

A Primer on the NYS Children’s Mental Health System for Local Education Leaders

**Information for Local Education Leaders on
Creating School and Mental Health Partnerships, including Implementing
the NYS Performance Based Early Recognition Coordination and
Screening Program***

***Outside of New York City**



Division of Integrated Community Services for Children and Families

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Creating School and Mental Health Partnerships, including Implementing the NYS Performance Based Early Recognition Coordination and Screening (Outside of New York City*)

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. 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 mental health clinics 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 clinics within the PBIS structure has been shown in numerous cases. In addition, the mental health system is now implementing the Early Recognition Coordination and Screening program that will greatly assist in the early identification of social emotional difficulties. . For these programs to be effective there is a need for strong collaboration between schools, other community agencies and the mental health system. 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 and provide some information about the Early Recognition Screening program in that context. A similar document has been developed for the mental health system's leadership and practitioners.

Core positives for schools include: Increased school engagement of children and families, improved student academic and behavioral outcomes and reduced reliance on restrictive settings 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 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 and their state operated children's psychiatric facilities, regional offices and related supports; 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 contained in the OMH budget that is developed by the Governor and the Legislature 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 severe mental illness. This can be done in conjunction with the legislature in establishing laws or through the development of regulations, policy and funding practices that will drive the local delivery system.

While OMH is the key state agency responsible for children's mental health, the delivery system is primarily provided through the 57 counties (New York City functions as one governmental entity for children's mental health). The local county leadership for children's mental health services is generally the Director of the county's Office of Mental Health. The terminology 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. All 57 counties have Community Services Boards, made up of individuals (professionals, governmental leaders, community advocates, parents, consumers, etc) who are appointed by the County Legislature or County Board of Supervisors. In counties with a County Executive (charter counties), these Community Service Boards are advisory boards, and their Directors generally report to the County Executive and the County Legislature/Board of Supervisors depending on the structure/terms used in any given county. In counties with a County Manager form of government (non-charter counties), the Community Service Boards have policy-making authority, and supervise the Director. Many of these counties often operate their own clinics that provide children's mental health services. They also fund and 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., United Cerebral Palsy).

The State Office of Mental Health (OMH)

The Office of Mental Health has responsibilities well beyond children's services. The agency is responsible for State operated Psychiatric Centers, adult services, including housing, forensic services, research and technical assistance, fiscal and audit responsibilities, etc. Many of the agency's divisions support the program offices. That understood, the OMH Division of Integrated Community Services for Children and Families is a key office in local mental health/school collaborations.

The Division of Integrated Community Services for Children and Families oversees five regional offices that monitor and provide technical assistance and development of policy and provision of medical support for the local mental health delivery system. This office implements key children's initiatives such as Performance Based Early Recognition Coordination and Screening and other programs targeted to children and their families that schools should be aware of. A 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 recent OMH initiative "Performance Based Early Recognition Coordination and Screening" is an initiative that provides funding for Early Recognition Specialists who maintain a community-wide, comprehensive, and efficient process by which active parental consent is obtained and children are screened for mental health problems in their communities. Partnerships with schools will greatly benefit access and can be a critical component to the success of this initiative. There is more information on Early Recognition Coordination and Screening later in this document.

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.

County Mental Health Services

School leaders are generally aware that there are 37 BOCES across NYS. The BOCES provide a variety of services and supports to schools. County mental health agencies are the mental health systems equivalent of the BOCES. There are 57 counties in New York State outside of New York City. Unlike in the education system, the other four large cities are considered part of the counties they are located in and depend on the counties for funding of a variety of services

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 will be necessary.

County Directors will oversee, even in large counties, a much smaller staff than generally available to school leaders. While there are always clinicians (generally LMSW) and other professionals who are licensed to work in mental health areas, the number of such professionals is often limited. Access to child psychiatrists is also a great concern upstate. Some counties operate their own mental health clinics and as such hire their own mental health professionals while others oversee/administer not-for-profit clinics and satellites that interact directly with schools or the community. As such, schools may find themselves negotiating collaborative arrangements concurrently with the county and, especially over the long-term, a not-for-profit provider.

A core principle in establishing school/Mental Health collaborations is that schools wanting to partner with the mental health system must establish a relationship with the county leadership. The Director of Mental Health and their Clinical Director are the key individuals.

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 will be licensed by the mental health system to provide mental health services to children located on school grounds or from community settings, with links to schools often being established. Hospitals also are a large component of the delivery system and often have satellite clinics located on grounds of schools or linked with school programs. 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 part of the human services system 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. County operated clinics and not-for-profit mental health programs generally work on a fee-for-service basis under contract with the county. Agencies do not have an annual tax-based budget that supports their staff. Simply put, such programs do not receive a budget backed by local property taxes as school districts do. They must provide treatment to clients to receive financial support through reimbursement for services provided, often tied to Medicaid rules. 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. In addition, private insurance can be used but reimbursement also depends on direct service provision. As a result, there are times when service providers while delivering appropriate and needed services may not be reimbursed. For example, discussions about children 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.

In working with schools, clinics may want to discuss ways that they can contract for services with the school or obtain fiscal relief through low cost use of facilities, day-to-day operating support (use of copiers, phones, etc.) or other means that enable them to absorb the cost of non-reimbursable services. To the degree the school can assist expands the capabilities of the clinic. Clinics should also understand the limitations of the school district so that they better understand the basis behind a district's decision. A frank and up-front dialogue on this issue is a critical aspect of the partnership.

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

- Mental Health school-based clinics 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 staff but simply to provide clinical treatment for children and families in a setting proven to be more effective and efficient than community-based settings. See Attachments 1-2 for a description of clinic and school staff roles and responsibilities and other considerations.
- Politics do play a significant role in how county programs function. The Director is responsible to the County leadership. The Director must assure that the chief officer of the county (e.g., County Executive) and the Board of Legislators or Supervisors is kept aware of county MH initiatives since any collaboration that affects resources will require their approval. This is not unlike the School Superintendents needing to assure that the Board of Education supports key initiatives.
- 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 building, 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.
- Counties do not have unlimited funds to use in any way a Director wants. Not unlike school districts, the vast majority of funds are accounted for through personnel contracts and other mandated services. While there is some flexibility in the use of funds, there are many competing priorities. The current fiscal situation and related tax caps and small appropriation levels result in county leadership being under great scrutiny on the use of funds.
- County or not-for-profit Clinical Directors 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 Building Principal is not showing an interest there is a problem with the collaboration that can’t be ignored.
- The structure of the clinic is often misunderstood. Depending on size, school based clinics can consist of a small number of professionals. Full time on-site support staff is a luxury most do not have. Supervision can be on-site or through visits. Article 31 clinics (let’s call them comprehensive as compared to satellite clinics) may employ a variety of “professional staff” and “clinical staff”, but must meet certain requirements with regard to the percentage of professionals on staff and the proportion of professional staff who are employed full time. In addition, all Article 31 clinics must meet a requirement regarding the availability of psychiatric staff. Most professional staff is either Licensed Master Social Workers or Licensed Clinical Social Workers, although 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”.
- 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 guidance 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 removal of a clinic's and the clinician's license. (See Attachment # 3 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.

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.
- Roles and responsibilities of mental health and Pupil Personnel Services Staff.
- Expectations for crises situations – recognition that mental health is only part of the answer.
- Schools are many and independent and counties must deal with all – Nine schools results in 9 different models/expectations. Not easy to manage.
- Impact on school staff time for collaborative activities can be challenging.
- 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.
- Services to district residents who do not reside in the county. Assuring that all students have equal access to services requires an up-front discussion and understanding.

Family Involvement and 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 is critical to success. The mental health system has been at the forefront of creating Family Support Services as a key component in addressing the mental health needs of a child in the context of their family. School districts also often 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. There are a number of good sources of information that can be found on the web. 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 the State Office of Mental Health: <http://www.omh.ny.gov/>.

Characteristics of Successful Collaborations

Successful collaborations go beyond simple collocation of services and actively form a partnership that can mature and address the ever changing needs of both systems as they emerge. 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. History shows that this is very important with school/mental health partnerships. Multiple levels of support are at the core of success in collaborations between schools and mental health. For example, support from Superintendents and mental health Directors/Commissioners; building level staff (educational and clinical supervisors/ teachers/social workers) 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. For example, the expectations and requirements of the education and mental health systems are extensive.

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. 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:

- Schools are expected and publicly monitored on their ability to meet State and Federal standards related to instruction and graduation (22 units of credit in mandated curriculum areas (e.g., English Language Arts, US History, Global Studies, Math, etc) and passage of 5 Regents exams), health, special education, transportation, safety, etc. Movement to the common core curriculum standards and teacher evaluation systems has requirements that are extensive and stringent. The number and specific certification requirements for staff create significant personnel problems. The level of public scrutiny has grown dramatically related to State standards, safety requirements, teacher evaluation systems and the Federal NCLB law. School student safety requirements (Dignity for all students Act) and the public awareness of them are significant factors in how schools handle disruptive students. 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.
- In a like manner, the mental health system, as well as the child welfare system and others, 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 difficult at best. Homelessness, a growing number of youth needing mental health services and family supports has put great fiscal and staffing pressure on county mental health agencies at a time when cutting budgets is a priority in virtually every county.

Other considerations include:

- Staff members from mental health and child welfare systems and schools are not interchangeable. All systems use social workers, psychologists and assistants in different forms.

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 funded appropriately.

- 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 to the same levels as school staff and will be working a 12 month year.
- State-wide many counties may provide services through contracts with community-based organizations (CBO). Therefore, while a school may have had discussions or arrangements with the county, the community-based organization may actually deliver the health, mental health, or other human services. If this is being done in the school, supervisory, administrative, information sharing policies and other policy issues must be addressed up front and consider the impact on multiple organizations.
- 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 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.
- School districts boundaries are not consistent with county boundaries. Not all children who attend a given school district, therefore, will be the responsibility of a given county. It is critical to address how this situation will be handled up front.
- Like any collaboration it is critical that it meet the needs of 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. 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.

** Schools keep a Directory of Information they may share with the public. A school has the option of specifying in its Directory Information Notice to district residents that it will only disclose directory information to certain third parties and provide a list of those third parties in the notice. But if it does, it must limit its disclosure of directory information to the third parties appearing on the list. Groups, for example, could be the parent-teacher association or a mental health partner. But if the school listed the groups to which it will disclose directory information and subsequently made a disclosure to a group not on the list, the feds would consider investigating such an allegation. Additionally, the school would have to publish a new directory information notice if it wanted to add a new organization to the list.

Under FERPA rules, a school may disclose directory information to a third party without consent if it has given public notice of: (1) the types of information it has designated as directory information; (2) a parent's right to refuse to let a school designate any or all of that information about the student as directory information; and (3) the period of time within which a parent has to notify the school in writing that he or she does not want any or all those types of information about the student designated as directory information.

Increasing Family Engagement

Parental notification, engagement and consent are obvious key components to any education and mental health partnership, including Early Recognition Coordination and Screening. 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 Early Recognition Coordination and Screening. Some things to consider in addressing the notification of parents include:

- If the focus is to be on young children, districts may 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, the Early Recognition initiative can be viewed more easily as part of early childhood screening efforts in general. 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 jr. 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 or other effort will have phone numbers where interested parents can get information if they have questions. 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) and encouraging parent participation may be of help.
- 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.
- Note that only under very strict circumstances could schools release parent demographic information to an outside agent (such as a mental health provider) so that the provider could do the mailing. See ** on page 11.
- Recognize that there are families who do not fully trust the school and address the best methods of engaging these parents. Consider cultural or historical issues and how best to increase parental trust. Family support programs have been a significant resource for mental health in addressing these issues.
- Linking efforts with community-based family supports has been shown to be a significant factor in increasing involvement of parents of students with emotional challenges.
- Research or 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.

New York State Performance-Based Early Recognition Coordination and Screening

Background

Seven years ago, New York State began a major shift in policy and adopted a public health approach to the early identification of children with mental health problems. To create an early identification program, OMH made available funding for one FTE Early Recognition Specialist in thirty-seven agencies from all regions in the state. The program started 1/1/2012 with an annual performance target of 1000 screens annually for each of the thirty-seven agencies. The Specialists' positions are supported by these OMH funds in acknowledgment that these staff people will not be generating revenue for their respective agencies but rather devoting 100% of their time to coordinating all early recognition activity within their designated area.

The objective of Performance Based Early Recognition Coordination and Screening Initiative (ERS) is to ensure that children who need mental health assessment are identified and engaged earlier in their development. Early Recognition Specialists:

- Conduct, coordinate and/or oversee all screening activity within a designated area;
- Implement stigma reduction curricula, social marketing activities, and program promotion activities;
- Network with parents, primary care physicians and other community leaders;
- Consult actively with family support service providers to improve engagement of families;
- Cultivate cooperative relationships with local primary care practices to promote screening activity and to facilitate referrals between clinics and primary care;
- Provide education to increase community awareness of social and emotional development and the importance of universal social emotional screening;
- Participate in existing child-serving agency networks, or facilitate the creation of new or stronger networks, and utilize those networks to continually evaluate for the need to target and screen particular populations;
- Conduct community outreach and develop effective strategies to obtain active parental consent for all children screened; and
- Meet or exceed annual performance target of 1,000 screens in year one. Performance target may increase in subsequent years. Screens counted may include those screens conducted by community partners as part of a coordinated, comprehensive, community-wide plan for early recognition which the Early Recognition Specialist oversees

The ERS Initiative collaboration can:

- Identify problems early and prevent a history of failure
- Improve school outcomes through increased emotional well-being
- Strengthen family engagement through the positive interaction that occurs in discussion about the screening.

To learn more about how your school can collaborate with ERS, see Attachment 4. Contact Kate Provencher at kathryn.provencher@omh.ny.gov for more information about ERS programs in your region.

Social Workers in Schools and Article 31 Mental Health Clinics

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 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 and/or with SSHSP staff at the NYS Department of Health or the appropriate staff at the Division of Child and Family Services in the NYS Office of Mental Health to avoid double billing.

Clinic Treatment Services

The following services are to be considered Clinic Treatment Services for School Mental Health Programs funded by NYSOMH. With the exception of mental health screenings, comprehensive mental health services, and crisis intervention services, students who qualify for these services must be enrolled in the SMHP clinic. In the case of crisis intervention services, it is important that school personnel distinguish between crises that require the intervention of a mental health professional and situations that can be effectively addressed by school personnel.

Required clinic services must be available at all primary clinic sites but not necessarily at each satellite site. (Clients who require a required service/procedure NOT available at the satellite location would be linked to the primary clinic site for this service/procedure.)

Clinics serving children are required to offer the following services:

Assessment

Initial assessment

Psychiatric assessment

Therapies

Psychotherapy:

- Individual
- Family/Collateral therapy
- Group therapy

Psychotropic Medication Treatment

Clinics may also offer the following optional services:

Developmental testing

Psychological testing

Psychiatric consultation

Health physical

Health monitoring

Injectable psychotropic medication administration – 2 types

A. Injectable psychotropic medication administration

B. Injectable psychotropic medication administration with education and monitoring

Enhanced Services

Crisis Intervention

Complex Care Management

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.

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.

Implementing Early Recognition Coordination and Screening– Some questions Educators may want to consider when talking to Mental Health leaders.

In developing support for implementing Early Recognition Coordination and Screening (or collaboration) you will have some questions and will also be faced with some questions that County Directors, providers and clinicians are likely to ask. Below is some information on Early Recognition Coordination and Screening. Having thought through these areas prior to meeting will help in solidifying support. It is a core principle of successful partnerships that working together to identify what the issues are and possible solutions is always a better way to handle agreements up front. If discussion leads to an issue, address it collectively up front. No surprises are a good rule! It is equally important that educators clearly understand their goals for the collaboration. Unrealistic expectations can ultimately limit the success of a partnership.

Provided below are some talking points to consider related to possible questions and issues that will generally emerge when establishing an Early Recognition Coordination and Screening program through a MH and Education partnership:

- What is Early Recognition Coordination and Screening and why should a school district should participate? What can we expect from the Early Recognition? How will this effort help us?
 - The program consists of coordinating the creation and maintenance of productive partnerships, conducting community outreach, engaging children and their families, obtaining active parental consent, and carrying out a community-wide plan for universal social-emotional screening of children. Each situation will be different but they will possibly need assistance from the schools in providing public information and linking with parents, access to youth who have permission for screening and other related assistance.
 - The ERS Initiative collaboration can:
 - Identify problems early and prevent a history of failure
 - Improve school outcomes through increased emotional well-being
 - Strengthen family engagement through the positive interaction that occurs in discussion about the screening.
- Will this program increase the number of the district's special education students? There are different thoughts. Consider these perspectives:
 - Many Special Educators have expressed the opinion that this program will actually lead to a reduction in special education placements. Youth and their families who have previously not received MH services and supports will now get them. The increased level of community services and flexible delivery of services is expected to assist these youth and their families in meeting their mental health needs, and could reduce the need for special education services. In other words, the children should do better when they receive research-based interventions and a greater level of support in the community. This should improve school performance and could reduce any given child's need for special education.
 - In addition, while an unknown number of these youth would likely need community services and other supports, including special education services, it is possible that a number of these youth are already receiving special education. They wouldn't be new to the education system, but would now be receiving flexible community-based services that support them and their families.

- It also could be argued that it is a legitimate perspective that universal screening could lead to early identification of kids who need special education services. This may indeed increase the number of Special Education students at early grades. However, it is also necessary to consider that early intervention will be more effective and result in ultimately moving kids out of Special Education, or, at the least, insure that the level of service they receive is more appropriate. This should reduce the intensity of service (and resultant increased expense) that result from delayed identification.
- The core question that should be addressed is: Will children who are identified and receive research-based services do better in school and the community? The answer is yes!
- What about Confidentiality? (Also see Attachment #3)
 - Confidentiality is a critical aspect of any school or mental health collaboration, including Early Recognition Coordination and Screening. At the core of the system is the parent's right to decide if they want their child to participate and who, if anyone, do they want to receive information resulting from the screening, assessment or services.
 - It is very important that a complete understanding of confidentiality is reached between the school and the provider(s) before the program is initiated.
 - The school must be aware that there are some families who will not want to share the information. School and Early Recognition staff must be aware that this is a prerogative of the parent.
 - Any agreement should address how the school and provider will work together to assure that parents are best positioned to make a decision about the sharing of information. This would include the benefits of a collaborative approach involving the school and treatment program. Questions may include:
 - How will confidentiality be addressed?
 - Will we learn the results of the screening and subsequent assessments?
 - What do the permission slips look like and how are they addressed with the parents?
 - What information will be obtained and how will it be shared?
 - See Attachment 3 for more information on Confidentiality
- How should records retention be handled?
 - If the question of records retention comes up, since this is an OMH program, OMH recommends that upon return, original forms do not stay with the district. Districts could retain copies of the documents (for those children who have signed releases). The provider has to retain such information three years after the child turns 21 or six years whichever is greater.
 - Information for school districts on student privacy/confidentiality can be obtained at: <http://www.p12.nysed.gov/irs/privacy.html> 
- How will notification of parents and obtaining consent be handled? Parents have to get information on Early Recognition and consent to the screening of their child, what are some of the best ways to handle this task?
 - There are options. Generally Early Recognition providers will look to the schools to explain how this is best handled by considering what methods have been successful in the past.
 - Many districts have suggested that focusing on young children through 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, the Early Recognition Program can be viewed more easily as part of early childhood screening efforts in general. Collaborative efforts at getting information out are also more easily accomplished in this format.
 - Since the program is not solely for young children, involvement of parents at other school transition points (e.g., elementary to middle school) has also been encouraged. Notification

of parents has generally been best handled by schools. If due to local policy, a school needs to request support for cost associated with the mailing, address with the provider 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.

If the Mental Health provider wants to send the notices, they need to understand that only under very strict circumstances could schools release parent demographic information to an outside agent so that the provider could do the mailing. (See ** on page #9 of this document.)

- The county may want to involve the media. It is necessary to get information out to assist in a positive response and avoid parents and community members from misunderstanding what Early Recognition is. How should the media be informed and media inquiries handled?

Again, joint agreement is important. The school leaders may or may not want a role in this process. However handled, it is important that the message convey a prevention theme, not an attempt to unduly identify children.

- If a school already has a clinic in the building, what will be different?

This will depend. Each program will look different, so the discussion should focus on what, if anything will be done through the existing school-based/school-linked program.

- Screening will be done by the Early Recognition Specialists “screeners.” Will the screeners be available if there is an emergency with a child?

Generally, no. The role of the Early Recognition Specialist is somewhat different in each county. The role should be discussed so expectations are clear. Discussions concerning implementing screening under Early Recognition Coordination and Screening point to the importance of being able to identify possible screening instruments and the provider and schools working together to determine how screening will be conducted. While it is important to reach agreement on how screening might be best accomplished, it is equally important to have an understanding of the tools to be used so that there is a clear understanding of the evidence-based instruments available. This will enhance any discussions with parents school staff might have.

- Does Early Recognition Coordination and Screening replace other requirements related to Child Protective Services (CPS) or how a district would refer student/parents to a hospital if they suspect a child is depressed or a danger to themselves?

No. CPS reports and psychiatric emergencies should continue to be handled as emergencies. If an existing clinic has a role in this process it should clearly identified.

- What will be needed from school leaders and their staff to make this effort successful?

The response will differ based on each situation. Generically, support within the community, access to school information dissemination mechanisms and school space for screening, and parent information sessions.

- Will Early Recognition Coordination and Screening cost the district any money? Are there other resources a district is being asked to provide?

In some cases, utilities and clean up support if a building is being used for meetings or screening, possibly postage if a separate mailing is anticipated, staff time if sharing of information is occurring, etc. The overall cost to the school district generally will be in-kind in nature.

- Will this effort take away from instructional time?

Not if well planned. The provider may not understand that in any given building this could be a significant issue. Work with the provider to find alternative times that the students will be available. Depending on ages, this might mean study hall time, recess time, after/before school etc.

- If the building principal has a problem with how things are going, who do they talk to and how will disputes be resolved?

This is an important aspect when constructing the program. It is effective to set up a collaborative leadership team that addresses conflicts or any a number of methods for dealing with issues. What is critical is that the partners are aware of the process and it is responsive to questions or issues.

There will be points where each system will identify why they cannot do something (usually some law, regulation or policy – not necessarily quoted accurately). While often these situations appear as possible serious impediments, keep in mind that collaborative programs have been going on for a long time. Generally there is a solution. An up-front, team approach to implementation can short-circuit these types of situations.

- Who do parents, teachers or other school staff contact when they have questions?

This is a program run by the mental health system; generally the school will want mental health representatives to address questions. Having a system in place to do so up front prevents issues from growing into real problems.

- What are the expectations for Early Recognition Coordination and Screening?

Early Recognition Coordination and Screening will not be able to meet the needs of everyone. A realistic expectation of what the Early Recognition Specialist can do is very important. Early Recognition was initiated through a RFP process. The Early Recognition Specialists were charged with creating and maintaining a community-wide, comprehensive, and efficient process by which active parental consent is obtained and children are screened for mental health problems in their communities. The Specialist's will be working across a continuum of community settings and locations based on the needs and priorities of the communities that they have defined.