

School & Mental Health Partnerships

What School District Leaders Should Know When Creating School and Mental Health Partnerships

“The NYS Mental Health System 101”

“A Primer on the NYS Children’s Mental Health System”

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Division of Integrated Community Services for Children and Families

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Creating School and Mental Health Partnerships in NYS

A Special Note from NYS OMH

Challenges and Opportunities Presented by An Evolving Children's Behavioral Health System

The children's public mental health system in New York State is rapidly evolving. There are multiple forces having significant impact upon the many providers and services that the NYS Office of Mental Health oversees, licenses, certifies and funds. These forces present challenges as well as opportunities for positive change. Many of these changes can be predicted but some cannot. The transition of behavioral health services into Medicaid Managed Care and the enrollment of eligible children into Health Homes are just two examples of the massive changes that the world of children's behavioral healthcare is experiencing.

The current state of flux makes it somewhat challenging to offer firm guidance to those wishing to partner with mental health providers. What had in the past been a fairly static field is now transforming before our eyes. The most useful advice to be offered at this point is that schools engage in comprehensive dialogue with local children's mental health providers. Listen to them. Try to understand the pressures they are under and the directions they are going. These providers will be looking to measure their outcomes in new and better ways, they may be struggling with new payment methodologies, they will be forging new partnerships with other healthcare providers, and they may start offering an expanded array of services that support children and families.

It is now, more than ever, critical for schools to explain to these providers what the needs of students and their families are. While services and payment procedures may change dramatically, one thing will remain constant: some children and families need help. It is and will continue to be the job of the public mental health system to help schools and others by offering expert opinion about what kind of help can be offered to each child and family brought to our attention. While the delivery system may evolve, we cannot and will not lose sight of this mission.

Why Mental Health/Education Collaborations are Important to Both Systems

Few would argue that children who come to school hungry are at a disadvantage in achieving the necessary educational standards required to fully participate in their communities as youth and adults. In a like manner, but less recognized is that children with severe mental health problems face significant barriers in meeting the challenges that school presents. Research on the prevalence and negative impact of Trauma and Adverse Childhood Experiences (ACEs) on children and their ability to learn and control their emotions clearly indicates the need for collaborative efforts to meet the emotional needs of children (See attachment 4 for information on Trauma and ACEs). Without early diagnosis and treatment these children will not come to school ready to learn either at an early age or on a daily basis. The Board of Regents and the State Mental Health leadership understand and embrace the need to collaborate to assure that children with mental health needs come to school able to focus on learning. School-based or school-linked mental health services are known as an effective practice in addressing the mental health needs of children that also positively impact school engagement of children and families and the creation of a positive learning environment. For those schools using Positive Behavioral Interventions and Supports (PBIS) the natural fit of school-based

or school-linked services within the PBIS structure has been shown in numerous cases. In addition, the mental health system is supporting universal screening for children to assist in the early identification of social emotional difficulties. The State law addressing mental health in education and implementation of SEDL standards provides an opportunity to work together to create curriculum that is effective. Strong collaboration between schools, other community agencies and the mental health system will only enhance the likelihood of positive outcomes. To develop successful partnerships between schools and mental health providers it is necessary that each system fully understand the expectations and limitations of their potential partners. This document is intended to assist schools interested in School/Mental Health partnerships in understanding the structure and issues that impact the mental health system when entering into such partnerships. A similar document on the education system has been developed for the mental health system's leadership and practitioners.

Core positives for schools include: Increased school engagement of children and families (i.e., student attendance and parental involvement), improved student academic and behavioral outcomes, positive youth development, improved school safety and student engagement due to more comprehensive and consistent interventions at school and home.

Core positives for mental health providers include: Improved outcomes through consistent access to children and families and increased productivity through better utilization of staff.

In effect both systems benefit as children do better in school, at home and in the community.

The NYS Mental Health System in General

For the purpose of navigating systems to create partnerships between schools and children's mental health, the New York State Mental Health system consists of three major components. The New York State Office of Mental Health; County operated and administered children's mental health services; and not-for-profit hospitals and agencies that provides the vast majority of children's mental health services in communities throughout New York State.

The NYS Commissioner of Mental Health (OMH) reports to the Governor and is responsible for developing and implementing statewide policy related to services and supports for children with serious emotional disturbance and their families. Funds dedicated to children's mental health services are established through the State's budget process. While educators will recognize the independent Board of Regents and the State Education Department as responsible for developing and implementing education system policy, it is the Executive Branch's Commissioner of Mental Health who is responsible for developing and overseeing the implementation of policy related to children with serious mental illness. This can be done in conjunction with the legislature or through the development of regulations, policy and funding practices that drive the local delivery system.

While OMH is the key state agency responsible for children's mental health, local county leadership and community-based not-for-profit organizations/agencies or hospitals also play an important role in the delivery system planning process. Key contacts for children's mental health services are generally the Director of the county's Office of Mental Health and the leaders of local Community-based not-for-profit providers. The terminology for county leaders may be different in any given county. He or she may be titled Commissioner or Director of Mental Health, Mental Hygiene, Community Services, or a variation on those terms. A number of counties operate their own clinics that provide children's mental health services. They also provide oversight to a large number of not-for-profit organizations/agencies or hospitals that serve as the primary provider of such services within the state. It is also not unusual for these agencies to provide services in many areas unrelated to children's mental health services and as such their names may not reflect this part of their mission (e.g., a local United Cerebral Palsy).

The State Office of Mental Health (OMH)

The OMH has responsibilities well beyond children's services. The agency is responsible for State operated Psychiatric Centers (including the Children's Hospitals), adult services, forensic services, research and technical assistance, fiscal and audit responsibilities, etc. That understood, the OMH Division of Integrated Community Services for Children and Families is a key office in local mental health/school collaborations. Children's Division staff is in each of the OMH Regional Offices. Regional Offices can be found at: <https://www.omh.ny.gov/omhweb/aboutomh/FieldOffices.html>.

This office also implements key children's initiatives such as HealthySteps, [Project TEACH](#), Family and Peer Supports, and other programs targeted to children and their families that schools should be aware of (See Attachment 3). Another program of great interest to schools has been OMH's efforts related to suicide prevention. Information on these and other programs can be found on OMH's web site: www.omh.ny.gov and www.omh.ny.gov/omhweb/suicide_prevention/. The OMH funded Suicide Prevention Center can be found at: <http://www.preventsuicideny.org/>

OMH licenses mental health clinics and satellite clinics, including those located on the grounds of schools or linked with schools. Outpatient mental health clinics are licensed under Article 31 of the NYS Mental Hygiene Law. They include school-based mental health clinics, which are generally satellites of a "primary" Article 31 clinic.

Role of the County in Delivering Children's Mental Health Services

School leaders are aware that there are 37 BOCES across NYS. The BOCES provide a variety of services and supports to schools. In a similar manner, County mental health departments coordinate mental health services in their region. Their role is similar but not the equivalent of the BOCES.

County leadership, generally the local mental hygiene Director, reports to the chief executive officer of the County (e.g., County Executive) and/or their Community Services Board, and responds to the County Legislature or a Board of Supervisors. It is important to note that, unlike schools which operate on a July to June calendar, counties operate on a January to December calendar year planning and budget cycle. Taking these differences (July to June school planning and fiscal year and the county's calendar year) into account when discussing collaboration may be necessary.

County Directors will oversee, even in large counties, a much smaller staff than generally available to school leaders. Some counties operate their own mental health clinics and as such hire their own mental health professionals while others oversee not-for-profit clinics and satellites that interact directly with schools, the community or a combination of options.

A core principle in establishing school/Mental Health collaborations is that schools wanting to partner with the mental health system should establish a relationship with the county Director of Mental Hygiene. A listing of County Directors can be found at www.clmhd.org

Local Mental Health Providers

Community-based not-for-profit providers are often the primary source of treatment services across New York State. They are licensed by the mental health system to provide mental health services to children either located on school grounds or from community settings, with links to schools often being established. Hospitals also are a large part of the delivery system and some have satellite clinics located on grounds of schools or linked with school programs, especially in combination with school-based health centers. This is especially true in larger cities. As such, these providers of services work closely with counties in determining the need for services and the manner in which services will be provided. These providers often wear multiple hats and are an integral human services provider in their communities.

Funding of the Children's Mental Health System

It is important for schools to understand the funding structure for children's mental health as it will impact what services and supports a mental health provider can commit to. Providers generally must provide specific services to receive reimbursement. Simply put, such programs do not receive a budget backed by local property taxes as school districts do. They must provide reimbursable services to clients and meet other criteria to receive financial support. NYS is moving Children's Behavioral Health Services toward Managed Care, and will continue to be heavily dependent on Medicaid. It is critical to recognize that not all children with emotional/behavioral problems are Medicaid eligible and not all services qualify for reimbursement under Medicaid. For non-Medicaid eligible children, private insurance, if available, can be used but reimbursement also depends on direct service provision and reimbursement is not always sufficient to cover any given service. Providers should make it clear what their limitations are and the policies that will apply in such situations. For example, discussions about children/families with school staff, staff time and transportation cost traveling to and from treatment sessions or conducting of training programs are not direct services to the client and, therefore, in many situations are not reimbursable.

The partners should also discuss how collaboration can improve the cost-efficiency of the clinic. For example, low cost or free use of space, utilities, maintenance, security, etc. can improve the cost effectiveness of the clinic. Considering how the clinic might also provide services to family members who do not attend the school may also be a strategy to improve the generation of resources while addressing significant factors in successful treatment strategies for the child. While schools cannot pay for treatment, the district can contract separately with the provider under very specific circumstances for certain services, generally, but not always, special education IEP driven evaluations or related services, **if** those services do not supplant existing school services and meet other stringent criteria. It is critical to note that such services may be covered under the School Supportive Health Services Program (see below) which allows the school to access Medicaid reimbursement. The service delivery requirements and billing process should be clearly understood to avoid double billing and disallowances. Schools may also contract directly or through the BOCES for screening services.

School leaders should make sure that Mental Health partners understand that under the School Supportive Health Services Program (SSHSP) which governs Medicaid payments to students with IEPs in New York State, only school districts may bill Medicaid for certain IEP services provided to students. This is a federal source of funding for school districts. The State Education Department's web site provides information on the School Supportive Health Services Program (SSHSP) that can be an information resource for providers. It addresses the program requirements including such services as transportation, speech-language therapy and counseling. It differentiates between services provided in the school and those provided by individuals licensed in a profession under Title VIII of the Education Law. Information on the SSHSP can be found at: <http://www.oms.nysed.gov/medicaid/>

Things Educators should know about the System, Culture and Day-to-Day Operations of Community Mental Health Services

School Districts and Community Mental Health providers serve the same children and their families, but operate in very different systems. While the systems have differences, there are also many reasons for working together. It is important that school and local mental health staff understand the structural, cultural and operational differences so that they can work effectively together to address the needs of the children and their families. As mentioned previously, a similar document addressing the education system has been developed for mental health system leaders.

- Mental Health school-based clinics are only one service model and provide treatment and support to children identified as “seriously emotionally disturbed.” School-based clinics are an effective practice of the mental health system due to enhanced access to children and improved utilization and success that results from consistent and comprehensive treatment. Clinic staff does not provide the same services as school district Pupil Personnel Services staff (e.g., School Social Workers, School Psychologists, etc.). They are not intended to duplicate the role of school clinical staff but to provide clinical treatment for children and families in a setting proven to be more effective and efficient than community-based settings. Coordination with school personnel is a critical component to success. See Attachment 1 for a description of clinic and school staff roles and responsibilities and other considerations.
- It should also be understood that while collaboration with schools is a priority, it is not the only service delivery “model” that communities use. The existing system has a variety of community-based programs. While utilization and effectiveness are critical issues, redirecting the system to new ways of service provision is disruptive, as it is in any system. Educators need only consider the difficulty and disruption surrounding changing middle school configurations, reconfiguring a district’s buildings, etc. to understand this dynamic. Mental health staff involved with school initiatives may be leaving a comfortable environment and entering a new and very different structure and need assistance in understanding it.
- The Clinical Directors of county or not-for-profit providers have a great say in programming. Not unlike how Principals, while reporting to Superintendents and Assistant Superintendents, are still the key person in developing and implementing a successful collaboration in their building, the Clinical Director is a key individual in determining what the MH program will do and how a collaboration will work. If either the Clinical Director or the Principal is not showing an interest or having significant conflicts there is a problem with the collaboration that can’t be ignored.
- It is important to understand the structure of the school based mental health clinic. Depending on size, school based clinics can consist of a small number of professionals. Most clinics are satellites of larger Article 31 clinics located in the community and have very limited staffing. Full time on-site support staff is a luxury most do not have. Supervision can be on-site or through visits. Most professional staff is either Licensed Master Social Workers or Licensed Clinical Social Workers, although some school-based clinics may also include licensed psychologists, nurse practitioners, and other individuals who meet Mental Hygiene law criteria as “professional staff” or “clinical staff”. Discuss staffing up front so that misunderstandings can be minimized.
- Just like teachers and Pupil Personnel Service (PPS) staff play significant roles in determining what programs are priorities in their buildings, so do the mental health clinicians in their clinics. Successful collaborations include the staff’s perspective. The local culture and the staff personalities, experience, etc. will often dictate who is a key supporter. Collaboration between clinical and school staff (School Psychologist and Social Workers, nurses and school counselors) is especially important.
- Sharing of information is also very important – but there are critical rules that must be understood. Clinical and school staffs have learned that a collaboration that does not share information and provide a real resource in addressing the needs of the kids runs the risk of losing support. However – see below.....

- ...it is equally important to understand the limitations on the sharing of information. While the education system must respond to FERPA requirements, the mental health system is driven by HIPAA (Health Insurance Portability and Accountability Act) rules. In addition, there are also state laws (Section 3313 of the Mental Hygiene law) that govern the management of client records. Educators should not underestimate the importance of these constraints on clinics and their staff. Violation can result in a number of consequences including removal of a clinic's and the clinician's license. (See Attachment # 2 for more information)
- Without parental consent it is almost impossible to share information. It is critical to show parents why each system needs certain information. This should not be a wish list. It is important to negotiate why information is needed and by whom. Working together to identify joint strategies for responsibilities when working with families who may have concerns about the sharing of information due to a difficult relationship with the school, or any other reason, is a critical step in assuring that parents are best positioned to make a decision about the sharing of information and its impact on MH providers and schools working together toward a common outcome.
- Clinic staff may have limited knowledge of the day to day functioning of schools. Superintendent days can be a very valuable resource for training. While most focus on improving staff instructional skills, there is an opportunity to involve the mental health partners and address training of staff on how a proposed collaboration will work. Consider, as schools work to implement the SEDL requirements and the NYS Mental Health in Education law, the partnership with community mental health providers can be a great asset. For more information on SEDL see: <http://www.p12.nysed.gov/sss/sedl/>

Be Aware of Issues that may emerge and be prepared to address them early on:

- Increased cost to mental health system of putting staff in schools. What ways might the school help to reduce those costs?
- Roles and responsibilities of community mental health and Pupil Personnel Services staff.
- Expectations for crises situations – recognition that this is a school responsibility and that mental health is only part of the answer.
- Schools are many and independent and MH providers must deal with all – Nine schools can result in 9 different models/expectations. This puts great pressure on the MH system.
- Impact on school staff time for collaborative activities can be challenging.
- Impact of providing treatment service on the child's education day.
- An inability to fund all requested services due to financial impact on MH system of Medicaid.
- Possible waiting lists and the impact on public relations with parents.
- Appropriate space for clinicians. Much more important than generally anticipated.
- School districts cross county lines. That may create issues for county-based services. Address this up front to work out solutions and make sure there are no misunderstandings.

Assessing the Impact of Your Partnership

Long-term support for your partnership can be more easily obtained if there are tangible outcomes that support continuation. All partnerships will at some point face pressures from leadership (e.g., new Superintendent of Schools, changes in County or Provider leadership, changes in school boards, etc.) to address the expenditure of funds or other issues. The benefits of the partnership can be more convincing if the partnership addresses how it will measure the benefits prior to such “challenges”.

What are the core indicators that a partnership should consider measuring and why?

- Attendance. A primary focus. Attendance is a key indicator of future school engagement/success in young children and prerequisite for academic success in older youth. Youth engaged in school are far more likely to complete their education than drop out. Addressing mental health issues early will improve school engagement.
- Social/Emotional Development and Learning indicators: The SEDL Guidelines and more information found at: <http://www.p12.nysed.gov/sss/sedl/>
 - Page 16 identifies key measurable markers of school climate:
 1. Violent incidences
 2. School attendance and absenteeism
 3. Student misconduct
 4. Availability of illegal substances
 5. Bullying, harassment, intimidation
 - School discipline indicators. Addressing suspensions and internal discipline referrals is important in getting a handle on the school’s learning environment.
 - Improved school/classroom participation. Could be addressed through school staff/youth surveys on school satisfaction and participation. Other considerations are linking (if possible and appropriate) to existing data gathering systems.
- Improved access to core health, mental health and human services for children and their family. Address impact on utilization and effectiveness of treatment/services and, if appropriate, if the partnership is comprehensive enough (i.e., not just related to access to mental health services but includes social services, health, substance abuse, access to employment opportunities for youth and families (e.g., use of NYS DOL’s Career Zone), after school programs and proactive youth development/delinquency prevention programs, etc.).
- Improved Family participation. Addressing improvements in consistent parent participation in their child’s education (e.g., on-going involvement with their child’s teacher and in key school functions, ability to assist with homework, etc.).
- Outcomes on School State Assessments. Ultimately, the school’s success is in large part determined by these outcomes. Note: Impact takes time. Don’t expect immediate improvement in an area that is very complicated. Patience and persistence is important.

Addressing systems integration indicators: The leadership team should address a number of items to assure that the evolving partnership does not veer off target. Consider:

- Are necessary school/community support groups/teams in place to assure that integration of the collaborative systems is implemented effectively?
- Is there ongoing support of school/community leadership at all levels?
- Are the appropriate leaders on each team?
- Are teams addressing roles/responsibilities, conflict resolution, access to training, etc.?
- As appropriate, are the MH community supports aligned with PBIS levels?

Characteristics of Successful Collaborations

Successful collaborations go beyond simple collocation of services and actively integrate services to form a partnership that can mature and address the ever changing needs of both systems as they evolve. A critical step is to involve leadership right up front. No different than partnerships of any kind, support grows from the relationships and trust built by being involved in key decisions as early as possible. Multiple levels of support are at the core of success in collaborations between schools and mental health for a number of reasons, including when turnover of leadership occurs. For example, support from Superintendents and county and provider Clinical Directors/Commissioners; building level staffs (e.g., educational and clinical supervisors/teachers/social workers, etc.) are all very important. Poor relationships at any functional level can potentially limit the capability of the program to fully meet the needs of children/families and the partners. Work to understand the culture and pressures on your partners. Also read “School and Mental Health Partnerships” document available on the OMH web site at:

<https://www.omh.ny.gov/omhweb/resources/publications/index.html#children>

History of collaboration in NYS and across the country indicates that there are many issues, including cultural issues that impact on collaborations between systems that at their core are often based on misunderstandings. Systems that are successful learn that they have many more commonalities than differences. Both systems are focused on helping families achieve positive outcomes for their children. Both have resources that can assist the other in achieving their primary responsibilities. However, often representatives of both systems feel like the other is only focused on “What can you do for me”. This generally stems from a limited experience with each other and the significant pressures both face in meeting expectations for the children under their care with limited resources. Effective collaborations understand that both systems play a role in the success of each other. A child successfully completing school and participating positively in their community is a goal of both systems. Given all this, it would be foolish to not take the time to understand each other and recognize that the pressures on both systems are very real. Consider:

- **School Districts:** Educators fully understand that schools are expected and publicly monitored on their ability to meet State and Federal standards related to instruction and graduation, health, special education, transportation, safety, English Language Learners, etc. New and evolving curriculum standards and teacher evaluation systems have requirements that are extensive and stringent. The specific certification requirements for staff are a key issue. School student safety requirements (Safe Schools Against Violence in Education (SAVE) law and the Dignity for all Students Act) and the public awareness of them are significant factors in how schools handle disruptive students and address creating a positive educational environment. This latter issue should be fully understood by both partners as they work to establish effective school-wide interventions and their role in implementing them. Schools are also greatly impacted by poverty and other social issues and the trauma they create for children.
- **Community Mental Health Services:** In a like manner, the mental health system, as well as the other human services systems, have their own set of extensive requirements, personnel issues and a greater level of cost containment pressure from county and State government. Growing fiscal issues and pressures on county leaders have made implementation of new initiatives challenging. Chief among them is the roll out of the Behavioral Health Managed Care system that while offering much opportunity to provide a greater range of services, will take time to fully implement and understand as it evolves. The MH system is also impacted, as schools are, by trauma associated with poverty and social issues and the challenges it creates for children and their families. Poverty impacts a growing number of youth needing mental health services and family support services, putting great fiscal and staffing pressure on the system.

Other considerations include:

- Staff members from mental health or other child serving systems and schools are not interchangeable. All systems use social workers, psychologists and assistants in different forms and with different credentials and requirements. For example, it is critical to remember that to provide school social work services, a social worker must be certified by the SED office for Teaching Initiatives as a School Social Worker and hired by the school district. If a local collaboration agrees to share a social worker who would split time between the mental health system and the school district, that person must meet appropriate licensure and certification requirements of both the school and the mental health system and be appropriately employed and funded.
- It is also important for school staff to be sensitive to the fact that county and provider staff of similar licensure (School Social Workers and LCSW) are generally not paid at the same levels as school staff and will be working a 12-month year.
- If you don't set up a mechanism to assure ongoing communication and methods of addressing concerns or resolving disputes it will come back to haunt you! Communication means with the leadership, building staff and the mental health staff. If someone criticizes the program and you say, "I have not heard of any complaints about this program" – it is likely that you already have a communications problem!
- It is equally important to make sure that the partners are able to share successes. Especially in the very beginning, and over time, people tend to focus on the problems and forget to recognize the very tangible benefits of the partnership. For example, work to find a way for both systems to take a look at aggregate data on a periodic basis to see if this collaboration is working. Mental Health workers could look at various outcome measures and share aggregate information, and schools could look at their educational and behavioral outcomes and see if positive changes were noted. Find a way to share success and it will serve you well in building support that will enable the collaboration to survive when the inevitable rough spots do emerge.
- Determine and measure key indicators to enable the partnership to build on effective practices and address areas that indicate ongoing improvements are needed. Link with the school PBIS structure as appropriate. See page 8 for assessment information.
- Like any collaboration it is critical that it meet the needs of all the partners. History shows that school-based mental health collaborations work when all parties feel that the children benefit and the program is flexible enough to meet the needs of both systems. Often compromise is the critical ingredient. In those instances where conflicts arise a successful collaboration has a mechanism to assure timely and fair resolution. If you don't have one – create one that involves staff.
- Assuring access to adequate and appropriate space can be a critical issue. It is recognized that space in many school building can be very valuable. While this may be a difficult issue, it is very important that sufficient and appropriate space be made available to mental health clinical staff who may be working in the schools. Sessions in broom closets (strange but true) are not conducive to successfully working with kids. While building leadership may struggle with this in certain situations, it is important to reach a compromise that meets the needs of everyone. MH Clinicians cannot be viewed as secondary citizens if they are to be effective.

* NYC schools are administered through the NYC Department of Education. While much of this discussion document would apply in partnering with any school in NYS, there are administrative structures and issues that are specific to NYC and are not covered. For information on collaborative school-mental health partnerships in NYC, contact the DOE/Office of School Health, School Mental Health Services at: <http://schools.nyc.gov/Offices/Health/SBHC/MentalHealth.htm>

Family Engagement and Family Supports

A core value of the children's mental health system, both in NYS and nationally, is involvement of families in all decisions affecting their child. Research clearly shows that treating the child in the context of the family results in better outcomes. The mental health system has been at the forefront of creating Family and Peer Support Services as a key component in addressing the mental health needs of a child in the context of their family. School districts also work hard at involving parents. District staff should be fully aware of this core belief in the mental health system as it will often drive decisions. In addition, by working together representatives of both systems may be able to enhance the involvement of parents and extended families which research has shown is a critical factor in successfully addressing the child's mental health needs and improving a student's school engagement. Many schools have found that linkages to family support programs leads to better school engagement. Family Peer Supports and Youth Peer Supports are emerging options that have proven successful. There are a number of good sources of information that can be found on the web. Among them are:

- Families Together NYS: <https://www.ftnys.org/training-credentialing/family-peer-advocate-credential/>;
- The Harvard Family Research Project's FINE Network (Family Involvement Network of Educators): <http://www.hfrp.org/family-involvement/fine-family-involvement-network-of-educators>;
- The National Federation of Families for Children's Mental Health: <http://www.ffcmh.org/>; and
- NYS Office of Mental Health:
 - <https://www.omh.ny.gov/omhweb/rfp/2017/statewide-family-support/>
 - https://www.omh.ny.gov/omhweb/consumer_affairs/transition_youth/resources/youth-peer-advocacy.html

Increasing Family Engagement

Parental notification, engagement and consent are obvious key components to any education and mental health partnership. This impacts both individual student/family actions and more general school-wide initiatives (e.g., behavioral health screening or collaborative social emotional development and learning activities). School personnel will know what methods have worked best to engage families and should assist the MH provider in identifying an appropriate direction to follow. Linking with the school to lend credibility to the collaboration is an option that should be made available to your partners. Make them aware of the different times of the year schools will be planning and preparing packets, in the form of newsletters, calendars, or "back to school" packets that are sent to families. These are potentially important tools to get out the word about the collaboration and access to services and supports. These supports may include early screening for potential behavioral health issues. Districts may contract with a provider or through the BOCES for screening services (See Community Schools COSER in attachment 3). In addition, parental consent for many actions (sharing of information) is required. Some things to consider in addressing the notification of parents include:

- If the focus is to be on screening for young children, districts may want to suggest that linking with kindergarten screening is a fairly good option to consider. It not only simplifies information dissemination and gets to all youth, but because kindergarten screening is so accepted, adding early screening for emotional/behavioral issues enables the initiative to be viewed more easily as part of early childhood screening efforts in general. It rightly becomes an overall health issue. Collaborative efforts at getting information out are also easier to accomplish in this format.

- Back to school nights in the fall and other transition points are great opportunities to get information to parents and assist students in understanding that assistance is available. Transitions from pre-school to kindergarten, elementary to middle school, middle school to junior high or high school generally involve “orientation days” or information nights for parents and/or students. If schools work with their partners to link with them in a discrete way (e.g., part of a school health presentation or information) it can assist in catching the attention of students and their parents.
- Information included in a mailing, web site or other effort will have phone numbers where interested parents can get information if they have questions on the mental health services. It is possible that parents would call the school, so make sure school staff knows where to redirect their calls.
- A letter from the school Superintendent and/or the building Principal supporting the purpose of the request (e.g., screening or an activity focused on behavioral health) and encouraging parent participation may be of help.
- Encouraging MH Provider participation in the School PTA or equivalent parent organization’s events and including the MH leaders in sending information to parents may also encourage parents to consider participation.
- Schools could handle disseminating the notification. If there is a local policy that the school be reimbursed for the cost associated with any mailing, address this up front.
- If schools do a mailing, reach agreement on where the responses should be sent. It is recommended that the original go to the MH provider with a copy to the school district, if the district wants a copy. If all materials are to be forwarded to the provider and the district wants a copy, make sure to address the process in the consent forms.
- It is recognized that there are families who do not fully trust the school. Addressing the best methods of engaging these parents with the MH provider can be helpful. Family support programs, including Family Peer Advocates have been a significant resource for mental health in addressing these issues. These programs often can consider cultural or historical issues and how best to increase parental trust. Consider development of student support groups/structures and link with them in outreach to students and their families. Mental health Youth Peer Advocates can be an asset in this effort.
- Linking efforts with community-based family supports has also been shown to increase involvement of parents of students with emotional challenges, including CSE students.
- Have the partnership research and discuss evidence-based strategies for more effectively involving parents. Information on strength-based, culturally sensitive and family driven decision making can be found on the web site of the National Federation of Families for Children with Emotional Disabilities - <http://www.ffcmh.org/> or a number of other sites.

Social Workers in Schools and Article 31 Mental Health Clinics

One of the major issues associated with school and mental health provider or other child serving system partnerships is the perception that the alliance allows for the partner's clinical staff to supplant existing or reduce the need for future school district clinical staff (e.g., School Social Workers). This perception is inaccurate and has significant licensure/certification consequences as well as resulting in reducing the supports and services needed by children and their families. Given the growing awareness of the significant behavioral health needs of children, this is the opposite of what these partnerships are intended to accomplish.

In order to acquire permanent certification, School Social Workers must be LMSWs or LCSWs. The majority of clinicians in Article 31 clinics are LMSWs and LCSWs. Because of this similarity in licensure credentials, it might appear that school districts could look to Article 31 clinicians to perform the work of School Social Workers, but that is not the case. Under certain circumstances (discussed in more detail below), school districts may contract with Article 31 clinics for clinical social work services, but, under no circumstances can schools supplant the services of a School Social Worker by contracting with an Article 31 clinic or any other entity or person. This is a critical issue and care should be taken to assure all staff that the intent of the partnership is to increase access to school and community supports, not to replace one or the other.

The primary reason for this lies in the training and certification of the School Social Worker position in New York State as part of the teaching and supervisory staff of public school districts by virtue of the definition of the function of the School Social Worker as *wholly or principally supporting the function of teaching*. This distinction means that individuals who perform the responsibilities of a School Social Worker must be employed by a school district or by a BOCES.

People sometimes have trouble distinguishing between what a School Social Worker does and what a clinician in a school-based mental health clinic does. Both may provide counseling services to children individually and in groups; both may conduct outreach to and work extensively with parents, and the work of both often includes interacting with teachers and other school staff. The crux of the difference between the two is that the work of the SSW is undertaken with the specific and primary intent of helping children to learn. The work of Article 31 clinicians may also help children succeed in school, but the focus is generally broader than that. The narrower focus of the School Social Worker requires a specialization which must be acquired through an experience requirement (for permanent certification), namely, at least two years Pupil Personnel Services experience. This experience provides knowledge and skills which are critical to the function of helping teachers address the special needs of children in relation to learning.

There are times, however, when the work of a School Social Worker may need to be supplemented by a mental health clinician. Because of supervisory and other requirements, School Social Workers may not be qualified to provide billable clinical social work services. In the event that a Committee on Special Education determines that a child with a disability requires clinical social work services to meet the goals of his or her IEP, the school district may contract with an Article 31 clinic, to provide such services as a *related service* in the event that school district personnel, including the School Social Worker, are unable to provide the needed service. Article 31 clinics with whom a school district contracts for such services should be aware of Medicaid billing requirements for students with IEPs under the School Supportive Health Services Program (SSHSP). Clinics should discuss these requirements with the school district, SED and/or the NYS Department of Health SSHSP staff to avoid double billing.

FERPA and HIPAA: An Alphabet Soup Meaning - Confidentiality!

Mental Health Clinic staff requirements for confidentiality and sharing of records emanates from the Health Insurance Portability and Accountability Act (HIPAA) and Section 3313 of the Mental Hygiene Law. In addressing parental and student confidentiality rights, schools are governed by the federal Family Educational Rights and Privacy Act (FERPA) and when addressing Medicaid funding, HIPAA as well. Serving the child in the context of the family is most effective. The goal is to have both systems work with the parent to encourage their willingness to approve the sharing of information that will assure a consistent school and community approach to addressing the needs of the child and the family. Issues surrounding sharing of information are at the crux of many disputes when implementing school-based mental health programs. With informed parental consent most of these issues go away. Without parental consent the mental health provider is not able to share individual child information related to Early Recognition activities. The partnership should be able to work out how to best use aggregate data to assess the effectiveness of the partnership in addressing school-wide outcomes.

What information or records can be shared between school staff and clinic staff?

Given informed parental consent, most anything is allowable. Informed consent reflects parental understanding about what will be shared and how the information would/could be used. The consent cannot be generic. It must be specific and updated to reflect current records and reports. Consider this an ongoing process that must be built into the relationship with the student/parent. In addressing this sensitive area, generally it is helpful in establishing a strong partnership that approaches this question first as, "What information is needed by staff from each system to more effectively do their job?" Once the partners reach consensus on the specifics of this information they can address how to go about discussing with the parent the what, who and how that leads to informed consent.

Clinics are governed by Section 3313 of the Mental Hygiene law and HIPAA. They would be required to obtain an additional consent of the parent to release the records related to any assessment conducted as a result of screening or any other reason. If the parent does not consent, the clinic is prohibited from releasing the record to the school district.

Opportunities and Resources Information for School-Mental Health Partnerships

The NYS OMH oversees a number of services that may be of significant benefit to students and their families. The information below may be used in dialogues with Mental Health providers in developing school/mental health partnerships and/or providing critical information on services and supports to students and their families.

Community Schools and Mental Health

Community Schools are public schools that emphasize family engagement and are characterized by strong partnerships and additional supports for students and families designed to counter environmental factors that impede student achievement. Community Schools coordinate school and community resources and maximize public, non-profit and private resources to deliver critical services to students and their families, thereby increasing student achievement and generating other positive outcomes. Community Based Mental Health Organizations can be key partners for schools developing a community based school structure.

For more information about Community Schools at NYSED see:

<http://www.p12.nysed.gov/sss/expandedlearningopps/CSGI/home.html>, and
<http://www.p12.nysed.gov/accountability/de/documents/CommunitySchools-FAQs.pdf>

Children's Aid Society - National Center for Community Schools:

<https://www.childrensaidnyc.org/programs/national-center-community-schools>

The Community Schools Resources COSER

The BOCES Community Schools Resources COSER supports delivery of co-located or school-linked resources to improve student's educational outcomes. This COSER enables the delivery of co-located or school-linked academic, health, mental health, nutrition, counseling, legal and/or other services to students and their families in a manner that will lead to improved educational and other outcomes. Community Schools Resources will provide for students' social, emotional, physical and intellectual needs through the following services: Family Resource Center, Medical Director, Early Literacy Opportunities/Parent-Child, Mental and Behavioral Health Services, Universal Social-Emotional Screening, Dental, and other recommended services.

Find a description of the Community School Resources COSER here:

https://eservices.nysed.gov/srr/gui_mainpage.

Project TEACH - Information for Parents

Pediatric MD access to child & adolescent psychiatric support

Pediatric primary care provides a window of opportunity to offer families information and support on their child's social-emotional well-being and growth in a non-stigmatizing environment. Many children receive mental health counseling and support through their primary care providers (PCPs) with no additional services. PCPs provide mental health support and can prescribe medication, but they may not have access to consultation or the training needed to make decisions for children with mental health needs.

Project TEACH is a statewide program, funded by the NYS Office of Mental Health, which strengthens and supports the ability of New York's pediatric primary care providers (PCPs) to deliver care to children and families who experience mild to moderate mental health concerns. Project TEACH is comprised of three interrelated services for PCPs: rapid access to child and adolescent psychiatric consultation, referral and linkage to connect children and their families with the resources and services they need, and educational based training.

Note that while this service cannot be used by schools, they should consider this as a resource for parents who have concerns that their child has behavioral or emotional challenges. Parents can talk to their pediatric primary care providers about this resource. The Project TEACH Parent Flyer can be found at:

http://projectteachny.org/wp-content/uploads/2017/11/ProjectTEACH_Parent_Flyer_Nov2017.pdf

Find more information about Project TEACH at <http://projectteachny.org/>.

Children and Youth Single Point of Access (C & Y SPOA)

The Children and Youth Single Point of Access (C & Y SPOA) was created in 2001 to "link and provide timely access to an array of intensive OMH services and supports based on the identified service need of the youth and his/her family." Every county and borough in New York State has a C & Y SPOA and operates under the auspice of each County's Director of Community Service (DCS). The C & Y SPOAs bring together Cross System partners in order to provide the right services to the right children and their families at the right time.

The children's system is a complex system for a variety reasons. Often in order to meet the needs of the child and the family, multiple systems must be involved to provide services and supports. For children with Serious Emotional Disturbance (SED) and/or Substance Use Disorders (SUD), the package of services and supports needed to be in place requires initial input and ongoing contact with many of the following systems: primary care providers; mental health or substance abuse treatment providers; the school system; the Local Department of Social Services (LDSS) if the child is in child protective services, foster care, and/or prevention services; county juvenile probation; and Family Court. C & Y SPOAs have the flexibility to adjust when necessary while providing the single point of contact to coordinate services for the child and the family.

For local information: http://www.clmhd.org/contact_local_mental_hygiene_departments/

NYS OMH 1915(c) Children's HCBS Waiver

The OMH Children's Home and Community Based Services (HCBS) Waiver provides services and supports to children with mental health needs and their families in their home and community.

Who Qualifies?

The HCBS Waiver Program is designed to provide community-based services & supports to youth at risk of admission to institutional levels of care. Eligibility criteria include:

Age: Waiver is available for youth between the ages of 5 and 21;

Level of Care: Youth must be at imminent risk of admission to a psychiatric inpatient setting or have a need for continued psychiatric hospitalization and must be capable of being cared for in the home and community.

Financial: The youth must be eligible for Medicaid. Only the child/adolescent's own income and resources are taken into consideration when determining Medicaid eligibility.

How to Apply: To start the waiver application process, or for further questions contact your local C & Y SPOA at: <https://shnny.org/images/uploads/SPOA-listings.pdf>

The New York State Pyramid Model

Support for Infants, Toddlers, Young Children and their Families

Vision: All NYS infants, toddlers, young children and their families will be supported in their social-emotional development to promote their success in school and life.

Overview: Social and emotional well-being sets the foundation for the development and learning of infants, toddlers and young children. The Early Childhood Advisory Council - comprised of experts in child care, education, health care, family support and mental health - has identified the critical need to better support and teach young children and families social and emotional skills. In response, NYS brought together a team of public and private agencies to provide more early childhood professional development opportunities. This new partnership is called the **New York State Pyramid Model**.

Goals: The New York State Pyramid Model Partnership will work collaboratively to:

- Increase the number of early childhood trainers and coaches providing professional development to the early childhood workforce to meet the social and emotional development needs of young children;
- Support partnerships between practitioners and parents;
- Support the implementation and sustainability of the Pyramid Model in early childhood settings; and
- Evaluate the effectiveness of the Pyramid Model in New York State.

More information on the NYS Pyramid Model can be found at: <http://www.nysecac.org/ecac-initiatives/pyramid-model/>

Understanding Adverse Childhood Experiences (ACES), Trauma Informed Care (TIC) and Linking with PBIS

What are Adverse Childhood Experiences (ACEs)?

Adverse Childhood Experiences (ACEs) are stressful or traumatic events that can lead to social, emotional and cognitive impairment, which, in turn, can lead to the adoption of high-risk behaviors, disease, and early death. Children who experience these trauma events often struggle in school. The cumulative effect of trauma and toxic stress can be significant and result in inappropriate behaviors, an inability to focus and process information and improper responses to classroom and social situations. ACEs reflect abuse (emotional, physical and sexual), neglect (emotional and physical) and household dysfunction (Mother treated violently, household substance abuse, household mental illness, parental separation or divorce, and an incarcerated household member). Studies on the impact of ACEs show that they can be predictive for a number of issues, such as physical health, substance misuse and other behavioral health issue

Research suggests that approximately 25% of American children will experience at least one traumatic event by the age of 16. A child's reactions to trauma, especially cumulative trauma can interfere considerably with learning and/or behavior at school. However, schools also serve as a critical system of support for children who have experienced trauma. Administrators, teachers, and staff can help reduce the impact of trauma on children by recognizing trauma responses, accommodating and responding to traumatized students within the classroom setting, and referring children to outside professionals when necessary. The National Child Traumatic Stress Network has developed tools and materials to help educators understand and respond to the specific needs of traumatized children. Resources for School Personnel, including a link to a Trauma-Toolkit can be found at: <http://www.nctsn.org/resources/audiences/school-personnel>

Trauma Informed Care (TIC) and PBIS In order to create, support, and sustain these elements specifically in schools; a tiered approach is suggested to create an environment with clear expectations for everyone, open communication, and a collective commitment to a safe and nurturing school culture. The tiered approach describes how trauma-informed practices can be applied both universally as a preventative approach and to help those in need of more intensive support. Note that this approach is very compatible with the Positive Behavioral Supports and Interventions (PBIS) structure used by many NYS schools. The aim of a trauma-informed tiered approach is to create a school-wide environment that addresses the needs of all students, staff, administrators, and families who might be at risk for experiencing traumatic stress symptoms. There are many ways to weave trauma-informed approaches into the fabric of schools all with a primary focus on creating and supporting academic achievement, behavioral competence, and mental health of all students, families, and staff. Schools may build on their existing PBIS tiered structure by infusing the universal and higher level trauma informed strategies (e.g., restorative practices) into the school's everyday efforts at ensuring a safe and supportive learning environment. Below is a link to the National Child Traumatic Stress Network's publication on this approach.

http://www.nctsn.org/sites/default/files/assets/pdfs/creating_supporting_sustaining_trauma_informed_schools_a_systems_framework.pdf