School & Mental Health Partnerships

What Local Mental Health Leaders Should Know when Creating Partnerships with NYS Schools

"A Primer for Understanding the New York State Education System"

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NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Division of Integrated Community Services for Children and Families

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A Special Note: Challenges and Opportunities Presented by An Evolving Children's Behavioral Health System

As a key component of the children's public mental health system in New York State, providers are fully aware that the system 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 planned transition of behavioral health services into Medicaid Managed Care and the impending enrollment of eligible children into Health Homes are just two examples of the massive changes that children's healthcare is experiencing.

The current state of flux makes it somewhat challenging to offer firm guidance to those wishing to partner with mental health providers. What had in the past been a fairly static field is now transforming before our eyes. The most useful advice to be offered at this point is that mental health leaders engage in comprehensive dialogue with local school partners. Let them know the pressures providers are under and the directions they are going. Issues might include changes in ways of measuring outcomes, potential issues with new payment methodologies, the uncertainty while forging new partnerships with other healthcare providers, and the potential of eventually offering an expanded array of services.

It is now, more than ever, critical for schools and providers to fully understand 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. Working with school partners will only enhance our ability to address those needs.

Why Mental Health/Education Collaborations Benefit 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 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 and treatment of mental health symptoms with evidenced-based practices. For these programs to be effective there is a need for strong collaboration among 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 local Mental Health leaders interested in school/Mental Health partnerships in understanding the structure, culture, and issues that impact potential school district partners. A similar document has been developed for the Education system's leadership and practitioners.

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

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

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

An Overview of the NYS Education System

The NYS Public Elementary and Secondary Education System in General

The New York State Education system related to the public elementary and secondary education schools consists of the NYS Board of Regents (BOR), the State Education Department (SED), regional educational entities called Boards of Cooperative Educational Services (BOCES) and the local School Districts. The BOR is the policy making board for education in NYS. They establish the policies and regulations that drive the pre-school, K-12 (Elementary, Middle and Secondary schools), higher education, the professions and cultural education in NYS. Regulations of the Commissioner of Education are approved by the Regents. SED is the state agency that oversees the implementation of the State's educational requirements.

The Board of Regents supports partnerships among schools and the health and human services systems as strategy for improving student achievement. Members of the Board represent Judicial Districts (made up of counties) or are designated as at-large members. Knowing the Regent who represents your area can be an effective tool in achieving school and mental health partnerships. Knowing the Regent who represents your area can be an effective tool in achieving school and mental health partnerships. Information on the Board of Regents website.

For the purposes of establishing partnerships between schools and local Mental Health providers, key components are the SED, Boards of Cooperative Educational Services (BOCES) and local school districts (often referred to as LEA or Local Education Agency).

State Education Department

The State Education Department is made up of five (5) Offices. The Office of Pre-kindergarten through Grade 12 Education (P-12) is the key office when addressing local mental health/school collaborations.

Office of Pre-kindergarten through Grade 12 Education

The Office of P-12 Education oversees pre-Kindergarten through 12th grade programs. When considering a partnership with Mental Health or other health and human service agencies, P-12 is the key office within SED. It is the office for addressing educational standards and day to day operations of local school districts. The office also addresses innovative school models and school support areas such as social work, guidance, psychological services and school health programs, etc. The three support areas mentioned above are often referred to as Pupil Personnel Services (PPS). P-12 also administers the regional technical assistance offices, including Positive Behavioral Interventions and Supports (PBIS) that can serve as a structure for the integration of mental health services into the school and improve identification of student's in need and access to students. The office coordinates school construction (i.e., space) issues which can impact collocated partnerships. The BOCES District Superintendents are also coordinated through this office. BOCES leadership plays a significant role in the success of local partnership programs in schools outside of the major cities. Regulations and polices related to special education, including collaborative programs such as school-

based day treatment programs (see * page 14), are also addressed by the P-12 Office of Special Education. There are regional Special Education Quality Assurance offices staffed by Regional Associates who monitor and provide technical assistance to school districts. Check here for regional Special Education office near you.

Boards of Cooperative Educational Services (BOCES)

There are 37 BOCES across NYS. The BOCES organizations are led by the District Superintendent of Schools, referred to as the District Superintendent or DS. These individuals have a dual role. The DS is a State employee responsible for providing leadership as the representative of the Commissioner of Education in their region. The DS is also the Chief Executive Officer of the local BOCES. This education leader, and their leadership team, is the key individual(s) in successfully implementing collaborative partnerships at the local level.

As well as providing leadership, BOCES is a service provider. By law, BOCES provides instructional and support services to component school districts when districts cannot provide such services as effectively or efficiently on their own (i.e., *Cooperative* Educational Services). BOCES provide a wide range of services. Special Education and Career and Technical Education (CTE) are well known BOCES services. Often they provide special education in collaboration with local Mental Health providers. Information and technology support and regional training and instructional support structures are also key services that can impact successful Mental Health-School partnerships. All school districts except large cities are component districts of the BOCES (e.g., Upstate - Buffalo, Rochester, Syracuse, Yonkers, etc. are not BOCES components, but may purchase certain services from BOCES. New York City is not associated with BOCES.

The BOCES DS is a critical regional education leader. However, it is important to recognize that local school district superintendents are independent. While collectively they work with the BOCES DS to provide education leadership within the region, they do not directly report to the BOCES DS. (See local school districts below). Check here for a listing of District Superintendents and their regions.

Local School Districts

There are just fewer than 700 school districts and over 4000 schools in NYS. Local School Districts are operated by a locally elected Board of Education. The chief administrative officer of a school district is the Superintendent of Schools. This leader oversees the total school program and reports to the Board of Education. While school districts are similar, most school districts have their unique administrative structure. Common personnel terms you might run across are:

Superintendent - The school superintendent is the leader of the school district and works for the elected Board of Education.

Assistant Superintendents - Other terms are used, such as Coordinator of: Curriculum and Instruction, Special Programs, Finance/Business, Grounds, Transportation, etc.

Pupil Personnel Services - Guidance, Social Work, Psychological Services and might include Special Education in smaller districts. Note that these individuals are considered instructional staff and are trained and certified to assist in the instructional process. See Attachment B for information on the roles and responsibilities of Social Workers.

Director of Special Education - Oversees the provision of special education for the district's pupils, including the Committee on Special Education (CSE). Larger districts will also have a separate Chairperson of the CSE

Athletics - Athletic Director (Note: important in providing leadership in assuring participation of all students in a variety of during and after school programs – significant motivators for students). They will have a significant say in establishing flexibility when addressing student mental health or other needs and active participation in extracurricular activities, including interscholastic sports.

Building level administrative/instructional leadership staff - Principals and Assistant Principals who are the instructional and management leaders in any given school building. While many functions are separated administratively within a school district, the **key leader** in any building within the district is the Principal, closely followed by the Assistant Principal(s). They will have a say in any program being considered for a building and ultimately its success.

Instructional Staff -Teachers or Teaching Assistants (different than Teacher Aides). Teaching Assistants are individuals who meet state requirements and assist students in the instructional process.

Teacher Aides - These individuals assist teachers in non-instructional areas. State requirements are different from Teaching Assistants.

School-based Medical Personnel - School Nurse Teacher and Nurse Practitioner. School Nurses have proven to be highly successful in integrating students facing challenges into health programs, screenings, etc.

New York City

New York City (NYC) schools are administered through the NYC Department of Education (DOE). While much of this discussion document would apply in establishing school-mental health partnerships anywhere in NYS, there are administrative structures and issues that are specific to NYC that are not covered. For information on establishing school-mental health partnerships in NYC, contact the DOE/Office of School Health, School Mental Health.

Things Local Mental Health Leaders should know about the Culture and Day-to-Day Operations of a School District/Building

- Boards of Education play a significant role in how a district functions. The Superintendent is responsible to the Board of Education. Not unlike assuring that the County Board of Supervisors is kept aware of county Mental Health initiatives, any collaboration that affects district funds or resources will require the

Board to give their support. Don't be surprised if discussions include issues such as concerns over negative public perception and the purpose of schools. While generally understood that school and human service partnerships advance student outcomes, different members of Boards of Education bring a broad range of perspectives that Superintendents must be sensitive to.

- Districts do not have unlimited funds to use in any way a Superintendent wants. The vast majority of funds are accounted for through personnel contracts, building and grounds maintenance and transportation. Just like at the county level, while there is some flexibility in the use of funds, there are many competing priorities. Also see Funding Issues below.
- The primary source of funding for school districts is a local tax levy. State aid and federal funds are other primary sources, but is generally less than 40% of the Budget. State aid also takes many forms with little flexibility. Some schools also receive other targeted support from the legislature. Districts can compete for School Innovation Funds (SIF) that can be used to address linkages with the community to enhance the school learning environment. There are also competitive Community School grant funds.
- Principals, while reporting to Superintendents and Assistant Superintendents, are still the key person in developing and implementing a successful collaboration in their building. If they are not showing an interest or are unwilling to integrate the program into the school, there is a problem with the collaboration that you can't ignore. This issue is especially important given the turnover rate of principals.
- Teachers and PPS staff members also play significant roles in determining what programs are priorities in their buildings. 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 with the School Psychologist and Social Workers is especially important. Also, don't forget the school Nurse as they are a key staff person in addressing the health and mental health needs of students. Guidance Counselors, while their training provides them with a broad range of skills, due to local culture will often be confined to academically focused leadership roles. However, like all of the above professionals, it often depends on the personalities involved and the district's perspective on their roles. The more you work at developing partnerships that integrate versus simply co-locate services the easier it will be to identify these key individuals. History shows that strong school-wide support can be invaluable when faced with leadership turnover (as per above).
- Sharing of Information: State-wide experience shows that a collaboration that does not share information and provide a real resource in addressing student needs runs the risk of losing support of the school staff. It is important to negotiate why information is needed to do what 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 among mental health providers and schools working together toward a common outcome.
- Each district has a number of Superintendent Days that allow for training. While most focus on improving staff instructional skills, there is an opportunity to address training of staff on a proposed collaboration.
- Positive Behavioral Interventions and Supports (PBIS). Many schools will be using PBIS to address their learning environment. School-based health and/or

mental health collaborations have shown that these supports are a natural partnership with PBIS. Research is showing improved educational and emotional outcomes when mental health services are integrated into the school PBIS structure. Simply collocating services can improve outcomes, but collaborative training and support leading to integration of the partners has been shown to enhance the effectiveness of both PBIS and the mental health services. Go to www.PBIS.org for more information on PBIS.

- Space in a 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 program staff who may be working in the schools. The building leadership may struggle with this in certain situations. It is important to reach a compromise that meets the needs of everyone. A fair resolution to any concerns is critical to both partners. It is not ok for the mental health program to be put in insufficient and/or inappropriate space (e.g., limited privacy).
- Waiting lists. The issue of waiting list is a significant one for school districts. It is foreign to their culture. For example, in special education there is law and regulation based time frames in which a student must be served. Every effort should be made to assure them that youth referred for services will be seen in a timely matter. The district will be concerned that the parent will focus concerns on them if a recommendation is made and follow through is significantly different than in the education system.
- Roles and Responsibilities. When establishing school-based or school-linked services always keep in mind that community treatment staff do 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. Working out appropriate roles and responsibilities prior to starting the partnership can significantly enhance the effectiveness of the school and clinic professionals. With appropriate training the integration of both systems can be infinitely more effective. See Attachments B for a description of clinic and school staff roles and responsibilities and other considerations. This is a critical partnership component.

Funding Issues

Behavioral Health Managed Care

As the State Mental Health system moves to a Behavioral Health Managed Care model, funding of services provided in schools or in collaboration with schools will be impacted. The managed care system will likely required some form of an agreement with schools and providers will want schools to fully understand the impact on the delivery of services. The need to manage the care and cost can be impacted in many ways. While schools cannot pay for treatment, the district can also contract separately with the provider under very specific circumstances for certain services, generally, but not always, special education Individualized Education Program (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. In addition, there are possible in-kind methods of contributing to the

fiscal viability of a school-based clinic. Low or no cost agreements for space, utilities, security, etc. can provide a significant benefit to a provider's bottom line. At the same time, providers do need to understand that unreimbursed participation of their staff in certain school functions may be required for both partners to realize the potential of the partnership.

School Supportive Health Services Program (SSHSP)
Most school districts participate in the SSHSP, a program where schools access Medicaid reimbursement for certain school provided services included on the IEP for qualified students with disabilities. Providers and schools need to address this program in their agreements/Memorandums of Understanding (MOU) to ensure against disallowances for double billing. Information on the SSHSP can be found at: http://www.oms.nysed.gov/medicaid/

Increasing Parental/Family Involvement

Parental notification, involvement and consent are obvious key components to any successful mental health services initiative. While parental involvement often is cited as an issue, the schools will know what methods have historically worked best. Linking with the school to lend credibility to the mental health program is an option that should be addressed with your partners. Conversely, Mental Health providers should also be aware that they will also run across parents who do not trust the school. In these cases the provider can work with the school to enhance participation. In any case, it is likely to take time to achieve the level of involvement desired. The partners should be mindful that patience and persistence will be necessary. You should be aware that at 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 screening or any other mental health initiative for children. To make sure that your information gets in these tools, you must address this as soon as possible to make sure the information is received at the appropriate time. Here are some things to consider in addressing screening options and the notification of parents concerning mental health programs and individual contacts:

- If you are focusing on the screening of 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, mental health screening 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. Many programs set up information booths during kindergarten screening or other family focused "nights" that can be used to increase awareness.
- Back to school nights in the fall and other transition points are great opportunities to get information to parents and assist students in understanding that assistance is available. Transitions from pre-school to kindergarten, elementary to middle school, middle school to junior high or high school generally involve "orientation days" or information nights for parents and/or students. If you link with them in a discrete way (e.g., part of a school health or Social Emotional Development and Learning (SEDL) presentation or information) it can assist in catching the attention of students and their parents.

- Make sure the information included in a mailing or other effort is short and to the point. Provide phone numbers where interested parents can get information if they have questions. Make sure those answering the phone during summer vacation periods are trained. It is possible that parents would call the school directly so make sure school staff knows where to redirect their calls.
- A letter from the school Superintendent and/or the building Principal supporting the collaboration activity and encouraging parent participation may be of help.
- Participation in the School Parent Teacher Association (PTA) or equivalent parent organization's events and including these leaders in sending information to parents may also encourage parents to consider participation.
- Schools may have Family Support workers who can be invaluable in linking with families in a timely manner.
- Schools could handle disseminating the notification. Due to local policy, they may request support for cost associated with any mailing. This is something that addresses treating all community organizations fairly and cannot be set aside for any given organization.
- If schools do a mailing, reach agreement on where the responses should be sent. It is recommended that the original go to the Mental Health provider with a copy to the school district, if the district wants a copy. If all materials are to be forwarded to the provider 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 14 of this publication.
- Most schools address Social, Emotional Development and Learning (SEDL) as part of the school culture and curriculum – very simplistically, Bully Prevention and other positive learning environment issues. Community Mental Health providers can link with the schools staff to provide assistance in these efforts.

Assessing the Impact of Your Partnership

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

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

- Attendance. A primary focus. Attendance is a key indicator of future school engagement/success in young children and prerequisite for academic success in older youth. Youth engaged in school are far more likely to complete their education than drop out. Social/Emotional Development and Learning indicators: More information found at: http://www.p12.nysed.gov/sss/sedl/
  - Page 16 provides information on key markers:
    1. Violent incidences
    2. School attendance and absenteeism (also see above)
    3. Student misconduct
    4. Availability of illegal substances

5. Bullying, harassment, intimidation
    - School discipline indicators. Addressing suspensions and internal discipline referrals is important in getting a handle on the school's learning environment.
    - Improved school/classroom participation. Could be addressed through school staff/youth surveys on school satisfaction and participation.
- 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, access to employment opportunities for youth and families (e.g., use of Career Zone), after school programs and proactive youth development or delinquency prevention programs, impact of School Resource Officers, etc.).
- Improved Family participation. Addressing improvements in consistent parent participation in their child's education (e.g., on-going involvement with their child's teacher and in key school functions, ability to assist with homework, etc.).
- Outcomes on School State Assessments. Ultimately, the school's success is in large part determined by these outcomes. Note: Impact takes time. Don't expect immediate improvement in an area that is very complicated.

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 system is monitored 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.?

"Lessons Learned"

What Makes a Partnership Successful?

First and foremost, involve the school 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 critically important in collaborations with schools. These characteristics apply to all partners – not just the mental health provider.

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 partnerships 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. Successful collaborations have understood 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:

- Education System. 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, Math, etc.) and passage of 5 Regents/or other exams), health, special education, transportation, safety, etc. The curriculum requirements are extensive and stringent. The implementation of the Common Core has created much anxiety among educators and parents and may reduce the time available for critical partnership meetings and training. The number and specific certification requirements for staff can create significant personnel problems, especially in PPS areas. Safety requirements and the public awareness of them are significant factors in how schools handle disruptive students. Note the publicity surrounding school report cards and the release of school safety data. The recent focus on teacher accountability could also create discussions related to any impact on instructional time.
- Community Mental Health Services. In a like manner, the mental health system, as well as the other human services systems, has their own set of extensive requirements, personnel issues and a greater level of cost containment pressure from county and State government. Growing fiscal issues and pressures on county leaders have made implementation of new initiatives challenging. Chief among them is the roll out of the Behavioral Health Managed Care system that while offering much opportunity to provide a greater range of services, will take time to fully implement and understand as it evolves. The Mental Health system is also impacted, as schools are, by poverty and the trauma it creates. Poverty impacts a growing number of youth needing mental health services **and** family supports, putting great fiscal and staffing pressure on the system.

Other considerations that contribute to a successful partnership:

- Staff members from mental health and child welfare systems and schools are not interchangeable. This is a critical issue to understand. 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. This is a deal breaker issue for schools.
- 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 your staff. If someone

criticizes the program and you say, “I have not heard of any complaints about this program” – you likely 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. Often people tend to focus on the problems and forget to recognize the very tangible benefits of the partnership so get out in front of this right away. For example, work to find a way for both systems to take a look at aggregate data on a periodic basis to see how the collaboration is working. Mental Health workers could look at various outcome measures (e.g., improved utilization) and schools could look at their attendance, behavioral and 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. If your partnership is with a school implementing a PBIS structure the ability to use data to show improved outcomes is greatly enhanced.
- Pick your partner(s) carefully. Any collaboration will not be able to meet the needs of everyone right away! A realistic expectation of what the collaboration can do is very important. Inevitably, the process will result in some school districts not being involved, at least initially as Providers determine the match is not a good one (e.g., a certain school has issues that make it clear it is not ready to partner). Carefully pick your partners based on the key issues identified in this document. Others can come on board over time.
- All things considered, ensuring active engagement of parents is the biggest challenge that the partnership will face. Working together on strategies and building trust through involvement with parent organizations, family support staff and support groups can help.
- Given the above, it is also important for everyone to understand that the system will evolve and that the ongoing relationship between the school districts and providers is a critical linkage in establishing a successful community children’s mental health system. It is also proven that a successful partnership is a win-win as it leads to greater school engagement – a significant factor in achieving school success. To that end, actively work to encourage an ongoing dialogue with school leaders and involve them in your children’s mental health agenda. As indicated earlier, the BOCES DS is an essential partner in this process.

* Please note that school-based programs (e.g., Day Treatment) are under review as the State moves to a managed care system. Significant changes are possible.

****** 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 Family Educational Rights and Privacy Act (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.

Attachment A

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 generally not able to share individual child information. The partnership should be able to work out how to best use aggregate data to assess the effectiveness of the partnership in addressing school-wide outcomes. What information or records can be shared between school staff and clinic staff?

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

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

Attachment B

Social Workers in Schools and Article 31 Mental Health Clinics

In order to acquire permanent certification, School Social Workers must be Licensed Master Social Workers (LMSWs) or Licensed Clinical Social Workers (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 staff with 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 (SSW) 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 (SSW) 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. This experience provides knowledge and skills which are critical to the function of helping teachers address the special instructional needs of children.

There are times, however, when the work of a School Social Worker may need to be supplemented by a community-based 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 and the school social worker is not qualified to bill Medicaid, 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. 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 staff at the NYS Office of Mental Health to avoid double billing.