conditions with the youth, in turn, creating an immediate relatability. Through a principled and ethical relationship, recovery can be achieved and maintained while decreasing the likelihood of relapse.

New approaches need to be explored to combat the overburdened mental health system we are facing today. Children, teens, and their families need to be educated on mental health, warning signs, and triggers. Barriers including stigma, lack of trust, and willingness to seek support need to be shattered for youth to access much needed services. Youth and Young Adult Certified Peer Specialists are the key to making this vision a reality. With the proper resources allocated from the state level, I am confident that the peer-based professionals working in the field can help schools promote to youth and their families the fact that recovery is not only possible, but probable.

On behalf of the Pennsylvania Peer Support Coalition, Pennsylvania Mental Health Consumers' Association, and Youth Move PA, I would like to thank Representative Ryan Bizzarro, Chairman Carla Walker, Leadership Research Analyst James Stanton, and the other Committee Members for giving me the opportunity to share my testimony on this platform.

Sincerely,

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Democratic Policy Committee
Roundtable on Mental Health in Education
March 3, 2021

PaPSC
PENNSYLVANIA PEER SUPPORT COALITION

- 85 Children and Teens within the Commonwealth of Pennsylvania participated a survey between the dates of 12/03/2021 to 01/12/2021

- When children are experiencing symptoms of mental health;
  - 50% of children would rather talk to a parent and/or friend about their symptoms
  - Whereas only 7% would talk to a teacher, doctor, or counselor

- If schools offered more resources, services, and/or support groups;
  - 33% said very likely to obtain or attend
  - 35% said likely to obtain or attend

When asked about barriers in their county:

- **64% of children and teens said lack or resources, stigma, raising awareness, and willingness to seek help are the challenges that need to be addressed to be successful in their pursuit to recovery**
- **91% children and teens surveyed feel that there is stigma associated with having or seeking help for a mental health illness**

Note: Engaging these children and teens does not fall solely on the youth. This is a two-way relationship. Engagement and best practices trainings are vital to success in this area of engaging young people in services.

Things we need to be doing more of:

- Checking in routinely with children and teens (Inspire)
- Listening and validating (Mentor)
- Helping children and teens focus on what they can control (Empower)
- Help children and teens find their voice (Advocate)

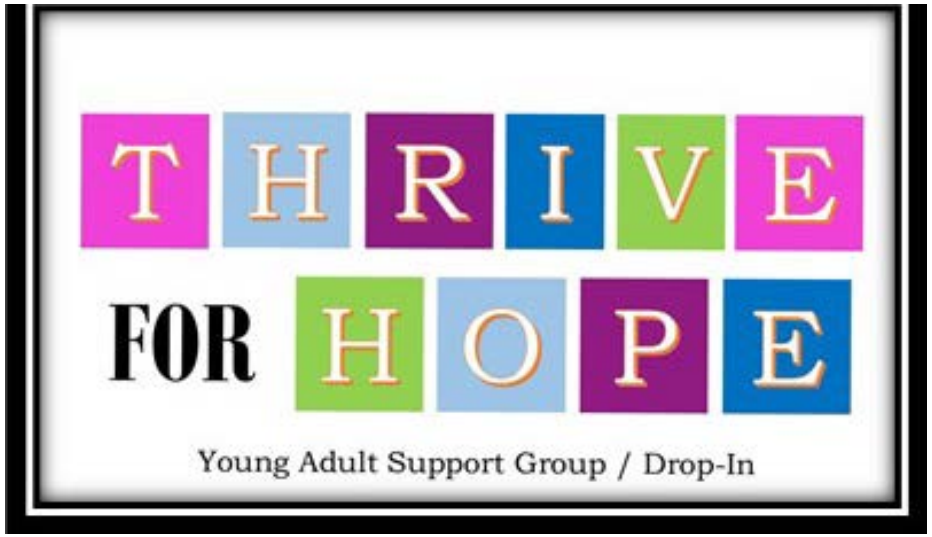
Youth and Young Adult Peer Support tackles all four of these!

Benefits of Embedding Youth & Young Adult Certified Peer Specialists within school districts include:

- Relatability to someone who has lived experience with mental health and/or substance use conditions
- Continued support throughout schooling and/or out of school as needed
- Healthy relationships built through shared experiences
- Relationships built on principles and ethics
- Recovery can be achieved and maintained while decreasing the likelihood of relapse.

Trainings & Support Groups Offered by Youth Move PA:

- Communication & Active Listening
- Etiquette
- Youth Engagement – for Peer Based Practitioners
- Social Media – What is it? Pros and Cons.
- Leadership Development
- Young Adult Roadmap
- Trauma Talk for Teens
- Trauma Talk for Adults
- Stigma Workshop/Training
- Thrive for Hope/Drop-In, Youth & Young Adult Support Group



Youth Move PA

I would like to thank all of you on behalf of:

PaPSC
PENNSYLVANIA PEER SUPPORT COALITION

PMHCA
Recovery Through Advocacy

Testimony of the

Pennsylvania State Education Association (PSEA)

Roundtable Regarding

Mental Health in Schools During COVID-19

Presented to the

House Democratic Policy Committee

March 3, 2021

By Michael Fiore MSW, LSW, HSV

School Social Worker/ Home and School Visitor

Council Rock School District

Chairman Bizzarro, and members of the House Democratic Policy Committee, thank you for inviting PSEA to participate in today's roundtable discussion. My name is Mike Fiore, and I am a School Social Worker at Council Rock School District in Bucks County. It is my honor to be here with you today to share my perspective on mental health in schools during the pandemic.

The COVID-19 pandemic has put pressure on all of us - school staff, students, and families. Our pupil services staff have been working hard helping our students and families deal with extreme levels of stress. We are also supporting our teachers who are under immense pressure, having to run two classes at once—in person and virtual—often while supporting their own families. All the while, we are all worrying about keeping ourselves and our loved ones as safe as possible from the virus.

Anxiety was by far the most prevalent issue school social workers saw before the pandemic, and student anxiety is even more severe now. Related to anxiety, and often hand in hand with it, are depression and obsessive-compulsive disorder. We see these conditions at each grade level. Each of these mental health issues can exist on its own or in a comorbid fashion, and one can exacerbate the other.

Here's one example to illustrate what can happen: A student is too anxious to go into school for reasons that might have existed before the pandemic but are just exacerbated now because the student is worried about getting sick or carrying the virus home to his family members. The student then misses assignments due to not attending school, which causes further anxiety and a repetitive cycle. Eventually, the student feels as if he is so far behind, he fears he can't recover on his own, leading him into depression. If the student has OCD, just a few missed assignments or a bad grade can send him into a downward spiral, and he stops responding to communications from school.

Suicidal ideation is probably the most difficult issue relating to mental health in schools today, and that unfortunately includes nearly all grade levels. Council Rock utilizes an evidenced-based prevention program known as QPR. QPR stands for Question, Persuade, Refer, and is designed to teach the warning signs of a suicide crisis and how to respond. Our school district trains every staff member in suicide

prevention. Pre-COVID, we were working towards having a suicide prevention trainer in each building to train all our secondary students in our suicide prevention program. Bucks County has a suicide task force which had begun training several more of our 13 districts in the QPR prevention model and is eager to refocus on that effort as well.

Our suicide intervention numbers have increased consistently over the years:

- 2013-2014: 168 interventions
- 2014-2015: 168 interventions
- 2015-2016: 176 interventions
- 2016-2017: 241 interventions
- 2017-2018: 215 interventions
- 2018-2019: 261 interventions
- 2019-2020: 246 Interventions

However, the cases in which we have been able to intervene are down significantly in the 2020-2021 school year, to only 80 interventions.

And while it sounds like a good thing to see lower reports of suicidal ideation in my district than in previous years, this is the early warning stage for intervention. Instead, the referrals we did receive this year were more severe, and further progressed, than those we typically see. And nationally, we're seeing more kids ending up in hospital emergency departments for mental health reasons, as well as increases in suicide attempts. These are trends that make me lose sleep at night. Our Safe2Say Something numbers are down as well, but that is still a valuable tool and has saved lives. We are thankful that system remains in place. But the majority of suicidal ideation reports typically come from peers or from school staff – and those support networks look very different right now.

COVID mitigation has limited interactions among peers, and as a result, concerned peers are making fewer referrals. Teachers are working harder than ever to balance multiple instructional modes and keep students engaged. Although school staff are trained to watch for certain behavior changes in students, it's difficult to spot abnormal behavior when literally everything is abnormal.

Many virtual learners have never met their teachers face-to-face this school year, making it more difficult for those teachers to connect with students on a deeper interpersonal level and establish trust. Further complicating matters, so many kids don't feel comfortable turning their cameras on during virtual instruction, and when they're in buildings students are masked and socially distanced. Both of these factors conceal important non-verbal cues that a student may be struggling.

I'm in a more affluent district, so perhaps things are better for some of my kids. And some students have benefitted during the pandemic from increased involvement with their families and fewer opportunities for drama with their peers, which have eased mental health issues for some. But even in my district, we've seen huge increases in the number of families who are experiencing the death of a loved one, job losses, hunger, alcoholism, drug use, and other serious hardships that have led these families to utilize services like our food cupboard and extra meals provided by our school district. And despite all the pain I'm seeing, I know that there are communities that are hurting so much more – and the kids are carrying all that stress around with them, or even worse, just sitting at home with all that stress and anxiety.

Schools play a huge part in service delivery for pediatric mental health, helping with early identification of issues, connecting kids and families with mental health resources, and teaching the types of coping and resiliency skills kids need to manage their emotions and deal with stress. There is a whole "mental health team" working in a school - the school nurses who, in addition to attending to physical health needs, see psychosomatic symptoms like upset stomachs and headaches, as well as the social workers, counselors, and psychologists who teach coping skills and provide counseling and intervention. Even before COVID, these teams were maxed out with other duties and the sheer volume of students they're responsible for, but during the pandemic their to-do list has gotten exponentially longer. And once kids are identified as needing additional help, they're often referred to outside agencies for specialized counseling and psychiatric services. Waiting lists for these types of services were lengthy before the pandemic but are now so much worse. For kids that have sought out supports, most therapy is virtual right now. Just like virtual school doesn't work for everyone, virtual therapy DEFINITELY doesn't work for everyone, and it's especially hard for kids.

My district has been providing hybrid instruction, and the secondary level has just recently come back full-time. And while it is helpful to have kids in buildings at least some of the time, everyone must feel safe. When students return to school buildings where community spread of COVID-19 is high, social distancing and masking guidelines must be enforced, and schools need funding for better ventilation systems. Otherwise, student and staff stress levels rise. The most urgent and impactful action policymakers can take to increase safety and keep buildings open is to prioritize school employees for vaccination.

This year is kind of a perfect storm for mental health issues for kids, and it could have a lasting impact on their development. If there are learning gaps, those can be addressed. But the work of relieving the trauma many students have experienced during this pandemic is going to take a concerted effort by all of us. If we do not address that trauma—if we do not successfully integrate students with a host of mental health and emotional needs back into our schools this year and next—academic remediation programs will not make a difference. Studies have shown that having just one caring adult in the school setting can be what helps a student succeed in life – and at no point is that more true than right now, when everything in students' lives is uncertain and often scary. We need to make major investments to adequately staff mental health teams in our schools – professionals who are trained to foster connections with kids and identify those who are struggling, and who have the dedicated focus and the resources to help. And significant investment and resources will be needed because districts are nowhere near having enough staff to meet nationally recommended mental health staffing ratios.

Fortunately, we are on the precipice of a historic investment of resources in our public schools. I plead with you to ensure some of those new resources go toward adding more nurses, counselors, psychologists, and social workers to our schools. My testimony provides more detail on some of the greatest challenges schools face in addressing students' mental health needs during the pandemic and includes specific legislative recommendations that will help schools provide support in a more comprehensive way.

In closing, thank you to each of you for recognizing the need to continue this conversation, and for recognizing that this pandemic has only magnified the crisis of our kids' mental health in this state. And I recognize that, just like COVID-19 vaccines, there's a huge demand for resources, but those resources are often scarce. I ask each of you to help prioritize the kids of this Commonwealth – not just their educations or their scores on standardized tests, but their wellbeing. Their physical and mental health. My colleagues and I do the work that we do because we love kids – and it's heart wrenching to know that kids everywhere are hurting and struggling. And they need our help.

Recommendations:

1.) Prioritize school employees for vaccination

Ensuring that the men and women who teach and serve Pennsylvania's children receive the COVID-19 vaccine as soon as possible is essential if we are to reopen our state's schools for in-person instruction and return to normal operations when the 2021-22 school year begins. Unlike 26 other states, Pennsylvania's vaccination plan does not prioritize school staff members, even though school staff members and students are in a uniquely dangerous position. Those who are delivering in-person instruction are gathered in reasonably large groups every day. For students and staff who are preparing to return to school in person, many are very concerned that the state's health and safety guidelines, particularly the guidance related to maintaining 6 feet of social distance in school buildings, may be extremely difficult to implement or enforce. The best way to reduce health risks in schools and ease social distancing guidelines is to vaccinate school staff members as soon as possible.

2.) Prioritize investments in school-based mental health professionals

The lack of connection and the increased loneliness and isolation experienced by students and educators over the past year has led to heightened levels of anxiety and depression. We know that students will need extensive, intensive social and emotional learning and academic remediation to recover from the hardship and trauma this pandemic has caused.

There is an immediate and ever-growing need for more certified school counselors, school psychologists, school social workers, and school nurses to support our students' behavioral and mental health needs. Not only are the resources falling short of ensuring there are sufficient certified professionals in our schools, but our state laws fall short as well. However, if properly staffed and resourced, schools offer the ideal setting and infrastructure for students to access the full continuum of mental health supports including prevention, intervention, and collaboration with families and community providers.

As the Pennsylvania General Assembly continues deliberations around the 2021-22 state budget, **PSEA strongly urges state lawmakers to re-authorize funding for the School Safety and Security Grant Program in the 2021-2022 fiscal year** and continue to prioritize investments into this program. While there are common challenges in addressing the COVID crisis, there is no one-size-fits-all approach to meeting the diverse needs of Pennsylvania's students, and the grant program provides flexibility for individual school districts to determine how respond to the needs of the local school community. Last year, my school district applied for, and received, funds through this program which allowed us to hire three additional counselors, who have been critical additions to Council Rock's school-based mental health team. These professionals have done so much to support students who are struggling mentally and emotionally over the past year. Because my social worker colleagues and I cannot be everywhere, with these additional team members we've been able to practice a form of triage – doing the initial home visits with kids who are missing school, determining if there are needs within the family that we can address, then letting our counselor colleagues assist with the many return visits it often takes to build trust and help students return to school. Without the grant funding that made it possible to hire those additional staff members, many students could have been without that critical support network – and I know many districts are facing that exact scenario.

In addition, **PSEA urges lawmakers to increase the state reimbursement for school nurse services from $7 per student to $12 per student**[i]. Both school districts and certified school nurses are finding the provision of school health services to the student population to be continually changing and challenging. State law requires that every child of school age shall be provided with school nurse services, and the

number of students under the care of each certified school nurse shall not exceed one thousand five hundred (1,500). This number includes students attending traditional public schools, charter and cyber charter schools, and private and parochial schools. This ratio was established in 1965, but the health needs of students in our school system look dramatically different today. Many school nurses are required to travel to different school buildings to attend to students and are finding it increasingly difficult to meet students' physical and mental health needs. The current rate of $7 per student was established in 1991. The proposed increase to $12 per student reflects a modest inflationary adjustment and will help alleviate financial pressures that prevent appropriate nurse staffing levels in all school buildings.

Although woefully inadequate, Pennsylvania's school nurse ratio does offer students more access to these professionals than to other school-based mental health professionals. As such, school nurses are uniquely qualified to identify students with potential behavioral or mental health concerns. In fact, schools often look to the number of student visits to the school nurse as a data source in tracking schoolwide trends, or for identifying individual students who may be at-risk for behavioral health concerns. According to the National Association of School Nurses (NASN), school nurses are often a student's first point of entry into behavioral health services and spend approximately one third of their time providing mental health services to students.[ii]

Finally, PSEA urges lawmakers to support HB 102, sponsored by Rep. Dan Miller, which would require all public-school entities to employ school nurses, counselors, social workers, and psychologists within specific professional-to-student ratios. The national conversation surrounding school safety has highlighted the need for additional mental health supports for children and has shown the life-changing impact of a child's developing a relationship with one caring adult in the school community. Despite the clear need for more school-based mental health professionals, Pennsylvania law does not require school districts to employ certified school counselors, school psychologists, or social workers. This means that some schools don't have a school counselor or another certified school-based mental health professional to provide support, intervention, referral, and follow-up to students in their time of need.

3.) Authorize parental opt-out to reduce the over-reliance on standardized tests

The mandate for annual testing via the PSSA and Keystone Exams is part of federal law, and unfortunately, last week, the U.S. Department of Education announced that it will not be granting states a waiver of standardized testing requirements this school year. The Pennsylvania Department of Education responded with a plan to extend Pennsylvania's annual testing window through September 2021, giving school districts more time to satisfy federal testing requirements. The decision of the federal government is very disappointing, and the response of the Pennsylvania Department of Education does not go nearly far enough to provide students, families, and educators with relief.

The high-stakes nature of these annual tests is fueling unnecessary anxiety for students, parents, and educators at a time when they are also trying to adjust to the ever-changing circumstances presented by this pandemic. If we truly want schools and educators to focus on learning recovery, we shouldn't be administering standardized tests at all this year. Our students have already lost too much classroom instructional time, and they do not need the added stress of standardized testing.

However, state lawmakers can ease the burden of PSSA and Keystone testing requirements by swiftly passing legislation to allow parents or guardians to opt their children out of state assessments, particularly for the 2020-21 academic school year. Standardized testing has already taken far too much time away from learning—and has prevented students from experiencing a well-rounded education that includes arts, music, recess, and a love for learning. At a time when social and emotional development is so critical, we must reduce time spent on testing and focus on helping students heal, learn, and grow.

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[i] House Bill 454 of 2015

[ii] National Association of School Nurses. (2018) *The school nurse's role in behavioral/mental health of students* (Position Statement). Silver Spring, MD.

PA House Democratic Policy Round Table on Mental Health in Schools
Written Testimony
Dr. Michae Ghilani
West Jefferson Hills School District
3/3/2001

In the past year we have seen a sharp increase in the number of students in crisis due to anxiety, depression, and lack of social interaction due to the COVID-19 Pandemic. Student mental health was already a focus of ours prior to the pandemic bnecause of the increases in cases we were seeing across the district from year to year. Three years ago we had a middle school student take their own life. Unfortualnately that disturbing trend has been exacerbated by the pandemic.

This year alone we have lost one high school student to suicide and had two others attempt to take their own life. The are other countless cases of depression, cutting, anxiety, and suicide ideation that have been reported in the last few months. Our school based therapists caseloads are maxed out and we have three times the amount of students receiving school-based therapy than we did just two years ago. Just last week I met with our school counselors and was told that they are completely overwhelmed with cases of student mental health. Even though we have good supports in place forour students, right now we are struggling to meet their mental health needs.

Increased funding and support to better meet this mental health crisis is greatly needed. More staff and programs that are aimed at developing coping mechanisms and providing support to families in crisis needs to be at theforefront of this funding.

As a former counselor, principal, and current superintendent, I have never seen anything like the mental health crisis that we are facing at

this time. If we don’t make supporting our students mental health needs a priority, the learning loss other negatiove impacts of the health pandemic will be lost.

Good Morning!!

My name is Shalawn James and I am the CEO of Total Journey LLC, and the former Acting Executive Director of the Mental Health Association in Pennsylvania. I am an advocate for mental health reform, awareness and suicide prevention, a motivational speaker, a trainer and workshop facilitator and a mother.

I grew in a beautiful Annapolis Maryland and I have come to realize that I lived a privileged life. Privilege, while often equated to race and race relation, in its simplest terms means benefiting from advantages that one did not earn. Growing up in Annapolis provided me with privilege to attend and receive a dynamic, impactful, life altering education. An education that not only taught me my ABC's and 123's but one that trained me for life, its ebbs and flows, its ins and out, and its ups and down. I distinctly remember going to school and learn that about Mr. Yuck, learning that "only you can prevent wildfires", stranger danger, take a bite out of crime, friends don't let friends drink and drive and help stop AIDS use a condom. More than 20 years later these slogans or as our youth would call them now, Hashtags still stick in my head as if I had just gotten out of the assembly presented at my school.

Those days are long gone. School has become a hustle and bustle of assignments, forced excellence, "achievement test", standards, pressure and expectation. I am not here to argue that these things are not needed nor to argue that their purpose is not valid. What I am here to argue is that while we are pushing our kids to greatness. "WE" (their parents, administrators, teachers and law makers) have forgotten to prepare them for what happens when we miss the mark. We are undoubted living in a world where expectations and standards for achievement are at any all time high. The joys or meeting a goal, earning that A or excel at a task is quite scientifically put endorphin promoting. Our instinct is to continue to achieve at a high level to continue the endorphin production.

What we have failed to do as a society is prepare for the what if of missing the mark. As adults, we have learned to respond to the casual Hello, how are you doing with a "fine", Oh I cannot complain, insert your favorite come back to that question. Often times we walk away know that we are not fine and not ok. We have trained ourselves to believe that "no sense in complaining because no one cares anyway" and on the flip side of that, how many of you have those people in your life that you have stopped asking how they are doing because you don't want to, or have the time to listen to days "sob story"?

Technology as great as it has been, has moved us away from a world of common courtesy, genuine salutations, family meals without electronics. And while our generations learned the other way, we have too assimilated to the way of this new world. As a result, our children have suffered the most. Our children do not know what their emotions are, they do not know how to handle rejection, disappointment, a misstep or failure. From the time our children are little until they are adults, we teach them about a fairytale. And in this fairytale, everyone wins, everyone gets a trophy, everyone is important enough to be recognized. (please understand that I am not knocking this type of praise, because I feel that everyone needs it) But there is a huge difference in being important all the time and being important some of the time.

The Solution

Believe it or not emotions and emotional regulation can be taught. What we are lacking now is a firm foundation for our youth that allows a accepted expression of emotion. Remember society is teaching

perfection. What do we do with the hurt, disappointment, jealously, envy, anger, sadness, despair? What do we do when we haven't prepared our youth to cope in the world? We are watching our children opt out of the world instead of buying into it because we have failed to teach them that troubles do come but there is always tomorrow. We have not provided safety and comfort within the homes and schools.

My solution is one that can be adjusted and curtailed to fit any school aged child. This program is comprehensive and can be started in every school across the Commonwealth, with minimal resources. This program engages the student, school and family in a comprehensive effort to support the students emotional and mental health growth. Student Ambassadors, Parent Ambassadors and School Administration work collectively. The Delivery is smooth, effortless and ultimately becomes ingrained in the day-to-day rituals of a normal school day and life at home.

The ultimate goal is to eliminate childhood suicide, while I can not promise that will happen. I can say that our ability to recognize, intervene and provide compassionate treatment will greatly decrease. Can we say that we are truly preparing our youth to compete in the world if we are not teaching them how to deal with their emotions.

My name is Laverne Krill. I have been employed by the West Mifflin Area School District for the past 25 years as a school counselor. Over the span of my career, I have also worked in a part-time capacity as an outpatient therapist for two behavioral health agencies. My current position is as school counselor for grades 4 and 5 which I have held for the past 8 years. Previously I worked with pre-k to grade 5 at one of our elementary schools and with grades 6 through 8 at the middle school level.

My educational background includes a bachelor's degree in Social Work and a master's degree in Education with an emphasis in School Counseling. Additionally, I am licensed as a professional counselor in the State of Pennsylvania as well as recognized as a National Board-Certified Counselor.

I was asked to participate in this roundtable discussion on Mental Health in the Schools due to my direct contact with students.

Over the past year, I have seen a dramatic increase in mental health concerns with students at the upper elementary/middle school level. Anxiety has been the overwhelming concern with many factors contributing. Students have been asked to change almost every aspect of their lives to accommodate the 'new normal' of the pandemic. We have families who have food insecurity, economic worries due to job loss, grief due to loss of family to COVID-19, changes in learning models, whether hybrid or remote, use of technology that has never been implemented to the level that is currently needed and many other concerns. Children/teens thrive on routine and boundaries. With the pandemic, daily worries about meeting basic living needs have been mounting. I have students who don't want to return to school because they are afraid to leave their parent, fearing that something may happen to them. I have students who worry that they are not being successful with their schoolwork, so they avoid doing it and get further behind. I have students who are anxious about returning to school because it is a drastic change in their routine over the past year where they have been able to enjoy being at home with little outside stressors impacting their daily mood. The ability to maintain focus, necessary for academic success, has been challenged by mental health concerns.

Online learning has been extremely difficult for many families to embrace. Technology challenges have led to failing grades for many students. Some parents are working outside the home leaving elementary school students in the care of elderly grandparents who are unable to assist with their struggling grandchildren. The lack of reliable internet access has interrupted the learning process for many families. Some children are fearful of being seen on "live" sessions with their teachers, for various reasons, creating a gap in the learning process.

During in-person learning, online assignments can limit the engagement that students would typically have during a school day. Socialization has been greatly impacted in the school setting during the pandemic. Socially distanced classrooms and mask-wearing limit the interactions that students have with peers. Socialization is limited to 30-minute lunch breaks at a socially distanced table with possible one peer within earshot to have a somewhat candid conversation. Typical peer conflict, which is normally a daily observation in my position, has been almost non-existent. Children need to learn how to resolve conflict to be successful in later life. This is part of the problem-solving skill set that is critical for laying down foundations for being career ready. These COVID-19 mitigations, although necessary, are negatively impacting the development of appropriate social skills in young school-aged children.

When students are learning in the remote model, routine has been a challenge as well. Parents, overwhelmed with financial hardships, isolation and limited family support, are struggling with enforcing routine at home due to their own mental health concerns. Children who can set a routine in their day are typically the most successful at tackling their assignments and making progress. Routine is critical for children. It provides a sense of control that diminishes stress and anxiety.

Both the remote and in-person models, with the masks and social distancing, are contributing to feelings of isolation. Students are reporting being 'bored' or 'lonely' and missing their friends. It is difficult to identify an emotional concern if a student is remote and never turns on the camera for live sessions. Finding a way to engage a student in conversation is vital to making a critical connection with that student.

As a counselor, I see the need to reach out to students and families during this time of uncertainty. The counselor's role is critical in providing resources, assessing for mental health concerns and making necessary adaptations to the student's school environment to make him/her find success. Our outreach is not limited to students, however, as many parents are struggling as well. The students' needs are not in isolation, the entire family is impacted.

The academic needs of the students will be impacted by the pandemic for some time. With failing grades, economic impacts of losing jobs, loss of socialization and increase of mood disorders, the need for more support staff in the schools is of paramount importance. Engaging students and families will help to heal the damage that the pandemic has caused. Personal connection with our students and families is needed to create of path for recovery.

Thank you for providing me with the opportunity to express my concerns and opinions regarding the mental health impact of the pandemic on school-aged children.

Written Comments for Christina Paternoster, Project Director, PA Parent and Family Alliance
Before the Pennsylvania House Democratic Policy Committee
Harrisburg, PA
Wednesday, March 3, 2021

Rep. Ryan Bizzarro
414 Main Capitol Building
PO Box 202003
Harrisburg, PA 17120-2003

Good morning, Chairman Bizzarro and the members of House Democratic Policy Committee. My name is Christina Paternoster, and I am the Project Director of the PA Parent and Family Alliance, a program of Allegheny Family Network. I am the mom of three great young adults, including one who is navigating the challenges of depression, anxiety, ADHD, dyslexia, and dysgraphia. The PA Parent and Family Alliance (Parent Alliance) provides one on one support, education, and connection to resources for parents of children who are struggling with mental health concerns anywhere in the state of PA.

Children are showing signs of the ongoing pandemic trauma through increased anxiety, fear, overwhelming sadness, worry, unhealthy eating or sleeping habits, changes in activity levels, substance use or other risky behaviors and difficulty with attention and concentration. While it will be some time before official information is available on deaths by suicide in PA, many localities are reporting an increase, often double, in calls to crisis lines. Deaths by overdose are at an all-time high. Mental health issues do not get better on their own. Many adults with mental health disabilities experience substance use disorders, trouble with the law, or the inability to hold down a job, to name a few.

Prior to COVID 19, children were already facing long wait times, anywhere from weeks to a year, for a formal evaluation for a mental health disability which is required before mental health treatment and supports can begin. If accessing services was this difficult before the pandemic it should come as no surprise that most of the parents who contact the Parent Alliance for support tell us that their children have been on multiple waiting lists for many months already. Getting a diagnosis is necessary before any formal supports in school can begin. In the meantime, children languish and problems multiply.

Truancy has been a major problem throughout this school year. Many schools are unaware of the updated requirements for truancy complaints and many who are aware simply go through the motions of completing paperwork, not actually finding a viable solution for children whose mental health issues get in the way of their school attendance. Parents report to the Parent Alliance that their children are unable to get out of bed and are unable to participate in their routine daily activities, so it is understandable that many are unable to log on for class. Parents who are essential workers may have no recourse but to leave their older children alone during the day. While some may be uninterested in attending virtual school, among the many reasons for legitimate absences some include lack of internet and the inability to follow the often-confusing steps necessary to log in and out of class after class. Often these issues are handled with referrals to local magistrates or child welfare agencies which only causes additional stress for the child and their family.

Many districts have not resumed in person education since last March so schools will face many challenges once students return. We will need to have robust in-school and community services, supports and resources available to students and their parents. Staffing positions such as crisis interventionists and school based social workers should be a priority. Schools need to be prepared for

post-COVID student reintegration. Students have been living in a crisis state for over a year. Their development has been delayed if not regressed. They have experienced trauma akin to those experienced during major world wars losing loved ones, facing isolation, missing rites of passage, moving/homelessness due to job loss and having their academic development seriously delayed. All children will need varying degrees of support to resume stability and deal with the trauma they will carry forward. PA's move towards becoming a trauma informed state will help with this challenge but more intensive and ongoing support will be needed. One of the many supports that can continue to be offered is telehealth which can allow children the ability to access quality specialized treatment their parents may be unable to find in their local community. It can also help relieve the stress on small communities who have difficulty finding psychiatrists. According to the American Academy of Child and Adolescent Psychiatry PA has a severe shortage of practicing child and adolescent psychiatrists (only 16 per 100,000 children) with many counties not having a single provider.

We need appropriate, clear, and consistent plans within school districts for handling mental health crisis emergencies. Students should never be led out of school by police, in handcuffs, in front of their peers just because they are in crisis. Schools should make it a priority to connect with the many local and statewide community programs that can help them find support and fill the needs they are unable to address. Not all schools see this as their role or responsibility, and this can hinder a parent's ability to act quickly to find services when they notice changes in their child's behavior.

It is important to mention that black and brown children as well as those living in poor communities have been historically less likely to be identified with mental health challenges and receive the help that they need so a concerted effort must be made to properly identify all children and not just those in the better school districts or whose parents know the right words to say to trigger an evaluation.

An on-going concern is that most schools do not know how to support students with mental health needs through their IEP's in a typical classroom setting. Many children with anxiety, depression, autism, etc. are placed in classrooms labeled Emotional Support rather than allowing the students to remain in class with their peers while receiving counseling and other necessary supports in their least restrictive environment. This increases the stigma associated with a mental health diagnosis and leaves many students without necessary treatment and support.

Finally, it is worth noting that children are resilient and with the proper supports and services can learn to manage the mental health crisis that COVID 19 has created but these services cannot be offered as a one-time treatment that fixes over a year of trauma. We should strive to make comprehensive services easily available to all our children who have experienced the many forms of trauma this past year has created and should also plan for support for our teachers and classroom aides who have done admirably in their efforts since last March.

Respectfully submitted by,
Christina Paternoster, MS Ed
Project Director
PA Parent and Family Alliance

Considerations for Virtual Adaptations to School Suicide Prevention Policies and Procedures

Comprehensive school-based suicide prevention involves multiple strategies and approaches that span a continuum from awareness and upstream prevention (e.g., school climate, trauma-informed practices, social-emotional learning), to intervention (e.g., screening, assessment, safety planning), to postvention following a death by suicide or other tragic loss. Given that all components of suicide prevention policy and protocols can be understood as part of comprehensive **prevention** efforts, it is important for schools to examine **all** components of existing policy and procedures from a standpoint of remote learning to consider how implementation of such prevention efforts may need to be modified. In the process of reviewing all components, schools should adhere to suicide prevention guidelines (e.g., safe and effective messaging) and continue to distribute universal resources. Below are some initial guiding questions, followed by action steps for schools to explore as they review and modify implementation of current policies and procedures.

Initial Guiding Questions

The following questions may help guide the prioritization of more immediate action steps for schools:

- What staff member(s) and/or teams (e.g., Suicide Prevention Coordinator, school mental health professionals, SAP or crisis team members, solicitor, IT staff) are available to review existing policies and protocols to determine feasibility in a remote environment?
- What are the current recommendations, guidelines, and resources by national and state governing bodies, suicide prevention organizations, and professional associations that may inform revisions (e.g., COVID-19 Mental Health and Suicide Prevention Key Messages)?
- What is the availability of school staff members and/or school-based crisis response teams to respond given existing intervention protocols and current restrictions?
- Is there a need to engage community partners (e.g., mobile crisis, SAP liaisons, community providers, hospitals) to respond collaboratively or in place of school staff? If so, what is their current capacity to respond, and how are protocols changing moving forward?
- How will information related to health, welfare, and safety (e.g., suicide warning signs, environmental safety, accessing crisis resources) be disseminated?
- What technology is available to support current protocols (e.g., Safe2Say Something, Crisis Text Line) and/or how can technology be utilized to adapt existing protocols?

Action Steps

The following action steps may assist schools in identifying areas in need of review and revision with consideration to how protocols designed for a brick and mortar setting may apply within a virtual or hybrid structure.

1. **Review existing suicide prevention policies and procedures with an equity lens to identify and mitigate disparities regarding access to strategies, supports, and resources, particularly within a virtual or hybrid environment.**
   - ✓ Apply a multi-tiered approach by ensuring connections are in place for **all** students, and that there is opportunity for targeted check-ins with youth that may be at increased risk for suicide.
   - ✓ Determine methods for outreach (e.g., phone call check-ins, in-person visits while maintaining physical distance, utilizing community partners for wellness checks) and consider the diverse needs within the school community, including those of underrepresented groups (e.g., crisis response plans in IEPs, translation of resources).
   - ✓ Explore how additional community partnerships and community-based resources (e.g., faith-based services, homeless shelters, libraries, LGBTQ+ supports, etc.) could be used to

help strengthen protective factors and mitigate existing inequities and risk factors by supplementing school suicide prevention protocols and resources.
- ✓ Identify and determine the ability to address logistical concerns that may pose barriers to communication, confidentiality, documentation, and follow-up (e.g., access to technology, private space, contact information, resources, etc.).

2. **Update the suicide prevention supports and resources that can be offered as part of universal prevention and targeted intervention efforts for staff, families, and students.**
   - ✓ Educate the school community on wellness, risk, and resilience with respect to how observable behaviors of concern may appear within a virtual environment and how to facilitate referrals within the school and community. Emphasize strategies for self-care, support, and advocacy for staff, students, and families whenever possible (e.g., National Center for School Mental Health, The National Child Traumatic Stress Network).
   - ✓ Confirm referral options and processes for the continuum of school and community-based resources and services, including SAP, 302 and crisis response. Determine how availability of resources aligns with **all** components of school suicide prevention policies, including prevention, intervention (i.e., during suicide-related crisis), reentry to school (whether virtual, hybrid, or brick and mortar), and postvention.
   - ✓ Utilize resources from national organizations, many of which have local or regional chapters that offer access to a range of supports and advocacy for individuals with lived experience of mental health challenges or suicide risk and those that support them (e.g., National Alliance on Mental Illness, American Foundation for Suicide Prevention).
   - ✓ Explore options for additional technology that can help support universal messaging, reporting, and monitoring of students (e.g., mental health or safety planning apps; local, state, and federal crisis supports).

3. **Explore adaptations to internal and external communication, including how to communicate with staff, parents/guardians, and students about suicide prevention, intervention, and postvention policies and procedures within a virtual setting.**
   - ✓ Establish expectations for general supervision and monitoring during remote learning, including how the level of supervision may need to change when students may be at risk for suicide (e.g., NASP Conducting a Virtual Suicide Assessment Checklist).
   - ✓ Determine how these expectations for supervision and monitoring may impact the school's ability to carry out aspects of existing suicide prevention protocols and how expectations will be communicated to parents/guardians (e.g., does an adult need to be present for a school staff member to conduct a risk screening or assessment?).
   - ✓ Evaluate the platforms that are being used to engage with students and families, to identify confidentiality concerns.
   - ✓ Acknowledge the limits of confidentiality pertinent to suicide prevention procedures while working remotely and address how to balance student/family privacy with safety, how confidentiality may be compromised, and how information will be shared.
   - ✓ Review and update protocols for communication and documentation when there is an immediate safety concern, whether internally with school staff or externally with the parent/guardian or crisis responders.
   - ✓ Consider how documentation protocols can be used to support communication and follow-up with students, families, school staff/teams, and external partners (e.g., notifying individuals who may be part of a student's safety plan).

ADDITIONAL KEY RESOURCES

National Resources

National Association of School Psychologists (NASP) Resources:
- Comprehensive School Suicide Prevention in a Time of Distance Learning

Mental Health Technology Transfer Center (MHTTC) Resources:
- School Mental Health Resources

Suicide Prevention Resource Center (SPRC) Resources:
- Suicide Prevention Resources for Schools

Pennsylvania Resources

Pennsylvania Department of Education (PDE)
- Act 71 page
- Student and Staff Wellness Guide

Pennsylvania Network for Student Assistance Services (PNSAS)
- Considerations for Tele-Screening/Assessment during COVID-19

Prevent Suicide PA
- Act 71 page
- Adapted Postvention Considerations for Schools
- Mental Health Mobile Applications

University of Pittsburgh Services for Teens at Risk (STAR) Center Resources:
- Postvention Standards Manual, 5th Edition

Developed by Paula McCommons, Ed.D., and Perri Rosen, Ph.D., NCSP (2020)

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GUIDANCE FOR SCHOOL POSTVENTION DURING COVID-19

A suicide in the midst of a larger crisis such as COVID-19 can present a significant challenge to a school community, particularly given the other types of losses occurring as part of this global pandemic. Due to the risk of contagion in the event of a youth suicide, it is important to prepare in advance for a suicide postvention, even though it is more likely that schools will experience a loss due to the impact of COVID-19 during this time. Although the current situation continues to change rapidly, schools should acknowledge and respond to any student or staff death as soon as is feasible and to the extent possible, particularly if it is a death by suicide.

There are clearly limitations to what can be put in place when schools are operating remotely within the context of a larger pandemic, and schools must also recognize that some youth and families may be even more isolated or vulnerable under these circumstances. Given these challenges, schools may want to assess what kind of response they are able to provide initially and over time, and in the event of multiple deaths, to ensure that response procedures are as consistent as possible. Regardless of the nature the response, communication should be guided by patience and flexibility, both for the decision-makers and for the entire school community.

BASIC CONSIDERATIONS

There is limited research on postvention, even in the absence of a global pandemic. The immediate health, welfare, and safety of students, staff, and families should serve as a guiding principle for any response effort, along with adherence to federal and state guidelines. In acknowledging that schools and their community partners may be operating differently, it is especially important to determine what the outreach to students, staff, and families will look like, as well as the capacity of resources available. In recognizing that a full comprehensive postvention response is unlikely during this time, the following considerations may guide a school's response:

1. **Utilize a team approach.**
   To the greatest extent possible, decision-making related to a postvention response should be a team effort. This can help ensure that no one staff member has to make difficult decisions alone and that multiple perspectives are considered to represent the diverse needs of students, staff, and families. Ideally, a multidisciplinary postvention or crisis team would already exist. If the members of this team are not established or are working to address other crisis-related issues, any effort to collaborate is still important, especially under circumstances of a larger crisis.

   The following questions may be useful to consider:
   - ✓ What is the availability of current postvention/crisis team members, and how are they accessed (e.g., school-issued devices, remote platforms)?
   - ✓ What additional team members may be able to assist given the demands and limitations brought on by the larger crisis (e.g., staff from the tech/IT department or the district's media spokesperson)?
   - ✓ What aspects of standard postvention procedures are feasible right now, and which activities may need to be altered or postponed?
   - ✓ What existing community partners, including crisis response and/or behavioral health agencies, are available to assist with postvention activities?

2. **Communicate.**
   Communication efforts related to postvention should consider how to best reach staff, students, families, community partners/providers, and the postvention team. One of the most pressing issues for schools during COVID-19, is to determine what modalities and/or platforms are available to enable communication to the school community, as well as if and how members of the school community will be able to communicate back with school personnel. It is important to acknowledge to the school community that during a larger crisis in which information is ever-changing, there may be inadvertent miscommunication, delays in messaging or resources, and possibly even conflicting information. Communication and messaging should be accessible to all members of the school community (e.g., readability level, language translation).

3. **Educate about stress and grief reactions.**
   As in any postvention response, it is important for schools to normalize the range of stress and grief reactions of students and staff while also keeping vigilant to more concerning reactions that may suggest a need for additional support or more immediate intervention. Within a remote learning environment, school staff are more limited in their ability to monitor students' stress and grief reactions the way they would if students were physically attending school. Schools may need to determine how to best educate both students and adults (e.g., staff, family members, etc.) on identifying and reporting observable behaviors of concern, including how these may appear virtually and through social media. Additionally, given the context of the larger crisis, it is important to recognize that acute stress reactions may lead to the onset of new or worsening mental health concerns among students, families, and staff (including postvention/crisis team members).

4. **Provide a continuum of resources and supports**.
   The full range of postvention-related supports and services are not likely to be available during a larger crisis such as COVID-19. The school should identify what resources are able to be disseminated to the school community, including those that address crisis (e.g., National Suicide Prevention Lifeline, Crisis Text Line, etc.), promote resilience and connectedness, and provide for safety and basic needs (e.g., local food banks, health advisories, keeping environments safe, etc.). To the extent possible, schools should also communicate how these resources can be accessed, while reminding the school community that availability may fluctuate with the changing conditions under COVID-19.

   Given the potential for increased risk of suicide and/or depression among youth following the suicide of a peer, schools will also need to determine the ability of school staff to respond. Particularly for these students, community crisis and mental health partners may be able to help expand the school's capacity to address these concerns through more intensive components of a postvention response such as screening, developing safety plans, referrals to local mental health/telehealth services, and educating on lethal means safety.

   In reaching out to community partners, schools may consider asking the following questions:
   - ✓ Is the agency or organization available to assist with postvention and what specific services are provided (e.g., crisis, screening/assessment, treatment, support groups)?
   - ✓ In what ways have existing services changed (e.g., availability, accessibility, etc.)?
   - ✓ What are the agency or organization's current protocols (e.g., key contacts, referral process, etc.)?

5. **Offer hope and reinforce protective factors.**
   As part of a postvention response, schools may identify a variety of resources that can be shared with the school community to promote resilience and healthy coping. However, given the amount of information associated with the larger ongoing crisis of COVID-19, it is important for schools to recognize that parsing through resources can quickly become overwhelming to members of the school community. Schools can be intentional and trauma-informed in the manner in which they share resources, by considering the following:
   - ✓ Acknowledge the "we" in this shared experience (e.g., "we are doing the best that we can") and avoid judgment and criticism.
   - ✓ Highlight what students, staff, and families **can do** in the midst of the ongoing uncertainty, while also helping them to prioritize and set limits as needed (e.g., "what's one thing you can focus on right now?").
   - ✓ Reinforce healthy practices (e.g., exercise, sleep), adherence to routines, and maintaining social connections, as means to counterbalance stress reactions and strengthen protective factors.
   - ✓ Emphasize individual preference and choice with regard to accessing resources. What works for one person may not work for others and may vary over time. It may be helpful to resend resources periodically and include updates.
   - ✓ Recognize that members of the school community may need to limit their exposure, even to information that is intended to be helpful. Remind them that they can refer back to resources as needed.
   - ✓ Encourage members of the school community (including members of the postvention or crisis team) to care for themselves and each other in the days, weeks, and months ahead, given the additional stressors that people are likely to experience due to COVID-19.

ADDITIONAL CONSIDERATIONS

In addition to the guidelines above, the following are additional considerations specific to the impact that COVID-19 may have on a school's postvention response:

- ➢ Any given school's ability to respond will likely be impacted in an ongoing manner, due to efforts to implement evolving state and federal mandates while balancing with the local needs of the school community.
- ➢ Preexisting individual, family, and environmental risk factors (e.g., family conflict, abuse within the home, access to lethal means) may intensify under the conditions of COVID-19 and may impact a postvention response with regard to the number of students in need of additional follow-up support, as well as their degree of risk.
- ➢ There may be additional barriers to follow-up evaluation and treatment that schools may need to anticipate, with regard to the impact of COVID-19 on families:
  - ✓ Due to national and state health advisories related to the spread of COVID-19, students identified as being at risk of suicide and their parents/caregivers may have concerns about going to a hospital, given risk of exposure.
  - ✓ Family structure, functioning, and dynamics may be affected by COVID-19 (e.g., family member becomes sick and must be hospitalized, family member is an essential employee and works long shifts, family member loses job and insurance coverage lapses) and may in turn impact the family's ability to respond to the school's recommendations.

- Schools may be able to reach out to community partners (e.g., county crisis services) to help identify and communicate to families about the risks and benefits of accessing services during this time. These partners may also have additional information about changes in standard protocols within health and behavioral health care settings (e.g., option for direct admit versus sitting in an emergency room).
- With many components of educational service delivery shifting to an online, virtual format, schools and their community partners may opt to explore how various aspects of the postvention response may be implemented remotely. This may include telecommunication or telehealth options for general outreach and more targeted follow-up (e.g., support groups, screening/assessment). The following questions may be useful to consider as part of these efforts:
    - ✓ What kinds of technology are needed by the school/provider and the family, and what virtual resources may be particularly useful during postvention (e.g., apps for safety planning)?
    - ✓ How will the district ensure that there is equitable access to essential information and services by all members of the school community?
    - ✓ What other legal and ethical concerns must be addressed (e.g., consent, confidentiality, safety)? For instance, during a screening/assessment, obtain contact information and location of the student in advance, in case of imminent risk or threat, or if a technology issue occurs before the student's safety has been verified.

CONSIDERATIONS POST COVID-19: RETURNING TO SCHOOL

The primary considerations upon returning to school following an adapted postvention response will involve follow-up, checking in, and monitoring of students that may have been identified previously as needing additional supports. It is important to bear in mind that the majority of students and staff will be resilient, given the natural healing afforded by the return to "normalcy" and routines.

Schools may consider the following as students and staff return to school:

- Identify methods to reestablish safety and continue to promote self-care, self-advocacy, and help-seeking for all students and staff.
- Recognize that prolonged exposure to stressors may impact natural coping strategies, and that the rate at which the school community resumes prior routines will likely impact the ability of students and staff to "bounce back."
- Review documentation from any prior postvention to identify students that may be in need of follow-up (e.g., check-in, screening, and referral).
- Encourage staff and families to continue to look for observable behaviors of concern among all students, with the understanding that acute stress and grief reactions from months prior may have resolved themselves or worsened.
- Further complications due to other aspects of COVID-19 may also emerge (e.g., death(s) of loved ones, disruption in mourning rituals, possible need for extended quarantine or further restrictions within a family or community).
- Note anniversary dates from any postvention prior to and during the larger scale crisis, as stress and grief responses may appear or resurface.
- Reassess the status of educational and behavioral health services (e.g., telehealth, online learning options), as their sustainability is yet unknown. New services may emerge, while others may be discontinued, resulting in unintentional lapses in care.

KEY RESOURCES

The resources below provide additional guidance on postvention, remote service delivery, behavioral health supports, and crisis response for schools and behavioral health providers.

Suicide Prevention, Intervention, and Postvention Resources

STAR-Center University of Pittsburgh
Postvention Standards Manual, 5th Edition (Pending posting on https://www.starcenter.pitt.edu/)

National Suicide Prevention Lifeline
Lifeline Online Postvention Manual

National Association of School Psychologists (NASP)
Comprehensive School Suicide Prevention in a Time of Distance Learning

Prevent Suicide PA
Act 71 Information

Behavioral Health, Trauma, and Coping Resources

National Center for School Mental Health
COVID-19 Resources
*Includes "Technology to Support School Mental Health" tab with multiple resources

Treatment and Services Adaptation Center
COVID and School Crisis Resources

National Alliance on Mental Illness
Home page
*Includes "COVID-19 Resource and Information Guide"

Crisis Resources

NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255) suicidepreventionlifeline.org

CRISIS TEXT LINE
Text PA to 741741
Free, 24/7, Confidential

THE TREVOR PROJECT
LGBTQ CRISIS HOTLINE
CALL 1-866-488-7386

Developed by Paula McCommons, Ed.D., and Perri Rosen, Ph.D., NCSP to accompany the release of the revised STAR Center Postvention Standards Manual, 5th Edition (2020).

Considerations for tele-screening/assessment during COVID-19

SAP liaisons conducting tele-screenings or assessments should be primarily guided by agency protocols. In developing these protocols, it may be beneficial for the agency and individual liaisons to consider what aspects of screening and/or assessment can be implemented similarly to how these services are delivered on-site and in-person. Wherever aspects of existing protocols may need to change, consider maximizing the similarities between approaches taken within a tele-screening/assessment environment and an on-site/in-person environment.

The Virtual Environment

- What logistic considerations must be in place prior to tele-screening or assessing, for both the liaison and for the student/family?
    - Some examples include internet access/bandwidth, audio and video capability, etc.
- Is the platform being used HIPAA/FERPA compliant?
- What is the liaison and student/family's familiarity with the platform being used?
- What measures are in place to maintain continuity of the screening or assessment process if there are technology issues (e.g., video freezes)?
- What aspects of the physical environment should be considered to minimize distractions, and maximize attention and engagement during the screening or assessment?
    - Some examples may include moving items out of line of sight, wearing headphones, finding a quiet space
- What aspects of the physical environment help to increase privacy and promote confidentiality during the screening or assessment?
    - Some considerations may include availability of private space at the liaison's location and in the student's home, time of day, etc.
- What aspects of the physical environment help to ensure student safety during the screening or assessment?
    - Some considerations may include people and/or objects in the space, proximity of the parent/guardian/family members, video vs. auditory format, etc.

Communication with Others to Support the Student

Parents/Guardians

- What communication is needed with the student's parent/guardian about the screening and/or assessment?
- Will the parent/guardian need to participate in or be available during the screening/assessment?
- What will be the timeframe and method of follow-up contact with the parent/guardian after the screening/assessment?

School SAP Team

- What is process for communicating with the school SAP team prior to and following a screening and/or assessment in accordance with previous practices and procedures?

  - Who is the current building level contact for SAP?
  - What is the appropriate method of contact?
- Are school SAP teams or SAP team members available to do follow-up after a screening and/or assessment?

Community Partners

- What is the current availability of referral and follow-up resources and supports in the community (e.g., crisis, agencies, hospitals) that may be needed following a screening and/or assessment?
  - Some considerations include whether these services are fully operational, whether procedures and protocols have changed, key contacts have changed, etc.

Legal and Ethical Considerations

- How will written parent/guardian consent for screening and/or assessment, as well as for telehealth services be obtained?
  - Agencies may consider whether there is an option to obtain this electronically.
- Are there additional aspects of the screening and/or assessment process that should be documented, and if so, how?
- How will the agency and individual SAP liaisons promote equity and cultural competence in tele-screening/assessment practices?
  - What are the cultural considerations for "entering" the student/family environment?
  - How will potential barriers to screening/assessment for some students and families be addressed?
  - What new or additional challenges does the current situation with COVID-19 bring to the student and/or family?
- What developmental factors should be considered in the screening/assessment process?
  - Some considerations include the age of the student, whether the student has a disability, etc.
- What are the established crisis protocols for students identified as at risk of harm to self or others, and do these protocols need to be altered in any way?
  - What is the physical location of the student during the screening/assessment?
  - Does the screening/assessment need to be visual (i.e., does the liaison need to see the student?)?
  - With regard to adult supervision during the screening/assessment, what is acceptable?
    - Consider whether there are alternatives if a parent/guardian is unavailable, as well as how this should be determined and then documented.
  - If results indicate that a student is at imminent risk of suicide and may need to be hospitalized, how will the SAP liaison/agency respond if parents do not want to follow-up based on increased risk of COVID-19?
- What are the follow-up options and timelines for screenings/assessments that do not involve crisis response?
  - Some considerations include the difference between a screening vs. an assessment that may determine a level of care. If screening only, consider whether the appropriate follow-up avenues are available within the school and community so that screening results and recommendations do not go unaddressed.

Considerations for SAP liaisons/agencies for outreach to schools during COVID-19

- Try to find out whether your school SAP teams are operating currently and if so, in what ways procedures may have changed.
    - For instance, determine whether teams are still taking new referrals, holding meetings, etc. This can help SAP liaisons determine whether to expect new referrals for screenings and/or assessments, and it may help the SAP liaison agency determine whether other types of liaison services may be helpful to the school during this time.
- Communicate the current status of your SAP liaison agency and individual liaisons with your school teams, so they know whether referrals are on hold or whether students are being screened and/or assessed during this time and if so, how protocols may have changed (e.g., tele-screening).
- Consider inquiring with school SAP teams to determine what procedures will be in place to follow-up with screened students once school resumes, and discuss what interventions and/or supports may or may not be available while students are out of school.
- Determine whether there may be a need to make adjustments to existing Letters of Agreement with schools.

Note: This document is not meant to provide guidance, nor are the questions and considerations within required. Rather, it is meant to serve as a helpful resource with suggested areas for discussion for SAP liaison agencies that may be adjusting current protocols during COVID-19.

Telehealth Service Delivery for the Pennsylvania Behavioral Health System: Stakeholder Survey Input During COVID-19

Final Report December 16, 2020

pennsylvania
DEPARTMENT OF HUMAN SERVICES

This report was prepared by Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS), Bureau of Policy, Planning, and Program Development (BPPPD), along with support from the Department of Drug and Alcohol Programs (DDAP).

Key Commonwealth staff supporting the development of the surveys, dashboards, and report included:

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Support for survey development and outreach was provided by the Pennsylvania HealthChoices Primary Contractors, Behavioral Health Managed Care Organizations, and the Coalition for the CommonHealth.

Questions regarding this report or OMHSAS telehealth policy can be directed to the: ra-pwtbhs@pa.gov

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Telehealth is so much more helpful and attainable for me as a single father...I was able to keep and engage in more appointments.

Telehealth should be used more often! Many of our children loved telehealth and looked forward to it!

Telehealth was very convenient...didn't have to use public transportation and wait in a waiting room, which together can be 3+ hours.

Introduction

The Pennsylvania Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) recognizes the critical role that telehealth plays in ensuring that Pennsylvania citizens have access to behavioral health services while maintaining their ability to promote public health by complying with stay-at-home orders and other social distancing measures. As such, OMHSAS issued *Telehealth Guidelines Related to COVID-19* just eleven days after Governor Tom Wolf's initial emergency disaster declaration, allowing for substantially increased flexibilities within the Pennsylvania Medicaid system to provide behavioral health services using telehealth delivery.

OMHSAS also recognized that the rapidly increased flexibility for telehealth delivery of services provided an opportunity to hear from our stakeholders on their experience with the modality and provide input into the future of behavioral health services in Pennsylvania. As such, OMHSAS has undertaken an extensive engagement initiative including outreach to stakeholder groups, the creation of a telehealth steering committee, holding focus group meetings, and conducting three statewide surveys. This report summarizes the results of the telehealth surveys conducted in spring 2020.

Key Survey Findings

Individual and Family Survey

- 7,029 respondents
- 80% White, 10% African American, 4% Self Identify, 1% Asian, .65% American Indian, .16% Native Hawaiian or Pacific Islander
- 90% non-Hispanic, 7% Hispanic or Latinx, 3% No response
- 92% of respondents report receiving services with the same frequency or more often than before COVID-19
- 96% of respondents received telehealth services at home
- 55% of respondents stated that they needed to cancel or reschedule appointments less often when using telehealth
- 75% of respondents want to continue using telehealth for at least some of their services after COVID-19
- Respondents noted that telehealth reduced the following treatment barriers: Travel time (66%), Transportation issues (58%), Conflicts with work (36%), Scheduling Issues (40%), and Child Care/Family Caregiving demands (30%)
- Lack of/limited internet and lack of/limited access to internet capable devices were the two most common barriers identified to receiving services through telehealth

Behavioral Health Practitioner Surveys

- 2,776 responses to the surveys
- 69% clinicians, 31% non-clinician
- 85% White, 7% African American, 3% self-identify, 2% No response
- 92% Non-Hispanic, 5% Hispanic/Latinx, 3% No response
- 54% of practitioners reported using little or no telehealth service delivery prior to COVID-19
- 56% anticipate using telehealth to deliver services a considerable amount (over 50%) after COVID-19
- 83% of respondent found that increased flexibility on telehealth rules improved access to services considerably or significantly
- 57% of respondents felt that they can provide effective services using telephone only
- 86% of respondents support new patients being established through telehealth

Individual and Family Survey

Methods

The survey included questions regarding the experience of individuals receiving behavioral health services and their families prior to the COVID-19 Public Health Emergency (PHE), during the first three months of the PHE, and service preferences following the resolution of the PHE. Respondents were asked twenty multiple choice questions and three open ended questions. Participants were given the option to provide their contact information if they were interested in participating in future stakeholder opportunities. Please see Appendix A for the full text of the Individual/Family Survey.

Survey announcements were distributed through multiple OMHSAS listservs. OMHSAS listserv subscribers include members of the Mental Health Planning Council, county human service agencies, county mental health agencies, single county authority administrators, advocacy organizations, and members of the general public. Stakeholders were encouraged to share with individuals receiving services. HealthChoices Primary Contractors (HC-PCs) and Behavioral Health Managed Care Organizations (BH-MCOs) also assisted with outreach to individuals within their service areas.

The online survey tool, SurveyMonkey was used to collect the majority of responses. The public SurveyMonkey link was open from May 29, 2020 through June 22, 2020. Several additional responses were collected by telephone and data entered into an Excel spreadsheet in partnership with local Consumer Family Satisfaction Teams (CFST).[1] This report analyzes a combined data set including both the telephone collection by CFST and the SurveyMonkey results.

Results

A total of 7,029 survey responses were received. It is not possible to calculate a response rate as the number of individuals who received the survey is unknown. The following charts provide an overview of the statewide results, along with representative comments from survey respondents.

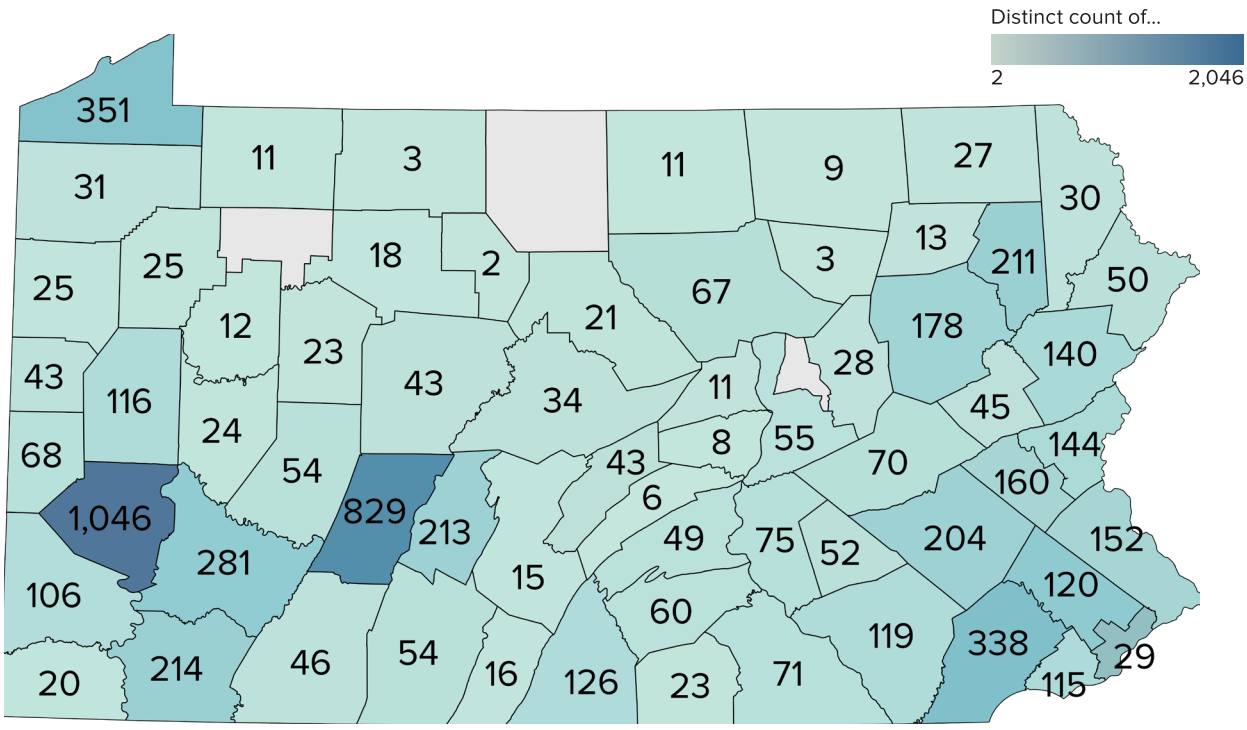
OMHSAS invites our partners across the system to utilize the public dashboard to view survey results for a specific county, region, demographics, etc. The public dashboard can be accessed here.[2]

[1]Consumer Family Satisfaction Teams work as a formal team to determine if individuals receiving behavioral health services and their families are satisfied with services and to help ensure that problems related to service access, delivery and outcomes are identified and resolved in a timely manner. Call for Change, pg 16, accessed 11/5/20.

[2]https://tableau.pa.gov/t/DHS-Public/views/TelehealthSurvey_FINAL_9420/RespondentDemographics?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no&:origin=viz_share_link

Respondents by County

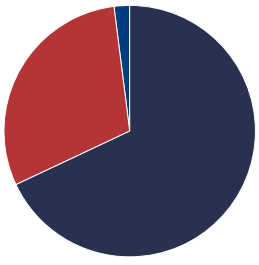
Survey respondents were required to identify the county where the individual receiving services lives. Responses were received from 64 of Pennsylvania's 67 counties.



Map based on the Longitude and Latitude (generated). Color shows distinct count of Respondent. The marks are labeled by distinct count of Respondent. Details are shown for County where the individual receiving services lives; 1. The data is filtered on Action (Demo Parameter), which keeps 4 members.

Respondent Role

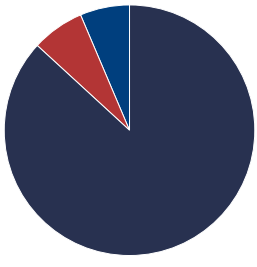
Each survey respondent was required to identify their role in the system as either an individual who received behavioral health services or the family member of an individual receiving behavioral health services. In addition, each respondent was required to identify which type of behavioral health services they or their family member received: mental health, drug and alcohol (D&A), or both.



Respondent Role

7,029 Individuals

- Individual 68% (n=4,803)
- Family Member 30% (n=2,080)
- Null/None of the Above 2% (n=146)



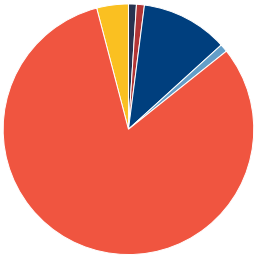
MH and/or SUD

7,029 Individuals

- Mental Health Services 86% (n=6045)
- D&A Services 6.72% (n=472)
- Both MH and D&A 6.33% (n=445)

Demographics: Race and Ethnicity

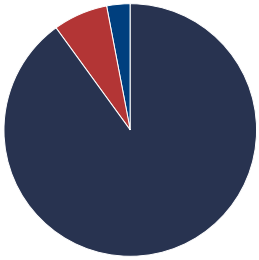
Respondents were asked to identify the race and ethnicity of the individual receiving behavioral health services.



Race

7,029 Individuals

- American Indian <1% (n=46)
- Asian 1% (n=83)
- Black of African American 11% (n=767)
- Native Hawaiian or Other Pacific Islander <1% (n=11)
- White 80% (n=5,637)
- Self-Identify 4% (n=312)



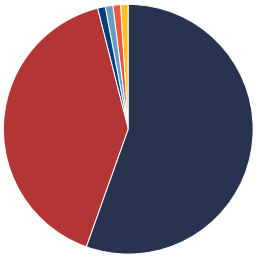
Ethnicity

7,029 Individuals

- Non-Hispanic 90% (n=6,356)
- Hispanic 7% (n=484)
- Null/No Response 3% (n=189)

Demographics: Gender and Age

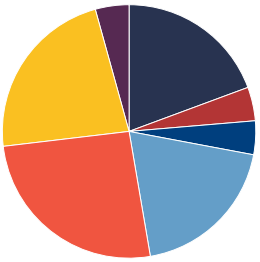
Respondents were asked to identify the age range and gender of the individual receiving behavioral health services.



Gender

7,029 Individuals

- Female 56% (n=3,921)
- Male 41% (n=2,874)
- Non-Binary <1% (n=53)
- Transgender Female <1% (n=17)
- Transgender Male <1% (n=35)
- Self-Identify <1% (n=10)



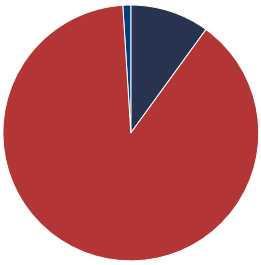
Age

7,029 Individuals

- 3 - 9 years old 18% (n=1,270)
- 10 - 17 years old 4% (n=284)
- 18 - 21 years old 4% (n=284)
- 21 - 34 years old 18% (n=1,692)
- 35 - 49 years old 24% (n=1,692)
- 50 - 64 years old 21% (n=1,451
- 65+ years old 4% (n=247)

Telehealth Usage: Prior to and During COVID-19

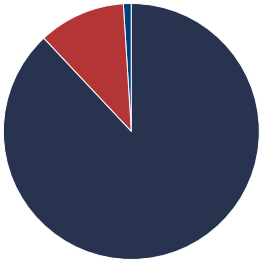
Respondents were asked yes/no questions regarding the use of telehealth prior to the COVID-19 PHE and during the initial COVID-19 PHE. As anticipated with the increased flexibility of state and federal telehealth policy during the COVID-19 PHE, the use of telehealth for the delivery of behavioral health services within the Pennsylvania Behavioral Health System increased dramatically in the first months of the PHE.



Used Telehealth Prior to COVID-19

7,029 Individuals

- Yes 10% (n-685)
- No 89% (n=6,282)
- No response <1% (n=62)



Used Telehealth Since COVID-19

7,029 Individuals

- Yes 88% (n=6,201)
- No 11% (n=769)
- No response <1% (n=59)

> [Telehealth] is very helpful to be able to use sign language via my phone during COVID to still see my counselor.

> Being able to receive my therapy remotely helped me to stay calm and avoid a crisis situation.

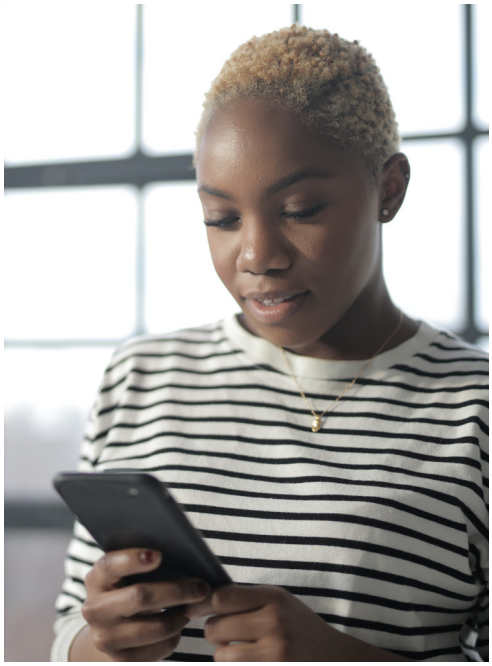
> Telehealth made it a lot easier to keep all appointments. I take medical transportation and will be on the van for 5 or 6 hours.

> As parents, we were more able to participate in IBHS sessions...and could better transition skills in the home.

> Living in a rural county where services are few and far between, telehealth appointments have been a godsend. It gives the person options for their treatment that are not available in [their] community.

> Before I missed a lot of sessions because I didn't have gas money... or someone to watch the kids. This telehealth is a lot less stressful for me.

Service Access During COVID-19



Respondents were asked several questions regarding the frequency and length of services provided during the COVID-19 PHE to gauge the impact of telehealth on access to services. Prior to the COVID-19 PHE most behavioral health services delivered through telehealth required that the recipient go to their provider's office where they would be connected with the remote behavioral health practitioner. Telehealth guidance issued in response to the PHE provided for increased flexibilities that broadly allowed individuals to receive remote behavioral health services from their homes or other non-office locations for the first time, and resulted in 97% of respondents receiving their services from their home during the PHE.

The increased flexibility to receive services from home through telehealth supported individuals in following Governor Wolf's stay-at-home orders and other social distancing practices during the COVID-19 PHE. Telehealth flexibilities also reduced barriers that many individuals experience while accessing traditional in-person services, with the most frequent including:

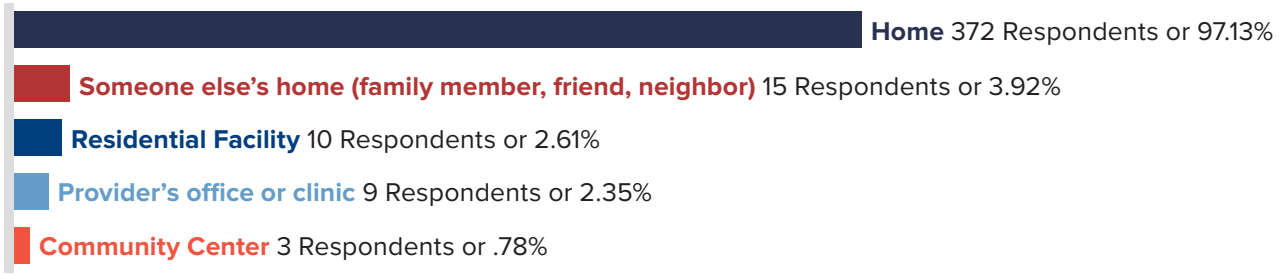
- 64% of respondents reported reduced barrier of travel time/distance
- 60% of respondents reported reduced barrier of transportation access issues
- 42% of respondents reported reduced barrier of scheduling issues due to work
- 40% of respondents reported reduced barrier of scheduling for non-work reasons
- 30% of respondents reported reduced barrier of childcare or other family care giving barriers

As a result of the increased flexibility for telehealth service delivery, over 90% of respondents reported that services were received as often or more often than prior to the COVID-19 PHE. 55% of respondents reported that appointments were canceled or rescheduled less often, while under 5% of respondents reported an increased need for cancellations/rescheduling. OMHSAS is aware of anecdotal reporting of difficulty maintaining session length; however, most respondents in this survey reported that on average their sessions lasted longer than 31 minutes (70.41%).

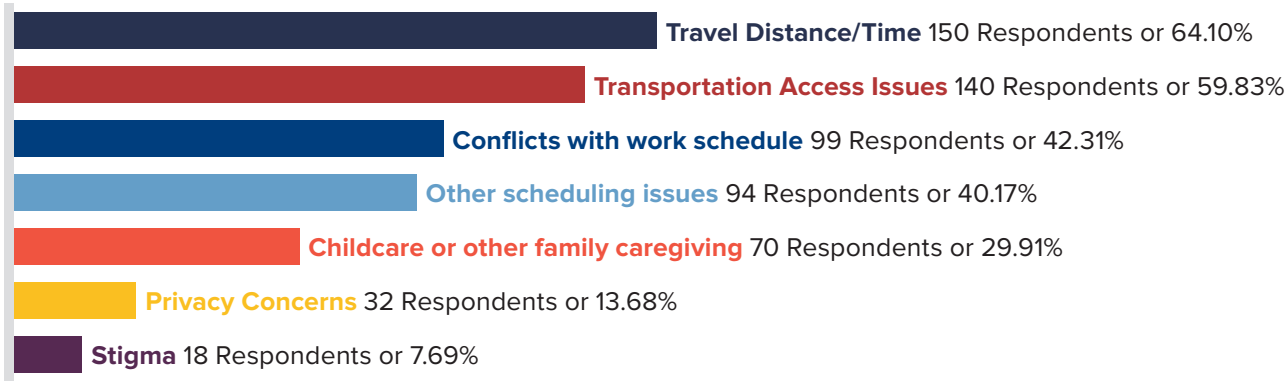
Most respondents indicated that they did not want any in-person services (47%) or received all the in-person services they felt they needed (9%) during the COVID-19 PHE. A significant number of respondents reported difficulty accessing some (13%) or all (31%) of the in-person services they felt they needed during the first three months of the COVID-19 PHE.

OMHSAS has heard an overwhelming preference from individuals and their families that the increased use of telehealth add new flexibilities to the behavioral health system, rather than replace in-person services. OMHSAS is monitoring the service system closely to ensure that service choices available to individuals served and their families are enhanced by telehealth, not limited by it.

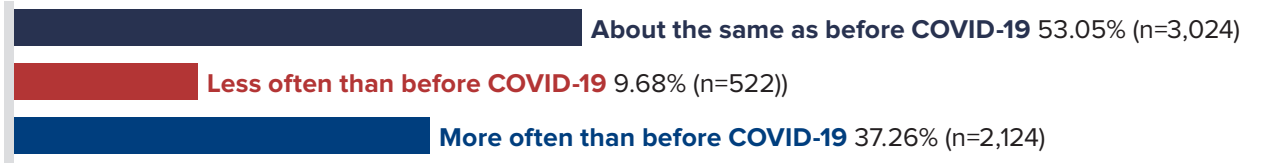
Where did you/your family member use telehealth services during COVID-19?



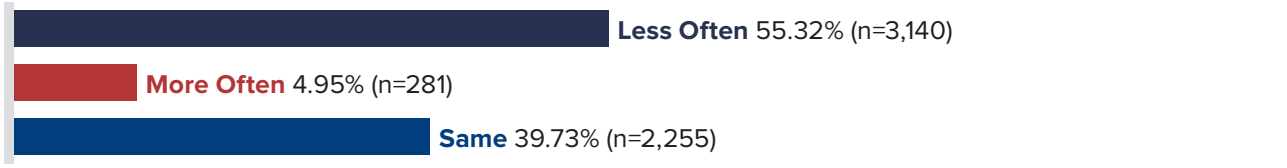
Did telehealth reduce any of these challenges to receiving services for you/your family member:



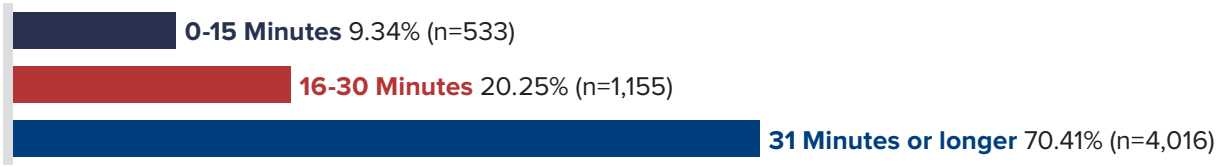
How often did you/your family member receive services during COVID-19 through telehealth?



Compared to receiving services in person, how frequently did you/your family member need to cancel/reschedule telehealth appointment?



How long did your telehealth service sessions typically last?



During COVID-19, did you/your family member receive any services in-person?

I hope that telehealth is still going to be an option. I have 3 children and when any are sick...I have to cancel my therapy appointment and I'm not always able to re-schedule in a time that is convenient. This service has been a lifesaver in keeping up with my mental health during these trying times in our world.

My daughter is a teenager. They live by the computer and smart phone. It was often embarrassing for her to go to therapy in an office setting. She was more confident and motivated to meet with her therapist on telehealth.

Can work from home and do my visit on my lunch break.

As a single parent with two medically fragile special needs children [telehealth] made it accessible for all of us to receive valuable therapies and treatments.

My dad has advanced Alzheimer's and the fact that I do not need to leave the house and arrange for care for my parents has been such a blessing. I hope we can continue with telehealth.

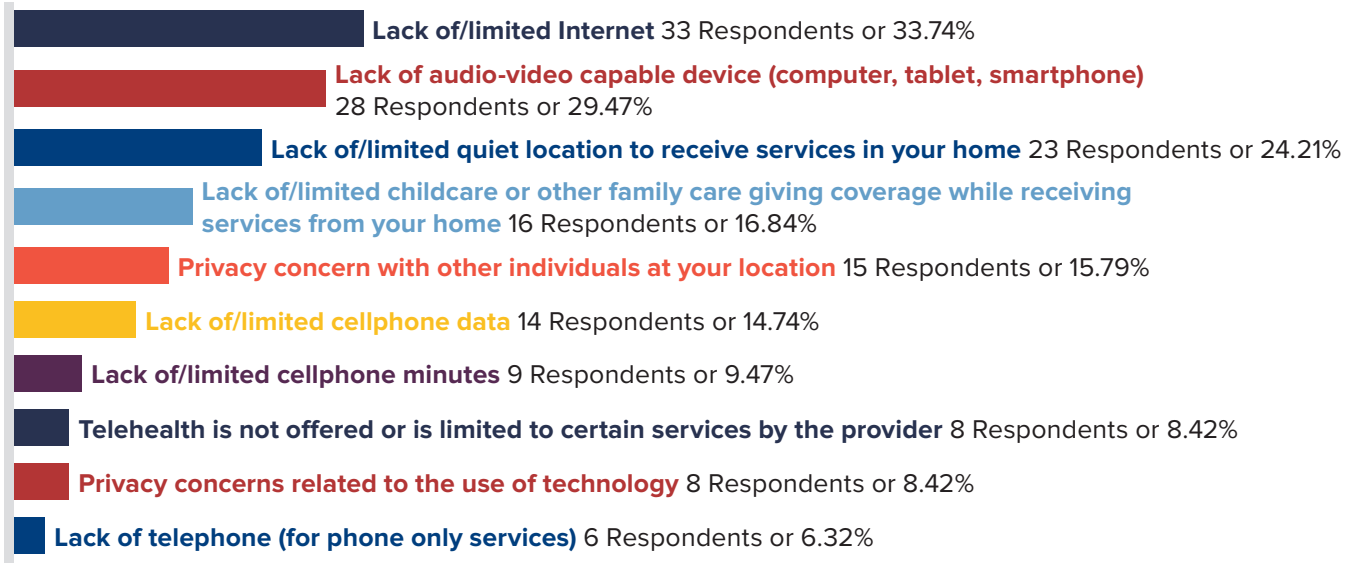
It is easier to "open up" to a therapist when in a more comfortable (home) place. My therapy has been MUCH more effective because of this. My relationship with my therapist has improved, too.

Telehealth Barriers

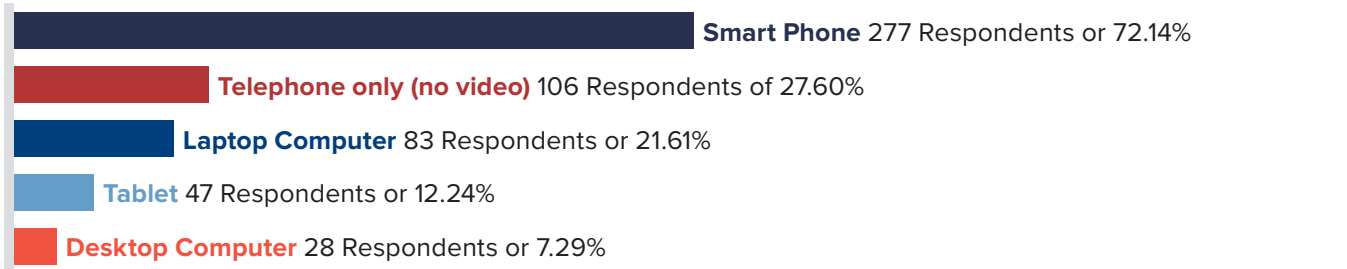
There is an overall increase in the availability of and access to behavioral health services as a result of the traditional barriers that telehealth eliminates/reduces; however, many respondents indicated experiencing new barriers related to technological access.

The majority of the survey responses were completed through a web-based platform and much of the outreach efforts for the survey were conducted by e-mail announcement. Although telephone surveys were conducted, it is likely that individuals with limited internet and device access are underrepresented in the survey results.

Were there any barriers that limited you/your family member's use of telehealth during COVID-19?

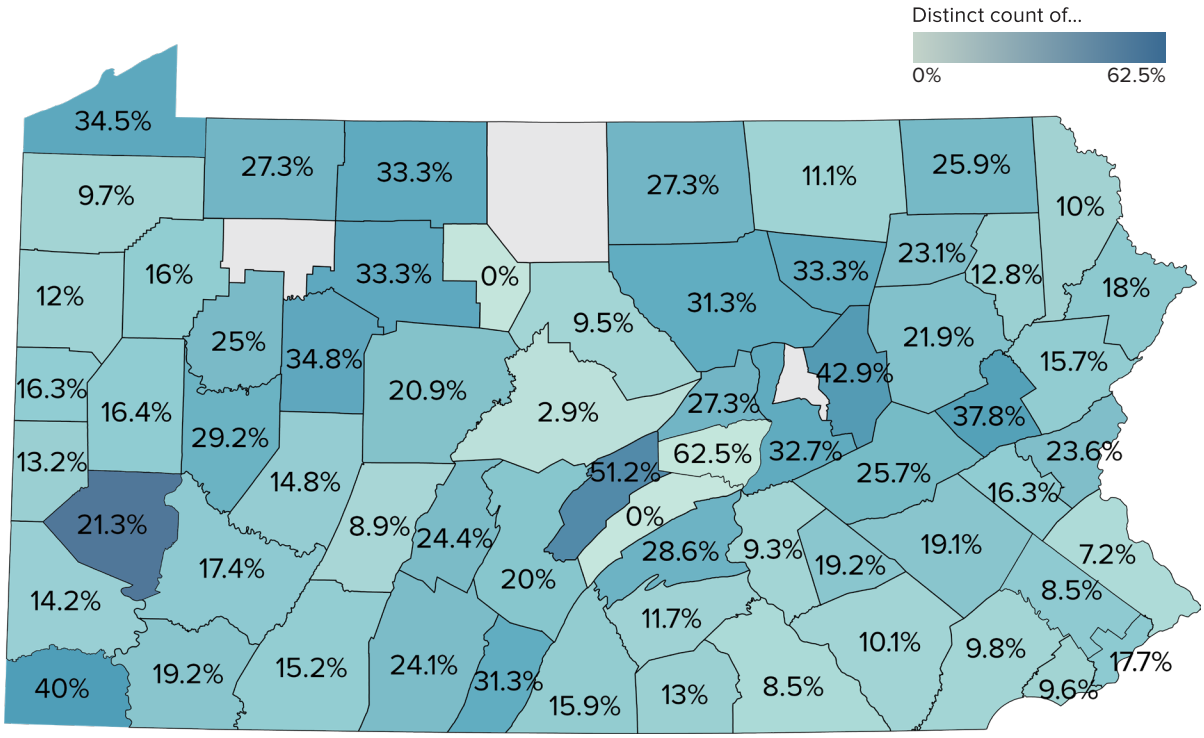


What devices did you/your family member use for telehealth services during COVID-19?

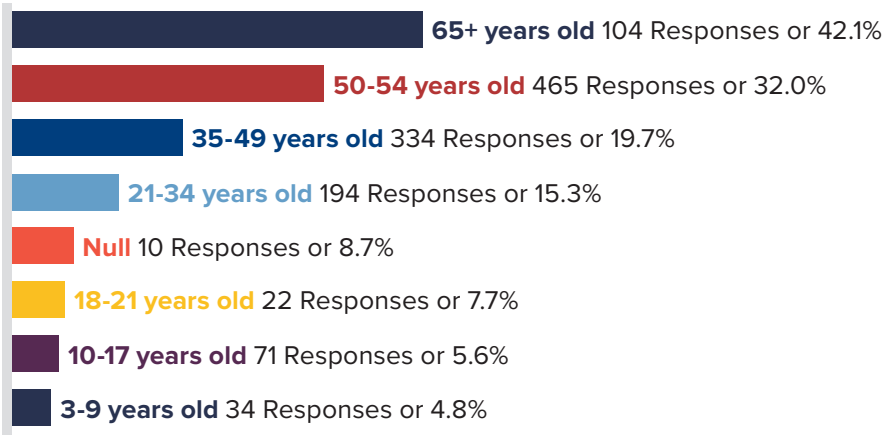


Telephone Only (no video)

Percentage of Respondents who indicated telephone only access (no video) as the only available device for telehealth service delivery.



Respondents Reporting Telephone Only Access (no video) by Age Group



Service Effectiveness with Telehealth

Respondents were asked to rank how helpful each of the services they or their family member received during the COVID-19 PHE were on a 1-5 likert scale (Note: on the dashboard these results have been scaled to 100 for clearer visualization). This survey was conducted during the early increase in telehealth usage due to the COVID-19 PHE. As a result, rankings may be impacted by hurdles associated with implementing a new program. While some services may not be clinically appropriate for telehealth delivery, it is possible that higher intensity services, which received lower ratings of helpfulness on the current survey, may benefit with additional resources, time, and adaption to the delivery method.

The services rated as most helpful when delivered through telehealth were, in order from most helpful to least:

1. Individual Therapy
2. Medication Visits
3. Psychiatric Rehabilitation- Individual Services
4. Medication Assisted Treatment
5. Certified Peer Support Specialists
6. Mental Health Case Management

The services rated least helpful when delivered through telehealth were, in order from least helpful to most helpful:

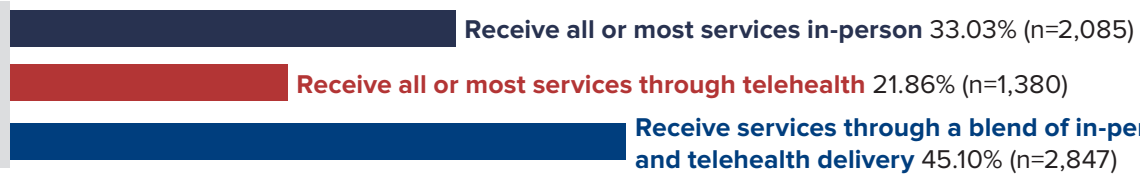
1. Partial Hospitalization (Intensive Outpatient)
2. Children's Residential Treatment
3. Psychiatric Inpatient
4. Assertive Community Treatment
5. Adult Residential Treatment
6. Group Services

> During this time, I experienced suicidal ideations and each service provider helped me through this difficult time with extra appointments, phone calls, and safety-checks [through telehealth].

Post COVID-19 Telehealth Preferences

Survey respondents were asked about preferences for service delivery following the resolution of the COVID-19 PHE. A substantial portion of respondents (78%) would prefer to receive at least some of their behavioral health services through telehealth after the COVID-19 PHE, emphasizing the importance of choice for individuals receiving services and their families.

After COVID-19, how wold you like to receive services for yourself/your family member?



Behavioral Health Services Practitioner Surveys

Methods

The behavioral health services practitioner surveys included questions related to the practitioner's experience with providing behavioral health services using telehealth prior to the COVID-19 PHE, during the first four months of the PHE, and the practitioner's preferences for service delivery following the resolution of the PHE. However, the primary focus of the survey was to develop an understanding of the impact of telehealth on the delivery of services during COVID-19. The surveys included 17 multiple choice questions, five of which included a comment field for the respondent to provide additional context to their answer, and one open ended question. Respondents were given the option to provide their contact information if they were interested in participating in future stakeholder opportunities.

To allow for targeted outreach two parallel surveys were created; one for clinicians and one for non-clinical behavioral health professionals. Both surveys included the same questions and the results were combined by OMHSAS during the data review process. The clinician survey was targeted to psychiatrists (MD/DO), non-psychiatrist physicians (MD/DO), licensed psychologists, physician's assistants, certified registered nurse practitioners, additional nursing licenses, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors. The non-clinical professional survey was targeted to psychiatric rehabilitation staff, Clubhouse staff, certified peer specialists (CPS), CPS supervisors, certified recovery specialists, certified family recovery specialists, mental health case managers (intensive case management, blended case management, resource coordination), substance use disorder case managers, supported employment/education specialists, housing specialists, homeless service specialists and "other" behavioral health service practitioners. Please see Appendix B and Appendix C for the full text versions of each survey.

Survey announcements were distributed through multiple OMHSAS listservs. OMHSAS listserv subscribers include members of the Mental Health Planning Council, county human service agencies, county mental health-intellectual disability agencies, single county authority administrators, advocacy organizations, and members of the general public. Stakeholder were encouraged to share with their membership.

The online survey tool, SurveyMonkey was used to collect responses. The public SurveyMonkey link was open from July 8, 2020 to July 22, 2020. The results were reviewed and cleaned, and visualization was completed by OMHSAS.

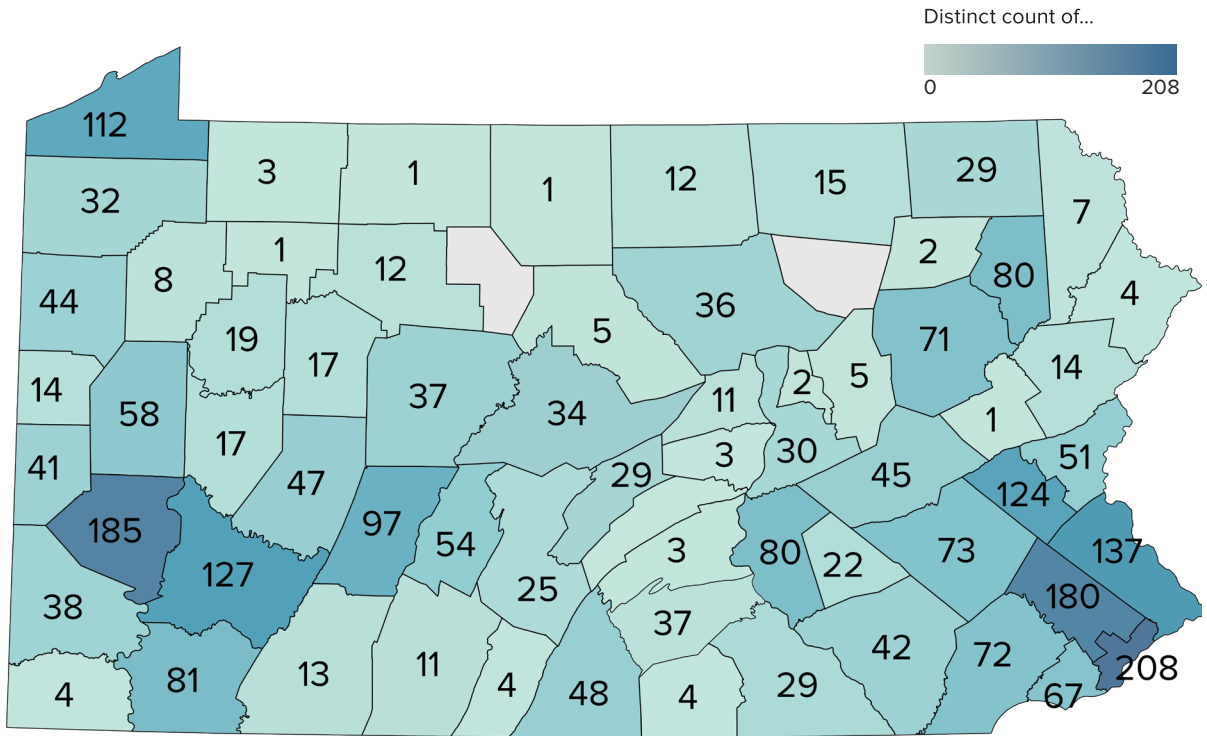
Results

A total of 2,776 survey responses were received. It is not possible to calculate a response rate as the number of individuals who received the survey is unknown. The following charts provide an overview of the statewide survey results, along with comments from survey respondents.

OMHSAS invites our partners across the system to utilize the public dashboard to view survey results for a specific county, region, demographics, etc. The public dashboard can be accessed here.[3]

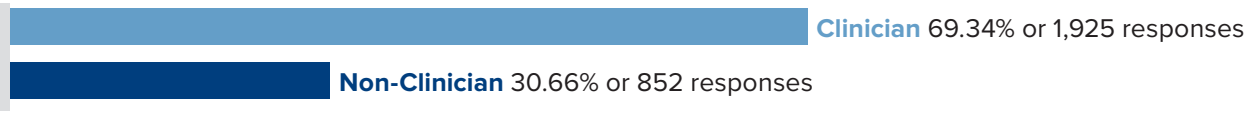
Respondents by County

Survey respondents were asked to identify the county where they provide the majority of their services. Responses were received from 65 of Pennsylvania's 67 counties.

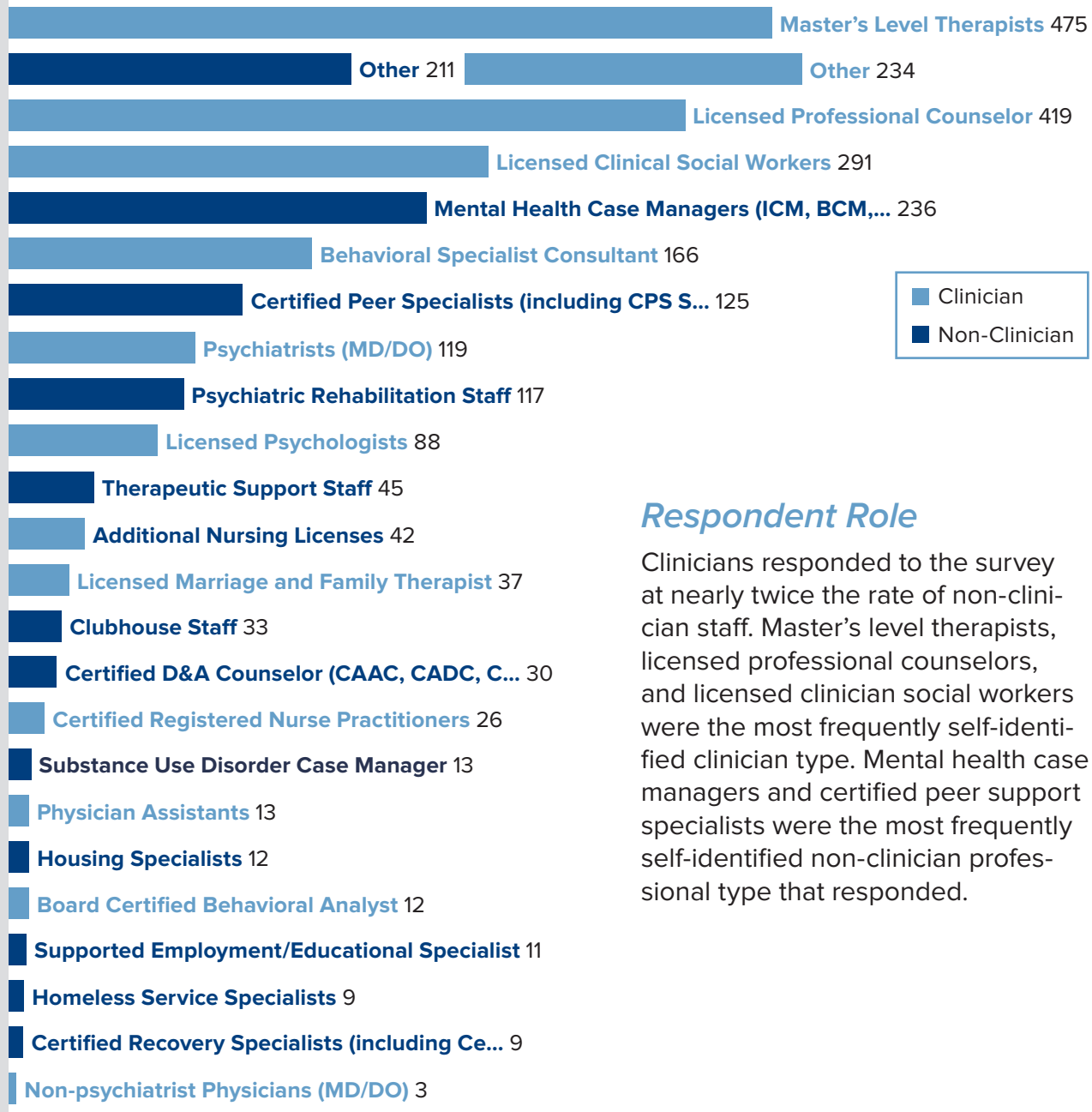


[3] https://tableau.pa.gov/t/DHS-Public/views/TelehealthSurvey_FINAL_9420/RespondentDemographics?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no&:origin=viz_share_link

Clinician or Non-Clinician



Practitioner Type

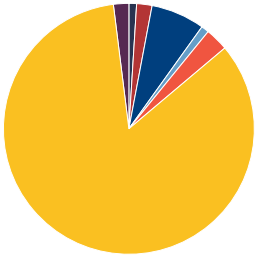


Respondent Role

Clinicians responded to the survey at nearly twice the rate of non-clinician staff. Master's level therapists, licensed professional counselors, and licensed clinician social workers were the most frequently self-identified clinician type. Mental health case managers and certified peer support specialists were the most frequently self-identified non-clinician professional type that responded.

Demographics: Race and Ethnicity

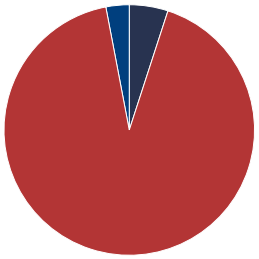
Each respondent was asked to identify their race and ethnicity.



Race

2,776 Individuals

- American Indian <1% (n=11)
- Asian 2% (n=41)
- Black or African American 7% (n=192)
- Native Hawaiian or Other Pacific Islander <1% (n=4)
- Self-Identify 3% (n=92)
- White 85% (n=2,370)
- No Response 2% (n=66)



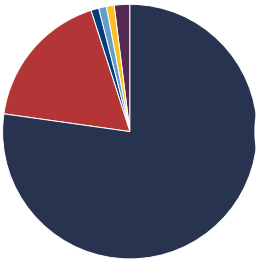
Ethnicity

2,776 Individuals

- Hispanic/Latinx 5% (n=128)
- Non-Hispanic 92% (n=2,565)
- No Response 3% (n=83)

Demographics: Gender and Age

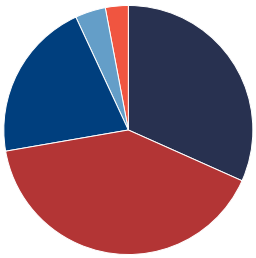
Respondents were asked to identify their age range and gender.



Gender

2,776 Individuals

- Female 78% (n=2,161)
- Male 18% (n=508)
- Non-Binary <1% (n=15)
- Self-Identify 1% (n=24)
- Transgender Female no responses
- Transgender Male .1% (n=4)
- No Response 2% (n=64)

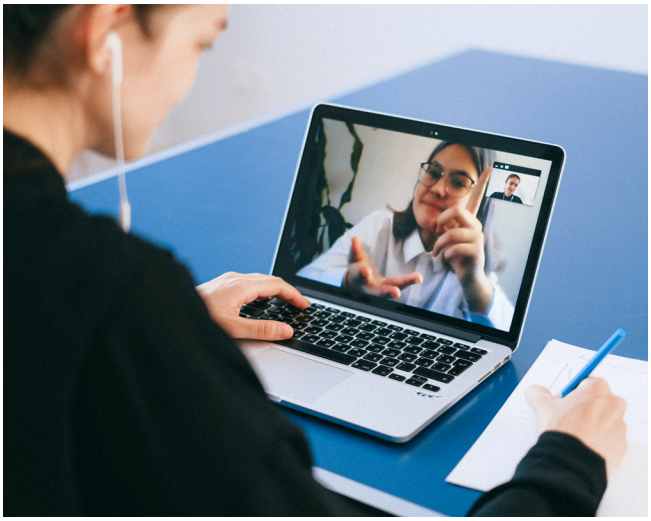


Age

2,776 Individuals

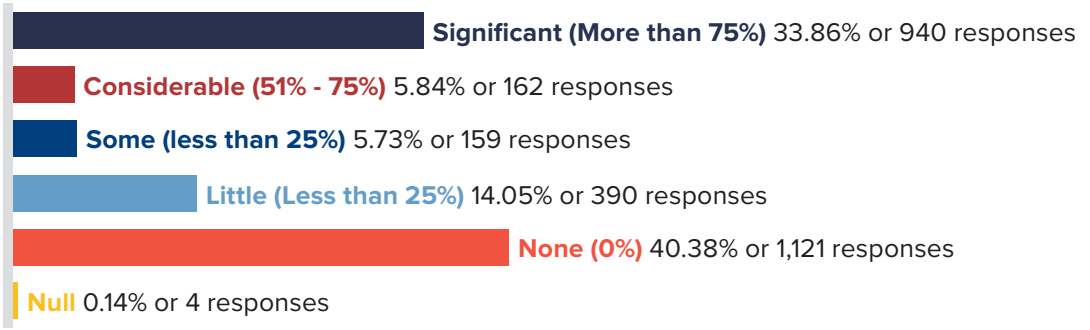
- 18 - 34 years old 32% (n=876)
- 35 - 49 years old 41% (n=1,129)
- 50 - 64 years old 21% (n=575)
- 65+ years old 4% (n=1230)
- No Response 3% (n=73)

Telehealth Usage: Prior to and during COVID-19

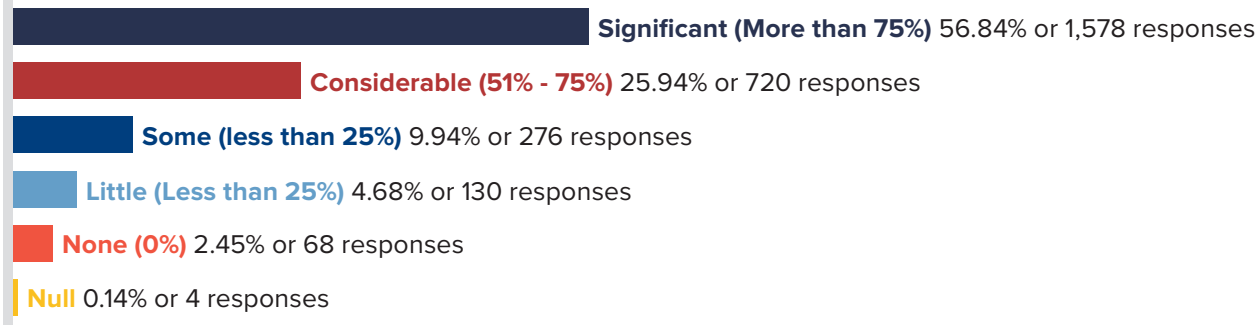


Respondents were asked to provide baseline information about their use of telehealth. More than half of respondents (54.43%) reported using little or no telehealth delivery prior to the COVID-19 PHE. During the COVID-19 PHE, nearly 93% of respondents reported that telehealth provided at least some increased access to care, with most of those respondents seeing the increase as considerable (25.94%) or significant (56.84%). Additionally, most respondents reported at least some improvement in the quality of their interactions (85.67%) and again most of these respondents saw the improvements as considerable (33.25%) or significant (33.00%). Survey respondents were also asked if telehealth had an observable positive impact on racial inequities in behavioral health. While most respondents reported observing no impact, those who did indicated it was positive (27.59%). Less than 2% indicated observing a negative impact.

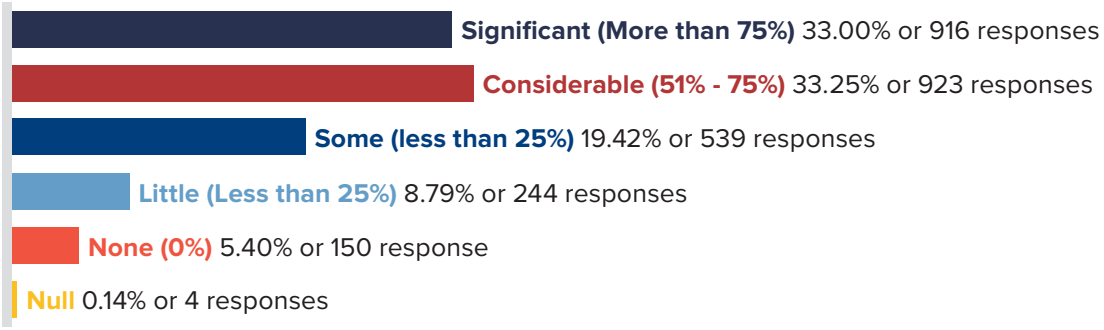
To what extent did you use telehealth (telephone and/or video) to provide services prior to COVID-19?



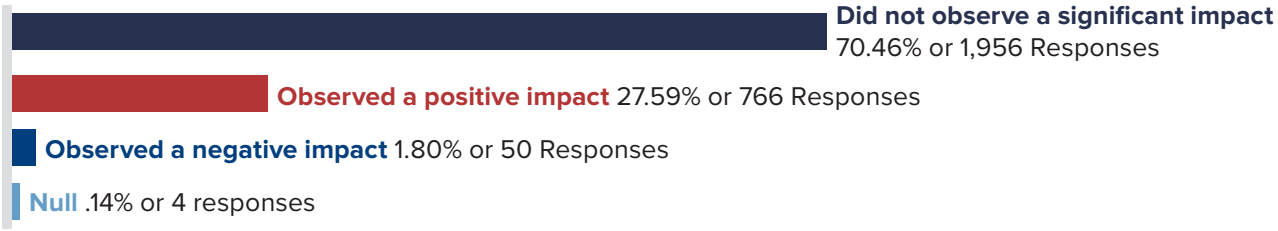
To what extent have you found the expanded telehealth rules to improve access to services?



To what extent have the expanded telehealth rules improved the quality of your interaction?



Do you feel telehealth has been able to positively impact racial inequities in behavioral health services?



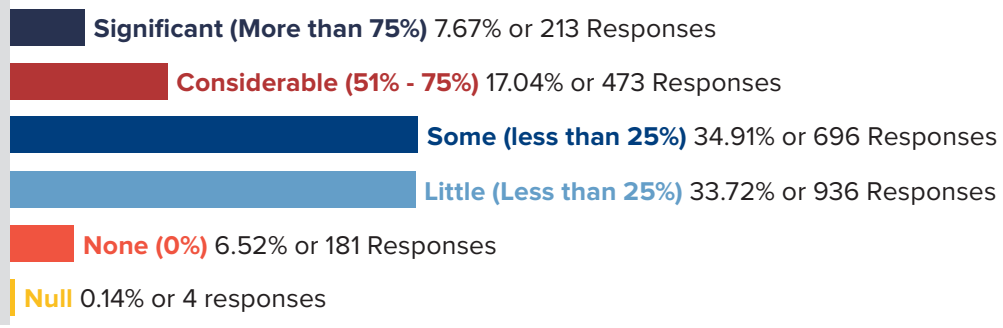
> The pandemic disproportionately impacted people of color from a health perspective. Telehealth access assured contact with trained [mental health professionals] throughout the lockdown and beyond.

> Some people with diversity concerns did not feel safe going out for sessions with the recent issues with race. However, they reported that telehealth offered them an option to be safe and still get the mental health treatment that was needed.

Telehealth Barriers

The majority of respondents (60%) reported at least some issues with technology for the individuals they serve.

How significant are problems of technology (cell phone availability, internet access, etc.) for the individuals that you serve?



> To improve telehealth services, we would need more up to date devices (cellphones, laptops, desktops). It would also be helpful if we could collaborate with a cellphone provider to donate refurbished or older model devices for participants that don't have their own.

Post COVID-19 Telehealth Input

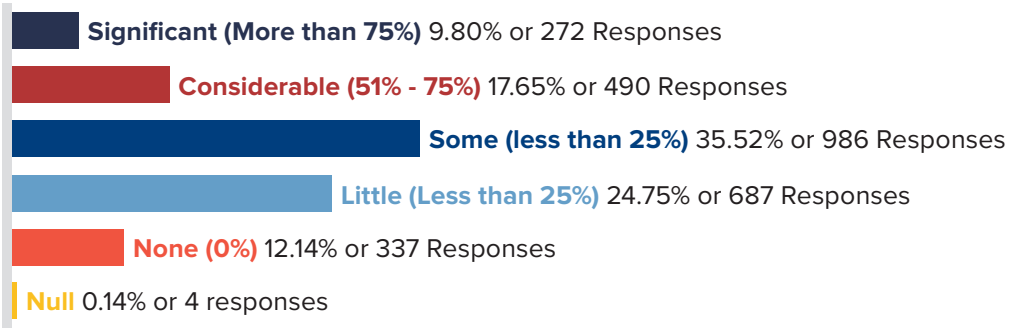
Respondents were asked several questions regarding the future of telehealth after the resolution of the COVID-19 PHE. Most respondents (62.97%) indicated at least some need for additional training in telehealth.

Regarding the future scope of telehealth, there is a clear consensus among providers that new clients could be established through telehealth delivered services (85.77%). Respondents had a split opinion on preserving the use of telephone only services (no video). Respondents opposed to continuing telephone only services after the resolution of the PHE (43.08%) cited concerns that certain behavioral health services were not clinically appropriate without video and that the use of telephone only needed to take into account the particular service and individual being served. Respondents supporting the use of telephone only following the resolution of the PHE (57.77%) cited concerns that requiring a return to audio-video would exclude vulnerable individuals who don't have the economic means to obtain internet and internet capable devices. Advocates of preserving telephone-only service delivery recommended allowing clinical judgment to make determinations for appropriate use.

Respondents were asked to identify interventions/services or populations that are not appropriate for telehealth delivery. A majority (76.26%) of respondents did feel there were some populations for whom telehealth may not be a viable modality, with the most com-

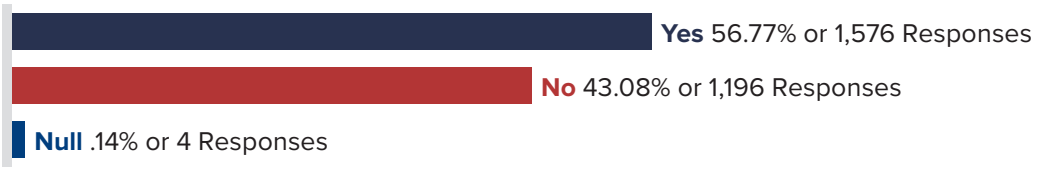
mon populations and modalities identified as: crisis services, skill building/social skills, young children, individuals with severe mental illness (including psychosis, delusions, risk of harm to self or others), and play therapy.

Based on your experience, do you feel you need more training on telehealth for your



Would you support new patients being established through telehealth?

Would you support new patients being established through telehealth?



Are there populations for whom telehealth may not be a viable modality for receiving services?

Are there interventions/services that you provide that are not appropriate for telehealth delivery?

Appendix A: Individual and Family Telehealth Survey

1. Introduction

During COVID-19, the Pennsylvania Department of Human Services (DHS) wanted to make sure that everyone could stay at home safely and still receive needed behavioral health services. Along with our system partners, we significantly increased telehealth and telephone service delivery.

The Office of Mental Health and Substance Abuse Services (OMHSAS) is the DHS Program Office responsible for the Behavioral Health Medicaid Program. OMHSAS is now asking for your help. We want to make sure that future behavioral health services through telehealth meet your ongoing needs. This survey is for individuals who received behavioral health services and their families. If both you and a family member received services, you may complete the survey separately for each individual. Thank you for sharing your experiences with us!

Questions about this survey can be directed to: RA-PWTBHS@pa.gov

Definitions

This survey uses the following terms.

Behavioral Health Services: includes mental health, drug & alcohol (also known as substance use disorder) and co-occurring mental health/drug & alcohol services.

COVID-19: The 2019 novel coronavirus is a new virus that causes respiratory illness in people and can spread from person-to-person.

Telehealth: in this survey telehealth is specifically referring to behavioral health services delivered through telehealth. Telehealth allows health care services to be provided remotely through audio-visual technology. Telehealth does not include telephone only (audio without video), however, during the COVID19 emergency, telephone only has been temporarily allowable when individuals served do not have access to technology such as smart phones, computers, and/or internet access.

Services: this survey refers to behavioral health services only.

This OMHSAS Survey will close on Monday June 22, 2020.

***1. I am answering this survey as:**

- ☐ An individual receiving mental health and/or drug and alcohol services
- ☐ A family member of an individual receiving mental health and/or drug and alcohol
- ☐ None of the above

2. Background Information

***2. County where the individual receiving services lives:**

3. Age of the individual receiving services:

- ☐ 3-9 years old
- ☐ 10-17 years old
- ☐ 18-21 years old
- ☐ 21-34 years old
- ☐ 35-49 years old
- ☐ 50-64 years old
- ☐ 65+ years old

4. Gender of the individual receiving services:

- ☐ Female
- ☐ Male
- ☐ Non-Binary/Gender Non-Conforming/Gender Queer
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Self-Identity (please specify)

5. Race of the individual receiving services:

- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Self-Identity (please specify)

6. Ethnicity of the individual receiving services:

- ☐ Hispanic or Latino/Latina/Latinx
- ☐ Non-Hispanic or Non-Latino/Latina/Latinx

***7. What types(s) of services do you/your family member receive?**

- ☐ Mental Health Services
- ☐ Drug and Alcohol Services
- ☐ Both Mental Health and Drug and Alcohol Services

***8. Did you/your family use telehealth before COVID-19?**

- ☐ Yes
- ☐ No

***9. Have you/your family member used telehealth during COVID-19?**

- ☐ Yes
- ☐ No

3. Telehealth During COVID19

10. What device(s) did you/your family member use for telehealth services during COVID-19? (Select all that apply)

- ☐ Desktop Computer
- ☐ Laptop Computer
- ☐ Tablet
- ☐ Smart Phone
- ☐ Telephone only (no video)
- ☐ Other (please specify)

11. Where did you/your family member use telehealth services during COVID-19? (Select all that apply)

- ☐ Home
- ☐ Provider's office or clinic
- ☐ Someone else's home (family member, friend, neighbor)
- ☐ Residential Facility Community Center
- ☐ Other (please specify)

12. How often did you/your family member receive services during COVID-19 through telehealth?

- ☐ More often than before COVID-19
- ☐ About the same as before COVID-19
- ☐ Less often than before COVID-19

13. Were the average length of your service sessions during COVID-19…

- ☐ Longer than before COVID-19
- ☐ About the same as before COVID-19
- ☐ Shorter than before COVID-19

14. How long did your telehealth service sessions typically last?

- ☐ 0-15 minutes
- ☐ 16-30minutes
- ☐ 31 minutes or longer Other (please specify)

15. Compared to receiving services in person, how frequently did you/your family member need to cancel/reschedule telehealth appointments?

- ☐ Appointments scheduled through telehealth were cancelled/rescheduled less often than in-person appointments.
- ☐ Appointments scheduled through telehealth were cancelled/rescheduled about the same number of times as in-person appointments.
- ☐ Appointments schedule through telehealth were cancelled/rescheduled more often than in-person appointments.

***16. Did telehealth reduce any of these challenges to receiving services for you/your family member: (select all that apply):**

- ☐ Transportation Access Issues
- ☐ Travel Distance/Time
- ☐ Conflicts with work schedule
- ☐ Other scheduling issues
- ☐ Childcare or other family caregiving
- ☐ Privacy concerns
- ☐ Stigma
- ☐ Not Applicable
- ☐ Other (please specify)

***17. How helpful was the specific behavioral health service you/your family member received through telehealth during COVID-19?**

	Very Helpful	Helpful	Neutral	Slightly Helpful	Not at All Helpful	Does Not Apply
Psychiatric Outpatient						
Individual Therapy						
Group Therapy						
Medication Visit						
Partial Hospital						
Assertive Community Treatment						

	Very Helpful	Helpful	Neutral	Slightly Helpful	Not at All Helpful	Does Not Apply
Outpatient D&A						
Individual Therapy						
Group Therapy						
MH Case Management						
Psychiatric Rehabilitation						
Individual Services						
Group Services						
Adult Residential Treatment						
Children's Residential Treatment (PRTF, RTF)						
Psychiatric Inpatient Treatment						
Family-Based Mental Health Services						
Intensive Behavioral Health Services/ Behavioral Health Rehabilitation Services						
Therapeutic Support Staff/Behavioral Health Technician						
Peer Support Services						
Certified Peer Support Specialists						
Certified Recovery Specialist Services						
Other						

If you chose other, please specify:

18. Please provide any additional comments on specific service(s) you/your family member received

***19. Were there any barriers that limited you/your family member's use of telehealth during COVID-19?(Please select all that apply)**

- ☐ Lack of audio-video capable device (computer, tablet, smartphone)
- ☐ Lack of telephone (for phone only services)
- ☐ Lack of/limited Internet
- ☐ Lack of/limited cellphone data
- ☐ Lack of/limited cellphone minutes
- ☐ Lack of/limited quiet location to receive services in your home
- ☐ Lack of/limited childcare or other family care giving coverage while receiving services from your home
- ☐ Privacy concerns related to the use of technology
- ☐ Privacy concern with other individuals at your location
- ☐ Telehealth is not offered or is limited to certain services by the provider
- ☐ There were no barriers
- ☐ Other (please specify)

20. Is there anything else you want to share about you/your family members experience with telehealth?

***21. During COVID-19, did you/your family member receive any services in-person?**

- ☐ Received all needed in-person behavioral health services
- ☐ Received some needed in-person behavioral health services
- ☐ Received no needed in-person behavioral health services
- ☐ Did not need/want any in-person behavioral health services

4. Telehealth after COVID19

***22. After COVID19, how would you like to receive services for yourself your family member?**

- ☐ Receive all or most services in-person
- ☐ Receive all or most services through telehealth
- ☐ Receive services through a blend of in-person and telehealth delivery

23. What else should OMSHAS consider for the future of telehealth?

24. Would you be interested in participating in a focus group to share more input on telehealth? If so, please list your contact email and phone number below.

- ☐ Email Address
- ☐ Phone Number

Thank you for completing the OMHSAS Telehealth Survey. Your input is important, and we appreciate the time you have taken to share your thoughts and experiences with us. If you have questions about this survey or behavioral health telehealth in Pennsylvania, please contact: RA-PWTBHS@pa.gov

Appendix B: Direct Behavioral Health Services Practitioners Survey – Clinicians

1. Introduction

During COVID-19, the Pennsylvania Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) wanted to ensure that as many citizens as possible could stay at home safely and still receive needed behavioral health services. Along with our system partners, we significantly increased telehealth and telephone service delivery.

In partnership with the Coalition 4 Common Health (C4CH), OMHSAS is seeking input from clinicians who are actively providing direct services to individuals and their families to help guide long term policy on behavioral health telehealth.

Questions about this survey can be directed to: RA-PWTBHS@pa.gov

Non Clinician Behavioral Health Practitioners (such as Certified Peer Specialists, Certified Recovery Specialists, Case Managers, and Psychiatric Rehabilitation Staff) can complete the non-clinician survey at: https://www.surveymonkey.com/r/TelehealthDirectServiceProfessionals

Definitions

This survey uses the following terms.

Behavioral Health: includes mental health, drug & alcohol (also known as substance use disorder) and co-occurring mental health/drug & alcohol services.

Telehealth: in this survey telehealth is specifically referring to behavioral health services delivered through telehealth. Telehealth allows health care services to be provided remotely through audio-visual technology. Telehealth does not include telephone only (audio without video), however, during the COVID19 emergency, telephone only has been temporarily allowable when individuals served do not have access to technology such as smart phones, computers, and/or internet access.

Clinical Services: This survey refers to behavioral health services only.

This Survey will close on DATE.

***1. Clinician Type**

- ☐ Psychiatrists (MD/DO)
- ☐ Non-psychiatrist Physicians (MD/DO)
- ☐ Licensed Psychologists
- ☐ Physician's Assistants
- ☐ Certified Registered Nurse Practitioners
- ☐ Additional Nursing Licenses
- ☐ Licensed Psychologists
- ☐ Licensed Clinical Social Workers
- ☐ Licensed Marriage and Family Therapist
- ☐ Licensed Professional Counselor
- ☐ Other (please specify)

2. Telehealth Feedback

***2. To what extent did you use telehealth (telephone and/or video) to provide clinical services prior to COVID 19?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51% - 75%)
- ☐ Significant (More than 75%)

***3. To what extent have you found the expanded telehealth rules to improve access to clinical service?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51% - 75%)

***4. To what extent have the expanded telehealth rules improved the quality of your clinical interaction?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51% - 75%)
- ☐ Significant (More than 75%)

***5. If the expanded telehealth rules are continued, to what extent will you use telehealth after the COVID 19 crisis subsides?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51%-75%)
- ☐ Significant (More than 75%)

***6. In your experience is there a need for more training for practitioners on use of telehealth?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51%-75%)
- ☐ Significant (More than 75%)

***7. How significant are problems of technology (cell phone availability, internet access, etc.) for the individuals that you serve?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51% - 75%)
- ☐ Significant (More than 75%)

***8. Are there populations for whom telehealth may not be a viable modality for delivering clinical services?**

- ☐ Yes
- ☐ No

Comments

***9. Are there clinical services/modalities that are not appropriate for telehealth delivery?**

- ☐ Yes
- ☐ No

Comments

***10. Would you support new patients being established through telehealth?**

☐ Yes

☐ No

Comments

***11. Do you feel that you can provide effective clinical services using telephone only?**

☐ Yes

☐ No

Comments

***12. Do you feel telehealth has been able to positively impact racial inequities in behavioral health services?**

☐ Observed a positive impact

☐ Observed a negative impact

☐ Did not observe a significant impact

Comments

13. What recommendations would you have for improving the use of telehealth in providing behavioral health services and supports?

3. Background Information

14. County where the majority of your services are provided:

15. Age:

☐ 18 - 34 years old

☐ 35 - 49 years old

☐ 50 - 64 years old

☐ 65+ years old

16. Gender:

☐ Female

☐ Male

☐ Non-Binary/Gender Non-Conforming/Gender Queer

- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Self-Identity (please specify)

17. Race:

- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Self-Identity (please specify)

18. Ethnicity:

- ☐ Hispanic or Latino/Latina/Latinx
- ☐ Non-Hispanic or Non-Latino/Latina/Latinx

4. Survey Closure

19. Would you be interested in participating in a focus group to share more input on telehealth? If so, please list your contact email and phone number below.

Name:

Email Address:

Phone Number:

Thank you for completing the OMHSAS/C4CH Direct Service Clinician Telehealth Survey. Your input is important, and we appreciate the time you have taken to share your thoughts and experiences with us. If you have questions about this survey or behavioral health telehealth in Pennsylvania, please contact: RA-PWTBHS@pa.gov

Appendix C: Direct Behavioral Health Services Practitioners Survey – Non-Clinicians

1. Introduction

During COVID-19, the Pennsylvania Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) wanted to ensure that as many citizens as possible could stay at home safely and still receive needed behavioral health services. Along with our system partners, we significantly increased telehealth and telephone service delivery.

OMHSAS is seeking input from non-clinician direct behavioral health service providers who are actively providing direct services to individuals and their families to help guide long term policy on behavioral health telehealth.

Questions about this survey can be directed to: RA-PWTBHS@pa.gov

Licensed behavioral health clinicians (such as a Psychologist, Physician, Physician Assistant, Nurse Practitioner, Nurse, or Licensed Therapist (LPC, LCSW, LMFT)) please complete the clinician survey at: https://www.surveymonkey.com/r/TelehealthClinicianSurvey2020

Definitions for this survey

Behavioral Health: includes mental health, drug & alcohol (also known as substance use disorder) and co-occurring mental health/drug & alcohol services.

Direct Services: this survey refers to direct behavioral health services only

Expanded Telehealth Rules: Refers to the OMHSAS Memo issued on March 15, 2020 and updated on May 5, 2020 that allowed for a significant expansion of behavioral health services that could be provided through telehealth during the COVID-19 state of emergency. The memo is available: https://www.dhs.pa.gov/providers/Providers/Documents/Coronavirus%202020/OMHSAS%20COVID-19%20Telehealth%20Expansion-%20Final%203.15.20.pdf

Telehealth: in this survey telehealth is specifically referring to behavioral health services delivered through telehealth. Telehealth allows health care services to be provided remotely through audio-visual technology. Telehealth does not include telephone only (audio without video), however, during the COVID19 emergency, telephone only has been temporarily allowable when individuals served do not have access to technology such as smart phones, computers, and/or internet access.

This Survey will close on DATE.

***1. Which type of direct service behavioral health provider role are you currently working as?**

- ☐ Psychiatric Rehabilitation Staff
- ☐ Clubhouse Staff
- ☐ Certified Peer Specialists (including CPS Supervisors)
- ☐ Certified Recovery Specialists (including Certified Family Recovery Specialists)
- ☐ Mental Health Case Managers (ICM, BCM, RC)
- ☐ Substance Use Disorder Case Manager
- ☐ Supported Employment/Education Specialists Housing Specialists
- ☐ Homeless Service Specialists
- ☐ Other (specify in the comment box)

2. Telehealth Feedback

***2. To what extent did you use telehealth (telephone and/or video) to provide behavioral health services prior to COVID 19?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51%-75%)
- ☐ Significant (More than 75%)

***3. To what extent have you found the expanded telehealth rules to improve access to the specific behavioral health service that you provide (such as peer support services, case management, etc)?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51%-75%)
- ☐ Significant (More than 75%)

***4. To what extent have the expanded telehealth rules improved the quality of your interaction with individuals who you serve?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51%-75%)
- ☐ Significant (More than 75%)

***5. If the expanded telehealth rules are continued, to what extent will you use telehealth after the COVID 19 crisis subsides?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51%-75%)
- ☐ Significant (More than 75%)

***6. Based on your experience, do you feel you need more training on telehealth for your role?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51%-75%)
- ☐ Significant (More than 75%)

(Optional) Specify any specific training/guidance you feel is needed for your role related to telehealth

***7. How significant are problems of technology (cell phone availability, internet access, etc.) for the individuals that you serve?**

- ☐ None (0%)
- ☐ Little (less than 25%)
- ☐ Some (25%-50%)
- ☐ Considerable (51%-75%)
- ☐ Significant (More than 75%)

***8. Are there populations for whom telehealth may not be the best way to provide behavioral health services?**

- ☐ Yes
- ☐ No

If yes, please specify

***9. Are there interventions that you provide that are not appropriate for telehealth delivery?**

- ☐ Yes
- ☐ No

If yes, please specify

***10. Would you be in favor of new clients starting services through telehealth?**

- ☐ Yes
- ☐ No

Comments

***11. Do you feel that you can provide effective behavioral health services using telephone only?**

- ☐ Yes
- ☐ No

(Optional) Please specify why or why not

***12. Do you feel telehealth has been able to positively impact racial inequities in behavioral health services?**

- ☐ Observed a positive impact
- ☐ Observed a negative impact
- ☐ Did not observe a significant impact

Comments

13. What recommendations would you have for improving the use of telehealth in providing behavioral health services and supports?

3. Background Information

All demographic questions below are regarding the direct-service behavioral health staff person themselves (the person answering this survey)

14. County where the majority of your services are provided

15. Age

- ☐ 18 - 34 years old
- ☐ 35 - 49 years old
- ☐ 50 - 64 years old
- ☐ 65+ years old

16. Gender:

- ☐ Female
- ☐ Male

- ☐ Non-Binary/Gender Non-Conforming/Gender Queer
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Self-Identity (please specify)

17. Race:

- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Self-Identity (please specify)

18. Ethnicity:

- ☐ Hispanic or Latino/Latina/Latinx
- ☐ Non-Hispanic or Non-Latino/Latina/Latinx

4. Survey Closure

19. Would you be interested in participating in a focus group to share more input on telehealth? If so, please list your contact email and phone number below.

Name:

Email Address:

Phone Number:

Thank you for completing the OMHSAS Direct Service Non-Clinician Behavioral Telehealth Survey. Your input is important, and we appreciate the time you have taken to share your thoughts and experiences with us. If you have questions about this survey or behavioral health telehealth in Pennsylvania, please contact: RA-PWTBHS@pa.gov

Pennsylvania School Counselor Staffing Report

A REVIEW OF PENNSYLVANIA'S
STUDENT TO SCHOOL COUNSELOR RATIOS

FEBRUARY 2021

PENNSYLVANIA SCHOOL COUNSELORS ASSOCIATION

The mission of the Pennsylvania School Counselors Association is to expand the image and influence of professional school counselors, to promote professional and ethical practice, and to advocate for equity and access for all students.

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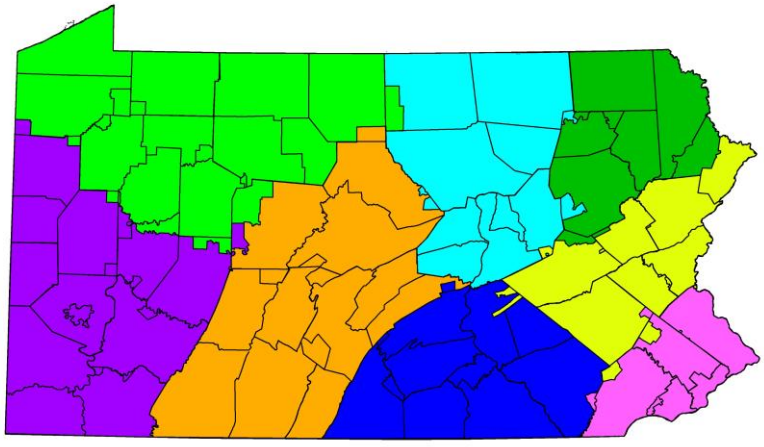

Special thanks is given to Adam Oldham and the PSCA Government Relations committee for their work in developing this report.

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What is This Report For?

This report is designed **to educate and empower school counselors** across Pennsylvania as they advocate for the investment in school counseling positions and programs in our K-12 education system.

This report is designed **to inform and spark interest with our legislative partners and elected officials** who set education policy, establish appropriations and funding, and who have the capacity to instill the value of school counselors and school counseling programs into law.

This report will serve as an **annual reference point** for the numbers and ratios of school counselors employed in Pennsylvania, and will be released each year during National School Counseling Week.

PENNSYLVANIA SCHOOL COUNSELORS ASSOCIATION

CALL TO ACTION

School Counselors for All Students

A Certified School Counselor
for Every Level

A Certified School Counselor
for Every Building

Reasonable
Student to School Counselor Ratios

Defined Use of Time

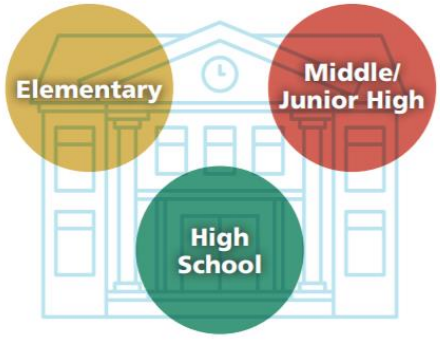
Who are School Counselors?

(The Role of the School Counselor, American School Counselor Association)

School counselors are certified educators who improve student success for all students by implementing a comprehensive school counseling program.

SCHOOL COUNSELOR QUALIFICATIONS

- **Hold, at minimum, a master's degree in school counseling**
- **Meet the state certification/licensure standards**
- **Fulfill continuing education requirements**
- **Uphold ASCA ethical and professional standards**



Also employed in district supervisory positions; and school counselor education positions

LEADERSHIP TEAM MEMBERS

School counselors work to maximize student success, promoting access and equity for all students. As vital members of the school leadership team, school counselors create a school culture of success for all.

- **School counselors help all students:**
  - apply academic achievement strategies
  - manage emotions and apply interpersonal skills
  - plan for postsecondary options (higher education, military, work force)
- **Appropriate duties include providing:**
  - individual student academic planning and goal setting
  - school counseling classroom lessons based on student success standards
  - short-term counseling to students
  - referrals for long-term support
  - collaboration with families/teachers/ administrators/ community for student success
  - advocacy for students at individual education plan meetings and other student-focused meetings
  - data analysis to identify student issues, needs and challenges
  - acting as a systems change agent to improve equity and access, achievement and opportunities for all students

Direct Services with Students

Direct services are in-person interactions between school counselors and students and include the following:

- Instruction
- Appraisal and Advisement
- Counseling

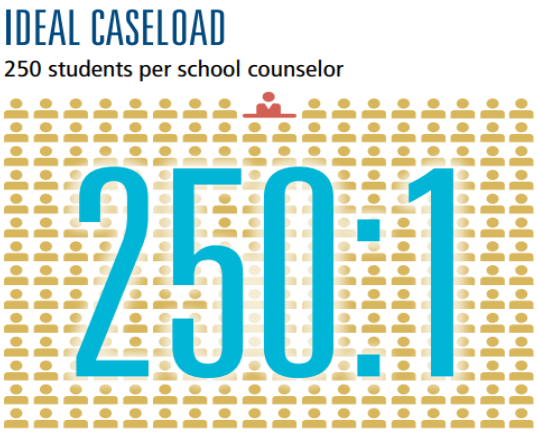
Indirect Services for Students

Indirect services are provided on behalf of students as a result of the school counselors' interactions with others including:

- Consultation
- Collaboration
- Referrals

Why Student to School Counselor Ratios Matter

AMERICAN SCHOOL COUNSELOR ASSOCIATION



The American School Counselor Association (ASCA) recommends a student to school counselor ratio of 250:1

Research demonstrates that lower student-to-school-counselor ratios are associated with higher student achievement measures, better graduation rates, and lower disciplinary incidents (Lapan et al., 2012; Goodman-Scott et al., 2018; Parzych et al., 2019)

Nationally, school counselor ratios are significantly higher, with the most recent comparison estimating a national average ratio of 430:1 (ASCA, 2020)

ASCA reports that Pennsylvania's ratio for the 2018-2019 school year was 369:1 (ASCA, 2020)

Overview of Pennsylvania School Counselor Workforce

LEA Type / Description	# of School Counselors*
School District	4225
Charter School	339
Intermediate Unit	153
Career and Technical Center	108
State Juvenile Correction Institution	4
Total	4829

Each year, the PA Department of Education releases the Professional Personnel ID Report listing out every public educator, and each assignment they had during the previous school year. Because each educator can have multiple assignments, the number of school counselors was determined by tabulating the listed Full-Time Equivalency (FTE) together for each individual educator.

In the majority of cases, each school counselor had a total assignment value of 1, though each individual school counselor may have been assigned to multiple buildings within an LEA. There were 113 school counselors that had less than 1 full position listed, and therefore it may appear, for example, that there are more school counselors practicing in public school districts (4225 on page 4) than are actually in physical buildings (4195 on page 11).

The numbers appearing throughout this report are focused on school counselor staffing in the 499 public "School Districts" throughout the Commonwealth.

A Certified School Counselor for Every Level

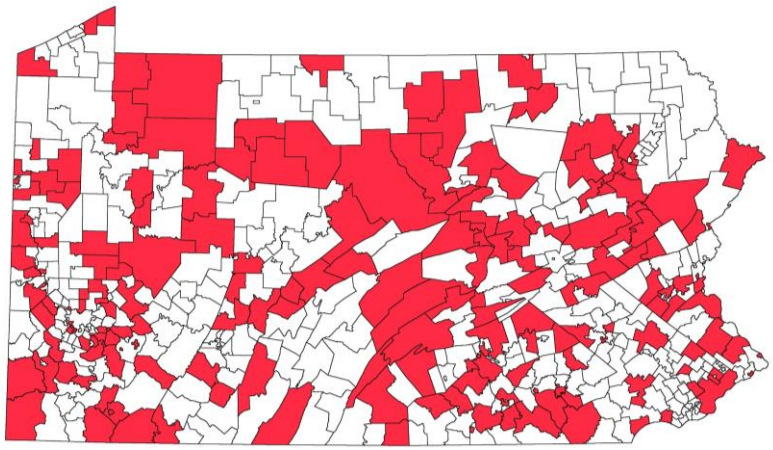
Building Level Configuration	# of Buildings	Average Ratio	Median Ratio	No SC Listed
Elementary (K-6)	1480	1: 479	1 : 449	136
Middle (6-8)	453	1 : 358	1 : 334	20
High (9-12)	435	1 : 299	1 : 280	14
Total	2368	1 : 420	1 : 383	170

80% of Pennsylvania's school buildings are configured by standard grade level (Elementary, Middle, High). Note that elementary school buildings may be primary schools (K-2), intermediate schools (3-5), elementary schools (K-5 or K-6), or another variation of the K-6 grade band.

Building Level Configuration	# of Buildings	Average Ratio	Median Ratio	No SC Listed
ELE + MS (K-8)	148	1 : 543	1 : 467	11
MS + HS (6-12)	161	1 : 312	1 : 296	5
ELE + MS +HS (K-12)	9	1: 151	1 : 143	4
HS (Jr High) (8-11)	4	1 : 320	1 : 306	0

20% of Pennsylvania's school buildings are configured with multiple levels within one building (for example, Junior/Senior High Schools). School counselors working in these buildings may then be responsible for students ranging from 5 years old up to 18 years old, which increases demand on their ability to address all levels of student development efficiently.

A Certified School Counselor for Every Building



45%

223 school districts (45%) have buildings served by school counselors who are assigned to multiple buildings, impacting over a quarter of a million students, mostly elementary school children.

In practice, this means a school counselor might be assigned to two elementary schools, and only be physically present in each two or three days a week. This puts increased demand on the school counselor to be able to establish relationships not only with multiple groups of students, but multiple sets of staff, administration, parents, and communities.

In some cases, a school counselor may be called from one building to go to another in the event of a crisis, or a crisis may be handled by another school employee who may not have the same qualifications and training as a school counselor. The analogy of a fire sprinkler system demonstrates the risk in this – you want the sprinklers to be available and working every day, not just on days when there is a fire!

A Certified School Counselor for Every Building

INEQUITY

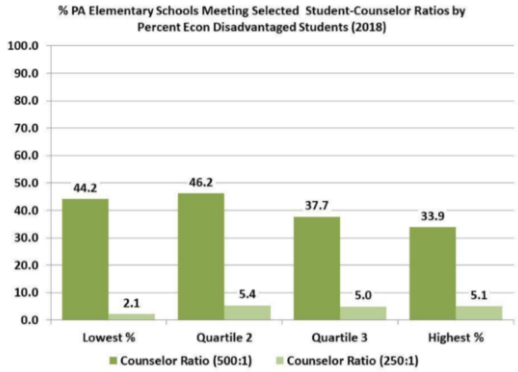
Total Public-School Buildings	No School Counselors Assigned	At Least a Fraction of a School Counselor Assigned	All Buildings Combined
Number of Buildings	190	2,500	2,690
% Title I	77%	56%	57%
Average % of Student Enrollment (not White)	43%	30%	31%
Median % of Student Enrollment Economically Disadvantaged	56%	43%	44%

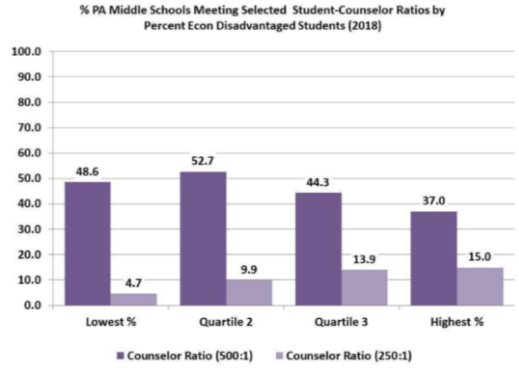
In comparison to schools with even a fraction of a school counselor assigned…

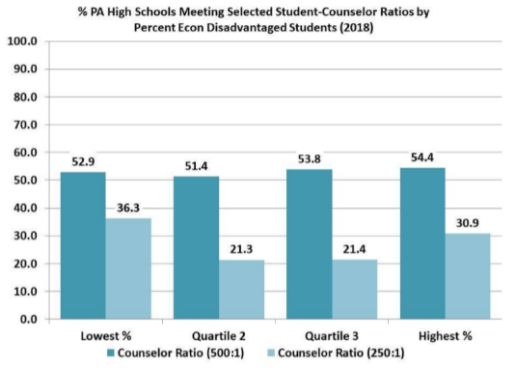
…school buildings without any school counselors assigned are:

- **more likely to be a Title I school**
- **serve students from minority backgrounds**
- **serve students who come from economically disadvantaged homes**

A Certified School Counselor for Every Building







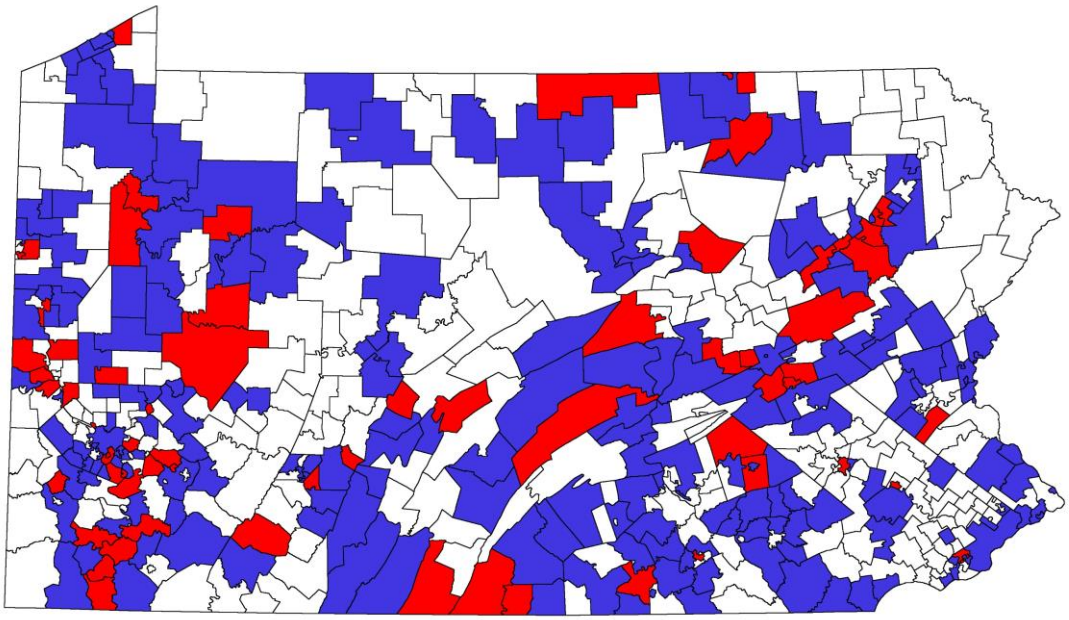
Research from Dr. Edward Fuller, Associate Professor and the Director for the Penn State Center for Evaluation and Education Policy Analysis (PCEEPA) shows that schools serving student populations with higher levels of poverty are likely to have higher student to school counselor ratios.

Public School Buildings with At Least a Fraction of a School Counselor Assigned	Title I Schools	Non-Title I School	All Buildings Combined
Number of Buildings	1543	1,147	2,690
Average Ratio	462:1	366:1	419:1
Median Ratio	428:1	331:1	377:1
Average % of Student Enrollment Non-White	41%	19%	31%
Average % of Student Enrollment English Language Learner	5.2%	1.7%	3.7%

School counselors in Title I school buildings have significantly higher caseloads than school counselors in non-Title I school buildings, and these caseloads involve a higher proportion of students from diverse backgrounds.

Our most vulnerable students are the most likely students to not have access to school counselors.

Reasonable Student to School Counselor Ratios
A Statewide Snapshot



1:377

Median Student to School Counselor Ratio
in PA Public School District Buildings

More than 50% of PA Public School Districts
have average ratios of **1:350 or higher**

1 in 10 PA Public School Districts
have average ratios of **1:500 or higher**

Reasonable Student to School Counselor Ratios

Number of School Buildings (School Districts)	**2,690**
Number of Students	**1,557,144**
School Counselors Needed for 250:1 Ratio	**6229**
School Counselors Assigned to Buildings (SY 19-20)	**4195**
Total School Counselors Needed	**2034**

ONLY 67%

Pennsylvania students only have 67% of the school counselor positions needed to meet staffing recommendations.

62%

of public school buildings need at least 0.5+ additional SC positions to achieve ASCA recommended ratio.

70% of these buildings are elementary schools, which serve our youngest students.

Building Need Categories	# of Additional SC Needed
Buildings Needing at Least 0.5 – 0.99 Additional SC	**780**
Buildings Needing at Least 1.0-1.99 Additional SC	**739**
Buildings Needing at Least 2.0-2.99 Additional SC	**128**
Buildings Needing at Least 3.0+ Additional SC	**30**
Total Buildings	**1677**

Reasonable Student to School Counselor Ratios

Ideal Staffing Price Point

$150 MILLION

Number of School Buildings	**2,690**
Number of Students	**1,557,144**
School Counselors Needed for 250:1 Ratio	**6229**
School Counselors Assigned to Buildings (SY 19-20)	**4195**
Total School Counselors Needed	**2034**
Median PA School Counselor Salary (SY 19-20)	**$73,130**

It would take approximately **$150 million** to hire the total school counseling positions needed in PA, which is **approximately 1% of the total state appropriations for education** for the 19-20 school year.

This investment would impact each district differently based on their specific staffing needs and salary schedules as determined by local CBAs.

Defined Use of School Counselor Time

The ASCA National Model, which outlines best practices for school counselors and school counseling programs, recommends that **80% of a school counselor's time be spent in direct services to students**.

While school counselors are willing team players in the overall functioning of a school system, these non-school counseling duties interrupt and detract from the professional service that they provide to students and families.

Pennsylvania does **not** currently have a defined scope of practice for school counselors. Unlike classroom teachers, who are hired to perform defined classroom duties, school counselors are often used as utility players in a school building – covering classes when teachers are absent and no subs are available, coordinating standardized testing, filling in on duty rotations, or serving as data and records clerks. They sometimes function as pseudo-administrators, tracking student attendance and administering discipline.

Providing a scope of practice would **help school counselors advocate for appropriate roles and responsibilities in their buildings** so that students and families get the services school counselors are uniquely qualified to provide.

Defined Use of School Counselor Time

STUDENT MENTAL HEALTH

The PA School Safety Task Force (2018) identified several key areas that require a multidisciplinary approach to prevention, intervention, and response – social isolation and bullying, comprehensive social and emotional education throughout a student's K-12 education, and insufficient staffing levels for both physical and mental health services.

School counselors are trained to **address student social and emotional development, as well as mental health assessment and response**.

SCHOOL SAFETY TASK FORCE REPORT

Top 5 PA Safe2Say Something Report Types (2019)
Bullying/Cyber Bullying
Cutting/Self-Harm
Suicide/Suicidal Ideation
Depression/Anxiety
Drug Use

Safe2Say Something is an anonymous reporting service for students to report unsafe or concerning activities in schools, implemented in 2019 by the PA Attorney General's Office.

Students have primarily used this service to report concerns about their mental health.

FUTURE READY PA INDEX

"School counselors are a critical part of Pennsylvania's vision to help all students translate their interests and aspirations into tangible college and career plans and choices.

However, **many school counselors are stretched thin, juggling several responsibilities and significant case loads, and are often isolated in their work**."

-Pennsylvania State Consolidated Plan, Every Student Succeeds Act, 2019 (p.96)

STUDENT CAREER READINESS

School counselors are also a primary vehicle for **college and career advisement and planning**.

As these domains of student learning are now a part of the Future Ready PA Index, which is a public dashboard of school quality and performance, the need for school counselors to be able to focus their work has never been greater.

PENNSYLVANIA SCHOOL COUNSELORS ASSOCIATION

CALL TO ACTION

School Counselors for All Students

A Certified School Counselor
for Every Level

A Certified School Counselor
for Every Building

Reasonable
Student to School Counselor Ratios

Defined Use of Time

CALL TO ACTION SUMMARY

A Certified School Counselor for Every Level

- Of the 190 school buildings with no school counselor, 80% of these are elementary schools

A Certified School Counselor for Every Building

- 45% of PA school districts have buildings served by school counselors who are assigned to multiple buildings
- Over a quarter million students have a school counselor who is assigned to multiple buildings
- In most cases, these are elementary school children
- Title 1 school buildings and buildings serving minority populations are less likely to have a school counselor and if they do, the ratios are higher

Reasonable Student to School Counselor Ratios

- 1 in 10 school districts have ratios of 1:500 or higher
- More than 50% of PA school districts have average ratios of 1:350 or higher

Defined Use of Time (80% Direct, 20% Indirect)

- School counselors often serve as test administrators, serve in duty roles, and perform "utility player" roles as needed in their buildings, as opposed to delivering school counseling services and content through a guaranteed and viable program
- Student social, emotional, and mental health are a priority and school counselors are uniquely trained to address these domains

PA SC Ratios Methodology

PDE PA Professional Personnel ID Report (2019-2020)

- Filtered by Elementary and Secondary School Counselor assignment description
- Filtered by Public School District
- # of School Counselors Assigned Per Building calculated by adding the full-time equivalency (FTE) of each school counselor assigned to each building ([FTE*0.01] *1)

Future Ready PA Data Files (2019-2020)

- Building Enrollment
- "Ideal" staffing calculated by dividing each building's enrollment by 250, in line with the American School Counselor Association (ASCA) recommended ratio
- District and Building demographic information
- Title I designation

Needed Difference calculated by subtracting each building's summed FTE # of School Counselors Assigned from the "Ideal" staffing

Source Material

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PA Department of Education, PA Professional Personnel ID Report (2019-2020)

PA Department of Education, Future Ready PA Data Files (2019-2020)

PA Department of Education, State Consolidated Plan, Every Student Succeeds Act (2019)

Summary of PA State Education Appropriations (2019-2020)

PA School Safety Report (2018)

PA Safe2Say Something Annual Report (2019)

Dr. Edward J. Fuller, Associate Professor of Education at Penn State University, Director of the Penn State Center for Evaluation and Education Policy Analysis (PCEEPA), and Associate Director of Policy for the University Council for Educational Administration

For questions about the data laid out in this report, please contact Adam Oldham at aoldham@epasd.org.

House Democratic Policy Committee
Public Hearing on Mental Health Services in Schools
March 3, 2021

The following testimony is submitted on behalf of The Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/DS). PACA MH/DS is a statewide association representing all county behavioral health and developmental disability programs, behavioral health managed care oversight agencies and county operated managed care programs throughout the Commonwealth.

Physicians and educators have long recognized that mental illness is a disease that can impact students in a variety of ways, including suicidal thoughts, depression and anxiety.

We also know and understand much more clearly that adverse experiences at home such as abuse or neglect can have a tremendous impact on students in the classroom. If a parent is absent or incarcerated, for instance, their children might need additional mental health support.

Growing numbers of students have family members impacted by the current COVID-19 pandemic as well as the opioid crisis and many are facing housing or food insecurities. There are any number of factors that can impact students and their ability to learn and thrive.

Against this backdrop, it is critically important that parents and students are aware that help is available for their children and family in many schools throughout our Commonwealth. Under the innovative statewide Medicaid Behavioral HealthChoices (BHC) program, county and school leaders are helping families address a myriad of challenges.

One example from the central region of the state, through the Capital Area Behavioral Health Collaborative, there are currently 239 satellite mental health outpatient clinics in schools throughout Cumberland, Dauphin, Lancaster, Lebanon and Perry counties. In 2019, 4,620 students enrolled in the Medicaid BHC program received counseling by a licensed clinician in one of these satellite mental health programs. The age of students who received this treatment is telling:

Ages 0-5: 155

Ages 6-12: 2,731

Ages 13-17: 1,734

During 2019 in just the five counties mentioned above, over $24 million was dedicated to a variety of school based mental health services. This effort would not be possible without the BHC program, which was created more than 20 years ago and has continued to evolve over the years to address consumers' needs.

Under BHC, each county has the opportunity to manage the Medicaid BHC program as the primary contractor or to work with other counties and form collaborative partnerships. Counties

have the ability to identify what innovative approaches can best meet the unique needs of their communities, including the local educational systems.

The BHC contract allows counties to "reinvest" a portion of the capped savings that they may realize though sound management and efficiencies. Reinvestment funds can be used to start up in-plan services, fund social determinants of health and to create additional innovative, cost-effective supplemental programs to further meet local needs. These programs and services are developed in partnership with consumers, providers, Behavioral Health MCOs, and the Office of Mental Health and Substance Abuse Services, which approves and monitors all of these initiatives. Some counties have used these funds to start their school based Mental Health Programs.

Making these resources available in schools makes perfect sense for several compelling reasons, starting with the obvious fact that typically we know where these young people are every Monday – Friday. This is a captive audience. The pandemic has impacted this to a degree but the school- based approach still applies even virtually.

In addition, we know from our experience that parents seeking help for their children and families are sometimes more comfortable going into a school building than an outpatient clinic. Our society has come a long way in accepting that mental health challenges are pervasive, yet we need to recognize that some families, and young people especially, can be fearful of the stigma that unfortunately still can be associated with mental health challenges and receiving help. By offering these services in the school, this barrier can be removed. These programs also offer resources to teachers and other school personnel as well, which improves the overall environment for everyone.

We also know that families live close to their schools, so these services are more accessible and are able to address issues more quickly. Consider a family, for instance, being able to drive to their local school for counseling, rather than having to make the drive to an unfamiliar setting in another city or town.

Parents should be encouraged to ask their school leaders and find out if these services are available in their children's school building or in their district.

PACA MH/DS appreciates the invitation to provide comments on this very important issue. The association looks forward to working with the Committee as you continue to explore ways in which to improve the lives of our younger population.