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TASK FORCE ON COLLABORATIVE SERVICES REPORT

A Report to the Minnesota Legislature

February 2006

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Legislative Directive

The Task Force was convened according to the following mandate from the 2005 Minnesota Legislature:

TASK FORCE ON COLLABORATIVE SERVICES. 435.17 The commissioner, in collaboration with the commissioner of education, shall create a task force to discuss collaboration between schools and mental health providers to: promote co-location and integrated services; identify barriers to collaboration; develop a model contract; and identify examples of successful collaboration. The task force shall also develop recommendations on how to pay for children's mental health screenings. The task force shall include representatives of school boards; administrative personnel; special education directors; counties; parent advocacy organizations; school social workers, counselors, nurses, and psychologists; community mental health professionals; health plans; and other interested parties. The task force shall present a report to the chairs of the education and health policy committees by February 1, 2006.[1]

Introduction

The role schools play in the provision of mental health services to school-aged children is a topic of growing study and debate. Research indicates that public schools are playing an increasingly important role in the provision of mental health services for school-aged children. A study published this year by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)[2] indicates that schools are responding to the mental health needs of their students, but the findings of the study also suggest increasing needs for mental health services and the multiple challenges faced by schools in addressing these needs.

The 2005 Minnesota Legislature[3] sought a review of this issue, requiring the Department of Human Services, in collaboration with the Department of Education, to create a Task Force on Collaborative Services: co-located mental health services and integrated services in schools. This report presents the discussion of the Task Force in the required areas of:

- promotion of co-location and integrated services;
- identification of barriers to collaboration;
- development of a model contract;
- and identification of examples of successful collaboration.

Additionally, the Task Force was charged with making recommendations on payment for children's mental health screening.

The legislation creating the Task Force stems from the Minnesota Mental Health Action Group (MMHAG), established in 2003. MMHAG is a coalition of individuals and agencies working on mental health reforms. The MMHAG co-chairs are the Commissioner of the Minnesota Department of Human Services and the Board Chair of the Citizens League. One of the subcommittees established by the MMHAG was the **"Integrated Pathways for Mental Health and the Schools."** The objective of this subcommittee was "to develop and implement strategies, initiatives and processes that improve school climate, mental health screening, and access to mental health diagnosis and treatment for students in need of mental health services, whether in special education or regular education."[4]

The focus of the subcommittee included three distinct but overlapping components of mental health and the schools:

- Positive School Climate

- Early Identification and Intervention
- Diagnosis and Treatment

In the area of diagnosis and treatment, the MMHAG Integrated Pathways Subcommittee recommended:

"Co-locate mental health professionals/agencies or develop contractual relationships with community providers to be available to schools and accessible for services when needed and appropriate. Providers can be agencies, individuals, Collaboratives, etc. However, it is important to make sure providers are credentialed (CTSS, MA, health plans) or enrolled with health plans to maximize coverage and payment. Use providers to do a wide range of things from consultation with classroom teachers, administrators, and others, to providing direct services and training. Services need to be available both during and after-school hours."

One of the recommended action steps from this subcommittee in the area of co-location was:

"Advance legislation to create a task force to promote co-location and integrated services, identify barriers to collaboration, develop model contract, and identify examples of where collaboration is successful."

The legislation passed by the Minnesota legislature was based on this recommendation from the MMHAG Integrated Pathways for Mental Health and the Schools Subcommittee.

Process

The Department of Human Services, in collaboration with the Department of Education, convened a 35 member Task Force with representation as stipulated in legislation (Appendix A lists the full membership of the Task Force.) The Task Force met on three different occasions to fulfill its mandate.

With input from the Task Force, the Department of Human Services (DHS), Children's Mental Health Division, prepared a survey designed to inform the Task Force on what was currently occurring in Minnesota schools with respect to co-location of mental health services and how these services were integrating with school support services. The Task Force considered information from current literature, the survey and the expertise of the Task Force members.

The web-based survey link was sent via e-mail on November 9, 2005, to:

- School superintendents
- Special education directors
- Mental health providers
- Task Force members (to re-distribute)
- Family Services and Children's Mental Health Collaborative coordinators

DHS received a total of 144 responses, from 92 school districts contracting with 63 mental health provider agencies. (The complete survey results can be found in Appendix B.)

Additionally, the Departments of Human Services and Education created a work group with participation from both agencies and representation from health plans to explore possibilities for payment for children's mental health screening. Staff from the work group updated the Task Force and included members' input in developing recommendations.

Findings

Co-location of Mental Health Services and Integrated Services in Schools

The most important issues identified by the Task Force in the discussion of co-located mental health services and integrated services in school were grouped as follows:

- A receptive climate and understanding of children's mental health issues in schools, in particular addressing issues related to stigma
- Funding for children's mental health services
- Use of evidence based children's mental health services
- Data privacy and confidentiality issues when delivering mental health in schools
- Parental consent and family involvement in the delivery of mental health services

The Task Force recognized the importance of the role of student support services – school psychologists, social workers, counselors and nurses - in the provision of mental health services in schools. (Letters to the Task Force from the student services associations are included in Appendix C.)

Key points:

- Parental choice is paramount in the determination of services. Parents should have the right to choose the service provider and determine whether they want to have services delivered within the school, the clinic, or other setting.

- Coordination and integration of mental health services is critical across the service continuum beginning at early identification of children's needs, through assessment and diagnosis to providing services or treatment, and after-care or supports if/when treatment is completed.

- The children's mental health needs should drive the level of services.

- Collaborative programs need to draw on the expertise of the existing systems and personnel and when that is done well, positive outcomes are achieved. Survey respondents noted a rise in grades and academic performance, an increase in school attendance, and less classroom disruption.

Promotion of co-location and integrated services

The Task Force agreed to the following definitions:

Co-located Services: Services that are set or placed together, for example, school-based or school-linked mental health services, or locating services, such as mental health services, from another agency at school facilities.

Integrated Services: Integrated services refers to the full continuum of children's mental health programs and services that encompass efforts to promote positive development, prevent problems, respond as early-after-onset as feasible, and to offer access to and coordination of diagnostic and treatment services. In an integrated service system student support personnel (school psychologist, school social worker, school nurse and school counselor) services are woven together with community resources and incorporated with the instructional efforts of the school to promote healthy development.

"Child" or "children" for purposes of this report refers to a person birth to 21 years of age, unless otherwise specified.

The Task Force identified the following benefits of co-located mental health services and integrated services in schools:

- **Improved functioning/reduction of symptoms of children with a mental health disorder, which reduces barriers to learning**

  The Task Force believes that when students' mental health needs are addressed early through coordination of care (that is, when professionals involved with the child are talking, working together), then positive outcomes are achieved. Being able to coordinate with student support services for specific accommodations led to these improvements.

  Some respondents to the survey indicated that students served by mental health programs in schools improved academically as well. They noted a rise in grades and performance, increased student attendance, less disruption in classrooms and more focus on academics. These findings are supported in current literature on the issue of mental health in schools.

- **Improved accessibility to mental health services**

  When mental health services are provided to children at their school site, many barriers are reduced, particularly for lower income, highly stressed populations. Parents may not need to take off work, find transportation, or take their children out of school for large parts of the day to get their children's mental health needs met. In rural areas, where driving a child to a mental health provider can take hours, having the provider in the school greatly facilitates access. Parents may be more successful in following through with referrals for therapy and keeping appointments consistently, all of which helps make treatment more effective. Overall, children will not miss as much class time to go to therapy sessions, and benefit from easier coordination of accommodations in school with other student supports.

- **Improved school climate towards mental health issues**

  When mental health services are provided in school there is a greater opportunity for the promotion and understanding of mental health issues among school personnel. Student support services, such as school counselors, social workers, psychologists and nurses, also work with providers to participate in creating a positive school climate towards mental health issues. Greater training and consultation for teachers has helped improve school climate toward mental health issues and reduce stigma against mental illness. In many cases, because families feel closer to schools than to other social service institutions, it also helps educate families around issues affecting their children.

- **Enhanced opportunities for funding**

  When a provider and / or a school district are certified by Medical Assistance (MA) / Children's Therapeutic Services and Supports (CTSS), and are part of health plans third party reimbursements can be accessed.

  Mental health services in schools may receive funding support from the Local Collaborative Time Study (LCTS) dollars. The Children's Mental Health and Family Services Collaboratives allocate LCTS dollars to support cross-agency interventions, such as co-located services, thereby bringing an additional resource to schools for these types of services.

- **Improved opportunity to clarify liability**

  When mental health services are provided in a school by a certified mental health provider the contract between the school district and the provider clarify liability. Liability related to the mental health services provided in the school is then assumed by the mental health provider. A certified mental health provider is able to access a full range of necessary mental health services for a child on a 24-hour/7 day a week basis. The provider develops a comprehensive treatment plan that includes psychotherapy, access to crisis services and hospitalization if needed.

Identification of barriers to collaboration

Task Force discussion and survey results revealed the following top three barriers to providing co-located mental health services through the schools:

1. Insufficient funding for delivering needed mental health services
2. Lack of appropriate space in schools to adequately provide services
3. Insufficient resources for professional development for school staff and mental health providers around the mental health needs and services for children and working collaboratively.

Discussions of the Task Force confirmed that these are current challenges to successfully co-locating and integrating mental health services within schools. Developments at the federal, state and local levels often drive resource issues, such as funding, space and staffing, for both schools and mental health providers. Concerns revolved around pending drastic reductions to Local Collaborative Time Study (LCTS) funding and complexities of third party billing.

The Task Force acknowledged that schools do not have enough space to adequately meet the co-location needs, in particular to maintain the privacy and confidentiality needed for this type of service. Members also discussed the need to increase understanding of children's mental health needs and available services because the connection between mental health issues and school achievement is not always recognized.

The Task Force also discussed other barriers related to the need to enhance school personnel's understanding of children's mental health needs and services. Many challenges come with connecting schools and mental health providers; each comes with their own policies, procedures and priorities. Occasionally concerns arise about supervision of co-located staff as well as disparity in pay between the school and agency staff. This is all further complicated by the societal stigma still surrounding students with special educational and mental health needs. Moreover, families can bring culturally diverse definitions of mental health and culturally appropriate treatment.

The Task Force considered other issues that sometimes get in the way of effectively providing co-located mental health services. The group verified the survey's finding that data practices (consent/release forms) often pose barriers. Another challenge is the lack of availability or accessibility of services. For example, there are often shortages of qualified mental health providers, particularly in rural areas, and not enough culturally specific providers throughout the state. The Task Force discussed challenges in determining, effectiveness of services and issues around ensuring service quality.

Elements of successful collaboration

The Task Force discussed the elements of successful collaboration in the area of children's mental health in schools:

- **Adequate funding**

  The Task Force recognized the significance of inadequate funding for children's mental health services and urged that it be among the first elements that need to be addressed. Not only was there insufficient funding when the children's mental health legislation was originally enacted, but over the past years changes in policy have resulted in more reductions. In particular, children that are underinsured or uninsured are at risk of placements and even more costly interventions to the systems that serve them. What is more, the Local Collaborative Time Study (LCTS) funding, which support many of the co-located programs, is at risk of being seriously decreased. Schools are having to fill the gap in community-based mental health services as a result in the reduction in funding for children's mental health services.

  The Task Force asserts that a comprehensive funding solution to support children's mental health be found, and that new funds replace LCTS dollars that may be lost. Current funding for student support staff is inadequate. For example, a situation of perceived inequity is created if a mental health provider comes to a school where there are limitations on hiring school psychologists or counselors.

  When third party reimbursement is insufficient or low, then the burden for paying for services may fall on the schools if services are required by a child's Individual Education Program (IEP).

  Additional money needs to be available to fund co-located and integrated services in the educational setting.

- **Clear determination of roles**

  The Task Force emphasized the need for positive partnerships between school student support staff and mental health providers that come to schools to provide mental health services to children with a mental health diagnosis. Successful collaboration was linked to clearly defining the roles and responsibilities of each type of professional in the school, and understanding that mental health providers come to school to work with children that require the intensity of service and specialization that they provide.

  The Task Force recognized the need to respect and value the contributions of the different professionals working in schools around the issue of children's mental health. Student support staff in schools play an important role in helping to identify children with mental health needs, helping inform school personnel and promoting a positive school climate toward mental health issues, and addressing the needs of the broader student population in the area of promotion of good mental health. Mental health providers contracted by schools – licensed psychologists, clinical social workers, psychiatrists, psychiatric nurses, etc. - provide the intensity of services that children diagnosed with an emotional/severe emotional disturbance need.

- **Focus on the children and meeting their needs**

  The Task Force stressed quality of mental health services. This included the need to identify children early, provide interventions at the earliest moment they are identified, and invest in interventions that have proven to work.

  Ultimately, the focus should be on the children and their needs. Students should be able to say that they were supported by their school and community and have been successful

socially and emotionally, as well as academically. Parents need to be able to say that their children's needs are being met.

In summary, the Task Force discussed elements of successful collaboration which include the following.

- Improved coordination and communication
  - Reduction in duplication of assessments and services
  - Integration of services driven by the family
  - Continued efforts in multi-agency team planning and coordination of care (IEP, IIIP, etc.)
- Development and implementation of positive school climate
  - Creation of positive partnerships throughout school building and community
  - Establishment of an environment accepting and embracing differences
  - Specifying time for planning, relationship building and training
  - Support from leadership and school administrators to promote collaboration
  - Education of school staff about mental health needs and available services
- Increased providers awareness and appreciation of school systems and services
  - Education of mental health staff about school support services (school counselors, nurses, psychologists, social workers, etc.)
  - Clarification of respective roles, responsibilities and relationships for meeting mental health needs
  - Building trust with staff and students at the schools

All these professionals working together create a comprehensive approach to children's mental health that improves a child's functionality, reduces symptoms, and increases attendance and academic success, so more children with an emotional disturbance can graduate from school, and remain in their school and community.

Sample contract

Samples of service contracts were received from some survey respondents. With these samples and input from members of the Task Force who volunteered to participate in a work, a sample contract can be found in Appendix D. Please note that the inclusion of this sample contract does not constitute a requirement.

Findings and Recommendations

Payment for Children's Mental Health Screening

The Task Force was charged with the responsibility to make recommendations regarding how to fund children's mental health screening. To facilitate this task, a small work group was formed. The work group consisted of staff from Children's Mental Health, Financial Management and Health Care Divisions of the Department of Human Services, a staff representative from the Department of Education and a health plan representative.

To guide the work group's effort, additional funding was included in the Task Force deliberations if a screening program had a children's mental health/social emotional component as well as federal or state mandate to implement the program (except private commercial health insurance). Screening programs vary according to the age of child screened and setting in which the screening occurs. It should be noted that many of the screening programs may also screen for physical health, vision and hearing, and/or other developmental domains. (See Appendix E.)

Findings

Although the charge of the Task Force was to make recommendations on how to fund children's mental health screening, the Task Force engaged discussion of the broader topic of screening.

The following is a brief summary of the topic areas discussed by the Task Force.

- **Lack of broad public awareness, understanding and agreement regarding children's mental health disorders and the role of screening**

  The Task Force discussed problems related to the lack of understanding children's mental health disorders and role of mental health screening. Without this understanding, it is easy to generate anxiety about and opposition to mental health screening. To promote an understanding of mental health disorders and mental health screening, a public relations and education campaign is essential to provide clear and accurate information about the benefits of identifying mental health problems early. This type of strategy will help to increase the acceptance of mental health disorders and mental health screening to build consensus, and promote related policy and funding strategies.

  Two specific aspects of screening were also discussed by the Task Force. First, the inclusion of parent involvement is pivotal in any successful children's mental health screening effort. It is fundamental for parents to drive the screening process, including parental consent before screening occurs. Parents should be given information about the benefits of screening, the screening process and have an opportunity to ask questions. A second key component of screening is to adequately address the language and cultural values of children and their families when screened. Unless this issue is addressed, it is difficult for some communities to trust and support children's mental health screening.

- **Timing**

  Children's mental health screening is currently occurring when the serious problems are already present, such as when the child is in the juvenile justice or child welfare systems, or has been suspended more than 10 days in schools. The Task Force discussed that when a child is already involved in these systems, screening can be too late and after the fact, so it needs to occur earlier.

- **Fragmentation**

  The Task Force discussed how many screening efforts and many components are scattered in different parts of systems and statutes, but they are not comprehensive or coordinated.

- **Early childhood screening funds**

  The Task Force acknowledged the inadequate funding in some school districts for the Early Childhood Screening Program for children. This is a state requirement for children before they enter kindergarten, and is targeted for 3 to 4 year olds. Screening for social emotional issues is a component of an early childhood developmental screen. The 2005 Legislature changed the reimbursement rate of the Early Childhood Program to the following: $50 for 3 year olds; $40 for 4 year olds; $30 for 5 year olds. In 2003-04, the average cost for the basic components of a developmental screen was about $60 per child.

  When Early Childhood Screening categorical aid does not meet actual costs, districts draw on K-12 general fund aid, in-kind contributions, community education funds, community resources, and use of volunteers. There are additional costs that affect the larger school districts such diverse languages (interpreters, follow-up calls, letters, etc.).

- **Service availability and accessibility**

  The purpose of screening is to identify possible problems and refer for evaluation and services, if indicated. The Task Force expressed concern about adequate availability of services for children that were diagnosed.

Recommendations

The Task Force discussion of how to fund mental health screening led to more policy questions, rather than actual recommendations of how to pay for mental health screening. However, the Task Force did make one funding recommendation and several policy recommendations. Below are the Task Force's recommendations:

- The Task Force acknowledged lack of broad public agreement about children's mental health screening. The Task Force recommends a coordinated screening approach which emphasizes early screening before problems occur.

- The Task Force recommends continued efforts in working with private commercial health insurance to encourage children's mental health screening in clinics and other medical settings.

- The Task Force acknowledged the inadequate funding for some school districts to implement the mandated Early Childhood Screening Program. Because general education funds and other resources (like volunteers) are used in some districts to supplement the funding for this screening requirement, the Task Force recommends additional funds for the Early Childhood Screening Program.

- The Task Force acknowledges the concern about children's mental health screening for diverse populations. The Task Force recommends an analysis of which social emotional/mental health screening tools and processes best reflect and respect varied cultural values and beliefs.

- The Task Force acknowledges concerns regarding the lack of resources available for diagnostic evaluation and service referrals for children who have been identified by the social emotional/mental health screens. The Task Force recommends the expansion of mental health services for children, especially in greater Minnesota.

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[1] Laws of Minnesota 2005, First Special Session, Chapter 4, Article 9, Section 2, Subdivision 9
[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *"School Mental Health Services in the United States, 2002-2003."*
[3] Laws of Minnesota 2005, First Special Session, Chapter 4, Article 9, Section 2, Subdivision 9
[4] MMHAG Integrated Pathways for Mental Health and the Schools Subcommittee Recommendations, June 2005.

Appendix A
Task Force Membership

Minnesota School Boards Association (MSBA)
Kirk Schneidawind

Minnesota Association of School Administrators (MASA)
Charles Kyte

Minnesota School Social Workers Association (MSSWA)
Anne McInerney

Minnesota School Counselors Association (MSCA)
Anne Erickson

Minnesota School Psychologist Association (MSPA)
Olivia Melroe

Minnesota School Psychologists Association (MSPA)
Ralph Maves

School Nurse Organization of Minnesota (SNOM)
Julie Young Burns

National Alliance on Mental Illness (NAMI)
Sue Abderholden

Minnesota Parent Leadership Network (MPLN)
Carolie Collins

Minnesota Association for Children's Mental Health (MACMH)
Deborah Saxhaug

Parent Advocacy Coalition for Educational Rights (PACER)
Renelle Nelson

Minnesota Association of County Social Services Administrators (MACSSA)
John W. Dinsmore

State Mental Health Advisory Council Children's Mental Health Subcommittee
Ramon Reina

Washburn Child Guidance Center
Steve Lepinski

HealthPartners
Stephanie Frost

HealthPartners
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United Behavioral Health (UBH)
Dana Fox

Blue Cross / Blue Shield Minnesota (BCBSM)
Cindy Goff

Behavioral Healthcare Providers (UCARE)
Katy Dale

Human Services Inc. (HSI)
Mark Kuppe

Range Mental Health Center
Kristin Lofgren

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Relate Counseling Center, Inc.
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Olmsted County
Patrick McEvoy

St. Louis County Family Services Collaborative
Edie Carr

Minneapolis Public Schools
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Intermediate School District 287
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Ann Boerth

Minnesota Department of Human Services
Bill Wyss

Minnesota Department of Human Services
Task Force Lead Staff
Amalia Mendoza

Appendix B
Co-located Mental Health Services in Schools
Survey Results

I. Overview

The survey:

Staff from the Children's Mental Health Division of the Minnesota Department of Human Services developed the survey, in collaboration with the staff from the Minnesota Department of Education, with the input from the members of the Task Force on Collaborative Service.

The web-based survey link was sent via e-mail on November 9, 2005, to:

- School superintendents
- Special education directors
- Mental health providers
- Task Force members (to re-distribute)
- Family Services and Children's Mental Health Collaborative coordinators

The survey was available from November 9, 2005, until November 30, 2005.

Respondents:

- DHS received 144 responses to the survey.
- Of these, 123 responded that the school had either a mental health unit in the school; the school contracted with a community mental health provider / agency to co-locate mental health services at school; and / or the school contracted with a community mental health provider / agency to provide services to students at a nearby satellite clinic.
- The respondents identified 92 independent school districts where these types of mental health programs exist. Respondents indicated 176 school sites where these co-located / contracted mental health services existed.
- The respondents identified 63 different mental health providers / agencies that have entered into contracts with schools to provider mental health services.
- 64 respondents were school professionals (22 school social workers; 11 school principals; 11 special education teachers / coordinators; 10 directors of special services; 4 school psychologists; 3 school superintendents; 3 school counselors).
- 56 respondents were mental health provider staff (program directors; licensed psychologists / therapists; mental health facilitators; practitioners).

II. Characteristics of the Clinical Mental Health Programs in Schools

Type of program:

Co-located mental health services in schools are the predominant type of mental health program, as reported by the respondents to the survey:

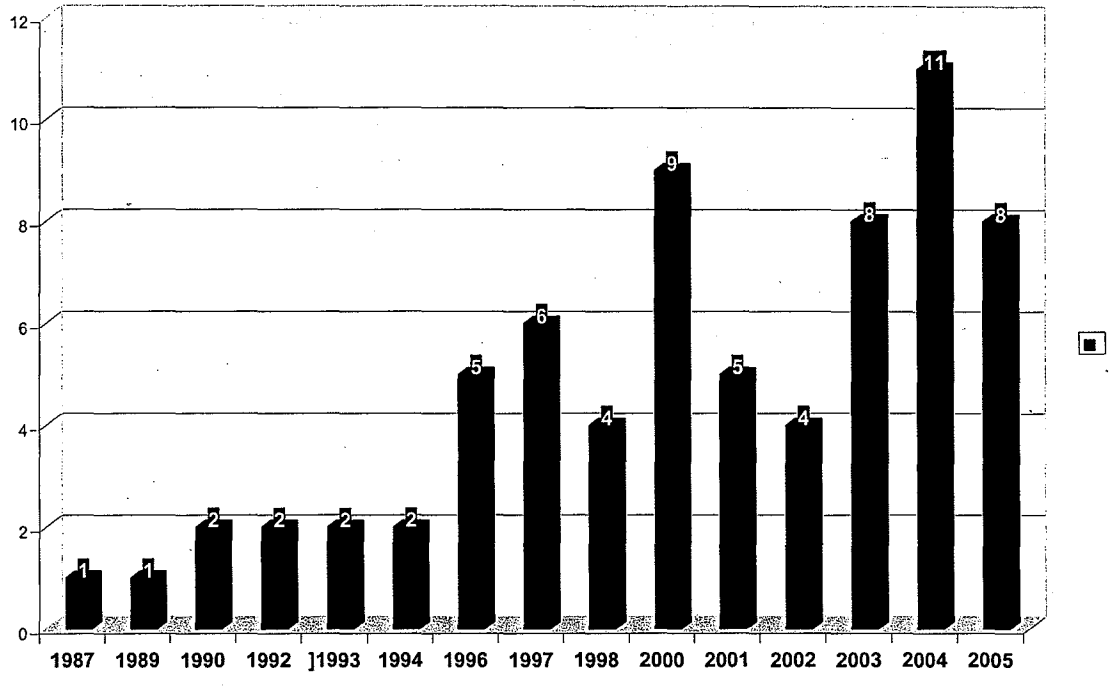
- 8 respondents indicated the school had a mental health unit, on-site clinic facility (which can include mental health services within a school-based health clinic).
- 101 respondents indicated the school contracts with a community mental health provider / agency to co-locate mental health services at school.

- 33 respondents indicated that the school contracts with a community mental health provider / agency to enhance access and provide services to students and families at a nearby satellite clinic.
- 8 respondents indicated all of the above.

Year the program began:

Only 74 respondents opted to answer this question. The predominant years can be seen in the graph below:

Year Mental Health Program in School Began



Type of mental health services being provided:

The two predominant contracted, co-located clinical mental health services reported were *individual therapy & individual skills training.* Services reported were:

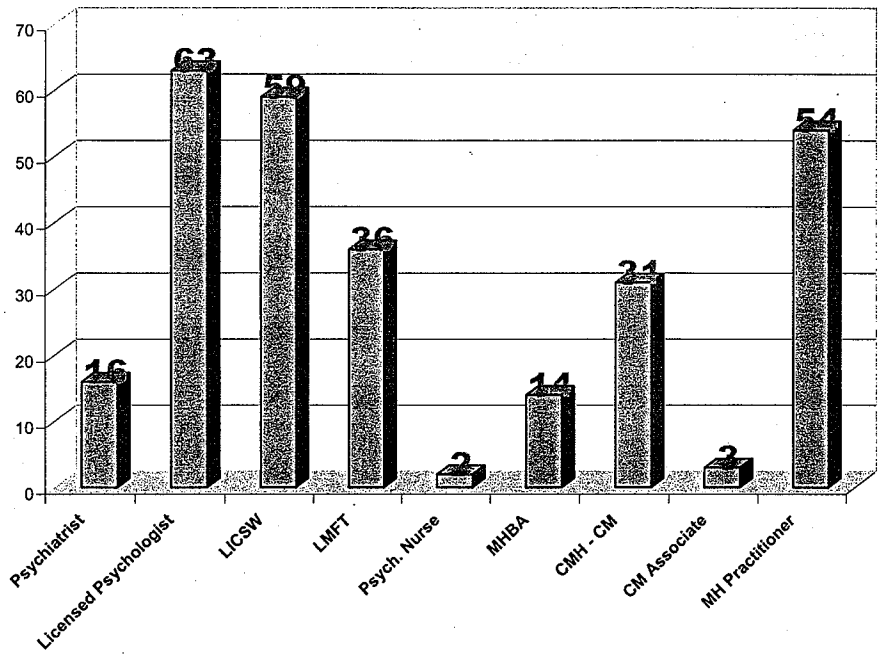
Individual Therapy	99	Day Treatment	45
Individual Skills Training	71	Children's Mental Health Case Management	42
Family Therapy	62	Family Skills Training	37
Crisis Services	62	Other	16
Group Therapy	59	Medication Management	13
Group Skills Training	57		

Among the "other" services mentioned: diagnostic assessment & referral, recreation therapy, relaxation and biofeedback, support in classroom, truancy interventions.

Type of mental health professional providing the co-located services:

The three predominant types of mental health professionals working in the co-located mental health program in schools are: licensed psychologists, licensed clinical social workers and mental health practitioners.

Type of Mental Health Providers
Working in Co-located Programs at Schools



Timing of service delivery:

Co-located mental health services are most frequently provided during school hours.

During school hours	117
During summer months	55
After the school day ends	54
Before the school day begins	34
During weekend hours	6

Grades of students served by mental health programs:

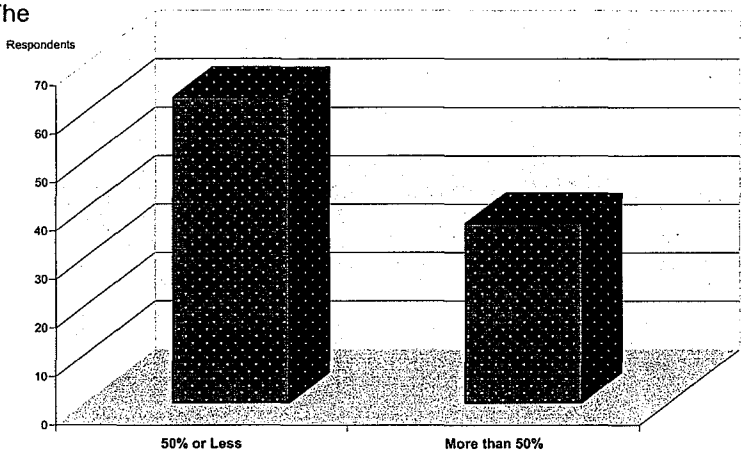
About 51% of the respondents reported that the program's services were available to all students in grades K-12.

For the other half that targeted certain grades, there was an even distribution of grades served, with 5th through 9th grades being slightly predominant.

Kindergarten	21	5th Grade	32	10th Grade	30
1st Grade	26	6th Grade	33	11th Grade	30
2nd Grade	26	7th Grade	34	12th Grade	31
3rd Grade	28	8th Grade	34	Non-graded as in LAC	7
4th Grade	28	9th Grade	32		

Students receiving clinical mental health services in school that are in special education:

The survey asked respondents to estimate the percentage of students served by the co-located mental health program in schools that were in special education. The chart below shows that most respondents indicated that 50% or less of the students receiving co-located mental health services were in special education. The average of all the responses was 23%.

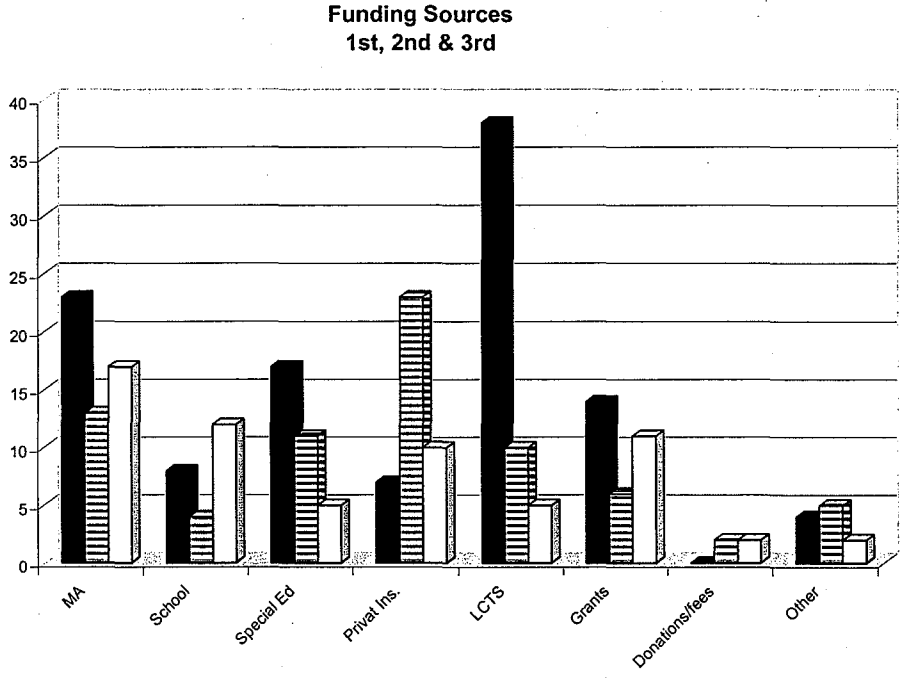


Funding of co-located mental health programs in schools:

The three predominant funding sources respondents mentioned were Local Collaborative Time Study (LCTS) funds, Medicaid billing and private insurance.

Local Collaborative Time Study (LCTS) dollars	65
Medicaid billing	63
Private insurance	53
Grants	41
School district funds	39
Special education funds	39
Other	19
Donation / Fees	12

The respondents were asked to rank their funding sources as "primary" , "secondary" and "tertiary" funding for the co-located mental health program in school. The following graph shows the results:



III. Integration of Clinical Mental Health Services in School

Student support services and related mental health services

The following services are provided in schools where co-located clinical mental health programs exist:

Type of Service	# of Responses	Professional Providing the Services (Most Mentioned by Respondent)
Providing Additional Supports to Students with Behavior Concerns	96	Special Education Teacher & School Social Worker
Group Counseling and / or Student Support Services (for example: Grief Counseling, Anger Mgt., Substance Abuse Counseling, Gang Interventions, etc.)	94	Contracted Mental Health Provider & School Social Worker
Individual Counseling (to students without a mental health diagnosis)	91	Contracted Mental Health Provider & School Social Worker
Classroom Behavior Modification Interventions	88	Special Education Teacher & School Social Worker
Education About Mental Health to School Board Members, Administrators, School Teachers, School Paraprofessionals, etc.	75	Contracted Mental Health Provider & School Social Worker
Mental Health Screening	73	Contracted Mental Health Provider & School Psychologist
Education About Mental Health in the Classroom (to students)	59	School Social Worker & Contracted Mental Health Provider
Mental Health Promotion in the School Building	55	School Social Worker & Contracted Mental Health Provider

Participation on school-related teams:

Most respondents (85) indicated that the contracted mental health provider was usually a member of a school team coordinating services for the student. The teams primarily identified were the IEP / IIIP teams:

IEP Team	74
IIIP Team	21
Wraparound Team	31
Student Assistance / Pre-assessment Team	39
504 Accommodation Planning Team	24
Other	7

Other types of teams specified: screening / referral team; crisis management team; school's referral review team; and case management / psychiatry.

Student's permanent school record:

Most respondents (101) reported that the mental health information is **not** part of a student's permanent school record.

Parent / Family involvement:

The following table shows how parents and families are involved in the mental health services for their children:

Consent for mental health services	114
Referral for screening / assessment / evaluation	104
Behavior management plans shared between school and parent	92
Participation on a team coordinating services for the child	90
Education about the child's needs to school staff and/or the child's classroom	88
Support groups for parents at school	14
Other	14

Other responses included: family therapy and skills training; parent presentations,; support group for parents.

Circumstances in which parental is *not* required:

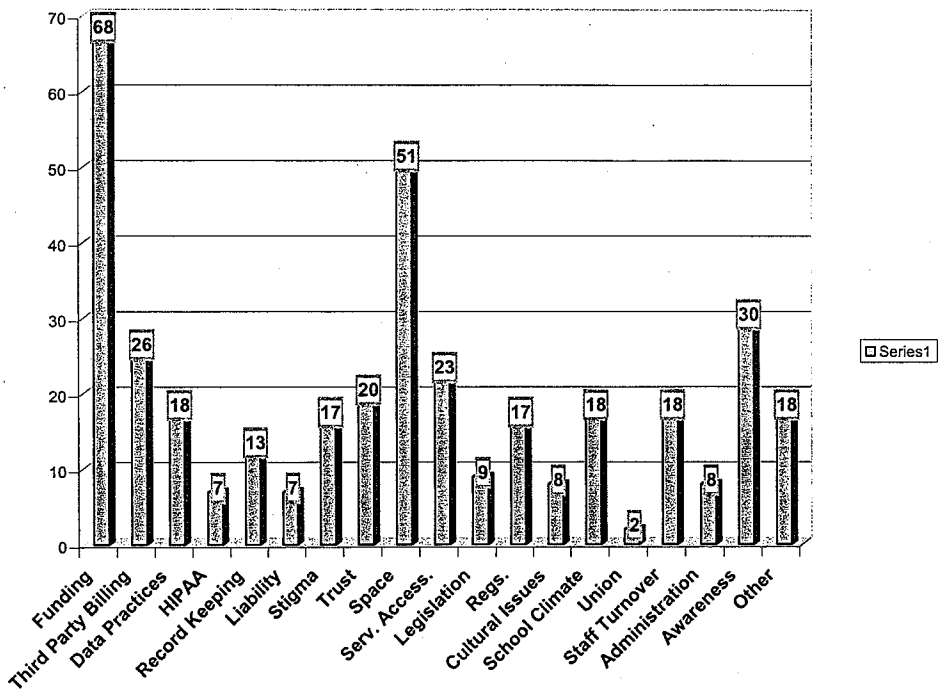
Basically all respondents indicated that parental consent is always required. Additional responses included:

- When intervening in a crisis situation, or when state law mandates that a parent does not have to be informed
- Court order
- When a student is in danger of harming themselves or others
- When the student is a ward of the state or if the county has custody
- When a student is over age 14 they are given some confidentiality rights and rights to request visits with the school social worker (not the contracted one)
- Assessment and referral
- For students over the age of 18, and for students who reside with another legal guardian, consent secured from the legal representative responsible for the student

IV. Challenges and Recommendations

Greatest challenges to providing co-located mental health services delivered though the school:

The three predominant challenges mentioned were funding, space and awareness of school staff of the need for and/or availability of services. Respondent responses have been group for challenges and recommendations.



Funding challenges, which was the main barrier identified, included:

- Insufficient and/or irregular funding
- Reduction in Local Collaborative Time Study funding
- Problems with MA & private insurance: requires significant administrative support fees & 3rd party payments are too low to pay for the cost of the service
- Some families cannot afford their co-payment or co-insurance
- Getting insurance information from families
- Third party billing does not allow for payment of some services
- Changes at federal, state & county levels : reduced levels of funding

Space:

- Schools do not have enough space to adequately meet the needs of the therapist, in particular to maintain the privacy and confidentiality needed for this type of service.

Awareness of school staff of the need for and/or availability of services:

- Need to increase understanding of children's mental health needs & services
- Staff do not always recognize the connection between mental health & school achievement; they may not recognize a student problem & see it as a discipline issue only.
- School climate not always student friendly, in particular to student with behavior issues.
- Some school staff are unaware of mental health concerns in children & often times see behavior as intentional & blame parents rather than looking at children's mental health needs.

Additional challenges referenced in the survey:

- Ability to find a qualified therapist to work in the school
- Once in a school, stay within boundaries of what MH personnel is there to do
- Parents do not tend to be involved in services provided at the school
- Students who don't keep their appointments
- The person from the agency & the school must be matched
- Department of Human Services & Education (and Special Education) need to work out issues related to FAPE & mental health in the schools as well as service duplication

- Getting authorization from county
- By combining school personnel & private agency staff in the same programming, supervision becomes an issue as does the disparity in pay
- Mental health providers are required to comply with a somewhat different set of rules than special education/school staff
- Conflicts of interest between school district & mental health agency

Recommendations

For funding....

- Mandating third party payments for school-site mental health services through legislation.
- An increase in the allotted CTSS hours.
- Simplification of CTSS rules & requirements. More technical assistance & collaboration between state CMH staff & local MH agencies to adapt requirements to maximize focus on service delivery by "keeping it simple" regarding CTSS, documentation & reporting requirements. Not all things that count can be counted.
- State mandating third party payers to fund day treatment at the level needed by clients.
- Third Party Billing - A more concrete process spelling out what you need to do & how much you are going to get.
- Having the Collaborative continue to have funding - I believe that is legislative issues, helping more rural families access MN Care & not raising the premiums so that family cannot afford it. MN Care has made a tremendous impact on mental health access in rural MN.
- Get out of the third part billing issues. It is tedious in the school setting, & lots of parents do not have insurance. Provide funding for the service knowing that many kids will use it & time will be better spent with kids than with computers trying to justify the service being offered or used.
- Fewer regulations so that the majority of the time can be spent in direct contact with children with an intensity of mental health needs. As there are less community services there is a greater demand on the school system to provide those services without adequate resources. There needs to be more incentives for programs & agencies to work together in tandem for students.

For space...

- Money & building.
- Consistent support, community wide, district wide & state wide.
- Use of federal funds to build/purchase space.
- A designated space that is always confidential & more consistency in staff so referrals come earlier in the school year.

For awareness...

- Continued ongoing communication & relationship
- The first change I would make is to change district practices to reduce the amount of school staff & student change & turnover.
- Staff need training.
- Retaining staff, same training days, staff development & team building activities.
- Overall better sense of services provided at school sites.
- 1) School administration interested in collaboration. 2) School staff who have a passion for teaching children with mental health disorders re: school administration has viewed these children as "bad actors" & if there would be more genuine concern about the welfare of these troubled kids on the part of administration & from individuals teachers, these challenges would have been much easier to have overcome.
- More school social workers in the schools to support & help with the large caseload. Support from legislators & understanding of the importance of mental health providers in the schools. Training of school staff on mental health issues.
- Better communication, participation & support from the school principals at stages of development, implementation, & continuity of services, and evaluation.
- Clear definition & understanding of the role of the co-located mental health provider in the school.
- More available funds to provide adequate staff, training, & space.
- Leadership from school administrators.

V. Outcomes: Co-located services and how they have contributed to improve student achievement

Responses were grouped under the following outcomes:

- Symptom reduction and improved functioning - improved mental health reduces barriers to learning
- Rise in grades and performance in daily classroom participation
- Improved student attendance
- Less disruption, allows student to focus on academics
- Improved accessibility to mental health services
- Use of less restrictive settings and reduced out-of-home placements
- Improved identification of mental health issues
- Improved school climate towards mental health issues
- Improved comprehensive approach, allowing for interagency collaboration (among schools, county, mental health provider and parents)

Appendix C
Letters to the Task Force
(Scanned in separate file)

STATE ADVISORY COUNCIL ON MENTAL HEALTH

and Subcommittee on Children's Mental Health

Council/Subcommittee Web Site:
http://mentalhealth.dhs.state.mn.us

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E-Mail: Bruce.Weinstock@state.mn.us

Date: 10/14/05

To: Mental Health and Schools Task Force as per 435.17 Legislation

From: Minnesota State Advisory Council on Mental Health and Subcommittee on Children's Mental Health

Subject: Proposal of Guiding Principles for Consideration

The Advisory Council and the Subcommittee on Children's Mental Health applauds the new legislation (435.17) that states that the commissioners of Human Services and Education shall together create a task force to discuss the collaboration between schools and mental health providers and submit a report by February1, 2006. We support the task force towards the goals of an integrated and effective system of mental health service delivery for schools. As a state subcommittee charged with providing input to these same goals, we recommend that the following guiding principles be addressed as it proceeds with its important task:

- Mental health needs of children from Birth to 21 are considered.
- Efficient and timely mental health services to all children are available.
- While immediate crises intervention is essential, mental health services through schools are proactive with emphasis on early intervention and not just be reactive to crisis.
- Mental health services connect home, school and community to ensure continuity.
- Health care companies shall use the administration of mental health screening to children in the primary health care setting as an indicator of quality care of service.
- All mental health services (including screening and early intervention) are culturally appropriate for the child and his/her family.
- Emphasis is placed on parental education and support.

We are confident that the task force appointed by the commissioners will make recommendations that will promote the overall mental wellbeing of all children in our state.

MSSWA Minnesota School Social Workers Association

312 N. Sherwood Ave. · Thief River Falls, MN 56701 · www.msswa.org

Over 36 Years of MSSWA: Serving Children Through Their School, Home and Community

November 21, 2005

To: Task Force on Collaborative Services, Co Located Mental Health Services in Schools
From: Minnesota School Social Workers Association
Re: Concern about the direction of the task force

The Minnesota School Social Workers Association would like to express our concern over the direction of the Task Force on Collaborative Services. As student support services, we work successfully with *collaborative* services in a number of our Minnesota schools. However, the task force seems to recommend supplanting our services with community mental health services. We are greatly concerned and opposed to this direction and would like to address this concern with the task force.

School social workers hold a Board of Teaching License and licensed from the Board of Social Work. School social workers can be LSW, LISW, LGSW, or LICSW. For example, St. Paul Public Schools has 70 LICSW and 70 LGSW! So you can understand our concern when the task force talks about the need for mental health professionals in the schools, when we are already there!

Student support services are involved with many of the following tasks:

- Early recognition and identification of mental health concerns including knowledge of related factors such as stress, chemical abuse, family/community or other environmental factors, history of school success or failure, etc.
- Coordination with care providers for a cohesive treatment plan
- Direct intervention in the educational setting including group and individual therapy
- Consultation with teachers regarding educational adaptations and classroom accommodations
- Crisis planning and crisis management

As you can see, many of these tasks are also done by the mental health community. Our concern is that if there are identifiable mental health issues in a school, the school district should address those concerns by utilizing the skills of the student support services, which may include outside mental health professionals. We feel strongly that instead of co locating staff, we should reduce barriers for school staff to provide mental health services.

Sincerely,

Minnesota School Social Workers' Association

December 13, 2005

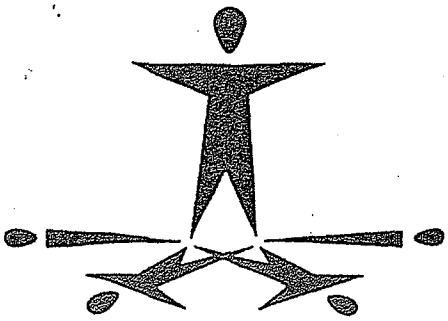
To: Task Force on Collaborative Services: Co-Located Mental Health Services in the Schools
From: Minnesota School Psychologists Association

The Minnesota School Psychologists Association would like to address some significant issues concerning the task force. School psychologists, as part of learner support services, have worked with students, families and community mental health providers with demonstrated success in creative collaborations across Minnesota. School psychologists, counselors, nurses and social workers are highly skilled mental health professionals who often hold better credentials than community based mental health professionals. The task force, however, has not acknowledged the services already provided by student support services in the schools and has not included any discussion of collaborating with these existing providers and services. Rather, the language and direction of the task force suggests that learner support services would be duplicated and replaced by community mental health service providers who function independent of collaboration.

The National Association of School Psychologists, as an organization, is committed to partnering with others in the delivery of mental health services to all children and families in need. The Minnesota School Psychologists Association advocates for fully staffed learner support services in all schools. The continuum of services already available addresses systems issues as well as the needs of individual students. The training of learner support services staff, including school psychologists, is unique and specific to the educational environment, allowing them to provide assessment and intervention for a wide range of learning, behavior and emotional problems. School psychologists address problems including adjustment, attendance, substance abuse, mental health problems, delinquency and dropouts, crisis intervention and emergency assistance along with addressing specific academic concerns. Our focus on early identification, intervention and prevention is comprehensive and specifically addresses systems change.

Schools and parents should be able to easily access student support services to address the mental health needs of students. The failure of the task force to recognize the expertise available in the schools now, and the importance of accessing that expertise, reflects a limited understanding of existing intervention frameworks and impedes the development of establishing a framework for working cooperatively.

Minnesota School Psychologists Association



MINNESOTA SCHOOL COUNSELORS ASSOCIATION

A CONNECTION TO SUCCESS

December 14th, 2005

Dear task force members,

On behalf of the nine-hundred plus school counselors who are members of MSCA (MN School Counselors Association) and hundreds of others who are not members, I want to state my concerns regarding some of the ideas discussed within this group. The focus of this group is to examine how co-located mental health services currently exist in high schools across the state and once examined, to make recommendations to Commissioner Seagren of best practices for continued delivery of such services.

Before we proceed, however, I'd want to express my perceptions of what the group is suggesting. It feels or seems as though there's an underlying tone suggesting mental health services will be offered to students without using/consulting the expertise of licensed school counselors working within buildings. I must let you know from the onset MSCA would not be in support of this suggestion.

Rather, we'd like to go on record stating kids do receive help for mental health concerns from licensed school support staff. School counselors are properly trained, have a master's degree in school counseling, and are licensed to do both prevention and intervention work with students experiencing mental health issues. We're limited in the amount of services we can provide due to huge case loads (350-1,000 students) most of us are assigned. As a matter of fact, MN has the second largest school counselor: student ratio in the nation (US Dept. of ED). We're trained and work with students and families in crisis as well as in academic, career, and post-high school planning. Often, school counselors are the first to hear concerns students and parents have about mental health issues as well as school issues in general.

Students begin developing a relationship with school counselors while creating their class schedules. If students have IEPs and 504 plans, counselors advocate for accommodations on standardized tests (ACT, SAT, BST, etc.). In addition, counselors are aware of student's academic achievements or lack thereof and work with students and families to find whatever barriers to learning may exist and develop strategies to overcome these barriers. Sometimes additional mental health and/or chemical use issues surface. Once so identified, school counselors work with both the student and family members to develop plans for the student's academic success.

Finally, school counselors (K-14) have both local and national relationships with other counseling professional organizations: ASCA (American School Counselors Association), NACAC (National Association of College Admission Counselors), ACA (American Counseling Association), Sylvan Learning Centers, the College Board, the American College Testing organization, and several other related organizations. We could also seek to earn credentials as a Licensed Professional Counselor (LPC)/National Board Certified Counselor (NBCC) if we so desired.

MSCA hopes that the members of this task force learn more about who school counselors are and what we do. In so learning, recommendations from this group will be based on collaboration with other mental health professionals also working with students and families. We'd like to strengthen the numbers of counselors and other support staff rather than support a recommendation saying we prefer community based agencies come into the schools and do the difficult work of providing crisis intervention work. This work is important, meaningful work school counselors have been providing for years. If we had more manageable case loads, we would be able to refer more people to get help for clinical mental health services. We have worked hard to achieve our credentials and know we have something important to offer students and families we see on a daily basis.

We thank you for your consideration of our needs as well as our desire to work collaboratively with others.

Respectfully yours,

Anne Erickson
Licensed School Counselor M.S., CDF
(Past Past President of MSCA)

Kitty Johnson
Licensed School Counselor M.S.
(MSCA President)

SCHOOL NURSE
ORGANIZATION
OF MINNESOTA

www.minnesotaschoolnurses.org

January 26, 2006

The School Nurse Organization of Minnesota is concerned with the task force direction of co-location of mental health services in the schools. Licensed school nurses (LSN) provide integrated physical and mental health services that support student learning and health. The LSN knows the students and their families well with relationships that carry forward for many school years with some over generations. The LSN understands the needs of the students and families and the community resources that will meet their needs. The LSN utilizes the community mental health resources collaboratively in community agency's or in co-located offices. The LSN also understands the education curriculum, teacher teaching styles, scope and sequence of grade level learning as it relates to student needs and is an active special education team member for students with an IEP.

Licensed school nurses meet student mental health needs in schools on a daily basis. Many students will use the health office and school nurse as the first stop for assistance with a mental health issue. Information from the 2005 SAMHSA report indicates that school nurses spent 1/3 of their time on student mental health issues/services.*

Co-location is not a new concept for school nursing services. Co-located school nursing service is practiced in some Minnesota school districts where schools contract for nursing services from the local public health agency. This has been a workable arrangement when broad, comprehensive in-school public health services are contracted between school and agency. However, one of the problems with contracted nursing arrangements is the lack of requirements as to the amount and comprehensiveness of services that are part of a school/agency contract. This can lead to many student health issues not being addressed during the school day and the lack of needed services impacting student learning.

The LSN, as part of the Student Support Team, works collaboratively to meet student mental health needs during the school day. The LSN is very often the first stop for a student with a mental health need. The LSN may spend the greater portion of their work day dealing with student mental health issues and assisting students and families with needed resources in the community.

Student Support Services teams provide integrated, comprehensive services to students. Supplanting these team members with community mental health service providers is not in the best interest of the student, the student's family or the educational community.
SNOM does support strong collaboration with community mental health providers as part of the mental health service continuum.

*Foster S, Rollefson M, Doksum T, Noonan D, Robinson G. (2005). School Mental Health Services in the United States, 2002–2003. DHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Cynthia Hiltz, RN, LSN, MS

Cynthia Hiltz, RN, LSN, MS
SNOM President

February 23, 2006

To: Task Force on Collaborative Services: Co-Located and Integrated Mental Health Services in the Schools

From: Minnesota Parent Leadership Network

Re: To express support for the co-location and integration of mental health services in the schools and to address the concerns about the direction of the task force voiced by the MSSWA, MSCA, SNOM, and MSPA

The Minnesota Parent Leadership Network wishes to commend the task force on a job well done. It is truly refreshing to see a group with such an incredible range of participants; school social workers, special education directors, school psychologists, superintendents, representatives from the Dept. of Education and the Dept. of Human Services, parents, advocacy groups, private providers and insurance companies come together to discuss ways to improve outcomes for our children dealing with mental health disorders.

We respect and understand that various groups would have concerns about system changes. The underlying themes of these concerns voiced in the letters from the groups listed above include:

- Co-location and integration of services would supplant the jobs of school personnel already providing services
- A lack of recognition by the task force of the services and talents already available for mental health services delivery in the schools.

While these concerns may seem realistic on the surface, we feel it shows a lack of understanding of what the task force was asked to do. We hope we can clarify the purpose of the task force in order that these concerns can be put to rest.

Our purpose was to discuss (see page 3 of the report) co-location and integration of services in the school. Our understanding was this proposal was to supplement, not supplant already existing systems. There are two areas in the report (page 5, the last bullet under Key points, and page 8's first full paragraph) that quite clearly recognize that most schools do have existing systems in place which include the use of school psychologists, nurses, social workers, and guidance counselors. If what is already in place was enough to meet the mental health needs of all students, (and all students do have mental health needs) there would have been no reason to discuss ways to improve outcomes for those students with a diagnosis of a serious mental illness (biological brain

disorder). One only need refer to graduation/dropout rates for students receiving special education under EBD to see we have a long way to go.

- *The dropout rate for students under EBD is twice that of general education students* (Lehr, Johnson, Bremer, Cosio, & Thompson,2004)
- *In 2000-2001 65.1 % of EBD students dropped out of school while only 28.9% left with a diploma..* (National Dropout Prevention Center)
- *Minnesota does not report stats according to special education classification, but in their 25th annual report to Congress, 51% of students age 14-21 with disabilities dropped out of school.*
- *One Minnesota district has 3 psychologists covering 3 elementary schools, 1 middle school and 1 high school. There are 3 social workers. One covers the middle school of 1200 students and 1 elementary school with over 600 students. One SW covers the 2 other elementary schools with around 1000 kids and one SW covers the high school with 1700 students. They are required to attend child study meetings and IEP meetings for students which leaves very little time to meet with students individually.*

The final bullet above emphasizes the need for assistance in supplementing not supplanting the work already being done in the schools. Resources vary district to district and sometimes building to building and even if there were more resources for support staff in a school and they were evenly distributed, we still need to integrate and co-locate services for certain children with the most serious need for intense individual treatment. There are many positive models of co-location and integration of mental health services in schools which show improved outcomes for all students with intense mental health needs, especially those with a serious mental illness (biological brain disorder). There is also encouraging data that this kind of collaboration reduces replication of services, provides for earlier treatment which can prevent more expensive school placements, and can help defray costs for schools. **But most importantly, the reports from schools already using a similar model to this proposal are reporting better outcomes for our children; i.e. higher attendance rates and higher graduation rates.**

I would hope that in the interest of all our children, we could put or differences aside and continue to work together in order to move forward in positive direction..

Respectfully submitted by: The Minnesota Parent Leadership Network Board of Directors, Carolyn Strnad, President and Carolie Collins, Vice President

MINNESOTA SCHOOL COUNSELORS ASSOCIATION

A CONNECTION TO SUCCESS

February 28th, 2006

Dear Ms. Mendoza,

Please add this letter from MSCA (MN School Counselors Association) to the appendix of the document created by the members of the Co-Located Mental Health task force.

In the section of the report addressing the mental health task force contract, MSCA would like to add the following:

It is understood that co-location service workers will not supersede or supplant the services of existing licensed school personnel (e.g., school counselors, school psychologists, school social workers, school nurses) and that such dually licensed school personnel will be consulted on a regular basis regarding the personal, social, mental health, and academic progress of those students served by such co-located service workers.

Also, it is possible for school counselors to be dually licensed with additional course work as a Licensed Professional Counselor (LPC) or a Marriage and Family Therapist (LMFT). Likewise, with additional coursework, School Social Workers can also be LMFT's and School Psychologists can also be Licensed Psychologist (LP's). All school nurses are registered nurses (RN's).

Respectfully submitted,

Katherine A. Johnson

Katherine A. Johnson
Licensed School Counselor
MSCA President

Appendix D
Sample Contract

Note: There is no requirement that the following model contract be used by schools to contract with a mental health provider. It is simply an example of a contract for the provision of co-located mental health services in schools. If a school chooses to enter into a contract with a mental health professional it is suggested that they utilize their own legal counsel when developing the specific terms of any contract.

CONTRACT FOR THE PROVISION OF CO-LOCATED MENTAL HEALTH SERVICES IN SCHOOLS

THIS CONTRACT, and amendments and supplements thereto, is between [Independent School District / Collaborative / etc. [1] Name and Address] (hereinafter referred to as the [CONTRACTING ENTITY]), and [Mental Health Provider Name and Address], (hereinafter referred to as the CONTRACTOR), for the period from [Beginning date of Contract] to [End date of Contract].

Recitals

Under Minnesota Statutes section _____, the [CONTRACTING ENTITY] , is empowered to enter into contracts to provide services and engage such assistance as deemed necessary to carry out its mission.

The [CONTRACTING ENTITY] is in need of the following services: _____
_____.

The CONTRACTOR represents that it is duly qualified and agrees to perform all services described in this contract to the satisfaction of the [CONTRACTING ENTITY] .

1. **Term Of Contract**

1.1 **Effective date:** This contract will be effective on _____, or the date that the [CONTRACTING ENTITY] obtains all required signatures. **The CONTRACTOR must not begin work under this contract until ALL required signatures have been obtained, and the CONTRACTOR has been notified by the [CONTRACTING ENTITY] 'S Authorized Representative to begin work.**

1.2 **Expiration date:** This contract will remain in effect through _____, or until all obligations have been satisfactorily fulfilled, whichever occurs first.

1.3 **Survival of Terms.** The following clauses survive the expiration or cancellation, or termination of this contract: 8. Liability; 10. Information Privacy Protection; 13. Publicity and Endorsement; and 14. Governing Law,

[1] The contractee can be the school district, a collaborative, a county or other relevant entity that is contracting for co-located mental health services in school with a mental health provider entity.

Jurisdiction and Venue.

2. **Contractor's Duties.** The CONTRACTOR, who is not an employee of [CONTRACTING ENTITY], will perform the professional services described as follows, contracting with the professionals with the following licensing requirements (Attach additional page if necessary which is incorporated by reference and made a part of this agreement.):

[Note: This is the main part of the contract where the services will actually be laid out. Things to consider including in this section:

- *licensing and credentialing of the professional*
- *type of services contracting for (for example: the provision of individual / group support and therapy through day treatment for students; or mental health case management and consultation to students, etc.).*
- *provisions regarding quality assurance*
- *provisions around maintenance of professional liability insurance for professional staff,*
- *among others.]*

3. **Time.** The CONTRACTOR will perform its duties within the time limits established in this contract unless prior approval is obtained from the [CONTRACTING ENTITY] .

4. **Compensation.** The [CONTRACTING ENTITY] will pay for all services performed by the CONTRACTOR under this contract as follows:

   4.1 **Compensation.** The CONTRACTOR will be paid as follows [hourly, monthly, quarterly, or per the attached payment schedule, which is incorporated into the Agreement]:

   4.2 **Reimbursement.** Reimbursement for travel and subsistence expenses actually and necessarily incurred by CONTRACTOR in performance of this contract in an amount not to exceed _____ **dollars ($_____.00).**

   4.3 **Total Obligation.** The total obligation of the [CONTRACTING ENTITY] for all compensation to the CONTRACTOR will not exceed _____dollars ($_____).

5. **Conditions Of Payment.** All services provided by CONTRACTOR under this contract must be performed to the [CONTRACTING ENTITY] 'S satisfaction, as determined at the sole discretion of the [CONTRACTING ENTITY] 'S authorized representative, and in accordance with all applicable federal, state, and local laws, ordinances, rules and regulations. CONTRACTOR will not receive payment for work found by the [CONTRACTING ENTITY] to be unsatisfactory, or performed in violation of federal, state, or local law, ordinance, rule or regulation.

6.1 **[CONTRACTING ENTITY].** The [CONTRACTING ENTITY] 'S authorized representative is_____ or his/her successor, who has the responsibility to monitor the CONTRACTOR'S performance and the authority to accept the services provided under this contract. If the services are satisfactory, the [CONTRACTING ENTITY] 'S Authorized Representative will certify acceptance on each invoice submitted for payment.

6.2 **Contractor.** The CONTRACTOR'S Authorized Representative for purposes of administration of this contract is _____ or his/her successor. The CONTRACTOR'S Principal Mental Health Professional for this Contract is _____ _____ or his/her successor. The CONTRACTOR'S Key Personnel required for this Contract is _____ _____ or his/her successor.

6.3 **Information Privacy and Security.** (If applicable) [CONTRACTING ENTITY]'S responsible authority for the purposes of complying with data privacy and security for this agreement is _____, or his/her successor. CONTRACTOR'S responsible authority for the purposes of complying with data privacy and security for this agreement is _____ or his/her successor.

7. Assignment, Amendments, Waiver, and Contract Complete.

7.1 **Assignment.** The CONTRACTOR may neither assign nor transfer any rights or obligations under this contract without the prior consent of the [CONTRACTING ENTITY] and a fully executed Assignment Agreement, approved by the same parties who executed and approved this contract, or their successors in office.

7.2 **Amendments.** Any amendment to this contract must be in writing and will not be effective until it has been executed and approved by the same parties who executed and approved the original contract, or their successors in office.

7.3 **Waiver.** If the [CONTRACTING ENTITY] fails to enforce any provision of this contract, that failure does not waive the provision or [CONTRACTING ENTITY] 'S right to enforce it.

7.4 **Contract Complete.** This contract contains all negotiations and agreements between the [CONTRACTING ENTITY] and the CONTRACTOR. No other understanding regarding this contract, whether written or oral, may be used to bind either party.

8. **Liability.** Each party shall be responsible for claims, losses, damages and expenses which are proximately caused by the wrongful or negligent acts or omissions of that party or its agents, employees or representatives acting within the scope of their duties. Nothing herein shall be construed to limit either party from asserting against third parties any defenses or immunities (including common law, statutory and constitutional) it may have or be construed to create a basis for a claim or suit when none would otherwise exist. This provision shall survive the termination of this Agreement.

9. **Audits and Record Disclosure.** The books, records, documents, and accounting procedures and practices of the CONTRACTOR and its employees, agents, or subcontractors relevant to this contract will be made available and subject to examination by the [CONTRACTING ENTITY] in order to exercise their responsibilities to monitor and evaluate compliance with standards, services and fund disbursements under this contract.

10 **Information Privacy and Security.**

10.1 **Information Covered by this Provision.** In carrying out its duties, CONTRACTOR will be handling one or more types of private information, collectively referred to as "protected information," concerning individual [CONTRACTING ENTITY] clients. "Protected information," for purposes of this agreement, includes any or all of the following:

(a) Private data (as defined in Minnesota Statutes §13.02, subd. 12), confidential data (as defined in Minn. Stat. §13.02, subd. 3), welfare data (as governed by Minn. Stat. §13.46), medical data (as governed by Minn. Stat. §13.384), and other non-public data governed elsewhere in Minnesota Government Data Practices Act (MGDPA), Minn. Stats. Chapter 13;

(b) Medical records (as governed by the Minnesota Medical Records Act [Minn. Stat. §144.335]);

(c) Chemical health records (as governed by 42 U.S.C. § 290dd-2 and 42 CFR § 2.1 to § 2.67);

(d) Protected health information ("PHI") (as defined in and governed by the Health Insurance Portability Accountability Act ["HIPAA"], 45 CFR § 164.501); and

(e) Other data subject to applicable state and federal statutes, rules, and regulations affecting the collection, storage, use, or dissemination of private or confidential information.

10.2 **Duties Relating to Protection of Information.**

(a) **Duty to ensure proper handling of information.** CONTRACTOR shall be responsible for ensuring proper handling and safeguarding by its employees, subcontractors, and authorized agents of protected information collected, created, used, maintained, or disclosed on behalf of [CONTRACTING ENTITY]. This responsibility includes ensuring that employees and agents comply with and are properly trained regarding, as applicable, the laws listed above in paragraph 10.1.

(b) **Minimum necessary access to information.** CONTRACTOR shall comply with the "minimum necessary" access and disclosure rule set forth in the HIPAA and the MGDPA. The collection, creation, use, maintenance, and disclosure by CONTRACTOR shall be limited to "that necessary for the

administration and management of programs specifically authorized by the legislature or local governing body or mandated by the federal government." *See*, respectively, 45 CFR §§ 164.502(b) and 164.514(d), and Minn. Stat. § 13.05 subd. 3.

(c) **Data Requests.** Unless provided for otherwise in this Agreement, if CONTRACTOR receives a request to release the information referred to in this Clause, CONTRACTOR must immediately notify [CONTRACTING ENTITY].

10.3 **Contractor's Use of Information.** CONTRACTOR shall:

(a) Not use or further disclose protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Agreement other than as permitted or required by this Agreement or as required by law, either during the period of this agreement or hereafter.

(b) Use appropriate safeguards to prevent use or disclosure of the protected information by its employees, subcontractors and agents other than as provided for by this Agreement. This includes, but is not limited to, having implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentially, integrity, and availability of any electronic protected health information that it creates, receives, maintains, or transmits on behalf of [CONTRACTING ENTITY].

(c) Report to [CONTRACTING ENTITY]any privacy or security incident of which it becomes aware. For purposes of this agreement, "*Security incident*" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. "*Privacy incident*" means violation of the Minnesota Government Data Practices Act (MGDPA) and/or the HIPAA Privacy Rule (45 CFR Part 164, Subpart E), including, but not limited to, improper and/or unauthorized use or disclosure of protected information, and incidents in which the confidentiality of the information maintained by it has been breached.

(d) Consistent with this Agreement, ensure that any agents (including Contractors and subcontractors), analysts, and others to whom it provides protected information, agree in writing to be bound by the same restrictions and conditions that apply to it with respect to such information.

(e) Mitigate, to the extent practicable, any harmful effects known to it of a use, disclosure, or breach of security with respect to protected information by it in violation of this Agreement.

10.4 **[CONTRACTING ENTITY]'s Duties.** [CONTRACTING ENTITY] shall:

(a) Only release information which it is authorized by law or regulation to share with CONTRACTOR.

(b) Obtain any required consents, authorizations or other permissions that may be necessary for it to share information with CONTRACTOR.

(c) Notify CONTRACTOR of limitations, restrictions, changes, or revocation of permission by an individual to use or disclose protected information, to the extent that such limitations, restrictions, changes or revocation may affect CONTRACTOR's use or disclosure of protected information.

(d) Not request CONTRACTOR to use or disclose protected information in any manner that would not be permitted under law if done by [CONTRACTING ENTITY].

10.5 **Disposition of Data upon Completion, Expiration, or Agreement Termination.** Upon completion, expiration, or termination of this Agreement, CONTRACTOR will return or destroy all protected information received from [CONTRACTING ENTITY] or created or received by CONTRACTOR for purposes associated with this Agreement. CONTRACTOR will retain no copies of such protected information, provided that if both parties agree that such return or destruction is not feasible, CONTRACTOR will extend the protections of this Agreement to the protected information and refrain from further use or disclosure of such information, except for those purposes that make return or destruction infeasible, for as long as CONTRACTOR maintains the information.

10.6 **Sanctions.** In addition to acknowledging and accepting the terms set forth in Section 8 of this Agreement relating to liability, the parties acknowledge that violation of the laws and protections described above could result in limitations being placed on future access to protected information, in investigation and imposition of sanctions by the U.S. Department of Health and Human Services, Office for Civil Rights, and/or in civil and criminal penalties.

10.7 **Additional Business Associate Duties.** To the extent CONTRACTOR is handling protected health information in order to provide health care-related administrative services on behalf of [CONTRACTING ENTITY], CONTRACTOR is a "Business Associate" of [CONTRACTING ENTITY], as that term is defined in HIPPA. As a result, in addition to the duties already detailed in this section, CONTRACTOR shall:

(a) Make available protected health information in accordance with 45 CFR §164.524.

(b) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526.

(c) Make its internal practices, books, records, policies, procedures, and documentation relating to the use, disclosure, and/or security of protected

health information available to the other Party and/or the Secretary of the United States Department of Health and Human Services (HHS) for purposes of determining compliance with the Privacy Rule and Security Standards, subject to attorney-client and other applicable legal privileges.

(d) Comply with any and all other applicable provisions of the HIPAA Privacy Rule and Security Standards, including future amendments thereto.

(e) Document such disclosures of protected health information and information related to such disclosures as would be required for [CONTRACTING ENTITY]to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.

(f) Provide to [CONTRACTING ENTITY] information required to respond to a request by an individual for an accounting of disclosures of protected health information in accordance with 45 CFR §164.528.

11. **Equal Employment Opportunity, Civil Rights, And Non-Discrimination**

11.1. The CONTRACTOR agrees not to discriminate against any employee or applicant for employment because of race, color, creed, religion, national origin, sex, marital status, status in regard to public assistance, membership or activity in a local commission, disability, sexual orientation, or age in regard to any position for which the employee or applicant for employment is qualified. Minnesota Statutes section 363A.02. CONTRACTOR agrees to take affirmative steps to employ, advance in employment, upgrade, train, and recruit minority persons, women, and persons with disabilities.

2. The CONTRACTOR must not discriminate against any employee or applicant for employment because of physical or mental disability in regard to any position for which the employee or applicant for employment is qualified.

3. CONTRACTOR agrees to comply with the rules and relevant orders of the Minnesota Department of Human Rights issued pursuant to the Minnesota Human Rights Act.

12. Workers' Compensation and Other Insurance.

12.1 **Workers' Compensation.** The CONTRACTOR certifies that, if applicable, it is in compliance with Minnesota Statute section 176.181, subdivision 2, pertaining to workers' compensation insurance coverage. If CONTRACTOR is required to comply with the above statute, CONTRACTOR must provide [CONTRACTING ENTITY] with evidence of compliance. The CONTRACTOR'S employees and agents will not be considered employees of [CONTRACTING ENTITY] . Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or

agents and any claims made by any third party as a consequence of any act or omission on the part of these employees or agents are in no way the [CONTRACTING ENTITY] 'S obligation or responsibility.

12.2 **Other Insurance.** CONTRACTOR certifies that it is in compliance with any insurance requirements specified in the solicitation document relevant to this Contract. If procurement was a single source, CONTRACTOR acknowledges that it has liability insurance.

13. Publicity and Endorsement.

14.1 **Publicity.** Any publicity regarding the subject matter of this contract must identify the [CONTRACTING ENTITY] as the sponsoring agency and must not be released without prior written approval from the [CONTRACTING ENTITY] 'S authorized representative. For purposes of this provision, publicity includes, notices, informational pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the CONTRACTOR or its employees individually or jointly with others or any subcontractors, with respect to the program, publications, or services provided resulting from this contract.

14.2 **Endorsement.** The CONTRACTOR must not claim that the [CONTRACTING ENTITY] endorses its products or services.

14. **Governing Law, Jurisdiction And Venue.** This contract, and amendments and supplements thereto, will be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this contract, or breach thereof, will be in the state or federal court with competent jurisdiction in [_____]County, Minnesota.

15. **Cancellation**

15.1 **Cancellation.** This contract may be canceled by the [CONTRACTING ENTITY] or CONTRACTOR at any time, with or without cause, upon thirty (30) days written notice to the other party. In the event of such a cancellation, the CONTRACTOR will be entitled to payment, determined on a pro rata basis, for work or services satisfactorily performed.

15.2 **Breach.** Upon [CONTRACTING ENTITY] 's knowledge of a curable material breach of this Agreement by CONTRACTOR, [CONTRACTING ENTITY] shall provide CONTRACTOR written notice of the breach and ten (10) days to cure the breach. If CONTRACTOR does not cure the breach within the time allowed, CONTRACTOR will be in default of this agreement and [CONTRACTING ENTITY] may cancel the contract immediately thereafter. If CONTRACTOR has breached a material term of this Agreement and cure is not possible, [CONTRACTING ENTITY] may immediately terminate this Agreement.

16. Contractor debarment, suspension and responsibility certification.

BY SIGNING THIS CONTRACT, CONTRACTOR CERTIFIES THAT IT AND ITS PRINCIPALS:

- Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, [CONTRACTING ENTITY] or local governmental department or agency; and

- Have not within a three-year period preceding this Contract: a) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract; b) violated any federal or state antitrust statutes; or c) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

- Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: a) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction; b) violating any federal or state antitrust statutes; or c) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

- Are not aware of any information and possess no knowledge that any subcontractor(s) that will perform work pursuant to this contract are in violation of any of the certifications set forth above.

- Will immediately give written notice to the [CONTRACTING ENTITY] should CONTRACTOR come under investigation for allegations of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing; a public (federal, state or local government) transaction; violating any federal or state antitrust statutes; or committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

IN WITNESS WHEREOF, the parties have caused this contract to be duly executed intending to be bound thereby.

APPROVED:

[CONTRACTING ENTITY]:

By:
Date:
Attest:

CONTRACTOR:
CONTRACTOR certifies that the appropriate person(s) have executed the contract on behalf of the CONTRACTOR as required by applicable articles, by-laws, resolutions or ordinances.

By:
Title:
Date:

By:
Title:
Date:

Appendix E
Children's Mental Health Screening Entry Points

Minnesota provides several children's social emotional/mental health screening opportunities. For most of these screening programs, the social emotional/mental health screening component is part of a larger screening package. Listed below are the screening programs discussed by the Task Force.

Follow Along Program
The Follow Along Program is a developmental screening program targeting children ages birth to 36 months. Children who are identified are referred for further assessment and services. The program includes screens for social emotional problems. The program is administered by the Minnesota Department of Health.

Child Welfare/Juvenile Justice
The 2003 legislature mandated county agencies to administer mental health screening for child welfare and juvenile justice populations ages 3 months through age 17. The legislation became effective July 1, 2004, and the Commissioner of Human Services must approve the mental health screening instruments. Children identified through screening for possible mental health problems are referred for a diagnostic assessment, which might lead to further services. County boards receive an allocation to help fund screening, diagnostic assessments, and mental health services when other funds are not available. The screening program is administered by the Minnesota Department of Human Services, Children's Mental Health Division.

Child & Teen Check Up
The Child and Teen Checkup (C&TC) program is Minnesota's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. It is a preventative health care program for children under 21 years of age who are enrolled in Medical Assistance or MinnesotaCare. The program's purpose is to inform and encourage families to have their children screened to detect any physical or mental health concerns by performing comprehensive periodic screening services. This program offers developmental screening, which includes mental health screening, diagnostic assessment, and services to address concerns before they negatively affect children and their families. EPSDT is administered by the Minnesota Department of Human Services.

Early Childhood Screening
Early Childhood Health and Developmental Screening was created to assist parents and communities improve the educational readiness and health of all young children through the early detection of children's health, development, and other factors that may interfere with a child's learning and growth. A developmental screen is required, which includes a social emotional component. This program is administered by the Minnesota Department of Education.

Head Start
Head Start and Early Head Start are comprehensive child development programs that serve children from birth to age 5, pregnant women, and their families. Head Start has as a primary goal to improve the school readiness of young children from low-income families. A developmental screening is required, which includes a social emotional component. This program is overseen by the Minnesota Department of Education.

Special Education
Students being evaluated for eligibility for Emotional and Behavioral Disorders (EBD) in special education receive a mental health screening. Special education is overseen by the Minnesota Department of Education.

Pupil Fair Dismissal Act

The Pupil Fair Dismissal Act (Minn Stat 121A.25 Subd. 3). If a pupil's total days of removal from school exceeds ten cumulative days in a school year, the school district shall make reasonable attempts to convene a meeting with the pupil and the pupil's parent or guardian prior to before subsequently removing the pupil from school and, with the permission of the parent or guardian, arrange for a mental health screening for the pupil. The district is not required to pay for the mental health screening. The purpose of this meeting is to attempt to determine the pupil's need for assessment or other services or whether the parent or guardian should have the pupil assessed or diagnosed to determine whether the pupil needs treatment for a mental health disorder.

Private Commercial Health Insurance

Typically, a well child visit includes the provision of developmental screening, which may include a social emotional/mental health screening.