

What Local Mental Health Leaders Should Know when Creating Partnerships with NYS School Districts*

“A Primer for Understanding the New York State Education System”

*** Outside of New York City**

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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 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 (i.e., parental involvement), improved student academic and behavioral outcomes, positive youth development, improved school safety 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.

An Overview of the New York State Education System

The 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 Board of Regents and SED also have responsibility for oversight of higher education, the professions and cultural education institutions (e.g., State Museum, libraries), but those components do not come into play when creating partnerships between mental health and 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. Information on the Board of Regents and its members can be found at: <http://www.regents.nysed.gov/> 

For the purposes of establishing partnerships between schools and County Mental Hygiene programs, 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 P-12 Education is the key office when addressing local mental health/school collaborations.

Office of P-12 Education (P-12)

The Office of P-12 Education oversees pre-K through 12th grade programs. The division has diverse responsibilities, including: **Accountability; State Assessment; Curriculum, Assessment, and Educational Technology; Information and Reporting Services; Innovative School Models; School Operations; Special Education;** and implementing the Regents Education Reform Plan and New York State's **Race to the Top (RTTT)** initiatives focused on implementing the Common Core Curriculum, establishing state-wide data systems, improving instruction and accountability with a focus on turning around low achieving schools.

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***, 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. The regional Special Education office near you can be located at: <http://www.p12.nysed.gov/specialed/quality/regassoc.htm> 

ACCES: This office is responsible for Adult Career and Continuing Education Services. This includes Vocational Rehabilitation services for adults with disabilities. ACCES also coordinates regional offices for Vocational Rehabilitation (VR) across the State. These offices play a large role in transition services for students with disabilities preparing them for adulthood and the provision of job skills assessment and training and other employment supports for adults with disabilities. The VR regional offices can be located at: <http://www.acces.nysed.gov/vr/do/locations.htm> 

Higher Education: Establishes standards and coordinates regulations and policy with NYS public and private institutions of higher education. This office includes teacher and other certification areas.

Professions: Establishes standards for the professions in NYS, including those professions that are the cornerstone of the mental health system in New York State.

Cultural Education: Oversees cultural institutions in NYS, including libraries, which can be a great source of information dissemination on local services and programs.

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 are well known services provided by the local BOCES. Often they provide special education in collaboration with local Mental Health Day Treatment providers. They also provide alternative education programs serving general education students. Information and technology support and regional training and instructional support structures are also key services. All school districts except large cities are component districts of their local BOCES (e.g., Upstate - Buffalo, Rochester, Syracuse, Yonkers, etc. are not BOCES components, but may purchase certain services from BOCES as needed). 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)

NYSED divides the state into nine Joint Management Team (JMT) Regions. Each JMT contains three or more BOCES. Such arrangements can facilitate situations where school district and county boundaries are not consistent and students who may need to be served are not residents of the county.

A listing of District Superintendents and their regions can be found at: <http://www.p12.nysed.gov/ds/directory.html>

Local School Districts

There are just under 700 school districts and over 4000 schools in NYS. While generally located within a county, there are also districts whose boundaries run across multiple counties.

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 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. Note that these individuals are considered instructional staff and are trained and licensed to assist in the instructional process. See Attachment B for additional 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 Committee on Special Education. This is also a key function.

Athletics - Athletic Director (Note: important in providing leadership in assuring access to participation of all students in a variety of during and after school programs). They will have a significant say in establishing flexibility in addressing student mental health or other needs and active participation in extra curricular 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 with challenges into programs, screenings, etc. They are often a very important to successful collaborations.

Things Local Mental Health Leaders Should Know About the Culture and Day-to-Day Operations of a School District/Building

- Politics do 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 MH initiatives, any collaboration that affects district funds or resources will require the Board to give their support. This is also true of collaborations due to the sensitive nature of discussions concerning the purpose of schools. While generally understood that collaborations involving schools and human service agencies advance the school's 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. Currently, districts are under great scrutiny on the use of funds due to the property tax cap issues and a few high profile fiscal cases in the state.
- 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. The level of aid is different for each district and is based on formulas that consider wealth. Special education aid is weighted aid and based on the number of students and their time receiving special programs and services. Federal funds (e.g., NCLB Title funds or IDEA (Individuals with Disabilities Education Act) are generally distributed based on student counts or formulas. The IDEA provides some flexibility for collaborative initiatives with special education funds, but the amount is limited. Race to the Top (RTTT) funding is also used within schools but is generally targeted. 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.
- 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.
- 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. In many school buildings there is an informal structure that relies on veteran educators, such as a teacher who has the respect of the rest of the staff. 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. Overall, if the staff believes a program will benefit kids and address issues the youth and staff face, it will get support. 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 the vast majority of school staff is invested in positive outcomes for their students. However, 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 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 and its impact on 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. Many 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 to the clinic 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.
- Serving nonresidents of the county. Mental Health providers generally serve the residents of the county they are contracting with. School-based programs must serve all students regardless of residency.

- 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. Working out appropriate roles and responsibilities 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.

Increasing Parental/Family Involvement in School-Based Mental Health Initiatives

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 worked best in their history. Linking with the school to lend credibility to the mental health program is an option that should be addressed with your partners. It is likely to take time to achieve the level of involvement desired. The partners should be aware 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 with school leaders 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 school 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 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 PTA or equivalent parent organization's events and including these leaders in sending information to parents may also encourage parents to consider participation.
- 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 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 13 of this publication.

Lessons Learned About the Characteristics of Successful Collaborations

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. It is important to note that 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:

- 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. The curriculum requirements are extensive and stringent. The implementation of the Common Core has recently created much anxiety among educators and parents and may reduce the time available for critical partnership meeting and training. The number and specific certification requirements for staff can create significant personnel problems, especially in PPS areas. The level of public scrutiny has grown dramatically related to State standards, teacher accountability, safety requirements and the Federal initiatives (e.g., NCLB, RTTT). 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 on any impact on instructional time.
- In a like manner, the mental health system, as well as the child welfare system and others, have their own set of extensive requirements and personnel issues and a greater level of cost containment pressure from county 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. 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.
- 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, and policy issues must be addressed up front and consider the impact on multiple organizations. Appropriate roles and responsibilities must be jointly agreed on and clearly convey to all involved.
- 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 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 share aggregate information, 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.
- 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 this issue up front. A Superintendent or school Principal may not even be aware of this, but when it comes up they will want to know what will happen to a student who needs services but is not a county resident. OMH

has indicated that school-based mental health programs must serve all students. The payment process will be worked out within the MH system.

- 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. Mental Health Commissioners will determine the priorities within their county. Inevitably, the process will result in some school districts not being involved, at least initially.
- 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 the county MH 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.

* **New York City:** NYC schools are administered through the NYC Department of Education (DOE). 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.

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

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.

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.

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 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 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. 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 Division of Child and Family Services in the NYS Office of Mental Health to avoid double billing.