

# **School and Mental Health Partnerships**

## **Improving School and Community Outcomes For Children and Adolescents with Emotional and Behavioral Challenges**

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Division of Integrated Community Services for Children and Families

## Table of Contents

Page	
3	Why Education/Mental Health Collaborations Are Important
4	Special Note: An Evolving Children's Behavioral Health System
5	School-based/School-linked Mental Health Clinics How to get started Creating Successful Partnerships
8	Fiscal Considerations Clinic financing, including Medicaid, Special Education and the School Supportive Health Services Program (SSHSP)
9	Staffing Considerations Understanding Qualifications and appropriate functions of school PPS staff and Mental Health Clinicians Distinguishing between PPS and Clinical functions
11	Other Considerations when Establishing a School-based/linked Behavioral Health Service System 11 - Facilitating Effective Partnerships: Key Concrete Examples 12 - Understanding Service Provision at School Mental Health Clinics 13 - Expenses, sharing space, and building aid 14 - Strategies to successfully engage kids and families 16 - Minimizing the impact of treatment on the student's day 16 - Establishing standards for appropriate referrals to the clinic 16 - Confidentiality 17 - Sharing information or records between School and Clinic staff 18 - Measuring effectiveness
	Appendix 1: Positive Behavioral Interventions and Supports (PBIS), Adverse Childhood Experiences (ACEs) and Trauma Informed Care (TIC)
	Appendix 2: Possible Components of a Partnership Agreement
	Appendix 3: Strategies for Open Communication
	Appendix 4: Sample Planning Form
	Appendix 5: Opportunities and Resources: Information for School-Mental Health Partnerships

## **Q: Why Are Education and Mental Health Partnerships Important for Schools and Communities?**

### **A: They Improve Child, School and Community Outcomes!**

The State Education Department (SED) and the State Office of Mental Health (OMH) strongly encourage school districts and local mental health systems to partner to ensure that children with mental health needs have improved access to services. Such access leads to early intervention and support which has been proven to result in better school, family and community outcomes for children with emotional and behavioral issues. This guide is intended to help school district and community mental health leaders' work together to establish mental health services based in schools or linked to schools. This effort builds on the commitment established in the New York State Children's Plan to improve the way we think about the mental health needs of our children.

### **What are the Benefits of School/Mental Health Collaborations?**

The research clearly shows that access to mental health supports has an enormous impact on school engagement. The goal of enabling all children to achieve high academic standards is enhanced when the education community joins with public and private sector health, mental health and social services providers to address the widespread conditions, including those that are trauma based, that interfere with student learning and students' prospects for a healthy adulthood. 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 Appendix for information on trauma/ACEs). Partnerships that address the mental health and developmental needs of children is one of the key strategies for improving the learning environment and academic performance. It is also well documented that early identification and treatment will reduce the risk that children will end up in the juvenile justice or other child-serving systems, improving the odds that they will grow into productive adults. Partnerships also increase access to information and services that can benefit community providers and families. For example, Primary Care providers can access psychiatric supports for families through Project TEACH resources. See appendix 5 for more information on Project TEACH.

Consider the benefits for both systems:

- **Schools.** School-based/linked mental health clinics and supports have been identified as an effective means of addressing the mental health needs of children and improving the learning environment. Partnerships between schools and mental health providers can result in improved academic outcomes through:
  - Improved school engagement with children being better prepared/able to concentrate on learning,
  - Increased attendance and reductions in drop-outs,
  - Treatment and service coordination with school staff,
  - Parents more likely to effectively participate in their children's education,
  - Assisting the school when addressing the Dignity for All Students Act, and
  - Mental health providers linking with additional community-based services to support the child and family.

- **Community Mental Health Clinics.** Mental health clinics based in or linked to schools provide better access to services for children with serious emotional or behavioral issues and their families. Increased access to clinic services will:
  - Facilitate early identification by appropriate screening, assessment and follow-up,
  - Improve efficiency and coordination of services among school-based professionals, clinic professionals and community service providers,
  - Maximize utilization of staff by eliminating redundant staff training and sharing critical functions, knowledge, skills and information,
  - Ensure more students' and families' consistent participation in treatment through linkages with the school's wellness programs, and
  - Reduce the stigma associated with mental health treatment by having clinics in environments where children are located.

This summary guide is intended to help community mental health and school leaders begin to explore the benefits of partnerships and to establish school-based collaborations. It will assist leadership to better understand some of the practical issues and steps to take related to creating and operating school-based mental health programs. It is intended to help leadership begin the dialogue leading to establishing school/mental health partnerships. There are also shorter versions of this guide targeting either education leaders (Mental Health 101 for Educators) or mental health leaders (Education 101 for Mental Health Leaders) at the link below: <https://www.omh.ny.gov/omhweb/resources/publications/index.html#children>

### **A Special Note: 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 occurring in children's healthcare.

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 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 eventually start offering an expanded array of services.

It is now, more than ever, critical for schools to explain to these providers what students' needs 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. We cannot and will not lose sight of this mission.

## School-based/School-linked Mental Health Clinics

School-based or linked Mental Health Clinics are one possibility among the many emerging behavioral health structures that can be used in School-Mental Health Partnerships. They can be part of a larger health clinic or a stand-alone model, including a satellite clinic. Taking the first steps in establishing a school-based mental health clinic can appear daunting, but many schools and counties/community agencies have paved the way. What follows reflects the experiences of those partnerships. This includes understanding how to get started, appropriate services, rules to understand, and issues for partners to address to prevent problems from emerging as two different systems and cultures interface to better serve children and their families. There are also many schools linked with community-based MH clinics where coordination of services and supports for children and families is handled through a partnership focused on improving access and coordination of services. In addition, in 2017 SED approved the Community School Resources COSER. This enables BOCES to contract with community mental health providers to work with component districts to provide access to early screening and other mental health supports related to community school initiatives.

### How to Get Started

#### Overview

School-based mental health clinics can be established if the school and the licensed mental health clinic agree and pursue state authorization. A local school district administrator, a board of education, the New York City Department of Education or Department of Health and Mental Hygiene, a county mental health commissioner or an agency authorized to provide mental health services can initiate the project. **Outside of New York City**, an authorized provider agency, and the school district superintendent/school leaders would work together to develop a written agreement for the operation of the partnership. Involvement of the local county Mental Health Commissioner (the terminology may be different in any given county) is also an important component of a successful collaboration. If the partnership includes a contract to provide mental health support services on behalf of the school (e.g., screening), a commitment by the local board of education will be required.

Outpatient mental health clinics, which include clinic satellites established in schools, are referred to as Article 31 clinics. Most clinic programs include both a main clinic and satellite clinics. A clinic (generally a satellite clinic) may be established in a school as long as it meets requirements, including size, condition and features of the physical space in the school where the clinic will be located (e.g., meets HIPPA privacy requirements). The mental health provider/operator is responsible for communicating these requirements to the school and applying to OMH for an operating certificate. Before beginning, it is important to note that the intent is for the community partner to supplement, not supplant, existing School District behavioral health services.

A school district interested in establishing a satellite clinic in one or more of its schools or in creating a partnership that enables effective coordination of school-based and community-based services and supports (commonly referred to as school-linked) may contact a mental health provider in its community directly or contact the county mental health agency that serves the geographic area in which the district is located. Go to: <http://www.clmhd.org> for county mental health department contact information.

**In New York City** there is well defined structure for identifying the need and establishing a school-based mental health partnership. Contact information for the DOE Office of School Health, School Mental Health Services can be found here on the [NYC Dept. of Education](#) website. Community-based mental health providers may also contact the NYS Office of Mental Health, New York City Field Office at (212) 330-1650.

### **Creating Successful Partnerships – A Summary**

Schools and community-based providers need to enter into the partnership with an understanding of each other's strengths and needs. The following provides a summary of information on how to approach creating a successful partnership.

#### **Making Partnerships Work: Best Practices in Effective Partnerships\*\***

\*\* Adapted from, "A Principal's Guidebook: School-based Mental Health Programs" by Scott Bloom, Director of School Mental Health Services, NYC Office of School Health.

##### ➤ ***Setting a Clear Vision and Goals***

Successful partnerships share a common vision in which to carry out their goals and objectives. The school and provider should reach an understanding of the vision and goals they bring to the partnership. Effective partnerships begin with a school-wide needs assessment to determine what current services can be leveraged and where the gaps lay. These goals can be shared with others and assessed as the partnership progresses. This works well within a school's PBIS structure.

##### ➤ ***Clearly Defined Purpose of Collaboration***

Collaboration is the key to successful partnerships. Both parties should clearly define what they hope to accomplish together. Frank discussion from each collaborator about what they hope to gain and why they think the partnership exists are crucial. Defining the purpose and the ways in which both partners can benefit should start at the initial meeting. Clearly identifying areas of concern and agreement on how to handle these areas will prevent problems in the future.

##### ➤ ***Maintaining a Formal System of Open Communication***

On-going communication must exist between the community partner and the school. Dialogue from the principal, school administration, PPS, and teachers within the school and the site coordinator and/or provider leadership and staff will allow both parties to recognize and address opportunities and concerns quickly. Regularly scheduled meetings should accommodate both partners. For example, schools should include providers in all building communications and meetings, including inviting the provider to regularly join the PPS and administrative team meetings and Mental Health providers can include school staff in appropriate agency or community meetings or committees.

##### ➤ ***Recognizing and Respecting Differences***

From the initial meeting onward, it is important to recognize that the school and provider will have different philosophies, roles, and relationships to children and the community. That each will have their own approach, language and beliefs that are equally valuable should be addressed in the beginning. The leadership

should be clear about the daily roles that each partner has as well as practice differences in various policies such as those regarding restraints, confidentiality (HIPPA/FERPA), CPS/ACS/LSSD communications, etc. The partnership should agree on what a clinic staff member can and cannot do under the direction of the host school (e.g., limiting class interruptions and providing unscheduled support). In addition, it is also essential that schools understand and support the providers' practice requirements (productivity) and documentation needed to meet funding requirements that ensure sustainability.

➤ ***Mutual Commitment for Long-term Stability***

It is important that the provider and school have an understanding of their commitment to the partnership and the mutual benefits. That is, the school can begin to incorporate the provider into their school philosophy and community, and the provider can commit to the nature of their mission and the ways in which it reflects a dedication to the school environment. Both partners must understand the associated strengths and limitations of this collaboration.

➤ ***Evaluation of Program Progress and Effectiveness***

As partners, it is imperative that services and relationships are continuously monitored to help each other maintain focus, improve effectiveness and accountability, ensure parent and participant satisfaction and identify changes that will improve outcomes.

➤ ***Trouble shooting - Have a defined process and time set aside for trouble shooting.***

Be prepared to address issues that inevitably will emerge when bringing two different cultures together. Maintaining a system for ongoing communication is one key to preventing issues from growing but good practice often dictates more than leadership meeting regularly. Having links to students, staff, parents and community leaders is also a valuable tool in fostering good relationships.

## School-Based/School-linked MH Clinics - Fiscal Considerations

### Clinic Financing, Medicaid, Private Insurance and Special Education, including the School Supportive Health Services Program (SSHSP)

A critical aspect of running a clinic that schools should understand is that Article 31 clinics are responsible for sustaining themselves financially. They do not receive fiscal support comparable to property taxes or state aid to schools to pay for their staff/services. Their chief sources of revenue are Medicaid (for Medicaid-eligible children and services) and third-party insurance. It is important for school staff to fully understand that generally clinic staff only generates revenue for direct treatment services provided to the youth. Meetings and training sessions do not generate revenue. Therefore, while such sessions are important and should be held, it is critical to the effective operation of the clinic that the time constraints of the clinicians be well understood before commitments are made. Clinic staff can easily inform their partners of the constraints and the best ways to enhance participation. It should be noted that with the advent of Medicaid Managed Care, the need for collaborative planning on the agreements required for effective delivery of services will grow. While Managed Care will allow for a larger array of children services, it will also create service delivery, budgetary and billing changes for providers.

The partners should also discuss how collaboration can improve the cost-efficiency of a clinic. For example, low cost or free use of space, utilities, maintenance, security, etc. can improve the cost effectiveness of both school-based and school-linked clinics. 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 they cannot contract 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) allowing 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.

Mental Health partners should 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 NYS Education Department's web site provides information on the SSHSP. 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/>

## Collaborative Staffing Considerations

### Understanding the Qualifications and Appropriate Functions of School District Pupil Personal Services (PPS) Staff and Community Mental Health Clinicians

In order to fully understand how clinics and schools can effectively partner, the key qualifications and responsibilities between school Pupil Personal Services staff and community mental health clinicians must be clear. Partners are encouraged to fully discuss roles and responsibilities to avoid potential conflicts. A key issue to avoid is any attempts at supplanting existing school district services through the use of clinical services/staff. The following information will assist in understanding the differences. Note: There is more on the appropriate roles and responsibilities later in this document.

**School PPS Staff:** The qualifications and requirements for school professionals and paraprofessionals are in Part 80 of the Regulations of the Commissioner of Education.

*School Social Worker:* Schools employ licensed social workers who are also a certified school social worker. School social workers are clinicians and considered an instructional employee and part of the pupil personnel services (PPS) staff. Duties are not limited to direct instruction of students, and include supporting the function of teaching, such as performing student and parent case work services and consulting and collaborating with other school personnel to establish and plan respective roles in the modification of student behavior.

*School Psychologist:* School psychologists are also considered instructional staff and part of the PPS team. They provide student counseling, conduct psychological assessments and assist other instructional staff in addressing the learning and behavioral modes and skills of children, including Functional Behavioral Assessments and Behavior Improvement Plans.

*School Counselor:* School counselors (their title has recently changed - historically known as guidance counselors) provide assistance in many different areas related to development of a comprehensive school counseling program including a guidance curriculum, individual student planning, prevention and student support services and support of district staff.

### Community Mental Health Clinic Staff

Clinics generally have LCSW, LMSW and Licensed Mental Health Clinicians (LMHC) staff, among others. Education Law establishes distinct requirements for licensure and authorized practice for LMSWs and LCSWs. An LMSW may practice clinical social work (e.g. diagnosis, psychotherapy) only under appropriate supervision from an LCSW, psychiatrist or licensed psychologist. This supervision, and what it permits the LMSW to do in an Article 31 clinic, is a significant distinguishing factor between a School Social Worker and an LMSW in a mental health clinic. School Social Workers do not typically receive clinical supervision and would therefore not be able to perform the LCSW duties unless they are themselves LCSWs. Under licensure requirements, it would not be appropriate for the clinical staff (e.g. LCSW) to supervise the practice of an LMSW in a school, as this blurs the difference between education and health care services and related factors (e.g. billable services, confidentiality, etc.).

State Education Law addresses the areas of social work, psychology and mental health counseling separately. While the majority of individuals who work directly with children and adolescents in clinics licensed by the Office of Mental Health, including school-based mental health clinics, are licensed master social workers and licensed clinical social workers, these clinics may also employ individuals who are licensed under Article 163 of Education Law (mental health practitioners) or Article 153 (psychology). The former includes individuals licensed to practice mental health counseling, marriage and family therapy, creative arts therapy, and psychoanalysis.

### **Distinguishing between District Pupil Personnel Services and Community Mental Health Clinical Functions**

Effective partnerships have found that they must establish procedures and practices that take into account the responsibilities of the professionals who will be involved in the clinic. These must be consistent with Education Law, which defines educational and support services provided in the school. Involving staff early in this process helps ensure a minimum of issues emerging over time.

A significant advantage of school-based clinics is the proximity of clinical staff with school PPS staff. This close working environment has been proven to enhance the working relationship and the consistency in strategies, expectations and supports across the school, family and community domains that sustain a child. When classroom and treatment strategies are consistent, youth are much more likely to benefit. While working in the same building/district has great positive potential it also can present considerations that need to be well thought-out when planning for a school-based clinic. Above all, effective programs have indicated it is important to clearly establish the functions of clinical and school district PPS staff.

Although they may hold similar professional titles, it must be clear from the outset that the duties of Pupil Personnel staff in schools (such as School Social Worker and School Psychologist) and the duties of mental health staff in licensed clinics (such as Social Worker and Psychologist) are not interchangeable. Differences in requirements for these positions (e.g., certification, experience, and/or supervision requirements) limit the performance of certain functions to particular titles. The primary distinction that must be kept in mind by both school and clinic staff is that individuals in Pupil Personnel Services titles perform *instructional support* clinical functions, while individuals in clinic positions perform *clinical* functions.

Pupil Personnel staff must meet licensure, certification and experience requirements which are school-related. MH Clinic staff must have appropriate licensure, as well as appropriate clinical experience and/or clinical supervision. While at times, the roles of PPS and clinic staff may appear similar, these roles, particularly as they pertain to supports provided to other school instructional staff, must be clearly delineated. It must be remembered that guidance regarding behavioral issues which relates to the engagement by a teacher of a student in the learning process is the domain of PPS staff. While clinic staff may consult with the teachers regarding child and adolescent mental health and behavioral issues in general and may even assist a teacher who is named as a “collateral” in a mental health treatment plan by suggesting particular behavioral management strategies related to a goal in the treatment plan, clinical staff should not suggest or recommend particular instructional strategies.

There may be instances where maintaining distinctions between the roles of Pupil Personnel and Clinic staff with regard to a student's behavior in the classroom becomes difficult. In these instances, it is strongly recommended that the PPS and clinic staff work together to develop strategies to assist the student achieve classroom-related goals that are also included in the treatment plans.

There are other limitations on how staff can be used. Partnerships must also be aware that even if these professionals possess appropriate qualifications, there are other legal considerations. For example, a board of education must fill a position on the teaching or supervisory staff, such as a school social worker, by appointing a district employee. A board may contract for such services only with a BOCES or a neighboring school district. Therefore, while a staff person working in the clinic may meet education licensure and certification requirements for a position in the school district, he or she must be hired directly by the school district. A subcontracting arrangement with the clinic would not be legal.

An example related to the clinic is somewhat different. A clinic could employ a school social worker who is also an LCSW to provide clinical social work services within an appropriately supervised setting. It would be possible for that individual to hold a full-time or part-time position as a school social worker and work part-time for the clinic. The individual must perform the appropriate responsibilities within the respective positions and perform the responsibilities of school social worker only as a school district employee. It would be critical to clarify the role the individual is filling, particularly in relation to privacy, privileged communication and billable services. The student and responsible parent may not be able to differentiate between the roles and restrictions, so it is the affirmative responsibility of the school and provider to receive informed consent before providing services.

## **Other Considerations for School-based/linked Behavioral Health Programs**

### **Facilitating Effective Partnerships: Key Concrete Examples**

Successful partnerships have found that when the following items are understood and negotiated up front between the school and the clinic, partnerships run smoothly and students and families get better results:

- Clinic and school staffs are clear about their respective participation on school teams (e.g., child study team, PBIS team, etc.).
- Mental health and school Pupil Personal Services staff have reviewed and understand their different roles and responsibilities, especially when both are working with an identified student with a disability.
- In crisis situations, it is recognized that the mental health clinic does not replace the school's supports and is only part of the school's resources.
- Mental health providers interact with each school facility individually; there is flexibility to allow each clinic to fit into its host school's culture.
- The amount of time that school and clinic staff is expected to spend on collaborative activities is made clear at the outset.
- The school is willing to hire substitutes so staff can participate in training provided by the clinic to enhance the partnership.
- The clinic is clear about what services they are able to deliver, and the school is clear about what they expect.

- The school understands that Medicaid and private insurance only reimburse for certain services, so the clinic may not be able to provide every service requested or needed unless a funding source is procured.
- Providers are clear to parents, students and schools regarding possible waitlists; efforts to triage are transparent and effective.
- The school and clinic give consistent messages to parents and students about the differing roles and responsibilities of school and clinic staff.
- The partnership agreement includes a mechanism to ensure that communication among the leadership, building staff and clinic staff is on-going; with concerns addressed and disputes resolved in a timely manner.

### **Understanding Service Provision at School Mental Health Clinics**

Outpatient clinic services are part of a continuum of mental health services available to children and adolescents with serious emotional or behavioral issues. They are intended to reduce symptoms and improve functioning while maintaining children in their natural environments. Supports are available to children and their families, as well as to individuals who will play a significant role in a child’s treatment plan. These individuals are known as “collaterals” in mental health treatment plans and may include a wide variety of individuals, including school staff. Moving these services into the school allows children and youth to more easily access them.

The degree to which the services and supports offered by school-based clinics are integrated within the school’s “host” environment may differ depending on a number of factors. These include the operating days/hours of the school-based clinic as well as the presence of financial support beyond a clinic’s normal operating revenues. For instance, a school-based clinic that is open whenever school is in session may be better integrated within the school environment than the school-based clinic which is open for only certain hours or days during the school week.

Some services offered by Article 31 clinics may not be available at all satellite locations but will be offered at the main clinic site. If a psychiatric evaluation is needed, for example, it may be conducted at the school site or the school-based clinic staff may arrange for it to occur at the clinic’s main site.

Services offered most frequently in school-based mental health clinics are generally provided by licensed clinical social workers (LCSW) and licensed master social workers (LMSW) under the supervision of a licensed clinical social worker or psychologist. A limited amount of services may be provided to children who are not yet admitted to the clinic. Clinics are required by regulation to admit children after a specific number of services have been provided.

With few exceptions, parental consent is required for a child to receive services. Consent and privacy rights under the Education Law, the mental health and public health laws of New York and the federal Health Insurance Portability and Accountability Act (HIPAA) are applicable to the treatment of an eligible student.

## **Expenses, Sharing Space and Building Aid**

Many schools interested in a partnership have questions related to understanding what, if any, costs fall to the school district. Unless the school is contracting with the clinic for specific services (e.g., universal screening) and supports beyond those which are billable, the cost to the school should be in-kind (e.g., the provision of space and basic utilities such as telephones, copying services, etc.).

Space for Article 31 clinics, including school-based satellites, must meet certain minimum requirements. For example, a clinic requires sufficient space for students to receive treatment comfortably and safely and for staff to meet with parents. Clinics also must meet standards related to ensuring confidentiality. There must be a clear understanding between the school and the clinic about the days and hours that the clinic space may be used. Mental health officials should discuss these requirements with their school counterparts when developing a partnership agreement.

Experience has shown that the success of a school-based clinic depends in part on being in a consistent location to minimize disruption to the school, clinic, and students and parents. Once established in a location, the clinic should not be moved unless necessary or more appropriate space becomes available. Use of the space during holidays, the summer and at other times when school is not in session should be part of the partnership agreement.

Some clinics are located within a “wellness center” in a school, where they are housed with other health and mental health professionals, including school employees and community health organizations located at the school. Often viewed as a Community School, this arrangement aids collaboration and places mental health counseling in a broader framework of wellness. Some districts have worked with students to identify space in close proximity to the clinic as a place where students can safely gather. This has emerged as a strategy that has reduced stigma and encouraged students to pursue help. Research continues to show that stigma is the greatest factor in children and youth not pursuing assistance. Many partners have found that actively involving youth in determining how best to address this issue produces desired results.

School building aid related to space used by on-site clinics is an area that districts have requested assistance in understanding. It should be understood that a school-based clinic housed in a school building is not eligible for building aid. A school district may use existing space for a clinic if that space is no longer generating aid. It would be inappropriate to use space for which the district is receiving building aid for a renovation that is less than 15 years old. Newly constructed space used for a clinic would not be eligible for building aid because there would be no rated capacity assigned to it. A district is not permitted to convert existing aidable space to a clinic and replace that space at state expense through a future capital project. Given the above, it is also important that any discussion on cost should include the fact that successful school-based clinics provide much benefit to staff and students. The proximity of support and well planned use of the space leads not only to better utilization of services but also reductions in stigma. Research clearly shows that students, who receive such assistance and support from professionals, and their peers, do better in school and in the community.

## Strategies to Successfully Engage Kids and Families

Successfully addressing the needs of children is often a product of positive family engagement. Children who receive treatment in the context of their families have a more robust and positive environment for consistent and supportive treatment strategies. Actively involving students in identifying and addressing the school's needs, generally leads to a more positive learning environment for all. Consider these strategies:

- **Key School Staff can open many doors.** Engage parents through linking with:
  - School Nurses
  - School Pupil Personnel Services (PPS) staff. These include Counselors, Psychologists and School Social Workers
  - Teachers who understand the need for emotional health
  - Music, Arts and Sports – Engage those school staff (e.g., coaches) who can and are willing to help address wellness as a component of overall health. These areas are very popular with students.
  
- **Link with parent groups** (also see “Rely on Kids” below)
  - Parent Teacher Associations (PTA)
  - Special Education Parent Teacher Associations (SEPTA)
  - PTO (Parent Teacher Organizations) – Some school parent groups don't belong to the NYS PTA and can't use the official name
  - Groups associated with after school activities (sports, music, theatre, etc.)
  
- **Rely on Family Support Parents and Parent Advisors**
  - Link with those individuals who can relate to parents and the issues they are facing (e.g., Family Support Parents, PBIS school parents)
  - Link with activities set up by these key individuals
  - Actively use Family Peer and Youth Peer Advocates, available to any child with Medicaid. This behavioral health service can enhance relationships. Licensed school professionals may refer to these services.
  
- **Rely on kids** – Involve them in solutions and parents will follow.
  - Involving youth allows them to help set a tone of acceptance of others
  - Allow kids to participate in identifying needs and solutions
  - Use student organizations to support efforts at addressing stigma and participate in solutions (e.g., student-to-student mentoring programs; anti-bullying programs)
  - Youth Peer Advocates are an effective way of breaking down barriers for students addressing behavioral health needs. Mental health and other systems are increasingly using this resource.
  
- **Stimulate involvement while addressing the NYS Mental Health in Education law.** Actively involving students and parents in lessons and projects will provide credibility and long-term benefits.
  
- **Promote “fighting Stigma” strategies**
  - Choose language carefully. Use prevention based language. For example, “Emotional Wellness” versus mental illness

- Focus presentations or participation in school promoted family-based events on real life emotional wellness issues versus mental health. For example: Helping kids deal with feeling depressed; moody; or handling stress; anger management; relationships; etc.
  - **Align efforts with the school's PBIS strategies.** Many schools use the Positive Behavioral Interventions and Supports (PBIS) structure to identify needs and develop strategies to address key school issues. Build on this structure.
  - **Promote Universal Social-Emotional Screening**
    - Social-Emotional Screening provides the opportunity to identify concerns earlier and assist children and families in connecting to resources.
    - Key components include:
      - Identify who will conduct, coordinate and/or oversee all screening activity within the school.
      - Use of a validated social-emotional screening tool.
      - Provision of phone/in-person follow-up to families when a screen is positive and makes referrals to appropriate resources.
      - Maintain directory of resources/work with school family resource center to identify resources for referral.
    - Participate in Normal School Screenings, Orientations or Transitions
      - By definition universal social-emotional screening is provided for all children in a school or specific grade level. Screening is not targeted to specific high risk populations
      - Schools may focus on specific ages to provide screening such as kindergarten screening; middle school transition; etc.
    - Promotion of Universal Social Emotional Screening fits well with Health and Wellness Campaigns or Health Fairs, etc.
  - **Build on the school's Social Emotional Development and Learning (SEDL) curriculum and initiatives.** Many components of SEDL reflect significant involvement of youth and their families. These efforts can lead to reductions in stigma and more openness in addressing the mental health needs of students. MH clinic staff, working in coordination with PPS staff, can play a very positive role in establishing a foundation for building SEDL skills.
  - **Help others to Understand and Promote the CASSP Principles:** The Child and Adolescent Support Services Program (CASSP) is based on a well-defined set of six principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders & their families.
    - Child-centered
    - Family-focused
    - Community-based
    - Multi-system (i.e., all child-serving systems involved in the child's life.)
    - Culturally competent
    - Least restrictive/least intrusive
- For more information on CASSP go to:  
<https://www.nyconnects.ny.gov/services/child-adolescent-service-system-program-cassp-principles-3014>

## **Minimizing the Impact of Treatment on the Student's Day**

It is important that the school and clinic work out how clinical treatment will be provided when children are in school. Removing a child from class can be disruptive to the child and the classroom. On the other hand, it is very important that the child receive the treatment services needed and that the clinic staff's time is fully utilized. For example, the clinic staff may be unable to see students in schools where core subjects are grouped during a particular part of the day, which would significantly affect the clinic's staffing. School and clinic leaders need to address this issue up front and determine how best to manage it. There is no cookie-cutter approach that will work in every school and every situation, as activities such as required testing, a child's condition, and the impact of emergencies or other issues on the clinicians will vary.

## **Establishing Standards for Appropriate Referrals to the Clinic**

Most new school mental health clinics go through a period of confusion regarding appropriate referrals at start-up. There is a learning curve for school staff to understand the difference between PPS services under Education Law and mental health services under the Mental Hygiene Law. As a result, some referrals made to the school mental health clinic may be inappropriate at first; however as education/mental health partnerships mature, the referrals generally become more appropriate. New partnerships can minimize the effect of this by agreeing on the parameters for referrals. Actively involving school staff in these discussions and providing regular training and feedback has been shown to maximize the clinic's effectiveness and clarify the roles of the school district and clinic.

For example, a common misunderstanding in schools when a clinic is first established is sending students who are acting out to a clinic in the same way they are sent to the principal's office for disruptive behavior. It must be established that this is not the purpose of the clinic. School and clinic staffs need to set clear expectations about when clinic involvement is necessary or appropriate in such a case. School staff is responsible for enforcing the school's code of conduct and should not rely on time-outs in the clinic as a solution to inappropriate behavior.

Use of clinics as a safe space for students who are also their clients may be handled differently. Some children have treatment plans that, with the school's knowledge and cooperation, permit them to use the clinic as a safe space to cool down following or in the lead-up to a trigger event at school. Schools' use of safe space practices is often viewed as a positive strategy to help children remain in their home school rather than be placed in an out-of-district program such as a BOCES or not-for-profit school-based treatment program (i.e., 853 school).

## **Confidentiality**

Confidentiality has proven to be a significant issue for a number of school-based clinics. The collaboration will bring into play laws that affect the school clinic and licensed professionals. Where disagreements and concerns arise, they often emanate from a lack of understanding of the laws and regulations that apply to the professionals and staff of the school and clinic. Also, school legal staff's desire to use certain clinic information that supports school district legal proceedings with parents sometimes creates conflict

over confidentiality. Successful collaborations have addressed these issues in advance by negotiating agreements that respect the responsibilities of school and clinic professionals.

Mental health clinic staff requirements for confidentiality and sharing records emanates from the Health Insurance Portability and Accountability Act (HIPAA) and §33.13 of the Mental Hygiene Law. For more information: <http://www.hhs.gov/ocr/privacy/index.html>

Schools are governed by the federal Family Educational Rights and Privacy Act (FERPA) for addressing parental and student confidentiality rights, and HIPAA for Medicaid funding. Professionals licensed under Title VIII of Education Law must comply with section 18 of the Public Health Law and may have privileged communications under the Civil Procedures Law (CPL 4507 and 4508).

The goal is to serve the child in the context of the family by working with the parent to obtain approval to share information that will ensure a consistent school and community approach to addressing the needs of the child and the family. Issues surrounding sharing information are at the crux of many disputes when implementing school-based mental health programs. With informed parental consent, most of these issues can be managed.

### **Sharing Information or Records between School Staff and Clinic Staff**

Informed parental, guardian or adult student consent is necessary before records can be shared between school and clinic staff. Informed consent reflects parental understanding about what will be shared and how the information may be used. Both the school and clinic must obtain consent (i.e., the school must receive consent to share a student's school information with the clinic and the clinic must receive consent to share clinical information regarding a particular student with the school). The consent cannot be generic; it must be specific and updated to reflect current records and reports. This is an ongoing process that must be built into the relationship with the student and parent. When developing an agreement, the partners should determine what information school and clinic staff will need to do their jobs more effectively and how to work with parents to obtain informed consent. It should be noted that 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 (e.g., improved attendance).

Some school districts contract with the clinic to conduct evaluations requested by the Committee on Special Education. While this is allowable, there are issues associated with confidentiality that must be addressed in the partnership agreement to protect the licensure of the professionals and the clinic. These include, but are not limited to the following:

- Because clinics are governed by §33.13 of the Mental Hygiene Law and HIPAA, the parent must give an additional consent for the clinic to release to the school district records related to an evaluation requested by the CSE. The clinic is prohibited from releasing these records if the parent does not consent, even if the CSE obtained parental consent to do the evaluation.
- The materials that result from such an evaluation are part of the student's educational record under FERPA. The school district that contracted for the

evaluation owns the records. However, HIPAA and §33.13 provide that these records are protected from further disclosure without parent consent. The district must establish procedures to ensure this confidentiality or risk jeopardizing the clinic's license to operate.

- Professionals licensed under Title VIII are accountable under Education Law and Regents rules, which define unprofessional conduct. The health professions must comply with §18 of the Public Health Law, which defines recordkeeping and access to records. The school, clinic and provider must ensure compliance with law in relation to records, clinical notes and other information about the student's health and treatment. Progress notes are part of the treatment record. It is not clear whether clinician progress notes would be considered part of the record under FERPA if they are related to an evaluation performed under contract with the school district. However, giving these notes to the school district could put the counseling relationship in jeopardy and lead to parents refusing to be fully forthright in discussing key issues associated with the child. HIPAA and §33.13 provide that records given to the district are protected from further disclosure without parent consent. This is a serious issue that could affect the counseling process and professional ethics of the counselors involved. A district's insistence on access to progress notes for school or clinic administrative reasons could compromise the contractual relationship. School districts are encouraged not to request these records.

Understand that the above issues don't reflect the entire spectrum that school and provider leadership and staff will face. Each Partnership will be different.

### **Measuring Effectiveness**

Summary: Ultimately partners will want to know if children are doing better academically and socially. The contribution of the partnership to these outcomes can be hard to definitively measure, but successful programs have concentrated on measurements of improved engagement in school and treatment. For example:

**Schools:** Improved attendance, especially when part of a school-wide strategy to identify and address chronic absenteeism, a proven identifier of poor academic outcomes; reductions in disciplinary actions; and improved parental/family engagement. Use the link below to get more information on how to use this critical information. Note that Dignity for All Students Act (DASA) and Violent or Disruptive Incident Reporting (VADIR) data is now referred to as School Safety and the Educational Climate (SSEC) incident data for schools, districts and BOCES.

**Mental Health Providers:** Increased youth and parental participation in treatment and school-wide/group structured activities.

Partners should address how they will measure effectiveness as soon as possible with a focus on continuous improvement. Fitting this effort in the school PBIS structure will have many benefits. More information on the impact of attendance and related improvement strategies can be found at: [www.attendanceworks.org](http://www.attendanceworks.org)

What are other core indicators that a partnership should consider measuring?

- Social/Emotional Development and Learning indicators: More information found at: <http://www.p12.nysed.gov/sss/sed/>

- Educating the Whole Child – Engaging the Whole School: Guidelines and Resources for Social Emotional Development and Learning (SEDL) can be found at: <http://www.p12.nysed.gov/sss/documents/SEDLguidelines.pdf> Page 16, provides information on key markers of school climate in an SEDL environment that can be measured:
  1. Violent incidences
  2. School attendance and absenteeism – a key indicator
  3. Student misconduct
  4. Availability of illegal substances
  5. Bullying, harassment, intimidation
- School discipline indicators. Addressing suspensions and internal discipline referrals is important in the school’s learning environment.
- Improved school/classroom participation. Could be addressed through school staff/youth surveys on school satisfaction and participation.
- 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 the partnership is comprehensive enough (i.e., not just related to access to mental health services but includes social services, health, substance abuse, after school programs and proactive youth development/delinquency prevention programs, etc.).
- Improved Family engagement. Addressing improvements in consistent parent engagement 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 has multiple factors and is very complicated.

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, making training available, etc.?

**Note:** The use of individual student information is governed by HIPPA and FERPA. Great care should be taken to protect confidentiality. However, 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.

### **Positive Behavioral Interventions and Supports (PBIS) and enhancing School and Mental Health Partnerships**

The State Education Department and the Office of Mental Health strongly encourage school district, provider and local government leaders to work together to establish school-based/linked community-operated mental health partnerships. It is important to recognize, however, that such collaborations, while critical to the ability of many children to function appropriately in their homes, schools and communities, is only one step in effectively serving children and adolescents with emotional and behavioral problems and their families. While research shows that school-based/linked mental health services will improve treatment outcomes, generally the needs of youth are more complicated and a structure that allows for serving the whole child, including viewing those needs in the context of their family, generally has greater positive impact. Research has shown the effectiveness of linking school Positive Behavioral Interventions and Supports (PBIS) with school-based mental health.

Many schools in NYS, working with the NYS PBIS Network, have implemented the PBIS structure in addressing improving the schools learning environment and addressing the social/emotional needs of their students. National initiatives are addressing the steps that can be taken to enhance the success of school and mental health collaborations, including how to more effectively plan and implement a partnership structured around PBIS. This structure is referred to as the Interconnected Systems Framework (ISF). The ISF builds from the established and effective platforms of PBIS and Implementation Science to integrate school mental health (SMH) programs and services into existing Response to Intervention (Rti) systems in schools.

The ISF involves collaborating community mental health providers working closely with school employees within a multi-tiered teaming structure, actively reviewing data and coordinating the implementation, fidelity and progress monitoring of supports delivered at multiple levels of intensity. For more information see: *Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support* *Editors: Susan Barrett, Lucille Eber and Mark Weist.* [http://www.pbis.org/school/school\\_mental\\_health/interconnected\\_systems.aspx](http://www.pbis.org/school/school_mental_health/interconnected_systems.aspx)

Additional resources on national initiatives addressing student and learning supports through PBIS and the integration of mental health and schools can be found at:

- New York State PBIS Network <http://www.pbis.org/pbis-network/new-york>
- The federal PBIS TA Center <http://www.pbis.org/>
- Center for Mental Health in Schools at UCLA: <http://smhp.psych.ucla.edu>
- University of Maryland's Center for School MH: <http://csmh.umaryland.edu/>

### Understanding 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 issues.

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 appropriately 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. 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 (SEDL) 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](http://www.nctsn.org/sites/default/files/assets/pdfs/creating_supporting_sustaining_trauma_informed_schools_a_systems_framework.pdf)

## POSSIBLE COMPONENTS OF A PARTNERSHIP AGREEMENT

This is a summary of items that any given partnership may choose to include in an agreement and should not be confused with a sample agreement. Any given partnership agreement would look different.

**Participants** Each agreement would reflect the participants in their situation e.g., school district, provider and local government.

### Possible Provisions

**A.** Purpose of the School-based Mental Health Program. For example:  
The partnership's school-based mental health treatment/consultation program has been developed to provide mental health treatment services to children/adolescents and their families as well as provide professional development for school staff through clinical consultation and training.

### **B. Fiscal Responsibility**

1. District's fiscal obligations.
  - a. In-Kind: Space; phone, utilities, etc. as agreed.
  - b. Mental health services, not otherwise able to be provided by school district staff, paid for by the DISTRICT are described below and the costs are detailed in an Appendix, etc.
2. Provider's fiscal obligations. The Provider shall provide, at no cost to the District, mental health services to children/adolescents and their families who are not otherwise identified in section "1b" above. Also consider addressing any rent, maintenance, security, etc. costs.

### **C. General Program Component Agreements**

The Provider and District hereby agrees the provision of treatment services will be done according to the following terms: **EXAMPLES** of items that **MIGHT** be included are:

1. Staffing of the clinic.
2. Roles and Responsibilities. Participants agree to work together to establish appropriate roles and responsibilities of clinic and district staff. Services provided by Clinic are not intended to replace services provided by the district's school guidance counselors, school social workers, and school psychologists.
3. Ongoing Communication. Both parties agree to bring concerns forward to mutually resolve any disagreements and/or problems that develop.
4. Consent requirements. For example, services to children/adolescents may only be provided with written consent from the parent or guardian. A non-CSE student, who is a minor older than sixteen who does not wish their parents/guardians be informed about their treatment services, may obtain treatment without parental consent per Mental Hygiene Law.
5. Payment structure.
6. Ability to pay for services. What will be the policy if there is an *inability* to pay? Will

- services be denied if a family/guardian is *unwilling* to pay? Etc.
7. Program effectiveness. How will the District and Provider measure program effectiveness?
  8. Hours of Operation.
  9. Employment status and obligations. The Provider assures that:
    - a) Clinical staff shall be employees or agents of the Provider. The District shall not be liable for obligations, if any, incurred by the clinical staff.
    - b) Staff will have/maintain appropriate licensure and/or certification.
    - c) It will comply with all applicable State and federal laws and regulations including, but not limited to: IDEA, Section 504 of the Rehabilitation Act, Article 89 of the NYS Education Law, HIPAA, and FERPA.
    - d) The clinical staff will perform all services in accordance with generally accepted practices and the standard of care.
    - e) The clinical staff shall be fingerprinted as per NYS Educational Law and documentation of such fingerprinting shall be provided to the DISTRICT.
  10. Confidentiality and sharing of information. The use of individual student information is governed by HIPAA and FERPA. Great care should be taken to addressing confidentiality in the Partnership Agreement. However, the partnership should also be able to work out how to best use aggregate data to assess the effectiveness of the partnership in addressing school-wide outcomes. See the sections on Confidentiality and Measuring Effectiveness starting on page 18.

Specific Obligations of the DISTRICT: Examples of areas that may be addressed.

1. Promote the program within the DISTRICT and market acceptance for the program with students, parents and community leaders.
2. Designate one staff person to function as a liaison between school personnel and the school based clinician(s). Note: Highly recommended.
3. Make referrals to the program under agreed on terms: Possible options include:
  - a. The DISTRICT will first gain the agreement and stated intent to cooperate from the student's parent(s)/guardian(s), where applicable.
  - b. Inform parents/guardians that at least one parent/guardian must be present for evaluation, where applicable.
  - c. Obtain written consent for treatment from the student's parent(s) or guardian(s) where applicable.
  - d. Obtain written consent, where applicable, authorizing the Provider to release information to the DISTRICT regarding the student's treatment. NOTE: Any special considerations should be addressed. For example, the release of Provider's therapist's progress notes should not be included.
  - e. Provide to the Provider, any records of psychological testing, if available, and other school records as applicable, in accordance with FERPA and HIPAA.
4. Contact the clinician/supervisor if a psychiatric emergency arises with a student on the Provider caseload.
5. Provide suitable confidential space in the school building, as mutually agreed to by the parties, for conducting evaluations and providing treatment services.
6. Provide access to an appropriate private telephone.
7. Provide a secured locking file cabinet where records can be maintained

Specific Obligations of the Provider: Examples of areas that may be addressed.

1. Assess the appropriateness of referrals from the school to ensure they meet

admission criteria for treatment.

2. For students not accepted for treatment, assist the referring party in identifying other services, as appropriate.
3. Ensure that written authorization to treat has been obtained, if applicable.
4. Explain confidentiality requirements and recommend to parent(s)/guardian(s), where applicable, that they sign a release of information between the Provider and school personnel when appropriate.
5. Review new referrals at an interdisciplinary staff meeting within a specified time frame following evaluation.
6. Provide outpatient clinic treatment and case management services in accordance with NYS OMH regulations.
7. Coordinate activities with the school liaison and consistent with consent(s), share any information relevant to the student's functioning in school.
8. Establish how a Psychiatric Emergency involving students NOT on the Provider caseload will be handled.

## Strategies for Open Communication

\*\* Adapted from, “A Principal’s Guidebook: School-based Mental Health Programs” by Scott Bloom, LCSW-R, Director of School Mental Health Services, NYC Office of School Health.

<p><b>Ways that schools can foster strong communication and mutual respect:</b></p>	<p><b>Ways that Mental Health Providers can foster strong communication and mutual respect:</b></p>
<ul style="list-style-type: none"> <li>• Organize an orientation of the school</li> <li>• Introduce Mental Health Provider staff to school staff, including APs, Guidance Counselors, Teachers, Custodians, and SSAs</li> <li>• Distribute written policies and procedures to Mental Health Providers</li> <li>• Provide Mental Health Provider with a copy of the school’s Crisis and other appropriate plans</li> <li>• Notify Mental Health Provider Of important dates and school closings, including planned construction and renovation or other events that could affect program space</li> <li>• Offer Mental Health Provider access to school bulletin board and newsletter to communicate with students and staff</li> <li>• Provide Mental Health Provider Staff opportunities to participate in school trainings, School Leadership Team, and other meetings</li> <li>• Provide leadership in building support for the provider with parents/family members</li> </ul>	<ul style="list-style-type: none"> <li>• Provide school with Mental Health Provider’s annual report, brochures, and mission statements</li> <li>• Meet one-on-one with key school personnel and teachers to introduce yourself and explain how you hope to support the school</li> <li>• Link Mental Health Provider’s resources to the school and respective community</li> <li>• Leave classrooms in their original condition; leave school liaison or classroom teacher a note so they know whom to contact with concerns</li> <li>• Follow-up with any communication or referrals; Thank You and notes of appreciation to all staff are good practice</li> <li>• Be part of Orientation and other school-wide events (e.g. Report Card Night, Health Fairs, Talent Shows, Parent Teacher organization meetings, etc.)</li> <li>• Provide training for faculty to explain programs and services, protocols, etc.</li> <li>• Actively engage family organizations in your efforts</li> </ul>

**SAMPLE – Examples Only  
Principal and Mental Health Provider Planning Form**

Task	Principal’s / School’s Responsibility	Mental Health Provider’s Responsibility	Shared Responsibility (Indicate How)
Decide on the type of services to be offered.			
Hire and supervise additional staff.			
Work cooperatively with potential research and evaluation components			
Schedule follow up meetings to assess progress of programs with key stakeholders			
Building needs: building permit, floor plans, accessibility, after-school hours arrangements, etc.			
Recruit students for referrals and mental health services.			
Communicate with parents about the content of programs: consents, shared information, outreach, integration events and meetings.			
Secure space for activities.			
Coordinate outreach and publicity in classrooms offices, orientation, established protocols, integrated forums, etc.			

Ensure respectful treatment and cleanliness of school property.			
Designate school point person to work with Mental Health Provider and provider liaison for school.			
Provide supplies and materials for programs.			
Ensure a safe storage space for supplies and materials.			
Develop protocol for emergencies and/or incident reporting.			
Handle discipline issues that arise in programs.			
Follow-up with students who are being served by program.			
Other (e.g., school should find out if Mental Health Providers are contracted to work holidays; Provider should know about any planned construction or renovation that will impact programming space)			

\*\* Adapted from, "A Principal's Guidebook: School-based Mental Health Programs" by Scott Bloom, LCSW-R, Director of School Mental Health Services, NYC Office of School Health.

## **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](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](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/](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/>