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HOUSE DEMOCRATIC POLICY COMMITTEE
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House of Representatives
COMMONWEALTH OF PENNSYLVANIA

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: Youth Mental Health

Lionville YMCA – Exton, PA

October 18, 2019

AGENDA

10:00 a.m. Welcome and Opening Remarks

10:10 a.m. Panelists:

- Dr. Jane Thompson, Clinical Psychologist, Chester Springs Clinical Associates, LLC
- Anna Wojcik, Student, Downingtown East High School
- Sara Stein, Student, Downingtown East High School
- Mary Kwiatkowski, Parent
- Dr. Bradley Dyer, FAAP, Pediatrician and Founder, All Star Pediatrics
- Perk Musacchio, MEd, Author, Retired Teacher, Educational Consultant
- Monica Reinhard-Gorney, MSEd, Author/Educational Counselor
- Cindy Kruse, Educational and Workforce Consultant
- Dr. Pamela Brown, Southeastern Region President, PSEA
- Dr. Bridgette Miles, Principal, Coatesville Area School District
- Cynthia Black, President of Board of Directors, Communities That Care of Greater Downingtown
- Candy Craig, Mental Health Deputy Administrator, Chester County Department of Mental Health/Intellectual and Developmental Disabilities
- Dr. Jason Lewis, Associate Director of Outpatient Program in Department of Child and Adolescent Psychiatry and Behavioral Sciences, Children's Hospital of Philadelphia

11:00 a.m. *Questions & Answers*

11:50 a.m. Closing Remarks

CHILD & YOUTH MENTAL HEALTH SUPPORTS:

Our Community

Law Enforcement

Higher Education
Colleges
Universities
Community Colleges

Faith
Churches
Synagogues
Mosques
Temples

Medical
Clinics
Hospitals/ERs
Doctors
Nurses
Therapists

Schools
Staff
Students

Family

Child & Youth Services
Caseworkers
Social Workers
Mental Health Specialists

BUILDING CAPACITY IN EACH PART OF THE COMMUNITY

Assess Needs
Collect input from those in need of services

Identify
Strategies/Interventions
Proactive approaches

Apply
Above strategies

Collect Data
Evaluate findings

Revise
Make changes as needed and keep going!

2017 PAYS General Overview

Victories to Celebrate

PAYS is recognized as one of the most comprehensive data sets available today. It offers both data that outlines the state's successes and continued challenges to help guide decision making at all levels. Some positives from the 2017 PAYS include:

- Overall, **83.4**% of students reported that they felt safe in their school.
- **77%** of students reported that they have chances to talk one-on-one with a teacher.
- **92%** of students in all grades reported that their parents knew where they were and who they were with. This increased in all four grades from 2015.
- 12th grade lifetime narcotic use decreased from **12%** in 2015 to **9%** in 2017, though this remains higher than the national average of 6.8%.
- The overall percentage of students reporting it would be easy for them to obtain prescription drugs decreased from **28%** in 2015 to **25%** in 2017. The sharpest decrease was among 12th graders whose rate dropped from **43**% to **38**%.
- **Heroin use remains low for 12th graders – lifetime: 0.5%, 30-day: 0.1%.**

Youth Mental/Physical Health

Pennsylvania youth are facing increasing challenges to both their mental and physical health. According to the statewide 2017 Pennsylvania Youth Survey (PAYS) results (a survey administered to over 250,000 youth in the 6th, 8th, 10th, and 12th grades), some of the health issues reported by youth include:

- **38%** of students reported feeling sad or depressed most days, including **44%** of 10th and **41%** of 12th graders.
- **40%** of 12th & **38%** of 10th graders reported that "at times I think I am no good at all".
- **20%** of 10th and 12th graders reported considering suicide and **12%** attempted to commit suicide.
- **13%** of students worried that food would run out before their family could buy more; **8%** of seniors reported skipping a meal because of family finances.
- **32%** of 10th graders and **28%** of 12th graders reported sexual contact over technology.
- **62%** of students, with a rate of **67%** for 10th and 12th graders, reported being emotionally abused through insults or name-calling.
- **14%** of students, with a rate of **15%** for 8th graders and **17%** for 10th graders, reported self-harm (e.g., cutting, scraping, burning themselves) over the past year.

School Experience

All of this data informs how students are faced with a variety of challenges in their lives. As we know, what is going on in a child's life outside of school impacts how well they are able to learn and succeed when they arrive at the school door each morning. PAYS also provides information about what is going on while they are at school:

- For the third straight year, the rate of students who said that they felt school would be important later in life dropped in all grades; **46%** of seniors agreed with this statement, compared to **80%** of 6th graders.
- Only **34%** of 12th graders and **35%** of 10th graders reported that they enjoyed being in school during the past year. These rates also continued to decrease for the third administration in a row.
- **21%** of students reported being threatened at school over the last year, including **24%** of 8th graders and **22%** of 10th graders.
- **11%** of 6th and 8th graders reported being attacked at school, compared with only **4%** of seniors and **8%** of 10th graders.
- **28%** of students reported having suffered some bullying over the last year; this was highest among 8th graders at **31%.**
- Only **63%** of students reported that adults stop bulling when they see it or are told about it; this ranges from **81%** for 6th graders, **65%** for 8th graders, **56%** for 10th graders, down to only **53%** for 12th graders.

How Do We Decrease These Youth Problem Behaviors? Risk & Protective Factors

PAYS also provides information about Risk Factors – conditions that increase the likelihood of youth engaging in problem behaviors. Some of the most prevalent risks include:

- Perceived Risk of Drug Use: **49%** of youth do not view using some drugs as risky.
- Parental Attitudes Favorable to Anti-Social Behaviors: **46%** are apt to model negative behaviors exhibited by their parents.
- Low Commitment to School: **45%** of youth do not feel attached to their school and academic success.

PAYS also provides information about Protective Factors – those people and conditions in a child's life that can buffer them from risks they face:

- The highest levels of protection are in the Family Domain – Positive attachment to their family (**63%**); Opportunities for prosocial Involvement through family activities (**62%**); and Rewards for engaging in prosocial activities with their family (**61%**).
- In the School Domain, **50%** of students reported having opportunities for prosocial activities and **52%** reported feeling rewarded by engaging in these activities.

Pennsylvania has the opportunity to help our students, their families and their communities by increasing the protections provided to students in ALL domains through increasing partnerships between parents and their schools, as well as implementing early, upstream prevention programs. PCCD's approach to prevention by using data to choose effective programming can be an essential factor in providing help to our youth so they can succeed in school and in life.

House Co-Sponsorship Memoranda

House of Representatives
Session of 2019 - 2020 Regular Session

MEMORANDUM

Posted: October 16, 2019 02:24 PM
From: Representative Danielle Friel Otten
To: All House members
Subject: School Free-Play Recess and Lunch Periods

Recess is an essential part of a student's school experience that contributes to a child's growth and development. Providing a regular period of unstructured time for physical activity and play gives children a necessary break for optimizing their social, emotional, physical, and cognitive development. Children who participate in recess have improved memory and concentration skills, and those who have at least 15 minutes of recess a day display less disruptive classroom behavior.

Despite the significant benefits of recess, schools in Pennsylvania are not required to provide a specific number of hours for daily free-play recess and lunch periods. Furthermore, there are no restrictions on schools making a child forfeit their recess or lunch periods for punishment, extra credit, testing, or to make up for missed work.

My legislation would require schools to provide students in elementary grades with at least 40 minutes of free-play recess each day and to provide students in secondary grades with at least 20 minutes each day, in addition to a minimum of 30 minutes of lunch daily for all students. Importantly, a school would not be able to replace these break periods with additional coursework or withhold it for disciplinary reasons.

This legislation will support our children's social and emotional development and ensure that they have the opportunity to be physically active and interact with others. I hope you join me in co-sponsoring this legislation.

AN ACT

Amending the act of March 10, 1949 (P.L.30, No.14), entitled "An act relating to the public school system, including certain provisions applicable as well to private and parochial schools; amending, revising, consolidating and changing the laws relating thereto," in terms and courses of study, providing for free-play recess and lunch periods.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, is amended by adding a section to read:

Section 1512.2. Free-Play Recess and Lunch Periods.--(a) Each school board shall provide at least forty minutes of supervised, safe and unstructured free-play recess each day for each student in elementary grades, at least twenty minutes of supervised, safe and unstructured free-play recess each day for each student in secondary grades and at least thirty minutes of lunch for each student in kindergarten through grade 12, subject to the following:

(1) Students shall not be permitted to replace free-play recess or lunch time with additional coursework or instruction.

(2) Recess and lunch time shall not be withheld, in whole or part, for punitive reasons or as a make-up period for missed work, extra credit or testing.

(b) Nothing in this section shall be construed to prohibit school staff from denying recess for a student on the advice of a medical professional or school nurse or based on the provisions of a student's individualized education program under the Individuals with Disabilities Education Act (Public Law 91-230, 20 U.S.C. § 1400 et seq.) or section 504 of the Rehabilitation Act of 1973 (Public Law 93-112, 29 U.S.C. § 794).

(c) As used in this section, "free-play recess" means a period of time during the regular school day, exclusive of time provided for meals, during which a student is given a break from structured classroom instruction and an opportunity to engage in physical activity or social interaction with other pupils or, in the case of the students in secondary grades, to engage in study when not receiving classroom instruction or in flexible club or activity periods.

Section 2. This act shall take effect July 1, 2020.

post-gazette.com
Pittsburgh Post-Gazette

Safe2Say keeps kids safe: Tipline revealed information that demands action

Attention must be given to students' mental and emotion well-being

August 24, 2019 8:06 AM

The Editorial Board / Pittsburgh Post-Gazette

Six months after the debut of the statewide tipline known as Safe2Say — an anonymous way for school-aged youths to report worries about themselves and others — the anecdotal information shows students' main concerns were about a range of emotional and mental health issues as opposed to school threats of violence.

Initially conceived as a way for students to report concerns about on-site violence at schools, a different and equally concerning issue emerged. Almost half of the students calling were reporting about bullying, cutting themselves, suicidal thoughts or anxiety. Only about 5% of the 23,000 tips concerned threats against the school or students.

This valuable tipline has revealed information that demands action.

Specifically, the number of school counselors should be boosted throughout the commonwealth. The student-to-counselor ratio at the average Pennsylvania school falls short of industry-recommended standards, according to a report by the American Civil Liberties Union using data from 2016. Also the training for teachers on how to prevent suicide should be enhanced. Currently, Pennsylvania law requires schools to provide staff with four hours of

training over five years. Inadequate. The suicide rate in Pennsylvania has increased over the last few years and is above the average rate of the U.S. as pointed out by America's health rankings.

Two-thirds of registered voters want more resources devoted to mental health services, in general, according to a new poll by Franklin & Marshall College in Lancaster.

After the deadly Parkland high school shooting in Florida last year, many school districts in the state bumped up security. But keeping children safe in school isn't just about more metal detectors and additional security officers. Safe2Say has shown us that attention must be given to students' mental and emotion well-being. And that means more counselors and school psychologists and more training for teachers, administrators and school staff to recognize the signs of distress.

First Published August 24, 2019 7:00 AM

FEBRUARY 20, 2019

Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers

For boys and girls, day-to-day experiences and future aspirations vary in key ways

BY JULIANA MENASCE HOROWITZ (HTTPS://WWW.PEWRESEARCH.ORG/STAFF/JULIANA-MENASCE-HOROWITZ) AND NIKKI GRAF (HTTPS://WWW.PEWRESEARCH.ORG/STAFF/NIKKI-GRAF)

(Getty Images)

(https://www.pewsocialtrends.org/2019/02/20/most-u-s-teens-see-anxiety-and-depression-as-a-major-problem-among-their-peers/psdt_02-20-19_teens-00-00/) Anxiety and depression are on the rise (https://www.nbcnews.com/health/kids-health/generation-risk-america-s-youngest-facing-mental-health-crisis-n827836) among America's youth and, whether they personally suffer from these conditions or not, seven-

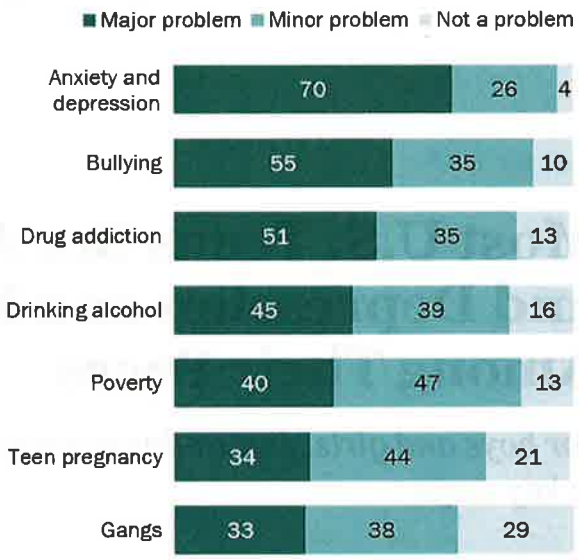
in-ten teens today see them as major problems among their peers. Concern about mental health cuts across gender, racial and socio-economic lines, with roughly equal shares of teens across demographic groups saying it is a significant issue in their community.

Fewer teens, though still substantial shares, voice concern over bullying, drug addiction and alcohol consumption. More than four-in-ten say these are major problems affecting people their age in the area where they live, according to a Pew Research Center survey of U.S. teens ages 13 to 17.

When it comes to the pressures teens face, academics tops the list: 61% of teens say they feel a lot of pressure to get good grades. By comparison, about three-in-ten say they feel a lot of pressure to look good (29%) and to fit in socially (28%), while roughly one-in-five feel similarly pressured to be involved in extracurricular activities and to be good at sports (21% each). And while about half of teens see drug addiction and alcohol consumption as major problems among people their age, fewer than one-in-ten say they personally feel a lot of pressure to use drugs (4%) or to drink alcohol (6%).

Anxiety and depression top list of problems teens see among their peers

% of teens saying each of the following is a ___ among people their age in the community where they live



Note: Share of respondents who didn't offer an answer not shown.
Source: Survey of U.S. teens ages 13 to 17 conducted Sept. 17-Nov. 25, 2018.
"Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers"

PEW RESEARCH CENTER

The pressure teens feel to do well in school is tied at least in part to their post-graduation goals. About six-in-ten teens (59%) say they plan to attend a four-year college after they finish high school, and these teens are more likely than those who have other plans to say they face a lot of pressure to get good grades.

(https://www.pewsocialtrends.org/2019/02/20/most-u-s-teens-see-anxiety-and-depression-as-a-major-problem-among-their-peers/psdt_02-20-19_teens-00-01/) Girls are more likely than boys to say they plan to attend a four-year college (68% vs. 51%, respectively), and they're also more likely to say they worry a lot about getting into the school of their choice (37% vs. 26%). Current patterns in college enrollment (https://www.pewsocialtrends.org/2018/11/15/early-benchmarks-show-post-millennials-on-track-to-be-most-diverse-best-educated-generation-yet/) among 18- to 20-year-olds who are no longer in high school reflect these gender dynamics. In 2017, 64% of women in this age group who were no longer in high school were enrolled in college (including two- and four-year colleges), compared with 55% of their male counterparts.

(https://www.pewsocialtrends.org/2019/02/20/most-u-s-teens-see-anxiety-and-depression-as-a-major-problem-among-their-peers/psdt_02-20-19_teens-00-02/) In many ways, however, the long-term goals of boys and girls don't differ significantly. About nine-in-ten or more in each group say having a job or career they enjoy would be extremely or very important to them as an adult (97% of girls and 93% of boys say this). And

‘My baby is not OK’: central Pa. residents pour out hearts over suicide

A Pennsylvania suicide prevention task force brought its listening tour to central Pennsylvania on Oct. 10, 2019.

YORK—Dozens of people came to a community center to discuss suicide on Thursday night, providing gut-wrenching accounts of suicides of loved ones or describing their own suicide attempts.

Or their worry about someone who is depressed or suicidal and the inability to obtain help.

“My baby is not OK and he does not have the support he needs,” Theresa Nixon of Harrisburg said. “I don’t know what to do. I’m lost.”

Nixon said one of her sons, in his early 20s, was diagnosed with a mental illness and prescribed medication. But he received no follow up or monitoring or additional treatment such as counseling, she said.

She and another son rely on a precarious safety net of phoning and checking on him as often as they can. But Nixon, a working mom, said she worries by the hour she’ll lose him to suicide.

The gathering at the Jewish Community Center in York County was a stop on a state-wide listening tour by a suicide prevention task force created by Gov. Tom Wolf this spring. Several more will be held around the state.

The task force includes state lawmakers, heads of state agencies and mental health advocates. It will devise a suicide prevention strategy for Pennsylvania, where 2,030 people died by suicide in 2018. That includes 11 National Guard members, reflecting a rise in suicides among people in the military and veterans. Pennsylvania’s suicide rate has risen by 34 percent since 1999 — well above the national rate of 25 percent. The listening tour is intended to give members first hand accounts of causes of suicide and barriers that prevent people from getting help.

Another major goal of the task force is to reduce stigma surrounding seeking help for suicidal feelings and for mental illness.

"We must talk about it. We must get out it in the open ... People are afraid to get help for fear of judgement," said Jacqueline Bieber, whose 25-year-old daughter died of suicide this year.

The event was well-attended by people who work in schools and who described many barriers faced by young people in need of mental health care and their families.

Speakers described major shortages of mental health professionals, long waiting lists and high insurance deductibles that can prevent people from obtaining mental health care.

Several people said young people seem to lack coping skills and networks of people to turn to when they are extremely troubled. As a result, things like bullying can trigger suicide.

"They just do things on a whim," said a woman whose son committed suicide as a high school senior, and who lost a nephew to suicide. "It could be circumstances that happen that day, that week, and they break down."

Several teenagers spoke during the session. One, who said she had been suicidal, said parents need to learn to talk to their children in a way that will clue them in about their child's dark thoughts and struggles, and to recognize warning signs.

Another explained students often don't regard school counselors as welcoming or trustworthy confidants, fearing the counselor will tell teachers and parents.

One of the students provided hopeful news: A group called York County Youth Mental Health Alliance, devoted to "mental wellness," involves students and school staff from every school district in the county, and has drawn 125 people to its meetings.

As a microphone was passed around the room, speaker after speaker discussed things ranging from months-long waits for appointments to widespread insensitivity toward people who have attempted suicide to low pay for mental health professionals, making it an understaffed field.

One speaker, who said she was part of a suicide-related group, said local suicides have included people as young as eight.

Another, who works in a nursing home, said mental illness is rampant among residents, but staff is ill-equipped to meet their needs.

Another described calling a local mobile crisis unit and being told no one was available.

Yet another said forces such as low wages and medical debt are contributing to the rise in suicides. "We have to address what is making people want to kill themselves on a daily basis," he said.

Cindy Richard is the longtime director of Suicide Prevention of York. She said York County alone saw 93 suicides last year, and 52 so far this year, with more than half involving older adults. While much of the focus is one suicides among the young, Richard stressed a need to help older people and also their caregivers.

Richard said she is notified by the coroner each time a suicide occurs, and she looks into the circumstances. She noted York County hasn't gone a month without a suicide in 20 years. She said many shortages and shortcomings must be overcome to break the trend.

"I just want one month without a suicide in York County," she said.

Mary Kwiatkowski, Parent
House Democratic Policy Committee Hearing on Youth Mental Health

I am the mother of a smart, creative, and kind young man who also struggles with mental illness. He was precocious and walked and talked early. But by the time he was 20 months old it became clear that there was something wrong. It took 8 more years to get a diagnosis and 11 years until we were on the road to improvement.

When he was 20 months old I signed him up for Gymboree. The toddlers ran around obstacle courses, sang songs, and ran under a parachute that the parents would lift up and down. Every time the parachute came up, my son had knocked down a child and sometimes had bitten them. He struggled in pre-school and elementary school with hyperactivity, aggression, defiance, and what I now know was grandiosity.

I could not understand what was going on with this child. He had a stable home, he was loved and given lots of attention. Everyone had suggestions for me: "123 Magic", Time outs, Stickers for rewards for good behavior. Nothing worked and frequently made it worse. Relatives had lots of suggestions: "if you only had more rules", "if you only kept a better schedule", "If you changed his diet and gave him healthier food", etc. I didn't know what was wrong, I didn't know how to fix it.

When my son was 7 years old the situation moved to another level. He started having aggressive rages. He would move into an irrational and paranoid state where his only goal was to hurt the people around him. He would kick, hit, bite, and throw things including on one occasion a knife. These rages could last up to 4 or 5 hours. This sent us into the world of psychiatrists, psychiatric medicines, IEPs, mobile therapists and case workers in and out of our home all the time, therapeutic schools, and worst of all, psychiatric hospitals.

We had years of trial and error with psychiatric medicines that had side effects like bed wetting, cognitive dulling, sleepiness, inability to wake up in the morning, drooling, and weight gain (as much as 50 pounds at one point). And all to no avail, he was getting worse. In the end my son got help only because we had the resources, both intellectual and financial, to find the right doctor for him. We eventually took him to a child psychiatrist who was a leading expert in early onset bipolar disorder out of Einstein University in New York City. This doctor put him on an experimental medication which I believe saved his life. It took away his aggression and irrational thinking and allowed him to complete high school at Owen J Roberts in Pottstown, PA. He was accepted to Drexel University to major in computer science. He was overwhelmed at Drexel and is now attending a local community college where he is thriving.

When my son was in elementary school, he frequently would not be able to fall asleep at night and he would rage into the late hours. One night he was finally able to tell me that this happened because he was terrified of going to school the next morning. When I asked him why, he responded that it was because he got into trouble every day at school and it was out of his control to stop this from happening. In IEP meetings I was told that my child was

manipulative and lazy. When in reality he was struggling just to get through the day. He lacked emotional regulation and coping skills and was overwhelmed with anxiety. We need all school staff to be trained on mental health. How differently would you approach a child who you think is being lazy and manipulative compared to if you think a child is struggling and overwhelmed but doing the best they can in that moment.

There are so many things about how the school system functions that is setting kids with mental health issues up to fail: early schedules, tons of homework, inflexible rules, lack of understanding about mental health, consequences that are shaming and enforce the idea that the child is bad instead of that the child is struggling. In addition, disruptive children receive attention but children who go inward and are not disruptive in the classroom often fall through the cracks.

There are too few psychiatric in-patient care facilities for children who are in crisis and the ones that exist are in great need of reform. My son's experience in psychiatric hospitals was extremely traumatizing. He had not suffered trauma before being hospitalized but for years afterward he would have panic attacks and could articulate to me that he was remembering things that happened in the hospital

Finally, I'd like to say a word about families. For many years having a child with serious mental illness consumed and defined our family. The stress of living with the unpredictability, aggression, and struggling with the stigma left lasting scars. Our younger son was frequently the target of our bipolar son's aggression. I believe that it is imperative that mental health services are available for not only the affected child but the entire family and especially the siblings.

Thank you for your time.

Mary Kwiatkowski

Statement by Bradley J. Dyer, MD, FAAP, Pediatrician and Founder, All Star Pediatrics

My name is Brad Dyer, and I've been practicing pediatrics in the community for over 25 years. I would like to share my perspective on the increasing incidence of mental health disorders in our youth, particularly teens. When I first went in to practice, our office had just one full time physician. We followed a few patients with anxiety disorders and depressive symptoms, mostly along with local pediatric psychologists, and, if medication was warranted, pediatric psychiatrists. Along with the community, our office has grown over the years and we now host seven physicians, two nurse practitioners, a staff of 30, and takes care of nearly 10,000 patients, all local residents.

Several years ago, my colleagues and I began to notice an uptick in telephone calls and office visits regarding mental health. As primary care physicians, we find ourselves being asked to provide counselling services and prescribe anti-anxiety and antidepressant medications—either by patients, their parents, their psychologists and counsellors, or even their school personnel. Ten years ago I could count the number of my patients on these types of medications on one or two hands. Now they number in the hundreds. This is something that none of us were trained for—but have had to learn because the demand for these services is so high.

The escalating trend has continued at an ever-increasing rate. Absolute numbers are difficult to come up with, because so much of what our nurses and physicians do is over the phone, and we currently do not track our calls by category. However, a brief query of our records shows that even when compared to 2016, new consult visits for anxiety and/or depression this year have increased by almost five-fold, to over 300, in 2019. (Depression from 10 to 70 visits in the first 3 quarters, Anxiety from 37 to 155). That's more than one new consult each day the office is open—for something that we're doing only because there is no one else out there to help!

And as many panelists will attest, our system for taking care of patients with mental health problems is fractured. Who and where we refer patients depends on their age, the nature of the problem, whether or not they have medical insurance, who that insurance company is, and whether or not the psychologist or psychiatrist is taking new patients. Urgent referral visits are almost non-existent, unless a patient is acutely suicidal. Wait times to see a pediatric or adolescent psychologist usually range from several days to several weeks, and to see a pediatric psychiatrist usually takes several months. The unfortunate patient or their family is left to make dozens of phone calls to find the right place to start. Those without mental health insurance, or those who can't wait long enough to see a provider within their network often pay out of pocket, just out of desperation. As primary care providers, we do our best when patients call us with their frustrations, which as mentioned often forces us into providing prescription medication while the patient waits to be evaluated by psychiatry.

We could talk all day long about theories as to why this is all happening. But I believe that many of the contributing factors are very difficult to control, and from a practical standpoint the urgent need is simply to provide timely, high quality care by trained professionals who are paid appropriately for their time. Mental health services have been undervalued in this country for decades, and this is nowhere more apparent than in insurance reimbursement for professional services. When one of my youngest patients is showing delays in development, I refer them to county intermediate unit services, where they are evaluated, and, if necessary, provided treatment as long as the condition lasts, regardless of family income or insurance coverage. Isn't it time we came up with a similar program to treat people with mental health issues?

Perk Musacchio, M.Ed
B.S. Elementary and Special Education, West Chester University; M.Ed. Special Education Temple University
Skills2Soar, LLC, owner, www.skillstosoar.com
~Wife, Parent of 3 sons, Grandparent of 4, and Retired Educator who taught 38 years in a local elementary school before retiring in 2015
~2015-present Owner of Skills2Soar, LLC, an educational consulting company
~Co-authored and published two books with Monica Reinhard-Gorney
A Student's Guide to Communication and Self-Presentation
No Manual? No Problem! Strategies and Interventions to Help Your Child Thrive in Today's World
~Trademarked, the PeaceWalk®, a conflict resolution mat, and then partnered with Youthlight, a company that provides primarily social and emotional resources for educators and counselors

Monica Reinhard, MS.Ed.
B.S. Psychology, Bryn Mawr College, Adolescent and Family Counseling, MS.Ed. University of Pennsylvania, School Counseling Certification, University of Pennsylvania
www.holisticeducationalcounseling.com
-mother of two girls, wife, educational counselor, 20 years of experience
-previously employed as a lead counselor in a partial day hospital program for adolescents, a boarding school, and a public high school, all in PA
~Co-authored and published two books with Perk Musacchio
A Student's Guide to Communication and Self-Presentation
No Manual? No Problem! Strategies and Interventions to Help Your Child Thrive in Today's World

Because we have witnessed so many alarming changes during our tenure in education, we decided we had to do something to share our combined knowledge, research and experiences with parents, educators and counselors, knowing that the schools could not solve these problems alone. Therefore, we co-authored two books and are trying to spread the word and work with others to help children thrive. We are so thankful to have concerned legislators who are also invested in our youth's mental health and education in general, and are taking the stand and introducing critical legislation that will make a difference now and in the lives of generations to come.

We have seen a significant increase in the number of referrals for problems that typically had not been global concerns in the previous 20 years, such as more children who were struggling with:
*health issues like obesity, allergies, asthma, and diabetes

*executive function skills including time and materials management and self-regulation
*behavior and emotional lability including increased frustration, anger, anxiety and depression even in the youngest learners
*delays in language development and gross and fine motor skills
*social skills and problem solving skills
*developmental delays and autism

These increased learning needs have led to:
*More students being identified for special education services under the category of "OHI or other health impairment".
*Different and more special education services being needed.
*De-escalation and sensory rooms being added in public school settings.
*More social workers, counselors, school nurses, and psychologists are being added, but there is still a shortage in many school districts.
*More districts no longer contract out services like S/L, PT, OT, and behavioral specialists but instead hire their own. They used to rely on the IU's for those services, but now they need more of these services that require full time positions and subsequently different services, trainings, and support from the IU's. (psychiatric, therapeutic settings, in addition to other previous critical services).

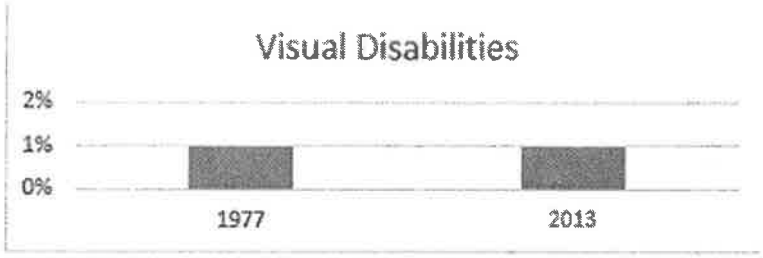
Our research revealed that these same trends are being seen everywhere and by everyone who worked with children, teens and young adults. The research is showing that real changes are occurring in the brains of children. WHY?

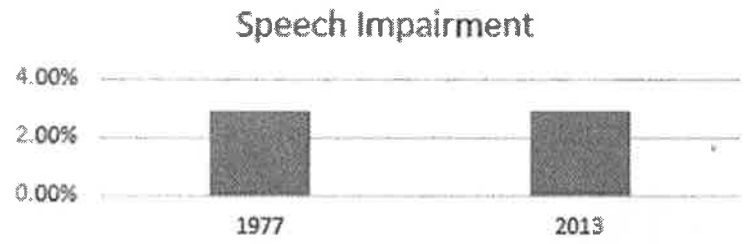
We attribute the "WHY" to a number of factors/culprits, though we are sure there are more. The ones we focused our research on were:
Inadequate nutrition
Environmental toxins
Lack of unstructured, creative play
Overuse of screens
Over-scheduled lifestyles

It is clear that we are facing a crisis that requires a global and holistic approach to parenting and education in order to combat the many of the physical, learning and emotional challenges facing today's children. That will require having the courage to take a stand and make hard decisions, as well as provide funding for programs and services to reverse these alarming trends.

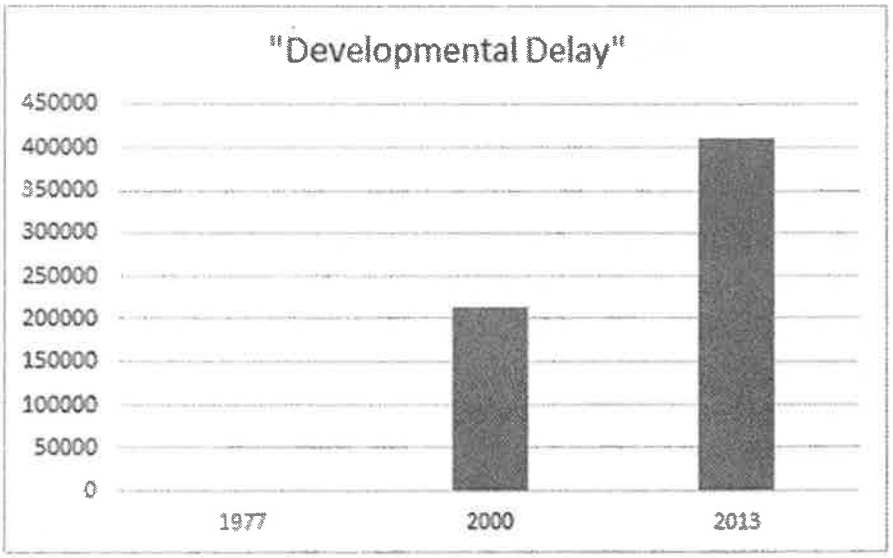
Alarming Data

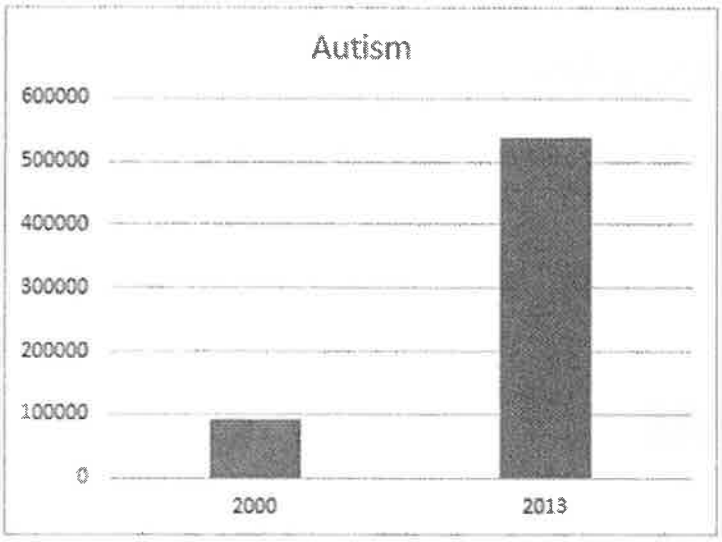
As you can see the rate of visual and speech impairments stays static (almost exactly the same) from 1977 to 2013.

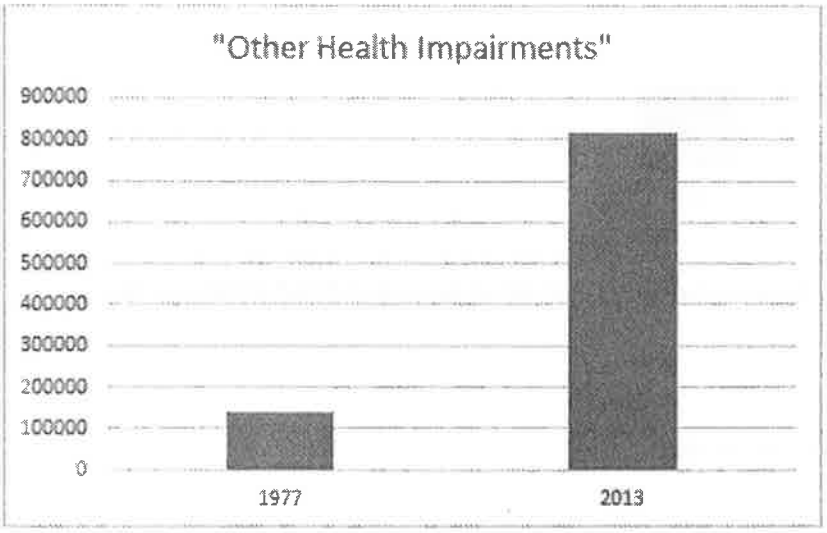




YET.... the rate of neurological, brain and physical health based disabilities is sky-rocketing....



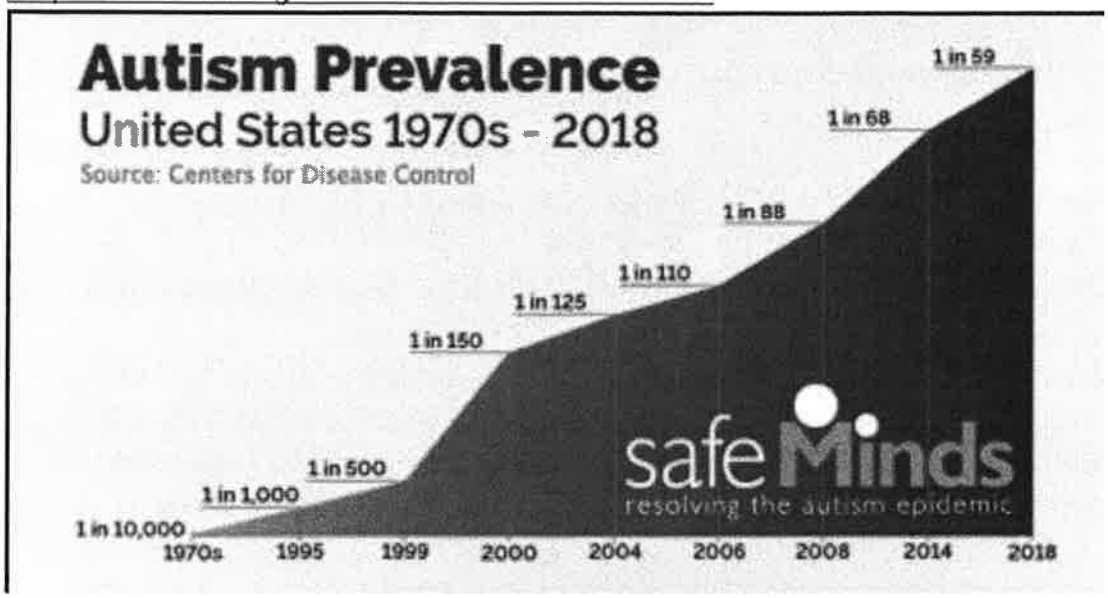




*25% of students aged 13-18 have a diagnosable anxiety condition
*1.5 million prescriptions issued annually to kids 18 and under for antidepressants
*Suicide is the 3rd leading cause of death in the 15-24 age group.
*American children consume 90% of the world's Ritalin supply (this translates into 3.5 million prescriptions annually for ADHD).
*The CDC says that 10,000 prescriptions are issued annually for TODDLERS aged 3-4 for amphetamine based ADHD medication.

Rising rates of autism (up 15% in 2 years)

https://www.cdc.gov/ncbddd/autism/data.html



The U.S. Centers for Disease Control and Prevention (CDC) reports that approximately 11 percent of children ages four to seventeen have been diagnosed with ADHD, and that number increased 42 percent from 2003-2004 to 2011-2012, with a majority of those diagnosed placed on medication. Perhaps more troubling, one-third of these diagnoses occur in children under age six.
Taken from following article on Harvard study:
https://fee.org/articles/harvard-study-shows-the-dangers-of-early-school-enrollment/?fbclid=IwAR132bAxSIGyZWkAOztnHfNgM4HLQIfHcHaY7JqEyHOZ62sRB8MEhDoObCI

One study that looked at executive function and self-regulation concluded:
"Today's 5 year olds were acting at the level of 3 year olds 60 years ago, and today's 7 year olds were barely approaching the level of a 5 year old 60 years ago."

Special Education Rates
Back in the late 70's and early 80's, a common targeted percentage for special education students in a student body was 4%. If it was more, we, as educators, were told to look at our programming and instruction because more than 4% was a red flag. And for a long time, that was absolutely the case.

In our state of PA, the rate has quadrupled and is now at 15.9%. Some would argue it may even be higher and closer to 20% given the demographics of children whose parents have opted for home schooling and/or private school. Yet, over the past

decade, special education funding from the state has dropped from one-third share to 22%.
Taken from https://www.elc-pa.org/wp-content/uploads/2018/10/Special-Education-Report-Online.pdf

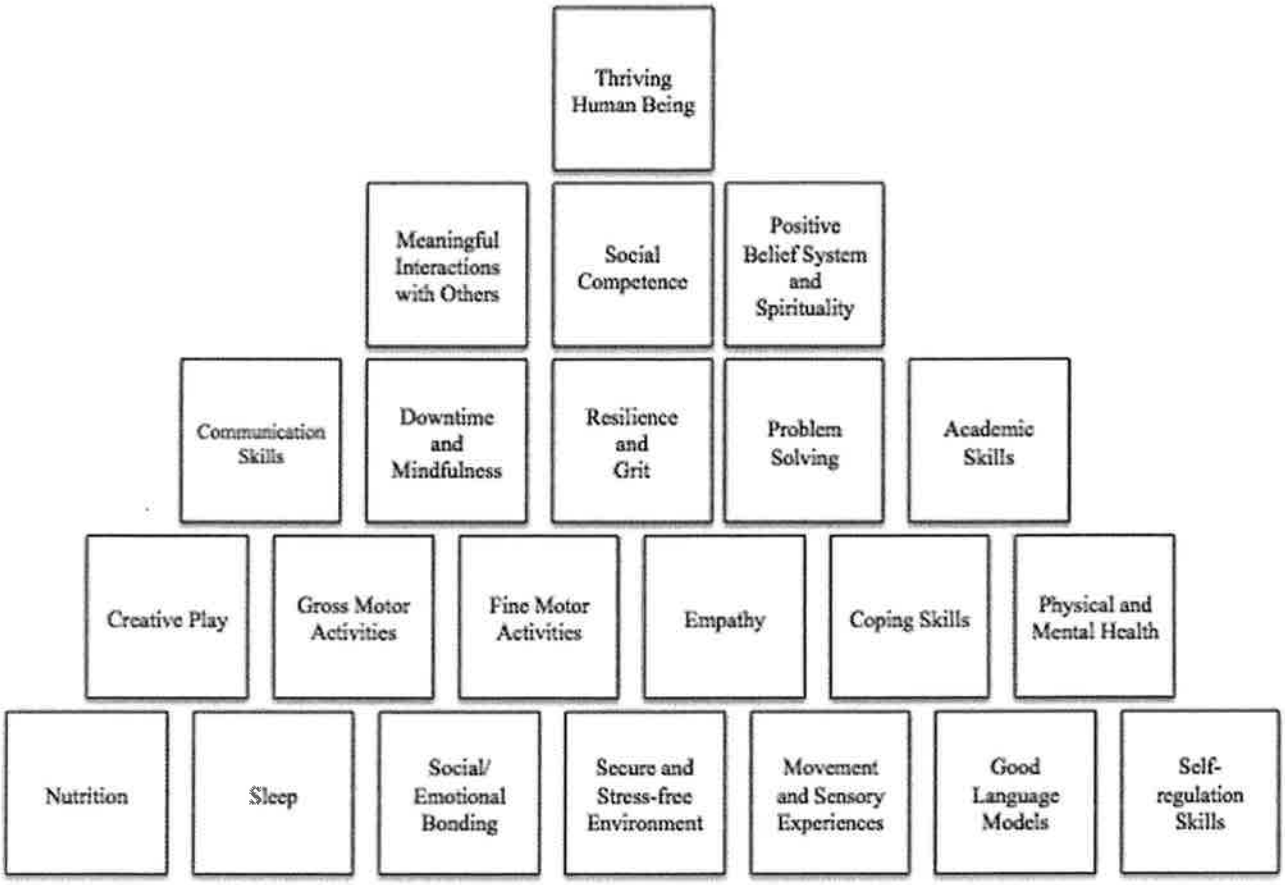
How do all these childhood issues translate into the secondary education level?

*As already cited, there is an increasing amount of students receiving services for mental and physical health needs, as well as learning challenges.
*In the three year period from 2007-2008 school year to the 2010-2011 school year, there was an increase of over 28,000 students needing accommodations on the ACT.
*In the five year period from 2005-2006 to the 2010-2011 school year, the number of students requesting special services on the SAT increased by 10,000 students.

Then there are the challenges that an increase of time using technology and social media presents. We address these head on in our book *A Student's Guide to Communication and Self-Presentation.*

As students spend more time on technology and engage in less personal and direct communications with others, there has been a resultant reduction in EQ or soft skills. Students are losing the ability to think critically, engage in discussion, self-advocate and work with others. This should be of concern given the below statistics.
*Only 46% who start a 2 or 4 year degree finish it.
*Only 56% who start a 4 year degree finish it within 6 years.
*There is now a diagnosis in the DSM V for technology addiction.

We believe these trends can be reversed and have offered a preventative and developmental model for parents that shows how to raise kids from the ground up. Like any structure that must withstand environmental assault and the test of time, a strong foundation is critical. Our pyramid serves as a visual model for raising children today. The pinnacle of the pyramid is a thriving human being. But, how do you get there? By having sturdy steps to climb!



Taken from *No Manual? No Problem! Strategies and Interventions to Help Your Child Thrive in Today's World*, copyright 2018.

Youth and Mental Health Policy Hearing 10.18.19
Testimony: Cindy Kruse, Educational and Workforce Consultant

As an educational and workforce consultant, I work with schools, districts, and organizations to provide learning opportunities on topics related to literacy, parenting, social and emotional learning, and creating trauma-sensitive learning environments. I am certified as a Youth and Mental Health National Trainer and am a national trainer for Responsive Classrooms (an approach to teaching which integrates social and emotional learning with academics). I am also a consultant for West Chester University developing and presenting workshops on social and emotional intelligence for new managers in businesses located in the Chester County area.

Our collective goal as parents, grandparents, educators, and legislators, is to create a healthy, innovative, and compassionate society. Relationships are the key to achieving this goal. Researchers agree that relationships have a huge impact on our well-being. People with supportive relationships enjoy better emotional, mental, and physical health.

The formation of our relationships is centered on our emotions. When we are able to identify, communicate, and regulate our feelings we can all live more positive and rewarding lives. The struggle of our youth to both understand their emotions and the emotions of others is evident in the data recently gathered regarding youth and well-being.

According to a recent report by UNICEF, American youths rank in the bottom quarter among developed nations in well-being and life satisfaction. Research shows that our youth have stress levels that exceed those of adults. The symptoms of stress are seen in these increases among young people including but not limited to: violence, drug and alcohol use, anxiety, depression, and suicide.

The impact of this struggle and decline in our youth's mental health and well-being has affected parents, our educational system, and even the work place. As I coach teachers in classrooms across the country as well as right here in Chester County, I see first-hand the increase of challenging behaviors exhibited by students and the frustration of both teachers and administrators who do not feel adequately prepared to meet the social & emotional needs of students in Pre-K through 12th grade classrooms.

Educators, as well as those in the business world, have come to the realization that academic learning is just one piece of the final picture. In order to ensure that our students reach their potential in school, in work, and in life, they must have the skills that help them to process and act on information effectively with others. These are often referred to as "soft" or "noncognitive" skills. However, these are truly "essential skills". Daniel Goleman refers to these skills as "emotional intelligence". In an article for The Harvard Business Review, Goleman states,

> *"The most effective leaders are all alike in one crucial way: they all have a high degree of what has come to be known as emotional intelligence. It's not that IQ and technical skills are irrelevant. They do matter, but...they are the entry-level requirements for*

executive positions. My research, along with other recent studies, clearly shows that emotional intelligence is the sine qua non of leadership. Without it, a person can have the best training in the world, an incisive, analytical mind, and an endless supply of smart ideas, but he still won't make a great leader."

As I work with companies to develop workshops for new managers, they express the need to explicitly develop these "essential skills".

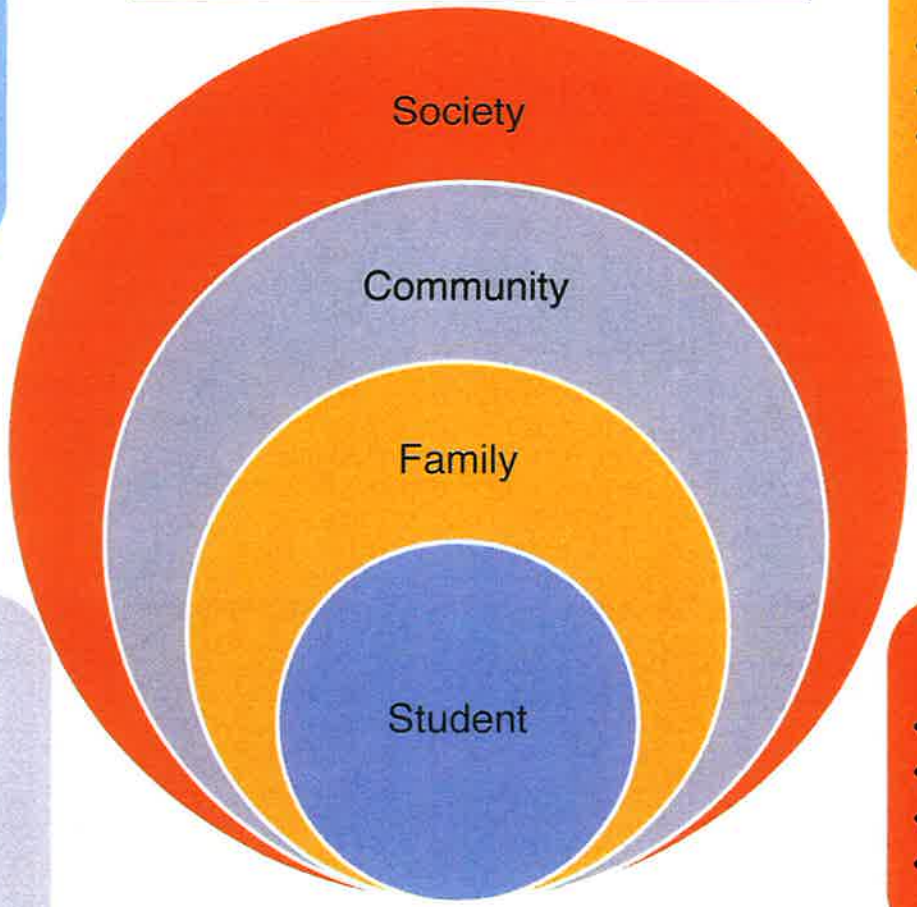
A nation's economy is only as strong as its work force. In 1945, General Lewis B. Hershey testified before congress that almost 40% of those rejected for the draft had been turned down because of poor diets. He recognized this potential crisis as we were in the midst of World War II. The US Congress passed a bipartisan bill in response to a serious need among children that was not being met: The National School Lunch Act.

It is time to acknowledge the crisis we are currently facing and take a proactive approach towards solving the problem. This hearing and the efforts of Representative Otten to create awareness and dialogue is one important step towards supporting the well-being of our youth. However, we must work together and dig deeply to address the root of the problem. One of the challenges we face is that our society is changing at a rate which our systems cannot adapt to quickly enough. This is why we need a task force focusing on youth and well-being that would compile resources, share research-based practices, and work to create circles of support. While schools are one way to provide support for youth, they cannot be the only way that support is given.

Human beings are born with an innate capacity for resilience (Zolkoski & Bullock, 2012). Research has shown that improving the resiliency of our children can help them to deal with the adversities they will encounter throughout their lifetime. How a child experiences and reacts to adversity is influenced by individual, family and community factors. These "circles of support" are identified in the graphic provided on page three of this testimony. Research points to the understanding that the foundation of resilience rests on quality relationships (Doll, Osborn, Dooley, Turner 2011). Building children's resilience requires the unified commitment of our families, our communities, and society.

Promoting Child & Youth Well-Being: A Framework For Building Resilience

Child Factors:
- Positive Relationships
- Coping Skills
- Self-Regulation
- Self-Confidence
- Healthy Thinking Habits
- Social Skills



Family Factors:
- Parenting
- Family Relationships
- Family Communication

Community Factors:
- Connections with peers
- Educational setting
- Opportunities to participate in healthy risk-taking
- Services Available
- Neighborhood

Societal Factors:
- Public Policies
- Social & Cultural Values
- Legislation
- Mass Media

Adapted from Beyond Blue Ltd. (2017). Building resilience in children aged 0–12: A practice guide

Dr. Pamela Brown
President – PSEA Southeastern Region
House Democratic Policy Committee – Youth Mental Health
October 18, 2019

Good afternoon, Chairman Sturla, Representative Otten, and members of the House Democratic Policy Committee. My name is Dr. Pamela Brown, and I am an Instructional Support Teacher at Hopewell Elementary in the Oxford Area School District. I also have the distinct honor of serving as President of the PSEA Southeastern Region, which encompasses Chester, Delaware and Philadelphia counties. Thank you for the invitation to be part of this important discussion today.

The growing crisis around students' mental health has long been a concern of educators and other school personnel. Schools are the cornerstone of nearly every community across Pennsylvania, and most children spend six or more hours in school each day. Teachers and other school personnel are on the front line of this crisis. Sometimes we can be first to notice subtle changes that could indicate that a student is struggling with an underlying problem. Sometimes, it's impossible to ignore because a student's behavior and mental health impacts their success in the classroom.

Even though school employees can be extremely effective in identifying red flags in student interactions and behaviors, we are stretched thin. In my position, I am frequently involved in a support role during oversight for students with severe mental and emotional needs that overwhelm the school staff's time and focus, leaving little personnel and time to attend to students with important, but less overt, mental health issues. In short – students who are not in immediate crisis are overlooked, robbing them of the assistance they need to reach their full potential.

There is a growing and unmet 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 to help ensure certified professionals in our schools, but our 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.

My testimony provides more detail on some of the greatest challenges schools face in addressing students' mental health needs and includes specific legislative recommendations that will help schools provide support in a more comprehensive way.

INCREASE THE NUMBER OF SCHOOL-EMPLOYED MENTAL HEALTH PROFESSIONALS

As class sizes and workloads continue to grow for teachers, so does the need for more non-teaching education specialists such as school counselors, psychologists, social workers and nurses. Education specialists work with teachers, school support staff, parents, community providers, and other education stakeholders to ensure students have the services they need to succeed in school and in life. Unfortunately, when schools struggle financially, these non-teaching specialists are often the first to be cut. And although state funding has been restored from the cuts that devastated our schools earlier this decade, many of these important positions remain unfilled.

The national conversation surrounding school safety has highlighted the need for additional mental health supports for children and shown the life-changing impact of children developing a relationship with one caring adult in their 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 professional to provide support, intervention, referral, and follow-up to students in their time of need.

In some cases, these non-teaching education specialists are employed by Intermediate Units (IUs), and local districts contract with IUs to provide these specialized services at a lower cost. Even where schools do utilize these professionals- either as employees of the district or through a contract with employees of an IU, the statewide data shows that their caseloads far exceed nationally recommended ratios. They too, are stretched thin.

In other districts, mental health services are simply contracted out to a private agency if one is available. These contracted providers are not certified to work in a school setting as an employee would be. Agency providers often operate in a siloed fashion without the opportunity to collaborate with other school-based personnel who are managing and supporting other key aspects of a student's care; their assignments and caseload management are directed by agency employers rather than school administrators; and the agency contract could be dissolved at any time. Children find it difficult to establish a relationship of trust when they have no continuity in their care providers. While these agencies provide critical services to students whose needs might otherwise go unmet, they are a band-aid solution to the problem of providing stable and quality care to students; certificated employees who are in schools every day and can develop relationships with students and staff are the gold standard of care.

Oxford Area School District, for example, would need to employ five (5) additional certified school counselors; four (4) additional certified school psychologists; fourteen (14) additional school social workers/HSVs; and one (1) additional certified school nurse to adequately serve our student population in accordance with nationally recommended ratios.[1]

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[1] 2018-2019 Professional Personnel Individual Staff Report and Public School Enrollments 2018-2019 – Pennsylvania Department of Education

This is consistent with what I hear anecdotally from my colleagues across the region and the state: All schools need more certified counselors, psychologists, social workers, and nurses to appropriately provide for students' behavioral and mental health needs. The other reality is that these non-teaching specialists are inundated with a variety of mandated reports and endless paperwork, which greatly limit the time they can dedicate to working directly with students on prevention and intervention.

Finally, roles and responsibilities of these non-teaching specialists vary from district to district. Too often school counselors are doing work that would be better executed by a full-time school social worker, leaving the school counselor unable to devote as much time as necessary to their own specialized services. School social workers frequently are assigned to cover multiple schools leading to unmanageable caseloads and limiting their ability to provide hands-on support to students, addressing family problems, or collaborating with their school counselor colleagues. While the role of a school nurse traditionally encompasses health screenings and medication administration, school nurses deal with ever more complex medical conditions and are often the first health professional to see a student experiencing mental health issues, which often manifest in psychosomatic symptoms such as headaches and nausea. In recent years, schools have relied upon school psychologists more and more for their expertise in trauma-informed approaches, violence prevention and threat assessment. Another critical function of a school psychologist involves student assessment and referral related to individualized educational programs (IEPs); due to the time-consuming nature and mandated timelines of that process, much of a school psychologist's limited time is devoted to testing, report writing, and special education compliance. As is the case with many professionals in a school setting, the school psychologist's role in supporting students often necessitates an intense focus on a small number of students with the most acute needs.

These are just a few of the challenges these non-teaching specialists face, and I encourage you to connect directly with the counselors, nurses, psychologists and social workers in your schools to obtain a more comprehensive understanding of their specific roles and responsibilities, the challenges they face in delivering their specialized services, and their suggestions for how to better meet local needs. I think you'll find them to be passionate about the work that they do, devoted to the students they serve, and eager to offer real solutions. As an addendum, I have attached a few infographics that provide a very broad overview of their areas of expertise and training requirements to help raise awareness and understanding of the value these professionals bring to the educational environment.

	Professional Association	Recommended Ratio	2018 PA School Safety Report[2] PDE 2016-2017 data	# LEAS employing staff with this title	Ratio in PA law	ACLU ratio[3] US Dept. Ed. 2015-2016 data
Nurses	NASN	750:1	809:1	552 (79.7%)	1,500:1	667:1
Counselors	ASCA	250:1	387:1	605 (87.4%)		380:1
Psychologists	NASP	500-700:1	1,164:1	435 (62.9%)		997:1
Social Workers	SSWAA	250:1	2,285:1	119 (17.2%)		3,416:1

Recommendations:

1. Urge passage of HB 1500 (D. Miller) which would require all public-school entities to provide school nurses, counselors, social workers and psychologists within specific student ratios:
    - The number of students under the care of each school counselor shall not exceed 250
    - The number of students under the care of each school psychologist shall not exceed 500
    - The number of students under the care of each school social worker shall not exceed 250
    - The number of students under the care of each school nurse shall not exceed 750 in a regular education population, 225 in a mixed regular education and special education population and 125 for students with severe or profound disabilities.

2. Increase state reimbursement for school nurse services from $7 per student to $12 per student.[4]

Both school districts and certified school nurses are finding the provision of school health services to the student population continually changing and challenging. State law requires that every child of school age shall be provided with school nurse services provided that the number of students under the care of each certified school nurse does not exceed one thousand five hundred (1,500). This number includes students attending public, charter, cyber charter, private

[2] 2018 Pennsylvania School Safety Report – Governor Wolf and Auditor General DePasquale Task Force Report

[3] ACLU Report, Cops and No Counselors: How the Lack of School Mental Health Staff is Harming Students

[4] House Bill 454 of 2015

and parochial schools.[5] 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.

Although woefully inadequate, Pennsylvania's school nurse ratio does offer more access to students than 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.[6]

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.

3. Urge passage of HB 1545 (Toohil) which would increase the minimum educator salary to $45k

Professionals employed in our schools support the needs of the whole child and they deserve recognition and respect for the important work that they do. Compensation cannot be overlooked as a key factor in recruiting and retaining the best and the brightest into the education profession.

Pennsylvania's minimum teacher salary is $18,500 and was established in the Public School Code in 1989. Thirty years later, there are educators with advanced degrees and years of experience earning just $22,000 per year working full-time in our public schools. That is unacceptable.

Nurses, psychologists, social workers, and counselors and other non-teaching education specialists are among thousands of professionals working full-time in Pennsylvania's public schools and earning less than similarly educated professionals. Many non-teaching professionals are in high demand and could earn a much greater salary in the private sector. The combination of lower salaries, high student loan debt, a lack of respect for the profession, and increasingly challenging teaching conditions, have all contributed to Pennsylvania's present and continuing shortage of professional educators. Increasing the minimum salary in statute is a clear demonstration to current and future educators and non-teaching professionals alike that their work is valued and respected.

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[5] See 24 P.S. § 14-1402(a)(1).

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

PROVIDE ADDITIONAL FUNDING FOR MENTAL HEALTH SUPPORTS IN SCHOOLS

The 2018-2019 School Year Report on the Safe2Say Something anonymous reporting system revealed the need for significant investments in mental health resources to support the needs of Pennsylvania students. Students consistently report that the greatest obstacles to their ability to feel safe and supported in school are not violent threats to their school or to their classmates, but bullying, anxiety, and thoughts of self-harm.[7] Attending to these issues requires dedicated, recurring revenue focused on supporting students' mental health needs.

The School Safety and Security Grant Program established under Act 44 of 2018 was an important first step in providing school entities with much need resources to implement evidence-based schoolwide intervention frameworks like the Multi-Tiered Systems of Support (MTSS), Positive Behavior Interventions and Support (PBIS), counseling programs for students, trauma-informed approaches, training for school staff, and hiring trained professionals with manageable caseloads to address students' mental, physical, and emotional needs.

Trends in the fiscal year 2018-19 competitive school safety grant requests demonstrate that school administrators also recognize the importance of a positive school climate and having the full continuum of supports in place to promote student wellness, prevention and intervention. In the program's first year of implementation, three of the top five categories selected by grant applicants included trauma-informed education, counseling services, and staff training in positive behavior supports.[8] Further, the total for all competitive grant requests by school entities was over $315 million, but only $40 million was available to award.

The 2018-19 trends also suggest that school entities overwhelmingly selected eligible uses for which there was a one-time cost to implement. School officials have been reluctant to apply for one-time grant funding to support uses that have a recurring cost, such as hiring school-based mental health professionals.

PSEA thanks you for re-authorizing funding for the School Safety and Security Grant Program in the 2019-20 fiscal year budget and urges the legislature to continue to prioritize investments into this program. There is no one-size-fits-all approach to meeting the diverse needs of Pennsylvania's students, and the grant program provides flexibility for local schools to determine how best to use available resources.

Recommendations:

1. Amend Act 1 of 2006 to add an exception for school safety and security costs

In addition to much needed state funding, school districts must have the ability to raise local revenue to support local needs. PSEA supports the following language as an amendment to Act 1 of 2006, which would 1). Allow school boards to respond to recommendations and make

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[7] Safe2Say Something Annual Report 2018-19 School Year

[8] School Safety and Security Grant Program Recipients: April 30, 2019

necessary improvements as identified in a school's safety and security assessment 2). Provide for a referendum exception to finance eligible uses under the school safety and security grant program. This provision is vitally important because the school safety law requires school entities to supplement, not supplant, local funds with the safety grant dollars. As noted above, requests for grant funding far outstrip the resources appropriated for the grant program, so districts must have a mechanism to fund necessary improvements via their own budgets.

AMEND SECTION 333(F)(2) OF THE ACT OF JUNE 27, 2006 (SP.SESS. 1, P.L.1873, NO.1), KNOWN AS THE TAXPAYER RELIEF ACT, TO INCLUDE:

(x) Costs to implement any recommendations or address any problems identified by a school safety and security assessment that meets the criteria established under Section 1303-B of the Public School Code, or to fund the annual costs of programs that address safety and security listed in Section 1306-B(J) of the Public School Code.

2. Establish a dedicated, recurring funding source for school entities to employ and retain school-based mental health professionals

PSEA supports the approach outlined in Senate Bill 1213 of 2018 (Langerholc), with a few minor modifications. SB 1213 would establish the "School Student Mental Health Assistance Augmentation Account" as a restricted receipt account within the General Fund. All money deposited into the Account would be used to provide grants to school entities to employ and retain mental health professionals.

PSEA recommends narrowing and redefining the list of professionals for which grant funding may be utilized under this model to include those who are specially trained and properly certificated to practice in a school setting. PSEA recommends using the following definitions when referencing these school-based specialists:

(1) A school counselor *- an individual who holds a valid certificate for Elementary and Secondary School Counselor issued by the department which qualifies the individual to be employed by and working within a school entity.*

(2) A school psychologist *- an individual who holds a valid certificate for School Psychologist issued by the department which qualifies the individual to be employed by and working within a school entity.*

*(3) **A school social worker** – an individual who:*

(1) holds an educational specialist certificate for school social workers issued by the department;[9]

(2) meets the exception for a school social worker as provided under section 20(a.1) of the act of July 9, 1987 (P.L.220, No.39), known as the "Social Workers, Marriage and Family Therapists and Professional Counselors Act"; or

[9] Pending creation of an educational specialist certificate for school social workers by PDE

(3) holds either a social worker license issued by the Department of State or another certificate issued by the department prior to the department's development of an educational specialist certificate for school social workers.

ENSURE THAT SCHOOL-EMPLOYED MENTAL HEALTH PROFESSIONALS ARE PROPERLY TRAINED AND CERTIFICATED

To qualify for professional employment in Pennsylvania's preK-12 public schools, candidates must obtain certification from the Pennsylvania Department of Education.

For more than a decade, PSEA has advocated for the creation of a school social worker certificate. Currently, PDE only requires social workers to be *licensed* to practice in public schools.

A PDE-issued certificate assures that those professional school employees not only possess the requisite content and practice knowledge, but also the requisite knowledge that is essential and specific to student needs, school system structures, policies and relevant laws. Because the provision of mental health services in schools differs from any other clinical setting, it is essential that these services are appropriate to the learning environment.

Certification ensures that mental health services are fully integrated and accountable and staffed by specially trained professionals who are committed to the long-term success of students and schools, rather than a supplemental or contracted service. Mental health professionals cannot be expected to perform their important work in isolation. Having a full complement of properly trained school-based specialists is the most effective and cost-effective way to deliver quality programs and supports.

As the need for school social work continues to rise, certification should be viewed as a means grow and support the future of school social work and the pipeline of professionals that is needed now and in the future. Certification for social workers is necessary to establish a distinct career path, provide the structure for advancement into administration positions, and would bring Pennsylvania in line with most other states and federal law with respect to the role and status of school social workers. Unfortunately, the absence of certification for school social workers means that they are not always recognized "professional employees" for the purposes of tenure, salary, benefits, career path, protections and responsibilities.

Recommendations:

1. Urge passage of HB 390 (D. Miller) which would require PDE to create a certificate for school social workers and apply certification requirements prospectively.

2. Amend the definition of "professional employe" to capture school social workers and other professionals who do not have a corresponding certificate and/or are not explicitly captured in the definition of "professional employee" in the Public School

Code. Because these individuals are not covered by the definition, they are not afforded some of the same rights and protections as "professional employes."

AMEND SECTION 1101(a)(1) OF THE PUBLIC SCHOOL CODE TO READ:

The term "professional employe" shall include those who are certificated, such as teachers, supervisors, supervising principals, principals, assistant principals, vice-principals, directors of vocational education, dental hygienists, visiting teachers, home and school visitors, school counselors, child nutrition program specialists, school librarians, school secretaries the selection of whom is on the basis of merit as determined by eligibility lists and school nurses[.], and those who are employed in professional positions that require a state or nationally-recognized license or other credential and that the Department of Education has determined and announced in a Certification and Staffing Policy Guideline do not require certification under Article XII for public school employment.

SCHOOL SOCIAL WORKERS

PSEA
PENNSYLVANIA STATE EDUCATION ASSOCIATION

School social workers support students' mental, social, and emotional well-being by providing direct and indirect services to students, their families, and the school community, helping our students thrive.

SCHOOL SOCIAL WORKERS ARE TRAINED EXPERTS IN:

Mental Health

Crisis Awareness

Community Resources

Behavior

THEY SUPPORT:

- ✔ **Students** by providing crisis intervention, individual and group counseling
- ✔ **Families** by assisting parents in accessing and utilizing school and community resources
- ✔ **School Personnel** by providing staff with essential information to better understand factors (cultural, societal, economic, familial, health) affecting a student's performance and behavior
- ✔ **School-Community Liaison** by advocating for new and improved community/school service to meet the needs of students and families

RECOMMENDED RATIO:

1 school social worker per **250** students[1]

CURRENT RATIO IN PA:

1 school social worker per **3,416** students

Some counties have **zero** LEAs that employ school social workers

[1] "Cops and No Counselors: How the Lack of School Mental Health Staff Is Harming Students," American Civil Liberties Union, March 4, 2019, https://www.aclu.org/sites/default/files/field_document/030419-acluschooldisciplinereport.pdf

SCHOOL SOCIAL WORKERS

PSEA
PENNSYLVANIA STATE EDUCATION ASSOCIATION

CERTIFICATION

Professionals working in schools should be:

Educated

Trained

Experienced

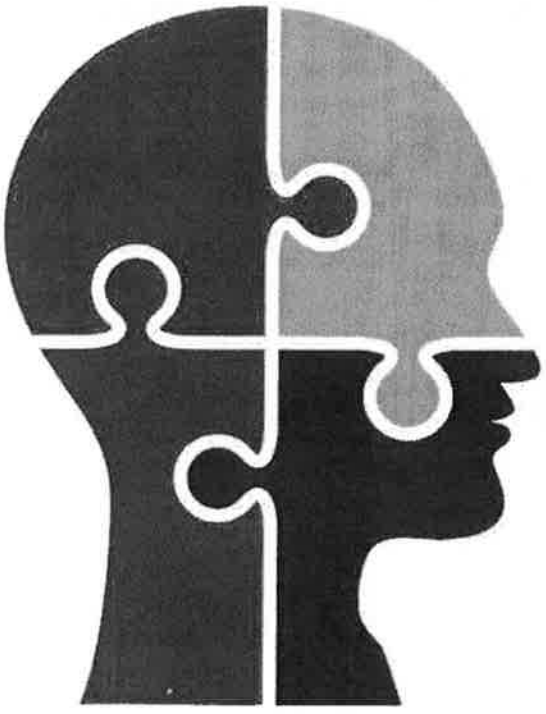
Prepared

SUPPORT HOUSE BILL 390

CERTIFICATION PROGRAMS PREPARE PROFESSIONALS FOR SUCCESS IN SCHOOLS AND FOR STUDENTS.

Employing mental health professionals in schools allows us to serve kids where they are, but there are challenges to navigate when performing this work in a school setting.

CERTIFICATION PROGRAMS PROVIDE PROFESSIONALS WHO:



- ✔ **Understand** the education system and are integrated into the school community
- ✔ **Collaborate** the work of educators, administrators, parents, and their team of specialized instructional support professionals
- ✔ **Commit** to long-term student success and continuity of care
- ✔ **Adhere** to the high standards required for other professionals in schools, including the Educator Code of Conduct and Act 48 continuing education requirements

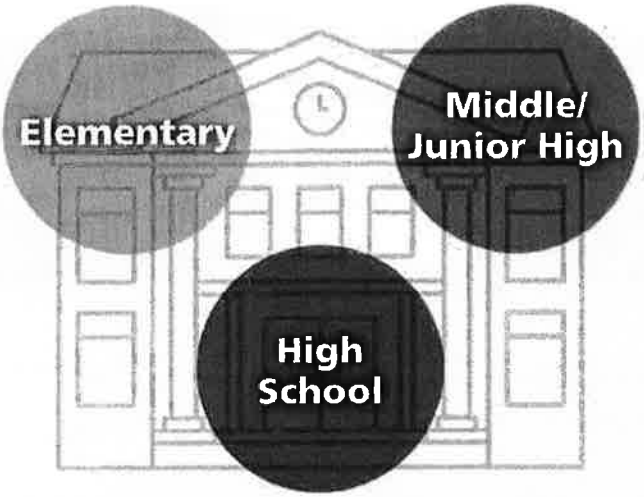
AMERICAN SCHOOL COUNSELOR ASSOCIATION

The Role of the School Counselor

Who are School Counselors?

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

EMPLOYED AT ALL LEVELS



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

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**

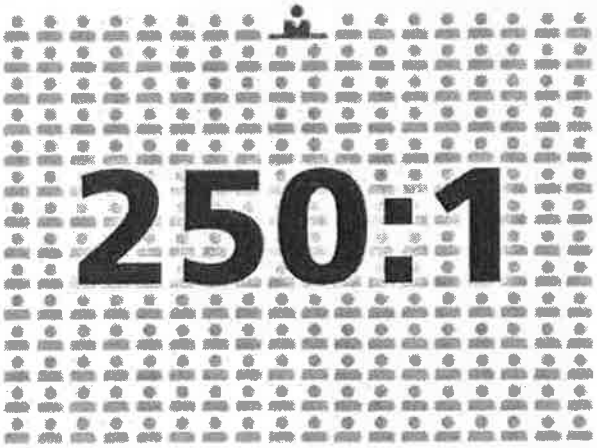
LEADERSHIP TEAM MEMBERS

School counselors are vital members of the education team and maximize student success.

- **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

IDEAL CASELOAD

250 students per school counselor



AMERICAN SCHOOL COUNSELOR ASSOCIATION

For more information, resources please visit *www.schoolcounselor.org*

The School Counselor's Role

School counselors design and deliver school counseling programs that improve student outcomes. They uphold the ethical and professional standards of ASCA and promote the development of the school counseling program based on the following areas of the ASCA National Model: define, deliver, manage and assess.

DEFINE

School counselors create school counseling programs based on three sets of standards that define the profession. These standards help school counselors develop, implement and assess their school counseling program to improve student outcomes.

Student Standards –
ASCA Mindsets & Behaviors for Student Success: K–12 College- and Career-Readiness for Every Student

Professional Standards –
- ASCA Ethical Standards for School Counselors
- ASCA School Counselor Professional Standards & Competencies

MANAGE

To be delivered effectively, the school counseling program must be efficiently and effectively managed. School counselors use program focus and planning tools to guide the design and implementation of a school counseling program that gets results.

Program Focus
- Beliefs
- Vision Statement
- Mission Statement

Program Planning
- School Data Summary
- Annual Student Outcome Goals
- Action Plans
  - Classroom and Group
  - Closing the Gap
- Lesson Plans
- Annual Administrative Conference
- Use of Time
- Calendars
  - Annual
  - Weekly
- Advisory Council

DELIVER

School counselors deliver developmentally appropriate activities and services directly to students or indirectly for students as a result of the school counselor's interaction with others.

These activities and services help students develop the ASCA Mindsets & Behaviors for Student Success and improve their achievement, attendance and discipline.

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

ASSESS

To achieve the best results for students, school counselors regularly assess their program to:
- determine its effectiveness
- inform improvements to their school counseling program design and delivery
- show how students are different as a result of the school counseling program

School counselors also self–assess their own mindsets and behaviors to inform their professional development and annually participate in a school counselor performance appraisal with a qualified administrator. The ASCA National Model provides the following tools to guide assessment and appraisal.

Program Assessment
- School Counseling Program Assessment
- Annual Results Reports

School Counselor Assessment and Appraisal
- ASCA School Counselor Professional Standards & Competencies Assessment
- School Counselor Performance Appraisal Template

SUMMARY

School counselors are certified/licensed educators with the minimum of a master's degree in school counseling and are uniquely qualified to address the developmental needs of all students through a school counseling program addressing the academic, career and social/emotional development of all students.

For research on the effectiveness of school counseling programs, go to *https://www.schoolcounselor.org/effectiveness*

For more information about the role of the school counselor, go to *https://www.schoolcounselor.org/role*

SCHOOL PSYCHOLOGISTS

support students' ability to learn and teachers' ability to teach.

THEY ARE EXPERTS IN

Learning | Behavior | Mental Health | School Systems

THEY PROVIDE

- Academic, behavioral, and mental health supports
- Evaluation, assessment, and data analysis
- Consultation with teachers and families
- Culturally responsive services
- Crisis prevention and response

THEY SUPPORT

- Struggling and diverse learners
- Student achievement and well-being
- Safe and supportive learning environments
- School–family–community partnerships
- School-wide data-based decision making

THEY SERVE

in schools and other educational and clinical settings.

RECOMMENDED RATIO

1 school psychologist per 500–700 students

Lowering barriers to learning is critical to children's success in school.

Contact your school psychologist to find out how they can help.

School Psychologists:
Helping Children Thrive • In School • At Home • In Life

www.nasponline.org

NASP
National Association of School Psychologists

THANK YOU!

CHOP Zero Suicide Workgroup

- Jason Lewis, PhD
- Steve Soffer, PhD
- O'Nisha Lawrence, MD

Want to learn more about Zero Suicide??

Go to - **http://zerosuicide.sprc.org/**

ZERO SUICIDE PROGRAM AT CHOP: KEY MILESTONES

- Staff Training
  - Developed staff training module in suicide prevention and assessment
    - 270 + providers (psychiatrists, psychologists, social workers, nurse practitioners) trained since October 2016 (50+ hours of training)
  - Launching of a CHOP Enterprise suicide prevention learning module
- Implementation of a standardized suicide Assessment Tool- Columbia Suicide Severity Rating Scale (C-SSRS)
- Development of a Suicide Care Pathway
  - Accurate and consistent identification of patients who present with elevated risk for suicide
  - https://www.chop.edu/clinical-pathway/suicide-risk-assessment-and-care-planning-clinical-pathway

ZERO SUICIDE PROGRAM

- Aspirational challenge and commitment to suicide prevention in health care
  - Sponsored by the National Action Alliance for Suicide Prevention and Suicide Prevention Resource Center
  - www.zerosuicide.com
- Provides a framework for organizing and maintaining suicide prevention initiatives
  - **Core elements** – Lead, Train, Identify, Engage, Treat, Transition, Improve
- Collection of tools, strategies, and technical support to improve suicide risk assessment, suicide prevention, and treatment of suicidal individuals

MAIN POINTS (AND EXTRAPOLATIONS)

Children and adolescents report suicidal thoughts and suicidal behaviors at higher rates than adults.

More children die from suicide than from most major medical problems COMBINED

Many youth at-risk for suicide are likely not receiving mental health treatment.

Healthcare systems, communities, and schools can play a role in preventing suicide in youth.

Provided by Dr. Jason Lewis

YOUTH SUICIDE – CURRENT STATE

Suicide is the **2nd** leading cause of death for youth ages 10-24 in the US

In 2017, there were more deaths (ages 10-24) from suicide than from cancer, heart disease, asthma, influenza, and pneumonia combined

22% of HS age girls and **12%** of HS age boys reported suicidal ideation at least once in the past 12 months

Compared to **4.3%** of adults ages 26-49 and **2.5%** of adults ages 50 +

During the years 2011-2017, there were **96** Philadelphia child deaths (under age 21) attributed to suicide

Compared to **20** child deaths from asthma and **76** child deaths from cancer

Data from *CDC, NIMH 2017 National Youth Risk Behavior Survey,* and *Philadelphia Child Death Review Report 2011-2017*