

Good Morning. My name is Kathy Whalen, and I am the Administrator of Juniata Valley Behavioral and Developmental Services. My Agency is located in Central Pennsylvania and our service region is Huntingdon, Mifflin and Juniata Counties. Each County is designated rural where poverty levels across the three Counties is 10 to 13%. Our Counties experience many challenges not unfamiliar to other rural Counties. Such as attracting providers, recruitment and retention of qualified staff, and the biggest challenge is transportation to access those services. It is my pleasure to appear before you to discuss mental health in schools from a rural perspective.

The COVID-19 Pandemic has impacted the world in a manner that we will be experiencing the repercussions of for years to come. Our most valuable, vulnerable population and our future our children have experienced the trauma of grief and loss, isolation, food and housing insecurities. Children are experiencing higher levels of anxiety and stressors as a result of virtual learning. Each of these factors have the potential to lead to negative outcomes such as increased mental health concerns, substance abuse and increased risk of suicide. Have we placed enough emphasis on programming for children's mental health? I can speak to what programming we have seen to produce successful outcomes for children they serve.

It has been our experience that a variety of programming for children is required to meet the diverse needs encountered.

We do have Providers who offer traditional Out-Patient Counseling, this works for some families. For many transportation is their biggest challenge to receiving consistent services to address the concerns with success.

We have found that School Based Mental Health programming provides opportunities for consistency, in addition to addressing concerns/issues in real time thus leading to positive outcomes. Working collaboratively with school personnel and families provides the child with opportunities for achieving success in the home and learning environment.

Our school based mental health teams can serve up to 18 children at a given time, depending on the needs of the children and families. A team consists of 1 to 2 bachelor level Behavioral Health Technician(s) and 1 master's level Mental Health Therapist. The team works collaboratively with school personnel and families. The team does offer summer-based programming. During COVID-19 many of

the teams continued to meet via Zoom. Not the best means of therapy for children, but it did assist in consistency and levels of functioning were maintained.

Each of the school districts in our region either has a School Based Mental Health Team or a Social Worker. In addition to the support of a Student Assistance Program. The primary goal of SAP is to identify and address barriers to a student's learning. This includes the identification of key behavioral health issues impacting students, including alcohol, tobacco, drugs, and mental health issues which pose a barrier to a student's success at school. Historically, these programs have been underfunded.

The Tuscarora Intermediate Unit #11 has been working on the development of a Partial Hospitalization Program for grades 6 to 12 to meet the needs of those with high acuity. This program will be able to serve 20 adolescents at a time. The goal is to keep the adolescent in their home, thereby, avoiding the high costs of placement outside of their family home.

As good as the planned services are provided to meet the needs of our children, the recent changes to the Behavioral Health Rehabilitation Services (BHRS) to Intensive Behavioral Health Services (IBHS) which changed the staffing qualifications for service provision to children and adolescents. This change has created a scenario where staff who have been providing services for years, now find themselves not qualified. Recruitment of qualified staff to provide services to our children/adolescents is at a critical level. The decrease in manpower directly impacts meeting the growing demand for services. Wait lists now are a norm.

In present time we are seeing children and adolescents presenting themselves needing a higher level of care such as In-Patient services or an RTF to protect their health and safety. It is not unusual for children and adolescents to be sitting in the Emergency Room waiting for a bed for 3 or more days. Finally, if a bed is found it may be for In-Patient services in another state. Imagine sending your 8-year-old who is experiencing a mental health crisis and has been sitting in an Emergency Room for 3 days waiting for a bed, being accepted to an In-Patient program in Maryland. I would be terrified for my child. This is a true story, due to a lack of In-Patient beds due to the high demand. As children/adolescents are holding onto an In-Patient bed while waiting on an RTF placement slot. Because of this back-log community-based services are serving children/adolescents with much higher needs in their home and community. Creating the situation of community-based services being reactive rather than proactive. We as providers are losing critical time to achieve positive outcomes for the children/adolescent and families.

As I stated earlier in my testimony children are our future. If we as leaders do not respond by providing the needed services a generation of children of trauma will become adults of trauma.

Thank you.