MH Affinity Group, October 19, 2009

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Breakout Group 1

MH Delivery - Topics for Discussion

Create an environment to increase School MH

Access to parents and students: MH providers got referrals from school personnel, and these providers spent summer contacting students and parents. Use Student Improvement Team. Get referrals from staff, two counselors do home visits. Conduct groups. One group not have success in getting parent permission at first, but were successful after home visits. Did billboards, brochures and newspapers to promote services.

Service utilization in school: To avoid stigma staff did not start out identifying staff at MH providers; called themselves school support personnel.

Service utilization in community:

Confidentiality

Consents: Have a release of information on form. Case Managers work with counselors and principals, making the first contact with the consent for release to anyone, including JJ.

Share information between school staff, MH, JJ, etc.: One site had a cover sheet for JJ, doctors, et al. where they would check off all the people they were working with, and would know even if the family was not willing to release information. Some releases are very specific as to where information may be given.

Creating a confidential space for SMH sessions:

Breakout Group 2

MH Social/Emotional/Behavioral Services – Topics for Discussion

Various SMH needs (view next slide)

Universal – prevention/awareness: One site using PBIS—phased schools in with training at different levels; systematic shift school by school. Plan is that all schools will use. One challenge—in high school level individual teachers have their own systems so all have not bought into the uniform system of PBIS. In another site, all support services people wrote down what services they provide; found that most services were secondary and tertiary, so site saw that they needed to work on primary prevention for universal audience. Another site uses PBS district wide now, identifying students to refer

to student improvement teams. Complements RTI. Positive Action intervention. Another site felt that most services were for 2nd or 3rd tier and needed to work on universal.

Indicated – early intervention:

Targeted – specific interventions: One challenge, struggling with getting reimbursement. Looking at ways to help children without a diagnosis. Don't have to have a diagnosis to serve them.

MH Diagnosis:

SMH:

MH provider in community:

Breakout Group 3

Referral Process – Topics for Discussion

Protocol for referrals: One site uses prevention specialists in all schools, who serve as gatekeepers in the referral process. The prevention specialists make referrals to mental health therapists. Referrals go from teachers, counselors, and principals to prevention specialist. One site uses Teen Screen (Columbia University) for all 9th graders, with parents signing consent to participate. Case managers make referral to school- or community-based services. If parent says no to Teen Screen, then a counselor or social work will contact parent, which sometimes results in parent's giving permission to participate in Teen Screen.

Teachers, guidance, parent, student:

Obtaining appropriate MH paperwork :

Parental Permission for SMH: One site talked about getting consent being different, dependent upon who was providing the services. There is a universal referral with everyone going through the guidance office; with a higher need clinicians may use a different referral process.

Consents for treatment: Informed consent for treatment which reviews the limitation of confidentiality. Other release form is HIPAA compliance form that goes to wherever they need to go. State of OH can have two sessions with students without permission from parents, but try to get consent at first session to be more conservative.

Information Sharing