School-based Mental Health Services: Project Prevent

QUESTION AND ANSWER SUMMARY

On June 4, 2015, the National Center on Safe Supportive Learning Environments (NCSSLE) hosted a webinar to discuss integrating school-based mental health services into schools. In attendance were Project Prevent and Elementary/Secondary School Counseling grantees. During the session, the presenters (**Elizabeth Freeman**, American Institutes for Research; **Nancy Lever**, Center for School Mental Health) received several questions from the audience. Because the presenters could not answer all of the questions submitted during the event, the Center has prepared the following Webinar Q&A Summary with responses to each question. For additional information, please email or call the Center (ncssle@air.org; 1-800-258-8413).

> *Please note the content of this summary was prepared under a contract from the U.S. Department of Education, Office of Safe and Healthy Students to the American Institutes for Research (AIR). This Q&A Summary does not necessarily represent the policy or views of the U.S. Departments of Education or Health and Human Services, nor do they imply endorsement by the U.S. Department of Education.*

Question 1: Are there good models for reintegration from hospitalization?

a. **Nancy**: At the University of Maryland (UMD) we have a school transition program for students coming out of psychiatric placement. It connects families to a family support partner, as well as a licensed clinician who works with the family and the school team for 90 days following the release from the hospital with the goal of preventing re-hospitalization. We know a large percentage of students who are hospitalized end up being readmitted in a short period of time, especially in the first 30 days. It has been very successful at UMD. One of the things we know is we cannot assume that the reintegration process is happening on its own and it is important to have a standardized practice to integrate them back into school. This includes everything from how will they explain their absence, to missed work, to how to transition back to the school setting.

Question 2: How do you select mental health providers? Do you look at non-profit agencies, county programs, and independent licensed professionals?

a. **Nancy**: In terms of selecting a community partner, that involves a MOU, thinking about the things you are looking for, and being able to understand if it is something that

agency or program can agree to. Do they have the reputation, staffing, and capacity to address those needs?

b. **Beth**: Some Safe Schools/Healthy Students (SS/HS) grantees have struggled with this as well. They had many providers in the community and struggled to select the best ones. What they did was put out a call for proposals sharing what they wanted their program to look like and the services they wanted. The community providers respond to the call for proposals, and the school districts chose the provider based on how they fit with what the district wanted to develop in schools and how they would partner. Then they created a memorandum of agreement (MOA) with that school. They found that some agencies might work better in different schools (elementary, middle, and high school) and based decision on what fit best. The principal should have a chance to interview potential candidates and qualified staff to make sure they fit with the school environment and school staff with whom they would work.

Question 3: How do you manage insurance and copays with community therapists on site? Are schools responsible for assisting parents with those fees?

a. **Nancy**: The community therapist would be responsible for collecting that copay. Often it would be done through their agency and sent to the family. Children are not often coming in holding their copay amount, so it would be billed. It is typically the responsibility of the community provider to send the bills, not the schools.

b. **Beth**: What we have found with many school mental health programs is that no money is exchanged at schools. All paperwork is done at the school and then the provider agency would bill for services just like any other type of medical provider.

Question 4: Do mental health professionals in schools bill insurance?

a. **Nancy**: For our outpatient community mental health center they do bill in the schools and they would be billing under their outpatient mental health center. They are credentialed and approved to deliver services through an outpatient program, so typically they are connected to a larger entity, not just the school setting.

b. **Beth**: A lot of times non-profit agencies will have a contract with a Medicaid agency or some other insurance agency whereby they would bill for those services, or they have a grant that would pay for those services. In part of your MOA you should talk about the specifics of what would be provided.

c. **Nancy**: One of the things that can be very helpful is including community partners – maybe a hospital, an outpatient program, a university – because they may have eligibility to access certain grants or funding sources that schools may not, and vice versa. You are potentially expanding your pool of available dollars.

Question 5: Should we use child psychiatric training programs? What are the benefits?

a. **Beth**: We have often used child psychiatric training programs in schools, and often that is part of one of your community-based programs. You would have a MOA with the

school and that program. They can provide a lot of services – from meeting with families and students, to looking at the types of services and treatment plan students might need, to medication (if needed), and even doing professional development for teachers on mental health issues. There are a lot of great ways to use this resource, so I would suggest getting in contact with the school district to suggest a psychiatric program you would like to use.

b. **Nancy**: Our psychiatrist trainees, as well as our social work, counseling, and psychology trainees, have been critical to our programs clinically but also it is really tremendous for the work force. I believe that our psychiatrists, many of whom end up in outpatient settings after they finish the program, will never quite look at schools the same way and they have learned a lot from the experience. It is part of their training and being in the school setting is so critical. We have hired many of our trainees into clinical positions so it is a known entity. The other benefit of working with trainees is that you do not have to worry as much about what is billable or not billable and you can focus more on prevention services.

Question 6: What role does the school have during the initial stage of services with a student (e.g., contacting parents, scheduling appointment times, etc.)?

a. **Nancy**: Typically the school's role would be around making the referral, sometimes as a discussion with parents, which is recommended, but often the actual outreach to the family will be done by the clinician who will be working with the family. That way the school would not have to take on added work, which is good since school staff often have little time and would not welcome taking on additional roles.

b. **Beth**: Often the school instead of the community provider makes the first official link by connecting the family with a school-employed staff member, such as the guidance counselor, as the first person to contact the family. It is so important that the family understands this is a resource and they have been linked by a trusted person in the school first to share this information with them, rather than the person providing the service contacting them like a cold call and the parent being blindsided.

c. **Nancy**: That is why it is so important that the person or the agency providing services becomes a part of the school. Ideally they are at the back-to-school nights and present at special activities, so people get to know them so when the school meets with parents, they can say, 'You can contact this person and use this resource if you have any concerns.' The more the provider is part of team, the more accepting our communities will be. It is also nice when providers are not just doing the top tier work and are also working with students who are doing very well and are partaking in the schools prevention strategies. That way when a student is working with a provider, it does not mean that they have an identified mental health concern. The provider is a resource for all students.

Question 7: If the services are provided by outside agencies and are necessary to support the individualized education program (IEP), how can the school control the services, goals, and supports?

a. **Nancy**: The services we are referring to are often outside and augmenting traditional IEP services. Because the IEP is a legal document, community mental health partners are not written into IEPs, and if they are written into IEPs there has to be a clear process for sharing because it goes into their educational record.

b. **Beth**: One of the things that I think is confusing to schools and providers is that when you have an IEP, the purpose of counseling services is educational in nature to assist with the student's learning abilities and is related to their education. If this is the purpose, then that would be under the "related" section that the school is responsible to provide or contracting with a professional to provide. If it is supplemental in nature and has to do with a child's emotional state, to deal with trauma or family matters or mental health diagnosis, and not really related to a child's educational ability, that is part of a supplemental plan. What you want to do is connect with the agency supporting the student who you know has an IEP and invite that agency to a student support team meeting often so they can give updates on how that student is progressing and create a chain of communication to make sure the services are being provided. The school is not liable for the supplemental services, but they are liable for the educational services.

Question 8: If it is not part of the IEP for special education students and the parents do not follow through with referrals, then how can we ensure there are school-based mental health services available?

a. **Nancy**: Our clinicians, community providers, and school support staff tend to be quite persistent with reaching out to families who may not initially return phone calls to make sure consent is signed and the student is seen. A benefit of having a continuum services is if they cannot get consent to receive individualized care, they are still being serviced in other ways such as classroom and school-wide activities.

b. **Beth**: A lot of times, parents or students might have trouble with the stigma around the word 'mental health' or being seen by someone on site at the school. Over time you want that person, that student in particular, to get to know the school mental health provider by going through some early intervention groups with their peers or doing some of the universal interventions in the classroom so they then can feel comfortable with that intervention and the provider. Also, reach out to the parents; have a parent partner who serves as a peer counselor for other parents go talk to other parents to share the benefits of meeting with the mental health counselor or provide small groups on topics of interest in the community or have a safe place to meet with parents in a partner agency or organization that the parents trust to reach out to families. We need a team of people to help us with all of the different student needs that we need to address, so if you are not reaching them one way, there are lots of other ways to find a comfortable level with that parent to partner with you and receive the services they need.

Question 9: Are there particular marketing strategies that you would recommend for use with parents who are resistant to mental health services for their children?

a. **Beth**: Have ways that parents can go to the website to get information for themselves for how they would reach out to their child if they are having a particular issue. For instance, place information on your school website about parent techniques for a variety of youth issues, from test anxiety to suicide. Find out what questions the parents have and let the parents help you build that website because they know what other parents are asking. Reaching out to them that way can help them become comfortable with creating a mentally healthy student and overcome that stigma of mental health.

b. **Nancy**: Talk about mental health as part of general wellness and overall health where, just like you would take your child to a pediatrician, this is just another strategy. Often parents, by the time a mental health professional is involved, are already frustrated with some of the negative experiences or phone calls they may have received and do not know what to do. We recommend joining the parent in a collaborative approach where parents get the message from schools that, 'We are here to help. We are a team. We are not here to be the expert to tell you what to do. We will work together. We know a lot about mental health, you know a lot about your child, and together we will figure out what could work.'

c. **Beth**: Parents are our best advocates, and what we know is that when parents are involved, children do better. Parents on your team will tell you how to make it user-friendly for them.

Question 10: Does the school system pay for school clearances or does the family pay for it?

a. **Beth**: If it is a school-related issue, the school generally would be in charge of that type of service. If the school hires, for example, a social worker, that is a service they are providing. If it is a community provider, then often that provider will be able to receive reimbursement to pay for their service. Sometimes schools will contract with a provider to provide mental health services in their school and it could be as small as $5,000 to do some professional development training and consultation, or it might be to provide services just for students under the IDEA category and using IDEA funds, or it may be paying for a person to come in and provide tier 1 and 2 interventions and then the community agency/mental health provider pays for the treatment interventions from their funding source. Make sure that you are following the guidelines for the use of funds – federal, state, or county.

Question 11: Many mental health clinicians are not trained in suicide risk assessment and treatment. Have you done any staff training, policy/protocol development, or other activities to be prepared to help a student who may be suicidal?

a. **Beth**: Yes, we have a lot of different types of trainings for suicide assessment. One of our grantees is doing the Signs of Suicide screenings in middle schools and screened 400 students with parental consent and found that 200 of them showed signs of sadness, depression, and anxiety based on a rash of student suicides that happened in the last two months in that community. The question then was how to get services to these students immediately. They reached out to community providers to help students receive the services they needed or referrals to community providers, whatever the parent and child felt most comfortable with. It took them a month to do this, but it really decreased the anxiety of the staff as well who knew half the students who were screened needed services.

I believe it was related to the suicides and that students needed to talk about the incidents, their feelings, and coping mechanisms.

Question 12: How can community providers best use school space during school, after school, and evening hours, when there may not be office staff available to help connect families with providers?

    a. **Beth**: A lot of times schools staff remain on site at school after school hours and community providers are allowed to stay in the school to meet with families, parents, and students. The providers can stay in the school as long as someone else is there. This allows the families better access to the mental health provider. In the summer they often use the space in the school to provide those services. Providers would not have a key to the school; they have to have the principal's permission.

    b. **Nancy**: You also need to be conscious of what other programs are in the building. There might be multiple programs that have a need for space in the evening on any given day.

Question 13: What program evaluation tools do you recommend to improve the quality of the coordination of the services between the schools and community partners?

    a. **Beth**: Most of our schools programs have developed a school mental health database that the school mental health staff will use but is not part of educational record or community mental health record. They track parent and youth satisfaction survey data, how many referrals were provided, how many sessions were held, what types of diagnoses were given, and what types of services were provided. They can analyze these data periodically to know how they are doing and if they need to revise their program. We do have a list of lots of evaluation tools that we can share with you.