HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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Public hearing on Mental Health

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House Human Services Committee

Irvis Office Building
Room G-50
Harrisburg, Pennsylvania

Tuesday, July 28, 2020 - 10:00 a.m.

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COMMITTEE MEMBERS PRESENT:

Honorable Thomas Murt, Majority Chairman
Honorable Barbara Gleim (virtual)
Honorable James Gregory
Honorable Doyle Heffley
Honorable James Struzzi
Honorable Tarah Toohil (virtual)
Honorable Parke Wentling
Honorable Mike Schlossberg, Acting Minority Chairman
Honorable Isabella Fitzgerald (virtual)
Honorable Joe Hohenstein (virtual)
Honorable Steve Kinsey

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STAFF MEMBERS PRESENT:

Erin Raub
Majority Executive Director

Emily Kendall
Majority Research Analyst

Kailee Fisher
Majority Legislative Administrative Assistant

Caleb Sisak
Minority Executive Director

INDEX OF TESTIFIERS

SUBMITTED WRITTEN TESTIMONY

SAS
Brandon Greife
Colleen Weldon

(See other submitted testimony and handouts online.)

MAJORITY CHAIRMAN MURT: Good morning, everyone. I'd like to call the House Human Services Committee to discuss mental health, behavioral health and COVID-19.

I'd like to ask my colleagues to please introduce themselves at this time. I'm Representative Tom Murt. I represent 152nd Legislative District, part of Montgomery County and part of Northeast Philadelphia.

Chairman Schlossberg.

ACTING MINORITY CHAIRMAN SCHLOSSBERG: Thank you, Mr. Chairman. My name is Mike Schlossberg, State Rep. from the 132nd Legislative District, representing the City of Allentown and South White Hall Township. I'll be Acting Chairman for the Democrats for today's hearing.

REPRESENTATIVE KINSEY: Good morning. I'm Steve Kinsey representing the City of Philadelphia.

REPRESENTATIVE WENTLING: Good morning, everyone. My name is Parke Wentling. I'm a State Representative in the 17th Legislative District. I represent parts of Erie, Crawford, Mercer and Lawrence counties. Thank you.

REPRESENTATIVE STRUZZI: Greetings. Jim

Struzzi, District 62, Indiana County.

REPRESENTATIVE GREGORY: Good morning. Jim Gregory representing the 80th in Blair County.

REPRESENTATIVE GLEIM: Good morning. This is Barb Gleim representing the 199th in Cumberland County.

REPRESENTATIVE FITZGERALD: Good morning. Isabella Fitzgerald representing the 203rd Legislative District, West Oak Lane, East Oak Lane, and the lower northeast in Philadelphia.

MAJORITY CHAIRMAN MURT: Anymore colleagues with us virtually who would like to introduce themselves?

A VOICE: Representative Toohil, are you on the call?

REPRESENTATIVE TOOHIL: Yes. Good morning, Mr. Chairman. Good morning, everyone. Representative Toohil, Luzerne County, northeastern Pennsylvania, 116th Legislative District.

A VOICE: Representative Davanzo, are you still on the call?

(No response).

MAJORITY CHAIRMAN MURT: Representative Davanzo was with us. I'm sure --

I just have some comments I'd like to

make and then give my friend and colleague, Representative Schlossberg, a chance to say something before we begin.

During this unprecedented time, we're all struggling on a day-to-day basis to adjust to a new normal. Since the stay-at-home order began in March, it suspended most of the in-person appointments. Physicians, psychiatrists and therapists were caught in the midst of how to provide person-to-person care without actually physically seeing their patients.

With the adaptation of telehealth, Zoom calls and FaceTimes, the world around us adapted to that new normal, as did our health care providers. Isolation can be crippling to one's mental health. The anxiety of the stay-at-home order, or even going to the grocery store, became a daunting task for most people.

Although we are not close to seeing the end of COVID-19 pandemic, we wanted to check in with the mental health community and really dive into how they handled the last few months. I do want to add that, anecdotally, we received feedback--much of it good--about how virtual counseling and therapy has been delivered and how

that, in many cases, it has been effective. We want to hear from the people on the ground as to what their experiences has been as well.

I do want to say that this hearing is being held at the behest of my colleague and friend, Representative Mike Schlossberg. Representative Slossberg recognized this is a very important topic that needed to be discussed and vetted, and we concur with him. I thank him for having the foresight to suggest this hearing, and that's one of the reasons we're here today.

So let me conclude by saying, we've invited the Department of Human Services, some health care practitioners, our county health administrators and providers together in one virtual meeting room to discuss this very important topic.

And before we call up the first panel, I'd just ask Chairman Schlossberg if he has anything to add.

ACTING MINORITY CHAIRMAN SCHLOSSBERG: And thank you, Chairman Murt, for both the kind words and for holding this hearing. While this is something that I brought to the attention of the Chairman, it's a conversation that I've had with

countless Democrat and Republican members. We're all very worried about the state of mental and behavioral care in the Commonwealth. We hear rumors, but we don't necessarily have this factual information.

What I'd like to glean out of this is a couple of things. First, I'd personally like to get a better assessment of where we're at from a behavioral health perspective in the Commonwealth today. And second, I want to hear from the experts to know what more we can be doing. There are, unquestionably, things all of us can do, working together, to improve behavioral health during this, you know, nightmarishly difficult moment. And that's what I'd like to do, and I'm looking forward to doing.

Thank you again, Chairman. I'm looking forward to hearing from the experts.

MAJORITY CHAIRMAN MURT: Before we have our first testifier, I just want to thank our executive directors, Erin Raub and Caleb Sisak, and Kailee Fisher and Emily Kendall for the great work that they do; not just today, but every day working in the human services area and moving along very good policy.

At this time I'd like to ask Secretary Kristen Houser from the Department of Human Services to please give her testimony. And, Secretary Houser, before you testify, I just want to thank you for the great work that you and your team have done over the years in the mental health and the substance abuse area. Thank you very much.

DEPUTY SECRETARY HOUSER: Good morning, Chairman Murt and Representative Slossberg, all the members of the Human Services Committee. Thank you for this opportunity.

My name is Kristen Houser. I've been honored to serve as the Deputy Secretary of the Pennsylvania Department of Human Services Office of Mental Health and Substance Abuse Services, fondly called OMHSAS. I just assumed this role on March 23rd just as COVID was beginning to approach our lives. And this is really an opportunity to, hopefully, just begin a discussion.

I think it's actually really quite early to know what the full impact of COVID-19 will be on the mental health and emotional well-being of Pennsylvania. So, I do hope this is the first of several opportunities.

Our office is among thousands of

behavioral health entities across the country that really believe that the behavioral health needs that have been -- that are being created by COVID will be much longer lasting than the acute health care crisis itself, and that the virtual blow-backs will be received for many years to come.

So quickly, the background on our office and on what we do. OMHSAS, in cooperation with other state offices, works to ensure local access to a comprehensive array of quality mental health and substance abuse services are available to meet the needs of citizens across the Commonwealth.

We also provide support and guidance for community-based providers. We are the primary payor for these essential services for 2.82 million Pennsylvanians that are enrolled in the health choices, behavioral health program or Medicaid funded services, for behavioral health in Pennsylvania. And there's some very simple guiding principles.

Number 1, provide quality mental health services and supports that facilitate recovery for adults, including older adults, and resiliency in children. We emphasize and focus on prevention and early intervention, and ensure collaboration with

stakeholders, community agencies and county service systems.

As they said, I think it's really very early days to be able to access the full impact that COVID is going to be on behavioral health, and that's because we are really still in the middle of it. Just to give some baseline information, we know that anxiety disorders are believed to impact approximately 18 percent of the United States population every year. Major depressive disorder and post-traumatic disorder are believed to affect nearly 7 percent and 3.5 percent of the adult population, respectfully.

And, frankly, we anticipate seeing these rates increase as a direct result of how COVID-19 is altering our sense of safety, our access to supports, and our exposure to prolonged stress and things that are resulting in tragedy for many Pennsylvanians.

We recognize that the highly contagious nature of this virus is creating prolonged feelings of helplessness, of hopelessness, fear of the unknown, unresolved grief, and that's not just grief due to death of friends or family, but grief also for a loss of security, a loss of income, our

social connections. And we are dealing with those things without having access to our normal cultural traditions for grieving and for moving through those processes to help resolve those feelings. We have a lot of those supports taken away right now due to what we need to do to try to curb this threat of the virus.

We know folks are certainly concerned for our health and not just for themselves, but friends, family, their children. Economic instability is adding to feelings of anxiety. As mentioned at the opening comments, isolation really may fuel feelings of depression and anxiety. We know that isolation can also add to an increase use of substances or even thoughts of suicide.

I wanted to mention that, just last week I was participating in a training hosted by the National Association of State Mental Health Program Directors, and the director there for the Federal Center for Mental Health Services and Substance Abuse and Mental Health Services Administration was stating that they too are expecting to see an increase in deaths by suicide as a result of the impact of COVID-19. They're making plans to expand access to the National Suicide Prevention Lifeline,

and also looking at expanding grant-making opportunities to communities in an effort to try to increase our capacity to intervene and provide support to people. So, we are not at all alone in our concerns about the very serious nature of the impact of COVID.

I think we had a little bit of a conversation, at least in the media, about the fact that sheltering in place and remaining at home often means for some people that they are sheltering with others to, maybe now or previously were in the past, abusive either physically, emotionally, sexually or verbally. And the need to stay in close proximity to those people and some of the other coping methods or escape that folks might have are no longer available right now.

So, that can absolutely be increasing the sense of hypervigilance about your own safety, sense of being overwhelmed. Shutting down emotionally is how a lot of people get through, again, increased use of substances.

We, again, as life begins to get back to normal and people begin to get back to their lives outside of those environments, we expect to see an increase in behavioral health care needs being made

to the state.

While it's hard to predict the overall impact, we do know that the impact for some groups of people may be more visible than for others. For instance, we know front-line workers in physical and behavioral health care; those who work in safety, emergency response and other fields, they actually might be at a higher risk to develop or re-trigger, re-stimulate post-traumatic stress disorder as a direct result of their work conditions during the pandemic.

I believe in my testimony we include some statements from employees who work at Norristown State Hospital, where we had numerous staff, as well as 81 patients, affected with COVID-19 and did experience some patients' deaths. But people who are talking about the level of fear and panic that the staff feel; the ongoing stress of working in an environment where we know we have very vulnerable populations with vulnerable medical needs, and not only having the ability to control those environments, needing to be out in the world, needing to be on transportation. But, you know, people aren't able to stay home. And dealing with panic and fear was being really experienced as

almost worst than watching the virus spread across the Commonwealth.

Another employee talked about their children having nightmares, regressive behavior such as bedwetting, losing housing, losing income, feeling -- the pull between being able to take care of children and also report to work, so really expressing feelings of being very overwhelmed.

Then, of course, when you were -- when your job is to take care of others and you're unable to take care of yourself, that really creates an inordinate amount of stress and increase for people.

Similarly, aside from work conditions, as I mentioned earlier, people who may have had past traumatic experiences may be re-experiencing senses of post-traumatic stress disorder, anxiety, depression and social isolation, not just because what happened to them in the past, but because the feelings that COVID brings on mimic those that you feel when your life is put in a precarious position or some other traumatic event.

So, you may feel helpless now because you can't control the health and safety of your friends and family, and it brings up those feelings

of helplessness from incidents in the past as well.

As I said, many people -- We have an inordinate ability to mask and suppress our emotions and our feelings in times of duress. It's sort of a Catch-22. I think with humans we are able to protect ourselves emotionally, but sometimes the way that we do that can create longer problems further down the road.

So we know, because we are not out of this crisis, we are still watching rates of infection grow. We're in a changing environment with regard to the economy. The information we're told as we're learning more about the disease, all of that uncertainty for a prolonged period of time can add to the likelihood of re-experiencing issues that have been problematic in the past, maybe people had thought they moved beyond, and now they're coming back and feeling them again.

I wanted to note that in March, calls to the National Distress Hotline saw a 200 percent increase from Pennsylvania. Primarily, callers were asking us to talk about financial concerns, fears around losing their jobs. Here in Pennsylvania, the Department of Human Services and our office launched a statewide Support and

Referral Hotline on April 1st to specifically to try to assist Pennsylvanians who are struggling with anxiety and other emotions due to COVID.

What we had had so far from April 1st to July 13th were taking barely seven and a half thousand calls from Pennsylvanians looking for information about COVID-related health concerns, support and referrals for their own mental health needs, as well as those of family members; referrals for basic needs like food and housing assistance, and also some callers who were truly in a crisis around their -- their life and safety that we were able to do support and also get them some immediate help.

We know, I mean, as I said, it's early to have good information about what this looks like from a ser -- service sys -- system of delivery, but we do have some early information. Through our behavioral health care organizations we know that crisis centers are recording a general decrease in utilization from March through May, as were children's mobile crisis teams and inpatient mental health services.

Admissions to psychiatric hospitals also varied around the state but were down overall. We

really think some of that decrease is, in part, due to the message to stay out of emergency departments, fears of contracting the coronavirus if people went out, and just in general, people who were afraid to leave home because of the contagion, and did not necessarily seek assistance for some of their immediate needs.

Our behavioral managed care organizations have also noted that services for substance abuse disorder treatment, including hospital and non-hospital detox, intensive outpatient and non-hospital substance use for treatment of adults and adolescents also decreased during March, April and May, coinciding with the pandemic.

However, we don't have full data from the other drug and alcohol service providers, and so, we're unable to give it a complete picture of what utilization may have looked like across the Commonwealth. So, that's just those that are coming in through our behavioral health system.

I did want to note that early data does seem to indicate an increase in overdose episodes across the Commonwealth. It's not necessarily resulting in death, but overdoses in general,

between February and June compared to last year's data. So we are watching that carefully and hoping to have some more firm information to share in the future.

As we noted, the use of telehealth has increased substantially, and we were able to blast guidelines to allow for that. It has a recorded mechanism to reach people at home. And we too were very curious about what was that experience like for users, for consumers. And our office has just completed a survey of more than 6,000 Pennsylvanians. We had respondents from 64 of 67 counties. Our data base is incomplete. We're hoping to have that fully analyzed by September or October, but the early results are very encouraging.

Ninety-eight percent of people who responded did receive services at the same rate or greater frequency than they did prior to the COVID pandemic. Fifty-five percent of respondents did report a reduction in canceling or needing to reschedule appointments, so it increased access. Fifty-six percent said that telehealth produced at least one barrier to treatment, like, transportation and child care, family caregiving,

et cetera.

We asked them, too, about their preferences post-COVID. How would you'd like to see telehealth available? Thirty-one percent wanted in-person appointments only, so rearranged our prior system. Twenty-one percent asked for telehealth only. They really liked being able to do it from the convenience of their home. And 47 percent wanted to be able to have both options available.

So, we are really working hard to try to preserve that flexibility and accessibility to strengthen our system of behavioral health care. We think it's important now more than ever.

I also wanted to note, with regard to Pennsylvanians who are needing to utilize their Medicaid system of care, a report from the Pennsylvania Medicaid Enrollment Projections through the COVID-19 Pandemic from our University of Pittsburgh estimated that the results of high unemployment as slow recovery, which is really what we're seeing, can reach up to an additional 1.34 million applicants. So, we -- we could see a significant influx to our system of care.

One last thing. I would be remiss if I

did not note that behavioral health care system did not receive any specifically allocated funding through Act 24 for behavioral health care providers, and that many community-based providers have been significantly challenged financially during this crisis.

We have put in place different alternative payment arrangements trying to get additional financial support to health service providers to get through the pandemic, but nonetheless, they are really strained to keep their doors open, keep their staff safe and healthy, as well as those that they're serving; paying for personal protective equipment, access to testing. We know supplies are difficult for both at times.

They need to pay overtime and incentives, and ensure that we have safe staffing levels. There have been times in some of our facilities where the impact of COVID resulted in incredibly high rates of staff calling off and also being ill. So, that has impacted services in some ways.

We had to hire additional cleaning staff; purchase additional sanitizing equipment, all things to try to keep a safety and healthy

environment; purchasing technology and enabling services via telehealth and telepsychiatry; and also supporting the additional financial administrative burdens that go with needing to -- to utilize quarantine procedures for residents who were testing positive for COVID, and isolating; changing the use of our physical space, et cetera.

Residential treatment service providers also had challenges related to the same things. Some needing to suspend or decrease admissions to mitigate the spread of COVID. We had fewer people seek care which impacted, then, the cash flow for payments and claims, to be able to pay staff, and that system definitely was disrupted.

Experienced decreasing income from reimbursements. Needing to hire additional nursing staff to care for residents who were ill. Some places needed to close entire units to accommodate overflow space for COVID-positive patients and allow for quarantine space.

So, we are collecting data. We are monitoring the landscape of behavioral health care. We are trying to get a handle on what all that looks like. There's definitely is a delay on the type of service to claims, to reporting, and our

ability to analyze that we are paying attention to all of that.

The last thing I'd like to note is that, the complexity of gauging the impact of COVID-19 or any other diaster is really difficult due to what I was saying before; that behavioral health is very unlike physical health. We have within ourselves the capability to ignore or stifle thoughts and feelings that we have during times of duress. It's really a survival mechanism. We may not be able to fully experience things until we are in a more stable place.

And so, it's very possible that it may be months or even a year or more before people are really able to tap into, what did all this do? You know, when you are sort of getting through, putting up, plowing through on a day-by-day, you're not necessarily accessing how the system impacted me; how I'm feeling about it; how my behavior's changed. Did I develop problematic behaviors that are now interfering with my ability to live and function in a healthy way?

So, we are -- we are watching that. And as I said, we really join the rest of the field across the nation and expect the demand for

behavioral health service to increase in the months and years to come.

Thank you for the opportunity to share all of that with you. As I said, I really hope it's the first of many conversations that we get to have about this.

MAJORITY CHAIRMAN MURT: Secretary Houser, thank you for your testimony. We do have at least one question for you, but we're gonna hold the questions until the end.

I know that you've only be in your present position for a few months, but I know that you've been involved in this mission and this ministry, if you will, for many years. Your testimony has reflected that and manifested that.

So thank you very much for the great work, as I said before, that you and your team do. You made some very, very important points in your testimony. We appreciate that. Thank you very much.

I want to recognize that Representative Joe Hohenstein has joined us virtually, and also my colleague, Representative Doyle Heffley, has joined us in person.

Before we ask our second panel to please

come forward, I just want to recognize my wife who is with us today, my wife Doctor Maria Murt. She's a full-time faculty member at Widener University. She wanted to be here today to hear the testimony. So, Maria, welcome. Thank you for being here.

Our second panel will be Doctor Maria Oquendo, Professor of Psychiatry at the University of Pennsylvania. Doctor Oquendo is also the Chair of Psychiatry at the Perelman School of Medicine at the University of Pennsylvania, and also the Psychiatrist-in-Chief, University of Pennsylvania Health Care System.

In addition, joining her will be Doctor Erika Saunders, the Chair of the Department of Psychiatry and Behavioral Health for the Penn State Health System.

Doctor Oquendo and Doctor Saunders, thank you very much for joining us today.

DOCTOR OQUENDO: Thank you so much for the opportunity. Good morning, Chairman Murt, Chairman Cruz, and members of the committee. I'm really pleased to be able to speak with you today about a vitally important topic, COVID-19 and its impact on mental health.

As you just heard from Secretary Houser,

the COVID-19 pandemic has presented unprecedented challenges for the Commonwealth of Pennsylvania and its residents. The impact it has had and continues to have on the mental health of our citizens, essential employees and patients is profound. And I think that there are five features that really increase the impact of the pandemic on mental health over and above what we see in other types of disasters and catastrophes, which also have documented impact on mental health.

First, there's the viral infection or the risk of illness and death. And in a way, this type of impact is not that different from when there's a tornado or a hurricane or an earthquake. It's a very direct threat to the physical and mental integrity of the individual and of the community.

But, if you add to that the fact that people have had to shelter in place and the impact of quarantine, that also has a separate and additional impact on mental health.

In addition, as you know, many of the individuals who fell ill with COVID-19 had very prolonged stays in both intensive care units and in the hospital, oftentimes, most of the time, with no

family visitors, which also, you can imagine, is quite traumatic having that kind of life-threatening condition without the comfort of your family around you I think is very really difficult.

And Secretary Houser mentioned this, that we had a loss of the usual mourning processes, so the usual ways, funerals, gatherings to remember and commemorate someone had been lost, and that, of course, puts individuals at risk for complicated grief. And then, of course, as you're all extremely aware, the economic impact of the pandemic also will have important consequences for mental health in Pennsylvania. And, of course, when you have mental illness increasing, that also has a -- an impact on the economy and productivity.

So, when you think about the imperceptible agent emergencies, things that are chemical, biological, radiological or nuclear, we see sequela across three different domains. So you see psychological consequences like insomnia, anger and irritability, extreme fear of illness even if not exposed; health risk behaviors, like increase in alcohol and tobacco use or social isolation; and decreased perceived health, which is actually associated with decreased life expectancy. In

fact, the CDC has already noted that these psychological consequences are already being exhibited across the country because of the pandemic.

In addition to this, and Secretary Houser mentioned that the psychiatric consequences are not trivial. We see post-traumatic stress disorder, anxiety disorders, major depression, somatization typically after these types of imperceptible agent emergencies. In addition, there are also social consequences, such as discrimination; the types of things that we've seen; for example, health care workers having difficulty of securing a ride home from a driver who might be fearful of picking them up, or stunization (phonetic) of individuals who have been ill.

So, for example, we know from previous information and we still are learning about the consequences of the pandemic today. But, for example, after the exposure to Anthrax in Washington, D.C. in 2001, we saw that almost 25 percent of individuals who were exposed had a psychiatric diagnosis. More than 12 percent had major depression. More than 6 percent had

post-traumatic stress disorder, and anxiety disorders and alcohol use disorders affected 3 percent each.

Interestingly, 5 percent of the individuals who had a disorder after that Anthrax exposure had never had a psychiatric disorder before. And I think this makes perfect sense if you think about the fact that, at any given -- in any given year, about 20 percent of the population will experience at least one psychiatric disorder, so that, you have 25 percent post-exposure makes perfect sense.

Interestingly, the effects of quarantine and social isolation are remarkably similar to the effects of disasters themselves. So, individuals who have to be placed in quarantine are often subject to tremendous stress. They experience depression, irritability, anger, frustration, insomnia, fear, confusion, boredom; and, of course, there's also stigma associated with quarantine if it's specific to the individual being exposed. And we know also about 28 percent of individuals who have to be quarantined experience trauma-related disorders.

Some of the remedies, importantly, are

things like keeping to routines. For example, making sure that sleeping, eating and exercise routines are adhered to; avoiding overexposure to news which sometimes can be very overwhelming, and you're receiving constant feeds through social media or other input about what's happening; and also, emphasizing altruism. And if we have time, I'd happy to talk about that more. I think it's a really unstudied and critically important way of coping.

Also important are the aggravating factors for impact on quarantine, things like greater duration of confinement, and heaven knows that we've had a very long duration of confinement. Inadequate supplies, difficulties securing medical care and medications, financial losses; and also importantly, conflicting messages from government and public health authorities.

I think that the clarity that Pennsylvania has had in directives has been extremely important as a protective factor for our population.

I wanted to also share with you some surveys that have been conducted in April by both the American Foundation for Suicide Prevention and

the Kaiser Family Foundation, and these were studies that were done of over a thousand individuals, each adults. And the reports of anxiety and sadness are above 50 percent of the respondents compared to before the pandemic.

And, interestingly, people are talking more about mental health, so we have seen about a 10 percent increase in conversations about mental health, as well as reports about increased stress and anxiety; about a 20 percent increase in stress and anxiety.

Very interestingly as well, about 35 percent of individuals reported that they were discussing mental health with others about once a week, if they had previously only spoken about their mental health concerns once a month. So you see that people have this very top of mind what the impact is on their mental health.

And so, it's consistent with what I just commented on. Fifty-seven percent of the respondents mentioned that exercise, listening to music, and other distractions helped with the stress. And, 45 percent of the respondents to the Kaiser Family Foundation survey reported that the pandemic had affected their mental health, and

19 percent reported a major effect on their mental health. So you can see, the population is clearly experiencing, in a very salient way, an impact on their mental health.

Of course, as always, there are some individuals who are going to be at increased risk for the psychiatric and psychosocial outcomes. So, for example, obviously, those who contract the disease are gonna be at a higher risk. Those who are high-risk individuals, the elderly, people who are immunocompromised. Those who are living or receiving care in congregate settings are also at increased risk for mental health consequences.

Those who are in the midst of a pregnancy, the understandable anxiety of the unknown consequences for the unborn child is something that is very distressing to expecting parents. Certainly those with preexisting psychiatric or substance use problems are going to be at increased risk for adverse outcomes, mental health outcomes, and those with high exposure to social media.

As Secretary Houser mentioned, health care providers, or on the front lines facing very challenging situations, also are at increased risk

for adverse mental health. And I wanted to spend a few minutes talking about health care providers, because their situation is somewhat unique. Not only do they have risk of exposure to the virus themselves, but they also experience a lot of concern, understandably, about infecting their loved ones; concerned about being able to care for their loved ones.

They're also concerned, understandably, about shortages and personal protective equipment. They face longer work hours, which, of course, increases stress.

And, certainly, early in the pandemic, there was a lot of concern about what it would be like to make the emotionally and sometimes, possibly, ethically fraught decisions about resource allocations. If you only have so many ventilators, who should be assigned a ventilator, for example. That is a very difficult decision for a health care provider to make, and one that in this country we don't often face.

And, of course, the witnessing of intense suffering and death is very stressful for health care providers and also increases risk.

Interestingly, in a survey of a health

caregiver provider -- providers, it was noted that compared to others in the community who are not health care providers, they had a much higher -- health care providers reported a lot more insomnia, almost twice as much anxiety, and almost 50 percent more depression, all at a statistically significant rate. These are our data from a study conducted in China immediately after the pandemic started getting under somewhat better control.

The studies of the effects of quarantine and social isolation on health care providers are also (discernible word). What has been noted is that, not only does quarantine of a health care provider predict post-traumatic stress disorder and depressive symptoms even three years later, but in the immediate consequence, we observe things like exhaustion, detachment from others, anxiety when dealing with febrile patients; irritability, insomnia or concentration, indecisiveness; and also, reluctance to work or consideration of resignation which, of course, poses very traumatic challenges for health care systems; trying to care for the patients inflicted with COVID-19.

In terms of possible interventions, I'll just mention two briefly that I think are very, to

my mind, promising interventions. For example, University of Missouri developed a very rapidly deployable intervention for health care providers who were responding to COVID-19. And they based it on the battle buddy system, which has been developed by the U.S. Army, and its a pier-support resilience intervention.

The idea is that the health system assigns buddies to all of the health care providers, and the buddies unit, wherever it is that they're working, are working on anticipating the kinds of stressors that they're likely to face and planning for them. And then, when they see an individual is having difficulty, they deter further consequences by providing additional support. It's a very simple idea, which is what the beauty of it is.

The health care providers are given these battle buddy pocket cards instructing them to contact their battle buddy two to three times per week or more, daily if needed, and the contact can be quick. It can be a text to check in, a short call to debrief, a Zoom meeting to hatch something out. The point is to listen, validate, and provide feedback, and identify any issues that may need

more support or attention. And also, importantly, to identify any operational issues that may need escalation to leadership.

And they're given sample questions like, what are you worried about today? What went well today, right? So there's a balance of asking about difficult things, and also instilling some kind of health -- rather hope for the battle buddy. And the battle buddies are also given pocket cards that have lists of the stressors that could be anticipated in the context of COVID-19, as well as some of the resilience factors.

I wanted to mention the resilience factors because I think they don't often get a lot of attention, but things like -- And this is something that is relatively easy for health care providers; and, in fact, for those of you who spend your life in public service. So, feeling that your work is meaningful and contributed to the greater good is extremely powerful in terms of aiding someone in developing assistance.

Feeling emotionally connected or supported by someone, also very important. I mentioned already the importance of sleep and having -- staying hydrated and caring for yourself;

keeping your eating routine, sleeping routines, exercise routine; and, importantly, expressing gratitude and compassion for yourself and others.

One of the most worrisome risk factors in what -- is when people feel like they cannot get rest because there's too much work to do. That lack of self-compassion can put the individual at risk for developing worse sequela.

Another very important resilience factor can come from religious or spiritual practices that can help the person feel more centered and connected to their support systems.

At Penn we've developed some web-based interventions that help us screen our health care providers. And one of the beauties of it is that it's completely confidential. People can access it from either their hand-held device or a desktop or laptop, and they're screen using evidence-based tools.

The name of the program is Cobalt, and the idea is that, depending on the level of distress that the health care provider is experiencing, they may be directed, for example, to web-based resources. Maybe they are directed to a mindfulness training resource that's a video -- a

three-minute video on the web. If they're having more trouble, we had trained coaches to provide psychological first-aid and help people with self-care and giving them tools to improve their resilience.

For those who are even further along in terms of developing symptoms or distress, we also had therapists available to provide care. And, of course, for those who are really suffering and already showing signs of significant psychiatric consequences, we also had psychiatrists and nurse practitioners who were able to do medication management. We are in the process of refining the Cobalt program and evaluating the possibility of deploying it to other health systems to help them address their concerns for their health care providers.

So I'm going to stop here, and thank you again for all of your attention and the opportunity to speak with you. And I'm happy to take questions, if you have any. Thank you.

MAJORITY CHAIRMAN MURT: Doctor Oquendo, thank you very much for your testimony and your time today. You raise some very good points. I'm going to ask the members if they have any questions

to please write them down.

Before we ask Doctor Saunders to give her testimony, I just want to mention that many of you know I served in Iraq in combat, and the concept of the battle buddy is a very, very good one. It's a very unsophisticated one, but it's one that the U.S. Army takes very seriously, encouraging soldiers to check on one another and to make sure that they're doing okay; and if they're not, to get someone to behavioral health or to counseling or therapy, or what have you.

So I'm really glad to see the professionals in the field have reviewed that approach and have found it very effective, because I can tell you, in a combat situation in Iraq, it was very effective. So, thank you.

Our next testifier is Doctor Erika Saunders, the Chair of the Department of Psychiatry and Behavioral Health for Penn State Health. Doctor Saunders, thank you very much for being with us today, and we appreciate your willingness to share your testimony.

DOCTOR SAUNDERS: Thank you very much. And good morning, Chairman Murt, Representative Schlossberg, and the members of the committee. I

really thank you for your attention to this topic and for allowing me to share some thoughts with you today.

First of all, I want to just emphasize that what you -- that I completely support what you've heard thus far. I think we've had a really rich discussion about the impact of COVID on mental health, and the state of mental health services in Pennsylvania from Secretary Houser and from Doctor Oquendo.

Mental health and addiction were problems that we're facing in Pennsylvania, certainly prior to the start of COVID-19, and given the statics that you've heard about mental illness and addiction, chances are every person in this room has a family member, loved one or friend affected by mental illness or addiction. I certainly have.

I've seen the devastation that's caused by mental illness and addiction on a personal as well as a professional level, including impact on families generation after generation, the ravages of addiction and trauma, families torn apart, the despair caused by loss to suicide, and untreated illness leading to early death.

This is an extremely important topic. And as we've heard, amplified by the impact that COVID-19 has had on our society and our world in the past five months.

We know that one of the most tragic consequences is death by suicide, and, unfortunately, the suicide rate in the Commonwealth was raising prior to this year as well.

We've heard from Secretary Houser that overdose deaths may be rising in this time even more quickly than in the past when we had seen some decrease in overdose deaths in Pennsylvania prior to this time.

We know that mental illness and addiction are brain illnesses. When the brain is affected, mental illness and addiction affect how we think, act, feel and communicate, affecting every aspect of life. But, and including, we have many effective treatments that can be delivered safely and should be delivered safely.

So, we've heard a lot about how COVID has -- COVID-19 has affected people and the mental health system, more trouble accessing care, social supports that are less available leading to isolation, homelessness, food insecurity. Fear has

kept people from accessing treatment that they need, and the front-line workers have been especially impacted, as we're heard. Certainly, the impacts of this tragedy will be with us for years to come.

So I want to talk a little bit more about how we responded to the crisis and kept treating the people who need us, and what we might do going forward.

So, as the pandemic started in March and we needed -- and it became clear that we needed to close our ambulatory psychiatric and addiction clinics for good infection prevention and to reduce the spread of the virus, we did launch a program of telehealth. We were able to transition almost three-quarters of our patients and visits quickly to a telehealth platform, and we swiftly heard good feedback. People were extremely grateful to be able to connect with their treatment team while staying safe at home.

After a few weeks, gratitude and the ability to connect the telehealth was certainly intermingled with the ongoing and increasing stress of staying at home, and the growing impact of isolation and loss of community support.

In my testimony I -- In my written testimony I added some specific details protected for confidentiality, of course, of situations of patients who have benefited from being able to see providers on telehealth. I think a point that was brought up by Secretary Houser, which is really important, is that, it's very important that we have the flexibility to provide the right medical care to the right patient at the right time, and telehealth is one of the options that can get us there.

However, even with telehealth, the more severe illnesses require in-hospital treatment, and that can still be difficult to access in our health care system. Sometimes they are not the right complexity of services to treat patients who need in-patient care. And patients can be stuck in the emergency department or on a medical inpatient unit for longer than is medically appropriate because of this situation.

So, we face exacerbations of the problem that plague our mental health care system before COVID. The telehealth waiver has been enormously helpful. One aspect that we're still struggling with is that, many patients don't have access to

the technology or the Internet or cellular service to use technology for telehealth. And this -- This is an issue that may become increasingly more important. And COVID has caused worse problems with access to care for the most severely ill.

So what have we done in addition to this to assist patients during this time? We've also launched tele-educational efforts for providers, connecting experts in the care of mental health and COVID with community providers using programs like the ECHO program. We've worked with the programs like the PacMAT program to help people with addiction and through the Office of Developmental Program, the ASERT program to help people who have autism spectrum disorder. And we supported our health care worker.

So, what can we do to provide excellent person-centered mental health and addiction care to the residents of the Commonwealth going forward? So, I will offer a few suggestions to consider.

I believe that we need to be able to have the flexibility to provide the right care to the right person in the right way at the right time. I suggest continuing the ability to practice telehealth as it is currently provided under the

waiver for emergency declaration. Of course, telehealth is regulated at the federal as well as the level of the Commonwealth, but I believe that there are things that can be supported by the Commonwealth that can help this along.

We need to have safe and accessible care. So, when medically appropriate, seeing people by telehealth services and being -- having flexibility in the originating site and the geographical restrictions around mental health services; providing comprehensive care; being able to provide all of the different types of care that we provide to people, including group psychotherapy through telehealth services, and supporting the ability of providers to deliver that care with financial models that can support the treatment services.

I think we need to protect our most vulnerable residents who have the most severe psychiatric illnesses and those in crisis. Our county crisis teams have been affected by the COVID pandemic, and in some cases have struggled to provide services. This need to be addressed as our county crisis system is an extremely important system for getting care to those who need it and

who are in an emergency situation.

The Mental Health Procedures Act is an act that's extremely important in regulating and governing how our patients who are in crisis get treatment and deserves some attention.

Housing can be an issue for our severely and persistently mentally-ill population, and we know that people who are homeless get into a cascade and a spiral of events and situations that dramatically reduces and worsens health and well-being.

Additionally, I would suggest considering that we need a larger workforce with more qualified psychiatrists in the state. The Commonwealth of Pennsylvania is home to several world class medical schools, hospitals and health systems that are at the cutting edge of providing the best medicine, discovering new treatments and innovations to improve health care.

What can we do? We can fund graduate training spots and psychiatric training programs, and think about things like loan forgiveness programs for psychiatrists who continue to serve the Commonwealth after graduation. We know that we particularly have a problem in many rural areas

with lack of psychiatrists, and there are ways to address this.

When people are at their most ill, we need to have a way to treat them. So thinking about how our most severely medically and psychiatrically ill patients are treated in hospitals is an area that deserves some attention as well. Sometimes the psychiatric units are unable to take people with severe aggression safely, and that is a problem.

So I will conclude. And, in short, I want to say that the Commonwealth of Pennsylvania has access to the world class psychiatric and behavioral health care for residents. The challenge is to strengthen the system of care that we have in a way that allows the focus to be on the residents who need that care.

Thank you very much.

MAJORITY CHAIRMAN MURT: Doctor Saunders, thank you very much for your testimony. I just want to thank you for being candid. Towards the end there you made some specific policy recommendations that I find very helpful. I know Chairman Schlossberg feels the same way about things that the legislature could be doing and

should be doing to make things better. So, thank you very much for your candor.

DOCTOR SAUNDERS: You're welcome.

MAJORITY CHAIRMAN MURT: Our third panel will include Gerard Mike, Administrator of Beaver County Behavioral Health Agency who is going to testify remotely.

Mr. Mike, are you with us?

DOCTOR MICHALIK: Mr. Chairman, I'm going to lead off. This is Doctor Ed Michalik.

MR. MIKE: Yes. And then I'll jump in right after Ed, if that's okay.

MAJORITY CHAIRMAN MURT: Sure. Okay.

Doctor Michalik, thank you very much. Ed Michalik is the Mental Health Administrator for the Berks County Mental Health and Developmental Disabilities Council. Thank you both for joining us. You're both members of the third panel. I would ask you now to please give your testimony.

DOCTOR MICHALIK: Thank you. Chairman Murt, Chairman Cruz, Chairman Schlossberg, and members of the committee, good morning.

On behalf of Gerard Mike and all of our colleagues across the Commonwealth who serve your constituents, we want to thank you for inviting us

to participate and for the privilege today of participating. I am Doctor Ed Michalik, County Mental Health/Developmental Disabilities Administrator in Berks County.

Gerard and I are here to speak about the critical role that county mental health programs continue to play in the COVID-19 response.

First, county programs have used every tool at their disposal to address problems this pandemic has created, and continue to provide the highest level of service for those individuals and families that so desperately rely on them. We are confident that the county-led initial response helped to save lives. Working with all of our partners, including lawmakers, the administration, providers and the whole of every county's human services team, we filled the gaps that the pandemic created quickly and efficiently.

Second, perhaps more importantly, we want to look ahead and provide some background regarding our ever-evolving role as we move forward. We are still trying to wrap our arms around the devastating long-term effects that this disaster has had on Pennsylvanians we serve and their families.

We confront some steep challenges in the coming weeks and months. We're going to have to pull together so we can continue to deliver behavioral health and drug and alcohol services.

Maintaining mental health, as our prior panelists have testified, is a crucial part of well-being, and county-based community mental health programs play a vital role in supporting a healthy society. Counties are required to provide certain services, including crisis intervention, support for individuals leaving state facilities, treatment, community consultation and education, day services, and prevention. We are proud of the degree of integrated, physical health and behavioral health services the counties are now delivering.

In light of COVID-19, I would like to provide a brief interview (sic) of the current crisis programming counties are providing. These services are a critical part of the community mental health response in any diaster.

In short order, mental health crisis services remain available 24 hours a day, 7 days a week, in every county in Pennsylvania. Anybody is eligible when they face mental health crisis

regardless of the insurance status or ability to pay. Crisis services are not funded through Medical Assistance, but with state funds.

The county program is the place people call when they do not know where to turn for themselves or a loved one. Most people do not call their family doctor during a mental health crisis. In fact, most individuals face a crisis often call 9-1-1; who are then connected with a county crisis team.

Every citizen shares common concerns in a pandemic, starting with the threat of infection and loss of life. Those who we serve are at an elevated risk and under incredible stress because many, many individuals with mental health concerns also have physical health challenges.

In addition, we know that half the individuals in this country who struggle with a mental health condition will also experience a substance abuse disorder at some point in their lives. These individuals are extremely vulnerable. We cannot quantify right now how the pandemic will impact the web of human services programming that makes up the fabric of our community safety net.

However, we do note that in every county

these services are fully integrated within this web. We work closely with our colleagues in children and youth, aging, substance abuse disorder programming and other services, and we'll need to continue to do so in the future.

At the beginning of the pandemic in Berks County, we saw the crisis numbers were down, as others have noted. However, as the weeks have gone on, our numbers have been steadily increasing with daily contacts in the low 60s. The reason individuals are calling us not specifically rated to the pandemic, but clearly can be contributed to it, issues such as anxiety, agitation, decompensation, substance abuse, relationship issues, and most disturbingly, suicidal ideation.

As we move into a more, quote, normal state, county mental health programs are going to be the ones that for a very long time help many of our most vulnerable pick up the pieces. History has taught us this. This is the same for any disaster; not just this pandemic.

We also know, as we look ahead, that an investment in ongoing counseling treatment and recovery-focused care after any traumatic event is absolutely essential. This care is the best

practice for ensuring individual well-being. It is also a defense against untreated issues that could manifest themselves months or years after the crisis, which you all noted. These challenges can have far more devastating consequences. Our consumers and the cost to treat these conditions are dramatically higher in the long run. All in, early treatment is essential.

Some examples of how Berks County's Human Services programs have responded to the crisis, and this is very similar throughout the Commonwealth that you'll hear from Gerard also.

We have conducted countless provider calls with mental health/developmental disabilities, early intervention, aging, home assistance programs, and school mental health outpatient providers to coordinate local efforts. We have assisted our developmental disability providers with payment for personal protective equipment. We have assisted aging and mental health providers by providing them with cloth masks. We have run billboards and bus advertisements regarding our crisis hotline and text line.

We have worked with and assisted the

Department of Human Services with the coordination of housing homeless individuals who presented in the emergency department of local hospitals, until either they were symptom free or obtained a negative test result. We assisted with the housing of families in hotels who could not access a shelter due to COVID restrictions: 105 adults, 22 children, and one elderly person.

We previously identified emergency housing situations. In-person outreach was also provided to ensure individuals and families had access to essential tangibles, such as food, medication, personal protective equipment, referrals to humanity resources, not only mental health treatment, but countless other services such as transportation to get to medical appointments and county assistance offices.

Clearinghouse for communications between resources and the provider community via e-mail distribution lists, and continued forensic diversion support for individuals on probation supervision, those released from our local jails, and state correctional institutions. As the pandemic took off connecting with those on early release was critically important since community

resources normally access, such as homeless shelters, were simply not accepting new admissions until they were able to do so safely.

All counties have had to be agile, bar none. For example, in some cases staff who were responsible for providing in-home services, which were temporarily suspended or moved to a virtual medium, were tasked with checking in on individuals who may be in need of basic care needs such as groceries or medications.

Staff have worked with our state program offices, such as the Office of Mental Health and Substance Abuse Services, to help ensure that the community-based provider network and skilled staff pool, that has been so painstakingly built over the last several decades will survive this pandemic. We will be able to continue to serve consumers once the crisis has subsided.

In Berks, in partnership with our managed care company, Community Care Behavioral Health, this has been accomplished by establishing in consultation with the approval of alternative payment arrangements for our service providers, supporting individuals enrolled in the Medicaid program, and similarly with the arrangements for

providers supporting our uninsured individuals utilizing block grant dollars.

The purpose of the alternative payment arrangements was to keep providers financially solvent. In the Medicaid slash Health Choices program, $9.1 million has been spent to date. These APA arrangements have been used across the Commonwealth, across all counties.

Telehealth has emerged as an even more essential tool as a result of the pandemic. Telehealth has assisted in meeting the needs for current services and supports, and when used appropriately, has been very effective. The medium has proven to have an astounding participation rate in a population where, for various reasons, such as transportation, child care. Traditional in-person no-shows have been a significant problem.

In our county, we continue delivery of site-based services although at a very limited capacity for safety, such as our drop-in center and site-based psychiatric rehabilitation programs. This was critical in the beginning of the pandemic as access to essential items like hand sanitizer, toiletries. Basic food staples were not readily available, or at a much higher cost for a

population who survives on a very limited income. These providers made sure that all who entered their doors had at least minimal supplies available until other resources, such as food distribution locations, were able to organize. We at the county level are grateful to the partnership with the statement of providers.

Lastly, we need to address the economic devastation that this pandemic has caused for many of your constituents seeking services who may not be Medicaid eligible or have any other type of insurance because they have lost their commercial insurance as a result of unemployment or reduced unemployment. County programs do not have the resources to help support the influx of individuals seeking basic behavioral health services. Counties will end up supporting them through our previously-discussed county-funded crisis system at far greater detriment and cost.

I noted the transition of some services to telehealth. Still, broadband is limited. They're not available in some counties, and we need to desperately close this gap. In spite of the crisis, some counties work with vendors who offer limited, free or discounted mobile time. For that,

we are very grateful.

However, as the pandemic has worn on, many carriers have had to cease this offering. Many consumers cannot afford additional costs of mobile phone-based therapeutic services and supports moving forward. These are life-saving services that these consumers need.

One of the few benefits, frankly, of the diaster is that, once the virus has subsided, the behavioral health programs will be able to more widely incorporate innovations like telehealth and, perhaps, permanently adopt emergency program regulation or add requirement modifications that have been proven to be beneficial in efficiency and effectiveness. The ability to take a fresh look and approach to the way we deliver services to different populations is a tangible positive take-away from this devastating experience.

That concludes the portion of my testimony. And I thank all of you for the privilege and opportunity to spend some time with you this morning.

Gerard.

MR. MIKE: Thank you.

MAJORITY CHAIRMAN MURT: I thank you,

Doctor Michalik, for your testimony.

MR. MIKE: Good morning. I also want to thank the committee for allowing Doctor Michalik and myself the opportunity to participate and share our thoughts this morning.

My name is Gerard Mike. I am the Mental Health/Developmental Services and Drug and Alcohol Administrator in Beaver County. I'm also the President of our Pennsylvania Association of County Administrators, at which is an affiliate of CCAP. Perhaps, maybe the most important I'm a life-long resident of Beaver County where my wife and I raised our two sons, where I've worked for 34 years very proudly in the county's -- with the county's most vulnerable populations. Beaver County is where my brothers and their families reside, as does much of my extended family and a lot of my friends that I've grown up with and care about greatly.

I share this background with you only because, I believe it's common for county administrators, my peers, that have similar ties to the community, which I firmly believe is the root drive behind the commitment to our continued success and service delivery. You simply don't

give up on family and friends. You work until you succeed.

This morning, if I can expand just a little bit on what my highly experienced and knowledgeable Berks County colleague, Doctor Michalik, presented, and talk briefly about the county's program's ability to adopt to social and environmental challenges. I think I can be brief because the presenters stated before me, the hope is that this is just the beginning of the conversation. We're still learning.

We currently don't know what the full impact of the COVID-19 crisis will have on families and individuals in our community or to the behavioral health system. We understand that crises are fluid, unpredictable in nature, but we have responded. I'm proud to say that all 67 of the Commonwealth's counties have responded by keeping support and treatment services intact and fully available, although, most often -- most often now by remote means, but we don't know yet how this pandemic will ultimately change our delivery models, our workforce culture, our society in general.

However, I do believe that given the

opportunity to address you again, as we stated, the other presenters have stated, in the months to come, we will have learned more, and we'll have a better handle on this information.

Crisis situations require immediate action, and I'm proud of the fact that county programs are responding, and we're learning at the same time that we're acting. Each county, each community will have a unique story to tell and lessons learned to build upon, and from these we will develop some new best practice models. This is one of the principal reasons I believe that Pennsylvania's Behavioral Health Choices program model has proven to be so invaluable and successful.

As you all are most likely already aware, Health Choices is a statewide behavorial health managed care program that's been county led for more than 20 years. The program is successful, I believe, because it reflects and responds to county specific resident needs and challenges. Beaver County is not Erie; is not Lehigh. It is not Allegheny County. And the program's ability to adapt to meet the distinct needs of our local population is a success, and it's proved to be

invaluable during the COVID crisis.

In Beaver County, the COVID-19 virus hit a long-term care nursing facility (video issues; muted) facility in Pennsylvania. Positive cases there involved, at last count, at least 332 residents, 113 employees. There were at least 73 COVID-related deaths at this facility.

As these numbers were rapidly increasing in the county, TV and radio broadcasts, newspapers reported on them in agonizing detail. Story after story highlighted family members devastated that they could not be with or comfort seriously-ill and dying loved ones. The emotional impact for our families and for the Beaver County community on whole was great and far-reaching, and the need for support was immediate.

Again, I'm happy to report that we, I think, are wealthy because of our knowledge of the community -- of -- of the -- of the county. We were able to provide that support. We and our provider network were able to do that very quickly.

I believe -- the (video issues; muted). As I mentioned, although at this time we have very little concrete data to share and analyze, our Health Choices MCO -- Beaver County's Health

Choices MCO partner, Beacon Options of Pennsylvania, did pull together a very high level year-over-year comparison of authorizations and claims for 2019 and 2020 for the counties in which they're contracted.

It's still too early to draw any infinitive conclusions from this data, but it does at least enable us to paint a very broad-stroked picture of the impact that COVID-19 -- of COVID-19 on some levels of care and maybe help us speculate on what to expect if the pandemic continues and when it ends and how we might best prepare for that.

Very briefly, because Deputy Secretary Houser did present a good bit of information that we know at this point. But specific to adult behavioral and health services, we have experienced, as you might expect, a decrease in utilization of group milieu services overall.

Inpatient services have also shown a decline. However, none of this was actually surprising and kind of expected given the risk of COVID-19 transmission in group and congregate settings, and CDC guidelines that limit such interactions to reduce exposure.

When the COVID-19 crisis ends or nears end, utilization is expected to climb again quickly to at least pre-COVID numbers, as the fear of contracting the virus will be less and CDC guidelines may likely be relaxed.

And very similar for children services. There has been some variability with regard to the impact of COVID-19, and -- but similar to adult services and most likely for the same reasons that group-based milieu services showed a decrease in utilization. However, utilization of programs that are -- that were -- that are more individualized to the child and the family, and residential services were impacted very little by the pandemic and remain an effective way for us to deliver needed care and support.

Very similar for substance abuse -- or substance use disorder services. You know, also there was a decrease throughout the pandemic for all levels of care. Again, the majority of these services are delivered in group settings. But, as is the case with mental health and child services, individualized services like case management and certified recovery specialists services have remained highly utilized throughout.

As the pandemic continues, I would like to echo Doctor Michalik's observation that in the coming months, scores of Pennsylvanians will be dealing with anxiety, grief, guilt over the loss of loved ones, loss of job or business, or just plain fear.

The stressors are many and varied, and their impact will be real intangible. Family, friends, neighbors will be forced to confront the anxiety and stress associated with long-term isolation and loneliness; the stigma associated with contracting this terrible illness; worry over the lasting impact on the next generation, our children, and our elderly population whom we owe so much, and COVID-19 seems to mercilessly target.

This list goes on and on, but the county behavioral health programs will be there. With your help we'll make it work in the communities we live in and that we're committed to.

Finally, I just want to say as president of our association of administrators, I'm very proud of the way that county programs, in coordination with our state partner program offices, have respond to the COVID-19 crisis. County staff understand their communities and are

able to work within their social framework to quickly and efficiently identify and assist vulnerable populations with what are referred to is social determents of health.

And very simply, you know, what we mean by that is, we make certain that in addition to treatment support, that our vulnerable pop -- the vulnerable populations we serve have a roof over their head, food to eat, a means to get to work, are able to fully contribute and participate in the community.

Counties are vested in working with individuals who are chronically, severely mentally-ill as well as those in crisis. We pride ourselves in doing whatever it takes to support our community, our family, our friends, our neighbors. It's that mentality and success, I believe, that comes from knowing and belonging to communities we serve.

With that, I thank you for allowing Doctor Michalik and myself to present today.

MAJORITY CHAIRMAN MURT: Thank you, Gerard. Thank you, Doctor Michalik. We appreciate your testimony.

We have one final panel today. We have

a testifier with us, Paul Denault, has taken the time to come down from Towanda. Paul is the President of Northern Tier Counseling. Paul, do you mind coming forward and maybe sitting at the table and giving us your testimony in person?

Yes, sir, please. Thank you for being here, first of all.

MR. DENAULT: Thank you for having me.

I'm not sure if I can add much to what Deputy Secretary Houser said in reference to the impact. I can speak to the pros and cons of telehealth. I can speak to what it's like on the front lines right now. It's exhausting.

We did not close any of our services. We represent rural counties, basically, Bradford, Sullivan, Tioga counties, up near the New York border. So, some of the issues that I'll talk about are specific to the rural areas and the problems that we're seeing.

We did, believe it not, we didn't lose any staff. And as of yesterday, we hired an additional 12 staff, one of them being a psyche certified CRNP to help out in our med department. Psychiatry in the rural areas is pretty much impossible to recruit. I don't know why it's a

beautiful area, but we don't have a lot of the luxuries of the cities.

So, we have been continuing to hiring staff. We actually opened up another office during this time period also in the Sayre area, which is closer to the New York border.

So, we transitioned really quickly. Luckily, we have an electronic health record so we were able to just buy more iPads. Fifty percent of our staff are mobile, which means they go out into the community to people's homes, and we have staff-licensed clinicians in 14 schools. Those staff, some of them were pulled back into the clinic to help out because our intakes went up.

We do walk-in clinics, so our intakes increased up to about 130 a month, which was quite a substantial increase for us. Those increases were largely due to people that have not received mental health treatments before. They were people in despair, distress, anxiety, small businessman, people that ran the restaurants; you know, the economic impact on folks. What am I going to do? The anxiety, the distress. So, they're new people coming into the field.

Now, we lost a lot of people clinically

in the field that were in treatment for such things as agoraphobia, social anxieties, other types of phobias, certain types of depressions. People who were, as Doctor Saunders had referred to, that were involved in domestic violence situations. Marriage therapy, they dropped out. So we lost people that needed to really still stay in, but because of the counter-productiveness of telehealth with those individuals and those diagnostics, so they were kind of replaced by new people coming into the field.

So my concern is, as things lift and as people start to feel more comfortable, and the spread lessens and, hopefully, we get a vaccine, I think we're going to be bombarded. I think the new people that came in, hopefully, will be less distressed. But I think all the people that have been kind of dropping out of care are gonna all flood back in. So we're going to continue to hire.

My staff has been fantastic. I can't give them enough credit. I'd like to thank Deputy Secretary Houser, her rural folks out of Scranton, that's our regional manager for OMHSAS, called me every week, helped us get equipment, helped us get grants. They were very, very helpful. So they

called every week out of moral support, so I wanted to thank OMHSAS for that.

So that's our organization pretty much in a nutshell. We're pretty diverse. We have started free telehealth and continue for, you know, mostly it's nurses and doctors from the local hospitals, and some of the folks from the nursing homes are quite distressed. So we do provide free telehealth for those individuals or any essential worker: Firemen, policemen, et cetera. So we continue to do that.

Major effort from our HR department is to keep morale up, so we're trying to do a lot of fun things in-house; lunches; just morale boosting stuff which was in the back of my mind, but our HR department has done a great job because our staff are stressed. So a lot of our staff have also engaged in a buddy system, or getting internal EAP work from other clinicians that are handling it a little better.

So, a lot of pros in reference to telehealth. I have not seen, and this is reported back from our med management department and outpatient clinicians. Better services as far as show rates to our Medicare patients. Our Medicare

folks, a lot of times, missed their appointments, forget their appointments even though we call them and remind them; can't get there because of transportation.

So once we were able to educate and have our peer support staff help them get set up, our Medicare patients, it's been the best service I've ever seen them have, and I've been in the field over 25 years, so that's a big pro for us. We service a lot of elderly in our area. It's a convenience, I'll be honest, in reference to our elderly patients getting to care.

It also has been helpful for people that have lost their license as a result of a possible DUI or whatever. We're able to continue with those services. It's been helpful for mobile families that are afraid of having our staff go into their homes, like our family-based or our peer-support services. We have had to utilize our nurses to deliver medications to certain homes because they don't want to even go to the pharmacy. So that's been very helpful.

We also have seen an advantage for the older school-aged children that have already had developed a relationship with their clinician

because we were in 14 schools, so that's been positive.

The schools did add us to their school links, and they added our facility that if their teachers or students wanted to get services through our facility, they could just press the link on their own school website, so that's been useful.

Show rates and outpatient actually went up. Some of this we feel is due to, we're very rural and it can take 45 minutes to get to our closest office, even though I'm spread out. And some of it is because of the convenience, to be honest. Certain folks, it's harder to not show when you're getting a beep on your computer that you have an appointment to make an excuse. So, we also feel that had something to do with it.

Just from a clinical perspective, before I go into the cons, although they're cons therapeutically, and from a treatment perspective from the front lines, the telehealth has been better than not having any service. So as I go through these cons, please keep that in mind.

Our children's manager services felt it was counterproductive as far as quality of care goes. They were not able to engage the children.

They were concerned about confidentiality, especially children with attention deficit disorders or conduct disorders. And then we had a few bad experiences. I talked to one of our docs that treats our autism population, children. She basically says, I'm not comfortable treating autistic kids age 6 or under.

We had one bad experience where a child, even with the parent there trying to coach, got very upset and broke down and cried, et cetera, et cetera. All she saw was a floating head, so we pulled that back. We're not going to be doing services that way.

Trying to treat certain diagnoses, as Doctor Saunders had mentioned, is difficult. The PTSD, the acute stress disorders, certain phobias, depressions, and we're worried about some of these folks because, if we are treating for certain anxiety disorders which involved them taking more risk out in public; going to a movie theatre that they couldn't go to because they have maybe a social phobia, or other types of phobias, or fears or paranoias, a lot of those patients dropped out of care. They said, you know, this is great. I love this social isolation. I like being at my

house. I can get food delivered here. I don't have to deal with reality right now, so I'm dropping out. So we saw that.

From a treatment perspective, that really concerns us. Those are the people I feel -- And it happened quite a bit. Those are the people I feel are gonna be flooding back in when they have to get back out into life.

We do what's called a systematic desensitization with those folks, which works, but it's like baby steps to face their fears or their demons, so we're concerned about that.

We have also seen one of our psychiatrists, who is an elderly gentleman, he is actually doing telepsyche from home. He's transferred a handful of persons, six to eight, to other clinicians because he felt they needed to be seen in person. He couldn't pick up on nonverbal cues. All my clinicians have mentioned that too. I can't tell. I'm asking this question. In the past I would see their knee fidget and I knew I was touching on the core issue, so we can't see the nonverbal cues, which, in a therapeutic relationship is extremely important. I'm sure my colleagues would agree with that.

Couples counseling, forget it. We have had some real bad experiences with that. We cannot assess for safety, as Doctor Saunders referred to earlier.

Domestic violence, again, if they're at the house with their abuser, they're not safe and we can't assess for safety, so we're concerned about those folks. We know and we tell them, you can call your clinician when you're safe or you feel safe or you're outside of your home, or go to your parents and call, some of them have done that, but that's a concern that we have.

Drug and alcohol relapses was already discussed. That's up. Drug and alcohol treatment philosophy and why it's successful is really based on group support: Alcoholics Anonymous meetings, group therapies, those types of treatment approaches. We did start a second IOP, so we have this kind of setup where we might have four or five people on the computer, looks like the Brady Bunch screen, and then we might have three or four people in the group room spaced out.

So, we are trying to meet the challenges, but our relapses have gone up, and we did have one drug overdose death.

We also have externally motivated clients that started not attending their telehealth, and part of that is due to everybody trying to come onto the new normal. So the children and youth entities, probation departments not going to homes to check on people initially, had people kind of saying, okay, it's kind of a free-for-all, and some of those folks have dropped out of treatment too. Now that the court systems and probation is getting back in gear, we're starting to see more of those referrals come back in, thankfully.

I already talked about the domestic violence.

An interesting con to telehealth is what some of my colleagues discussed earlier was boredom. So, our sessions are an hour long, 75 minutes max. We're having trouble because people are so socially isolated and causing symptoms of depression, et cetera, that we're having trouble cutting them off their session to get to the next client. So we are trying to space out based on, maybe, some of the folks that just need, you know, more contact, human contact. So that has been kind of a con, but interesting.

I think one of the major, major issues that Doctor Saunders discussed for our area is, we're very rural and the broadband access to WiFi to our consumers' homes, our patients' homes is poor. So what's happening when we do have sessions, and even if the consumers and the clients of patients do have access to a computer, they might not have enough RAM so it cuts out, or we lose the audio. You know, we can't hear them.

So what we've done is, we might be able to see them, so then we call them on the telephone. We're talking to them on the telephone while we are looking at them on the screen, if the screen doesn't cut out. Sometimes the screen cuts out, too. So, we just try to get in contact with those people. We have peer supports that we have tried to contact those people, go to homes, et cetera, to keep checks on folks.

So, I think we have found a HIPAA compliant platform called Doxy dot me. The Zoom platform was not HIPAA compliant, and in some meetings, groups, it was hacked into by outside resources, so we do not use Zoom. Some of the schools use Zoom, and there's a virtual waiting room that you can make sure you only check in from

that waiting room, so there are some advances.

When we first used Doxy.me, it worked great for the first two weeks into early April, and then it was a disaster because I don't think they were ready for the influx. They have since fixed that, so we continue to use Doxy.me.

Most of our clients, 80 percent or more, are coming back into the clinic. We practice all the CDC protocols, take their temperatures, ask the questions, make sure they have masks. If they don't, we supply masks. One of our programs are severely mentally-ill folks, are schizophrenics, et cetera, have started a project in the program, socially distance with sewing machines and have made masks for our staff, and actually are shipping them to other hospitals, Strong Hospital, et cetera. So that's been actually good for them emotionally, to feel part of the solution instead of a victim of all the fear that's surrounding everybody right now.

I could get into more of the clinical aspects. I just would ask a couple of things of the committee.

One, we are severely concerned about the onset of flu season. Currently, our physicians in

our area, if somebody is showing symptoms of a sore throat or a fever, they're having them go get tested. Unfortunately, the testing is five to eight days. That's going to create a coverage problem for us come flu season. I'm not gonna have clinicians come flu season if I have a dozen or 20 of my clinicians with flu symptoms and their doctors are saying, get tested for COVID, we're going to be in deep doo-doo.

So, my request would be that for front-line workers in health care, if there's any way that we could be prioritized for rapid test results, I'd appreciate that. I think it would help all of our providers across the state. Otherwise, we could see a lot of other problems occur. That would be very, very, very, very good.

I'd also like, as we move forward around the telepsyche aspect, that the professionals could be part of determining what diagnostics could be treated effectively and which ones should not. There are certain phobias and illnesses, and addictions, pornographic addictions, et cetera, where telehealth could be counterproductive. So I'd like the professionals diagnostically to be part of what could be and what shouldn't be treated

through this mode.

I think telehealth is great. It's been advantageous, and it's been positive. I just am concerned about what the decision-making process is going to be going forward. We should be doing no harm. Certain diagnoses should not be treated that way.

I don't think I need to really --

MAJORITY CHAIRMAN MURT: We're going to ask you to stand by because we might have some questions. I have a question for you.

But, before we ask our last testifier to give her testimony, I just wanted to tell you that you told us, I think, what we're looking for. We're looking for people on the ground facing the challenges of delivering behavioral health and mental health services, therapies, in this pandemic climate. You were very blunt, in a good way, candid, and that's what we need to hear if we're going to address this situation in a meaningful way. We appreciate that all. Thank you very much.

MR. DENAULT: Thank you for having me.

MAJORITY CHAIRMAN MURT: I have been to Towanda numerous times to see Representative Pickett, and to discuss with her some issues

relating to insurance, so I know that area pretty well. I'm from Philadelphia.

MR. DENAULT: She's been very helpful, actually.

MAJORITY CHAIRMAN MURT: Okay. Our last testifier will be Cherie Brummans, the Executive Direct of The Alliance of Community Service Providers. Cherie, thank you very much for being with us today. Can you give your testimony at this time?

MS. BRUMMANS: Yes, yes. Thank you.

Good morning, distinguished members of the House Human Services Committee.

As you said, my name is Cherie Brummans, and I am the CEO and Executive Director of The Alliance of Community Service Providers. The Alliance of Community Service Providers is affectionately known as The Alliance is a trade association that represents dozens of human services organizations that happen to employ hundreds of thousands of individuals in the southeastern Pennsylvania area.

Our member organizations provide services to children and adults who struggle with mental health issues, substance abuse disorders,

intellectual disabilities and autism. We are not only committed to providing the best possible care to those in need, but also ensuring that the voices of our member organizations and the individuals and families that we serve are heard and acknowledged.

So I'm here today before the committee to talk about the impact that COVID-19 has had on human services providers, as well as some of the policy levers available that we think will significantly impact in a positive way.

So one of the biggest issues, and these are in no order of importance here or priority, they're all issues, but I want to talk about the serious lack of personal protective equipment available to our providers.

As all of us are more than aware, PPE is essential if we're going to keep our employees and the people we serve safe from COVID-19. Right now a lot of our providers are forced to grapple with questions like, how often do we change our masks, and are there enough fresh gowns, masks and thermometers and other available items to keep us safe? Do we keep COVID-positive individuals on the premises to quarantine and contain the spread to the general community? And if so, how are we

going to keep ourselves safe? As you can see, there's a lot of moving pieces to it.

Obtaining PPE has been an ongoing struggle. Back in April, The Alliance began the process of making a bulk purchase of PPE for our providers. It is now July 28th, and we are still working to complete that purchase because the supply chain has been really slow, it's been unpredictable and ever-changing. The cost of PPE is far above what it should be, and our providers are already working with razor-thin margins to begin with.

So, there must be more funding available and a more consistent effort to provide PPE to those who need it in our industry and across the health care industry. The chaotic system of procuring PPE that we were faced with when COVID-19 first came onto the scene does not seem to have improved much, and clearly that is not acceptable.

In addition to the shortage of PPE, testing has not been universally available, and we cannot get results in a timely fashion. Our former speaker just talked a little bit about that. Residential program workers, they haven't had the ability to do telehealth or telepsyche. They have

had to be on the scene. Other direct support professionals, they're often moving between multiple locations which, as you can imagine, that increases the number of people they come in contact with. So, without widely available testing that includes timely results, we are all at serious risk for contracting COVID-19.

Also with this pandemic has come the switch to utilizing telehealth. And we really appreciate the former speaker in this panel talking about the pros of telehealth. It's been game changing for our providers to be able to connect therapists with patients. This has been a good thing, and in many cases a lifeline to the people we serve.

While there are cons to telehealth, and I would agree with much the former speaker talked about, we do need telehealth to continue past COVID-19 because, by changing the structure, many providers have been able to keep their staff safely at home and working without the need for significant layoffs, and this has been a big deal for us. So, for this we're very grateful, and it's been a good thing for providers overall.

I will say that the switch to telehealth

did not come without significant costs to providers. So, equipping employees with technology at home to provide telehealth, along with the purchase of software, those costs are not insignificant.

The final issue I want to talk about today is a really important one, and that is, the mental health of both workers and the people that we serve.

So this pandemic has been extremely tough for everyone involved. I think everyone can agree with that. And there is no way of knowing if and when this will come to an end. Probably we know it will come to an end, but it makes it really harder for us to deal with not knowing when.

Our essential workers wake up every day knowing that going to work could pose a serious risk to their health and their families, and yet, staying home for some of our people -- for actually many of our people, could mean foregoing a paycheck.

So, we say that we support and admire essential workers, I've heard that in the media over and over and over again; and yet, providers are not reimbursed enough to substantially increase

the amount of money that we pay these employees. I would go as far as to say, it's a huge disconnect between what we say we value and what we're able to do to show those individuals who are risking their lives that we appreciate them and value the work we're doing -- they're doing.

On a related note, we are asking the human services providers be added to the list of essential services for the State of Pennsylvania. The idea that, in the case of a budget impasse, providers would not be paid because they don't appear on that list is unacceptable, and especially in the midst of a global pandemic; cannot pay human service providers will all but ensure that many would not be in existence at the end of the pandemic.

So our employees are not the only people whose mental health is impacted by COVID-19. Most of the people that we serve have been isolated for months. We talked a lot about that this morning. We know that for those who are struggling with depression, substance abuse, disability, and other issues, the lack of social interaction can have serious consequences. Providers who are doing amazing and creative things to keep people

connected to services, while maintaining health and safety of everyone, are working hard.

And I think that these are, you know, only a few of the many issues that plague human service providers and the people that we serve. Because even once we get past COVID-19, some of us will not fully recover. There will be relapses in mental health and sobriety, and some providers will be unable to stay afloat. We know that when support systems fall apart, mental health falls apart.

Many of the children and young people also suffer through difficult home lives. In the City of Philadelphia, I don't think it's unlike many other cities in America, people -- children are often living in homes where poverty, domestic abuse, food insecurity and addiction are actual real realities. Sometimes going to school is the best part of their day.

So, in the pandemic, those issues are only made worse, and the impact and the trauma resulting from this crisis is not benign. COVID-19 will likely continue to affect children and their families for years to come. We need to keep this in mind as we think through how to appropriately

budget for human services in the future.

So, there are several policy levers that I believe would address some of these issues. First, I think PPE must be made more accessible and affordable for providers and their employees. I don't feel this is negotiable. It's essential.

Testing for COVID-19 needs to be more available, and the time frame for receiving results needs to improve.

Telehealth should continue as a means of keeping vulnerable people connected to services. Even when some of us -- many of us are going back to normal, many of the people with preexisting conditions that we're working with will still be unable to leave their homes until vaccines are widely available. We need to funnel more resources into telehealth to ensure that patients are receiving quality care in the safest way possible.

And finally, essential employees need to receive pay that is commensurate with the level of risk of their job. This cannot only be in the form of 10- to 12-week grants. It must be assumed that essential workers would be compensated for the risks they take and the hard work that they're doing.

So, I want to thank you for allowing me to speak before the committee today. I look forward to talking more with each of you in the coming weeks and months on these important issues. I just want to say, we must make sure that we're prioritizing the mental and physical health of all Pennsylvanians every single day.

Thank you.

MAJORITY CHAIRMAN MURT: Thank you, Cherie, for your testimony and for your work in this area. We have some questions. I'm going to ask the testifiers to please do the best you can with the questions.

Our first question will be for -- from Representative Struzzi. Jim.

REPRESENTATIVE STRUZZI: Thank you, Mr. Chairman.

I'd like to thank everyone who presented today. I think this is some really useful and helpful information that we will be able to, hopefully, utilize to provide the services that are needed in our mental health and behavioral health care communities.

From my perspective, our offices, our district offices have had to deal with many people

calling in are stressed over from losing their jobs, over closing their businesses. And I appreciate all the testimony today because I really think this is the hidden health crisis that we're gonna deal for many years to come because of this.

Many of these mental health issues are going to result in physical health issues as well because, even if you don't have a mental health issue per se that you're dealing with, people in our communities are torn right now, torn over the mask issue, over various businesses being opened, various businesses being closed, not being able to receive unemployment. Even at the staff level in our district offices, there's a higher level of stress and anxiety.

But I think my question is, really, if Deputy Secretary Houser is still on the line, and anybody can chime in on this, but I'm a big believer in after-action reviews, you know, in looking how we approached the situation; what did we do right, what did we do wrong? I know many of you have given us a lot of things to build on to provide those services.

But, I think in the initial response to some of this, decisions were made that created a

lot of these mental health issues that we're gonna be dealing with. And, in hindsight, and I know hindsight is 20/20, but looking back, are there things we could have done differently at the beginning of this pandemic to, perhaps, lessen some of these mental health issues that we're discussing today?

(Pause).

MAJORITY CHAIRMAN MURT: Is Secretary Houser still with us?

DEPUTY SECRETARY HOUSER: I'm here.

MAJORITY CHAIRMAN MURT: Okay. Thank you, Secretary. Can you address that concern, to the best of your ability?

DEPUTY SECRETARY HOUSER: Sure, to the best of my ability, certainly.

I think that's a really difficult question because there were decisions made in so many different arenas that all had ripple effects, and sometimes that system in one area have detriments in another.

I think we are looking at some of the processes around our ability to suspend regulations, to communicate, to be consistent across departments, trying to make sure that our

communication is consistent so that we were causing less confusion for care providers.

I think as well, some of the decisions that we made pre-COVID, for instance, around relaxing telehealth and incorporating technology, we certainly didn't see anything like this coming. We could have had more supports in place, more training in place for our professionals to be able to utilize it well and effectively; that we're now, in hindsight, looking back to say, we did the best what we could during the crisis, but we could have, perhaps, been a little bit more forward thinking in our service delivery models to enable, you know, better care during the crisis.

So I do think there are things we are learning. Some things with methods for delivering medication, for medication assistance treatments and some of the perimeters around that. I think our focus was very much in on the system of care; not as much, maybe, on the greater picture on the horizon.

REPRESENTATIVE STRUZZI: I appreciate that. Thank you. I think it's very important that something like this, God forbid it happens again, that we respond appropriately to prevent these

unknown and unseen consequences from occurring. Process mapping I think is so vitally important in how we respond, and I appreciate your response, so thank you. Thank you all for being here today. I really do think this is valuable testimony.

Thank you.

MAJORITY CHAIRMAN MURT: Thanks, Jim. Chairman Schlossberg.

ACTING MINORITY CHAIRMAN SCHLOSSBERG: Thank you, Chairman Murt.

Deputy Secretary, as long as we have you here, one of the great fears that's been touched on by a few folks is that, we're gonna wind up seeing an increase in suicides in the long run. Is there any evidence to indicate so far that that increase is already happening?

DEPUTY SECRETARY HOUSER: My understanding is that right now we are not seeing those numbers. And again, I don't have access to a whole lot of data right now.

I will reference back to the training I was participating in last week with the spokesperson from SAMHSA. I think that we're looking more at the prolonged impacts of loss, loss of finances, ongoing stressors. We're just not too

far into the crisis. I know for many of us it feels like this has been going on for a very long time. But I think, in reality, as the longer it goes on and the less able we are to get back to life as we knew it, you know, that increases people's sense of desperation and helplessness.

Those are some of the thoughts that are, I think, fueling the expectation that we're likely to see an increase. I don't know if any of the other panelists want to add to that.

MAJORITY CHAIRMAN MURT: Paul does right here. So --

DOCTOR MICHALIK: I would like from --

(Cross talk).

DOCTOR MICHALIK: -- we are not in Berks County seeing the increases in suicides yet. But as one of the chairmen noted, the long-term effects of trauma, the longer this goes on is my biggest concern. That could lead to an increase in suicide which is why -- I sought every county. I know this stepped up the support of DHS and OMHSAS to beef up our crisis presence and reaching out to people.

I'm really concerned about the long-term effects of trauma, most importantly than anything right now.

MAJORITY CHAIRMAN MURT: Absolutely. Paul, please.

MR. DENAULT: I'll just make a comment in reference to the new patients that are coming into our system as a result of COVID, because of the loss of their business or their restaurant. These are people that have not been in the mental health system before.

People that have been in the mental health system with a maniac depressive disorder or bipolar disorder they know. My meds aren't working; something's not right. My brain is feeling mushy. I've got to go get some help.

People are just coming into the mental health system that are in severe despair, feeling like failures, losing a family business that has been a family business for multi-generations, those are the folks that I'm fearful that will commit suicide, because it's a quick action to their pain. So I'm more concerned about the new influx of people that have not been in the system previously.

REPRESENTATIVE SCHLOSSBERG: We know so much of it is economic related.

MR. DENAULT: Right.

MS. BRUMMANS: I think we, too, we're

gonna see a group of people for whom, when we get back to whatever we're going to call normal, we're gonna see a group of people who still don't have jobs, whose aid has been cut off, who have -- who look around and say, the rest of the world is getting back to normal, what's wrong with me? I think --

That's a dangerous place for us to be at with people, whether they're already in the system or not, jobs are not going to just come back tomorrow. And, you know, we're looking right now at our legis -- our federal legislators trying to make decisions about aid. I think if something doesn't happen where people who have lost their jobs are not cared for, we might see it sooner than we expected.

DOCTOR MICHALIK: I think we saw with the last economic downturn that the suicides greatly increased. The longer people are unemployed, lost their long-term livelihoods, their families fall apart, and that's why the long-term effects of this are so important.

I couldn't agree more with Cheryl (sic). The longer this goes on, the more problems we're gonna see, from an economic standpoint, when people

lose everything they have.

DOCTOR SAUNDERS: I'd just like to add that there's a very specific biological and neurobiological reason that we have a long event horizon after trauma, and especially prolonged trauma like we're seeing now, which is, that the effects biologically on the brain which we are aware of through studies of neuroimaging and neurobiology take months to -- to occur.

That's why a lot of our treatments take months to work, and the effect of trauma take months or years to realize. So, in so many of the case you've heard so much today about how the impacts are going to be months and years down the road, that's not only because the psychosocial stress accumulates of all of the troubles that we have been talking about, but there's a very specific biological perspective that we know a lot about neuro- biologically about why that happens.

MR. MIKE: Could I just add, too?

I think we are anticipating, you know, there are new folks coming into the system right now. One place we have been successful is our outreach efforts. Health Choices requires that. So, we have been stepping those up.

Telehealth has enabled us to communicate even more than we ever have in the (audio issues).

A VOICE: That's what happens.

MAJORITY CHAIRMAN MURT: I was about to ask about the telehealth issues.

MR. MIKE: So I think we will continue to reach out (audio issues) what purposes were there. Excuse me?

MAJORITY CHAIRMAN MURT: Thank you. Thank you all very much.

I'd like to ask a question, and I think this is probably best directed to Gerard or Doctor Michalik. I have heard from many families concerned that loved ones with seriously mental illness who are repeatedly cycling through the system; going through repeated involuntary inpatient commitments; sometimes being incarcerated, and the repeated failure to adhere to voluntary medication and treatment plans. These individuals are generally well-known to both the local mental health agencies and law enforcement due to repeated cycling through the system.

My question is, has this problem increased or decreased during the COVID-19 pandemic?

DOCTOR MICHALIK: And as, from our perspective, at least from Berks County's perspective, it has decreased because our prison population is not what it once was. People are not out and about; not being arrested.

Many counties have very rigorous forensic diversion programs such as ours, and so many across Pennsylvania. So, I can see it's an added benefit, if there is a benefit, of a pandemic, is that people are not out and about and they're not being committed and -- or ending up being incarcerated. So we're seeing a great decrease.

Just kind of a perspective, we respond to over 12,000 crisis calls a year, and Berks County's commitment rate in terms of involuntary commitments been around 425. So, when you think out of 12,000 crisis calls and we've committed 425, that's not a lot of people. But our prison population is way down. I think we're holding our own now on that.

As communities open up at some point, I hope we are going to open up at some point, once we get vaccines and more effective treatments in place, (audio issues) for that, so you raised a

very important point.

MAJORITY CHAIRMAN MURT: I have another question. But before I do, I just want to see if any of my colleagues that are with us virtually have any questions. Do any of our colleagues have questions for our testifiers?

REPRESENTATIVE TOOHIL: Mr. Chairman, I'm not sure if you can hear me. Tarah Toohil, I have a question. I'm not sure if you can hear me, though.

MAJORITY CHAIRMAN MURT: We can hear you, Tarah. Please go ahead.

REPRESENTATIVE TOOHIL: Excellent. Thank you. And thank you to both chairmen for having this forum and putting forth this information. I think we need to be far more vocal and more educated on this, and this is a great first step. I found this to be very helpful, so thank you to all the testifiers.

My first question for the Deputy Secretary, I wanted to see, Deputy Secretary Houser, on page 2 and 3 you have a small reference to children, and I know you're not Office of Children and Youth and Families. But it was talking about the decrease in utilization, March

through May, and the decrease with the children's mobile crisis team. I didn't know if you could elaborate on that. That's probably a separate hearing with the Children and Youth Committee maybe combined with the Human Services Committee.

All of these adults that are having all of these issues, many of them are in homes with children and the stress of, you know, raising your children, and everyone being sheltered in place. I mean, there's so many stressful triggering situations going on right now. I just wasn't sure if there was something you could highlight for the committee that we should be focusing on.

DEPUTY SECRETARY HOUSER: Thank you.

I think another panelist mentioned, for adults services we were able to transfer a lot of our interactions to telehealth and telepsychiatry. And it is a much more difficult transfer for children services.

We also know, as I stated, that fear of contagion, particularly in those early months, you know, inhibited families from seeking care and being out and about and activating some of those supports.

But as I said, we are still collecting

data, still collecting information, and I'll be more than happy to take that back to our children's bureau. And we do work closely with the Office of Children and Youth. So we can either dig into that a little bit more and get back to you on that.

REPRESENTATIVE TOOHIL: Thank you, Madam Secretary. I mean, it's just of concern especially with the testimony you provided.

I think Doctor Oquendo, what she provided with the shelter in place and the long duration, and families are already having issues, how all of this could be exacerbated, as well as being isolated for long durations with your prior abuser and that situation. So, I know that's more of a children and youth item. But, if the Human Services, if there's something we could be looking at with that, even if it's funding stream.

One item, Mr. Chairman, I just wanted to note -- And Chairman Murt has been excellent with mental health parity. That's something he's worked very long and hard on. I just wanted to see if there's something specific where there's not coverage, or the telehealth, like, if you're talking to your psychologist, are they only covered for five remote sessions?

I know some people have complained that they just can't talk over the phone. It has to be through one of these portals that makes it more difficult to access care. I think if maybe there's legislation that we need to be much more flexible, that's something this committee could focus on, and even to lengthen if people are more comfortable with just a telephone call, without the -- being the person on a Zoom or on a portal, that's a place where now some people are getting care that wouldn't have gotten care before or would refuse to come into the office setting.

So I guess any kind of recommendations like that that you all as testifiers can make that are specific that we, as the committee, can hold onto is very helpful as take-aways, even if it's a written submission.

I know that -- I believe Doctor Michalik had some very good comments, but then I couldn't find the testimony. But it might be that, because I'm not in the room, that I don't see the paperwork.

And then, Mr. Chairman, one more comment?

MAJORITY CHAIRMAN MURT: Absolutely.

REPRESENTATIVE TOOHIL: And then we were talking about funding, and I know it was referenced during the hearing, that Act 24 that -- the fiscal code and Act 24 which had more money in there for nursing homes and senior citizens that that did not translate to more mental health coverage down to our counties, and I did want to just reference that. You probably all are experts so maybe you've already done this.

But, the CARES Act funding, some went directly to the counties, like Philadelphia I believe, and Allegheny. But all of our other counties we distributed that through a vote that we did in the legislature. So, if there is a way that the counties can go to their administrators or to their county council and just mention that --

I mean, there's millions of dollars that were distributed, and I hope to see that you are going to be in receipt of a portion of that funding, if it is necessary for your survival and for enhancement of services.

I just wanted to put that out there with the CARES Act funding; that we have to stay on top of that and how it's distributed.

Thank you, Mr. Chairman.

MAJORITY CHAIRMAN MURT: Thank you, Representative Toohil.

I just wanted to follow up on one of Representative Toohil's suggestions. To all of our testifiers, Paul, and the testifiers that are with us virtually, we are in earnest when we say we need suggestions. If you have policy suggestions, legislation that should be considered, introduced and vetted, to make this situation better, and not just the current pandemic climate, but also just how we take care of our brothers and sisters that struggle with mental illness.

I think it was Doctor Saunders or Doctor Oquendo mentioned that, chances are everybody in this room has a loved one who is struggling with some kind of behavioral health challenge. Former Speaker Turzi used to mention that frequently when we were having discussions about human services, and we always appreciated his support with that.

But, if you have any specific suggestions for legislation, please contact myself or Chairman Schlossberg, and we'll talk about it and get it drafted into a proposal and get it introduced because we, as I said before, we're in earnest about wanting to address this situation in

a meaningful way.

Are there any other questions?

(No response).

MAJORITY CHAIRMAN MURT: I just have one more. Paul --

REPRESENTATIVE GLEIM: I just have one question. Can you hear me, Chairman Murt?

MAJORITY CHAIRMAN MURT: Sure. Representative Gleim, please go ahead.

REPRESENTATIVE GLEIM: It's very quick. I just wanted to thank everybody for being here.

But my one question is actually to Deputy Secretary Houser. I know we've been talking a lot about COVID and the impacts that we're currently facing. But, I'm hoping that your department can be looking now, after COVID, what state needs you will have -- or will need financially through the budget.

I know that, you know, you have -- You're the largest line we have in the budget is human services. But, if you know now that you're going to have long-term effects from this, I'm hoping you have somebody there that is looking outside of the CARES Act dollars and how those long-term effects are going to impact the budget.

DEPUTY SECRETARY HOUSER: Thank you for that. We are very concerned about that and have been looking ahead. It's been certainly, early on, a guessing game, but that is part of why we're asking the managed care organizations for behavioral health, their providers, to be tracking the expenses. I'm hoping that it gives us some parameters to work with so we are making more educated guesses and predictions for our needs moving forward. So thank you for that.

REPRESENTATIVE GLEIM: Thank you. And thank you, Chairman.

MAJORITY CHAIRMAN MURT: You're welcome, Representative Gleim.

MR. DENAULT: Can I comment on that?

MAJORITY CHAIRMAN MURT: Yeah. I ask Paul to please address that. Go ahead, Paul.

MR. DENAULT: Just part of our trade association, we're finding that providers that provided a lot of children services are taking the biggest financial hit, and that's because a lot of our services for children are given right in the schools. So, March, April, May, June, beginning of June, a lot of those services went away.

So the big financial losses for

providers -- Thankfully, I'm diverse enough where I just don't do children services. But I can't imagine if I just did children services, we probably still wouldn't be open. So the children services on the mental health side took a big hit financially.

MAJORITY CHAIRMAN MURT: The unique characteristics of paying for treatment for mental health is unique. Whereas, someone with a broken arm, we can do an X-ray. We can set that arm, put it in a cast; have that person in physical therapy in a couple weeks, and they'll be playing baseball quickly.

Sometimes it takes weeks, months, sometimes even years for someone who's a victim of being in combat or a victim of a sexual assault or a violate crime for -- or child sex abuse. We see victims of child sex abuse coming forward 40 years after they've been sexually abused by a loved one or a scout leader or a priest, or what have you. And it sometimes takes a very long time to peel back that onion for the victim to finally say, here's what happened to me and to get a diagnosis. And then sometimes the individual will be in treatment for years just to come to grips and to

have a calming effect on a person's life.

So, it requires a commitment and an investment of assets and resources. I just think it's important for our policymakers to -- to know that.

One last question I think you can answer quickly, Paul. What is the unique attributes of the rural areas of Pennsylvania that present certain challenges? Is mental health illness more common in rural areas? Is there more depression or bipolar or post-traumatic stress in rural areas, or is it an underserved area or the least practitioners in that geographic area? What are some of the unique dynamics of your area or any rural area in Pennsylvania?

MR. DENAULT: A couple of things. I'm the leader, so I'll start on the finance side of things.

I think the three counties we serve are either at or just over the national poverty percentage index, so I think poverty is one. A lot of the farm communities have gone out of business. And when you have a farm in a family for seven generations and then it's failing under your -- why can't I do it? So, we see a lot of depression with

the farm culture in the rural areas.

I think we have to be very, very creative. As I mentioned earlier, trying to recruit psychiatrists, we've spent thousands of dollars trying to hire recruiting forms, get psychiatrists up there. We've had them actually come up to the county. But then when they see we don't have the amenities of a city, we can't entice them. So, we do have a problem with recruitment of staff.

I recruit a lot of my people from Binghamton. I recruit a lot from Scranton-Wilkes-Barre area, licensed clinicians. So recruitment is a big deal.

Then we have to be creative because of the distance between, you know, geographically, so we do our own transportation. Like I said, 50 percent of my workforce is mobile, so I have like 14 people that are licensed clinicians that go into family homes where children are at risk being placed out of the home, sent to an inpatient unit, because of either sexual abuse or incest or physical abuse, or a drug environment whether it's just neglect and they don't get fed, et cetera. The worst of the worse. So we go right to the

homes and to the schools for those treatments.

Then we have other mobile therapists in other programs for adults and other ones for kids, too, IVHS services.

So, we actually do our own transportation. We hired our own transporters, and we have own vans. We have a fleet of, I don't know, 10 to 12 vehicles, so we have to be more creative. A lot of that on-the-road time is not paid for. So, retention is an issue. When we have people with master's degree that can go and work at Walmart and make more, it's a problem.

So, it's a noble profession. I think it's the noblest of all professions and under-appreciated. In the rural areas, we just have to be a lot of more creative.

Does that answer your question, Chairman?

MAJORITY CHAIRMAN MURT: It does. But I think we, if you don't mind, we can talk again about some suggestions to address that. Because when there's a significant geographic part of the Commonwealth of Pennsylvania, the rural areas, which there are many rural areas in the Commonwealth --

MR. DENAULT: Right.

MAJORITY CHAIRMAN MURT: -- that are being underserved, this is a problem that needs to be discussed. I think it's best discussed in this committee. I know I certainly care about it. I know Chairman Schlossberg has an interest in it as well.

MR. DENAULT: The pros during this has been, our real estate is good because we see people wanting to move out of the cities to the rural areas. Social isolation isn't a big issue because it's a very expanse area, as you know if you've been in Towanda.

MAJORITY CHAIRMAN MURT: I just want to say one thing, and I'll give Chairman Schlossberg an opportunity to say something before we end the hearing.

But, anecdotally, I'm being told that there's going to be a decrease in admissions to nursing programs. And one of the reasons has been, with the pandemic that many perspective nursing majors, young men and women that want to enter the nursing profession, what has happened in the spring semester is that, the clinical experience where nurses learn how to do wound care or

catheterization, things like that, the hands-on activities that a student nurse would learn under the supervision of an RN, BSN or MSN, that this has been done virtually, because institutions of higher learning are concerned for the health and safety of their nursing students, and they've required the clinical experiences to be done virtually.

And this is really a novel concept, and I understand that it's been fairly successful. But a young man or a young woman, the best and the brightest that want to go into the nursing field want that hands-on. Some of them might delay entering a BSN program in the fall until the pandemic concludes, and we have the green phase all around. So, this is something that we might be looking at a shortage of nurses entering the field.

MR. DENAULT: I think, just to emphasize, I think some of our current regulations that require on-site psychiatrists--I do have one luckily--I think that's outdated. I think it's archaic.

The 5200 regs were just revised from a work group that started in 2014. It allows half of the on-site to be covered by a CRNP that's cert -- psyche certified, but there's no way that we can do

staffing and consultations virtually with psychiatrists, especially in the rural areas.

I don't understand why that on-site, when you have licensed clinicians that actually know what they're doing, they're very, very highly skilled people on site, why we can't do some of the psychiatry virtually for the regulatory consultation and staff meeting requirements.

MAJORITY CHAIRMAN MURT: That's the kind of policy amendment that we need to discuss, and we will. We'll follow up with you on that.

MR. DENAULT: Thank you. I appreciate that.

MAJORITY CHAIRMAN MURT: Chairman Schlossberg anything?

REPRESENTATIVE TOOHIL: Mr. Chairman, I'm sorry. Tarah Toohil again. I just have one more question.

MAJORITY CHAIRMAN MURT: Go ahead, Tarah.

REPRESENTATIVE TOOHIL: Thank you so much for your indulgence.

My question, Paul Denault, you just had some good testimony and he referenced children's behavioral health services, children's therapies

that are administered during school hours, that there would be a decrease now in those mental health services, even to the impact where if that's all you've provided in your counseling agency that you may go out of business.

If we could just request to the Deputy Secretary or her staff, if there is a number that's been compiled, if you could get us the number for how many -- the decrease in mental health services that were being carried out in school so we can kind of tear that apart and dissect it and really figure out what's going on with our children with mental health services. Maybe some of those businesses are not at risk if they were doing their PPP program. But, I'm not sure. It depends.

And then, to just put that out there to all of the experts that are testifying right now, as a forefront of all the teachers' minds, grandparents' minds, parents' minds, and children is, are we going back to school? The 500 different school districts are creating a plan to go back to school, and there's cross-sections, obviously, with other entities.

The mental health impact of school having been closed, now having seven months of what

would have typically been your two-and-a-half-month summer, is there any comments from the experts on the closure of schools, maybe not going back to school, and the effect on parents and children?

MAJORITY CHAIRMAN MURT: Tarah, was that a question to the testifiers?

REPRESENTATIVE TOOHIL: Yes, if you'll allow it, Mr. Chairman --

MAJORITY CHAIRMAN MURT: Sure.

REPRESENTATIVE TOOHIL: -- just because it's such a timely question and something that we're all grappling with. And, of course, you know the Governor, depending on the state of emergency, we may open schools and then he may end up closing them. But there's just so much --

Like, what's the mental health in their opinion? Do you have an opinion on the positives of being in school and the impact on children and families as opposed to not being in school, mental health impact?

DOCTOR MICHALIK: My one response would be, it varies depending on the family. In many of our school districts in Berks County, a full 20 percent of parents do not want to send their kids back to school no matter what. They want to

continue online.

We all know that what's best for children, young children, particularly is the socialization and the education that they get, is at safe? Even if they're safe, what will they bring home to their parents and grandparents? We have a lot of grandparents who are caregivers and watching their grandchildren. So what's going to happen with that adds another level of anxiety, and fear and dread.

So, to say -- It's not an easy answer to say what's best. What's best is, I wish the pandemic would go away and the world would go back to normal because, for some children in adolescence online learning works best and it's fantastic that that's expanding, but having many educators in my family, they would all tell you, online learning is not everybody's cup of tea, and it won't be.

The fear that this is striking people's hearts is (audio issues). There's no one opinion on what's best, because even if there was no pandemic, some -- some young people do much better with on-learning and they thrive.

That's probably not a definitive answer, but it's a reflection of the diversity of opinions

within our communities and among educators.

MAJORITY CHAIRMAN MURT: Thank you, Doctor Michalik.

Any of the other testifiers want to react to that?

MR. DENAULT: I just think it's a good point that, you know, I made earlier, that, hopefully, the professionals in the mental health system are able to make the determining factor of who gets treated, telehealth or not. Maybe the other educators should be allowed that same diversity.

MAJORITY CHAIRMAN MURT: Thank you.

DOCTOR SAUNDERS: I'll just add that -- Excuse me. I apologize.

I'll just add that I absolutely agree that shortening the length of the pandemic through effective infection prevention measures is ultimately, I think, the best thing for children and families and communities. And then supporting mental health programs that also are providing care through primary care offices, supporting those primary care offices, primary pediatric offices, as I know there's some support there as well. That's important too.

MAJORITY CHAIRMAN MURT: Thank you, Doctor Saunders.

Representative Toohil, is that okay?

REPRESENTATIVE TOOHIL: Yes, sir. Thank you.

MAJORITY CHAIRMAN MURT: That was a good question, Tarah.

REPRESENTATIVE TOOHIL: All right. Thank you, Mr. Chairman. And thank you all for your help and -- and your expertise.

MAJORITY CHAIRMAN MURT: Okay. We're gonna conclude our hearing.

Mike, are you okay?

ACTING MINORITY CHAIRMAN SCHLOSSBERG: Thank you very much, Chairman.

MAJORITY CHAIRMAN MURT: I just want to thank Herb Logan, our I.T. specialist, for all of your support, and also Justin, our professional photographer, for his support as well. We had another photographer from the Democratic caucus who was with us. Is it Barbara?

(Off-the-record discussion).

MAJORITY CHAIRMAN MURT: Jamie. We want to thank her as well.

Thank you to all the members who

participated. Thank you very much to the testifiers, and we will be gathering up the testimonies. I just want to end with one suggestion or request.

Please let us know if you have suggestions for policy considerations, new legislation, bills and so forth, so we can discuss them and get them introduced. So, thank you very much.

Okay. That's going to conclude our hearing.

(At or about 12:24 p.m., the public hearing concluded).

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C E R T I F I C A T E

I, Karen J. Meister, Reporter, Notary Public, qualified in and for the County of York, Commonwealth of Pennsylvania, hereby certify that this proceeding was recorded by me in stenotype, to the best of my ability via virtual recording, and subsequently reduced to computer printout under my supervision.

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Dated this 16th day of August, 2020.

Karen J. Meister
Court Reporter, Notary Public

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