Connecticut School-Based Diversion Initiative

CONNECTICUT SCHOOL-BASED DIVERSION INITIATIVE MANUAL

Funded by the John D. and Catherine T. MacArthur Foundation

Coordinated by the Judicial Branch's Court Support Services Division in collaboration with Connecticut Department of Children and Families

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INTRODUCTION

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This manual summarizes the major activities of the Connecticut School-Based Diversion Initiative (SBDI); an initiative funded by a grant from the John D. and Catherine T. MacArthur Foundation. The manual is intended to aid communities in developing their own school based diversion programs with the goal of diverting youth with mental health needs who experience behavioral health concerns and crises in the school from entering the juvenile justice system.

The manual split into three parts. The first provides an introduction and offers various statements and documents that are useful for schools and communities in understanding the scope and goals of the initiative. The second section describes implementation steps and processes for establishing the initiative in a new school or community. The third section provides a training curriculum that can be used to enhance the knowledge, attitudes, and skills of school professionals in working with youth with mental health needs, and their families.

Program Eligibility Criteria

The program provides training and coordination to school professionals in an effort to build capacity to meet the needs of children and youth in the target population. Therefore, the initiative has eligibility criteria that apply to children as well as the school professionals and community members that provide services to these youth.

Program Eligibility

- Student enrolled at [SBDI School Site]
- Student is experiencing a behavioral health problem or crisis in the school
- Student has past involvement with the juvenile system
  or
  Current behavioral crisis places student at-risk for juvenile justice involvement

In addition, the Connecticut SBDI works with school personnel in demonstration schools by providing training and professional development opportunities in the areas of mental health, juvenile justice, and working with their local mental health provider network (particularly EMPS).

A diverse group of school personnel are eligible to participate, including special education teachers, learning specialists, school counselors, school psychologists, school social workers, and others interested in mental health and/or juvenile justice. Community members are welcomed to participate in the initiative, including such stakeholders as law enforcement, probation staff, and community mental health providers. Finally, family members and family advocates are encouraged to participate in the initiative.

Program Description

The Connecticut School-Based Diversion Initiative (SBDI) is a component of the John D. and Catherine T. MacArthur Foundation Models for Change Mental Health/Juvenile Justice Action Network. Connecticut's SBDI has been designed **to reduce the number of children and youth with mental health needs whom schools refer to the juvenile justice system.** It is a collaborative effort by the Judicial Branch Court Support Services Division and the Department of Children and Families and works in conjunction with the existing community collaboratives within the state of Connecticut.

The goal of the project is to reduce the number of youth with behavioral health needs that come into contact with law enforcement and juvenile justice. To accomplish this goal, we work to build capacity and skills among teachers and school staff to recognize and manage behavioral health crises in the schools, and build linkages among school personnel, the local mental health provider community, and local law enforcement.

Consultants at the Connecticut Center for Effective Practice of the Child Health and Development Institute coordinate the Connecticut SBDI. In that role, CCEP provides project coordination, training, data collection and evaluation, and compilation of a program and resource manual for the purpose of replication.

Project Coordination: The SBDI selects schools by obtaining buy-in from school superintendents, and evaluating: 1) Interest, 2) Need, 3) and Capacity. The term "interest" refers to a school administration's desire to participate in the SBDI. In the context of the CT-SBDI, "need" refers to a school's relative need for a diversion initiative based upon rates of referral, and mental health crises in the school. Finally, exploring the level to which a school is able to meet the demands of the initiative in terms of personnel, data collection, training time, and deliverables assesses "capacity".

The SBDI brings together stakeholders including schools, local mental health providers, and law enforcement. Formal and informal agreements are put into place specifying roles and responsibilities of each party in accomplishing project deliverables. The SBDI makes every effort to work in coordination with existing initiatives and community providers. Therefore, the SBDI utilizes existing community expertise and resources to address the overrepresentation of youth with mental health needs involved with the juvenile justice system.

Training: The SBDI provides training to school staff. Law enforcement personnel and parents/families are invited to participate in selected training activities when appropriate. Trainings are provided in a number of content areas including but not limited to: crisis planning and

response; effective collaboration with EMPS; diversity and cultural competence; increasing collaboration with parents; understanding the behavioral health services system; and classroom behavior management strategies.

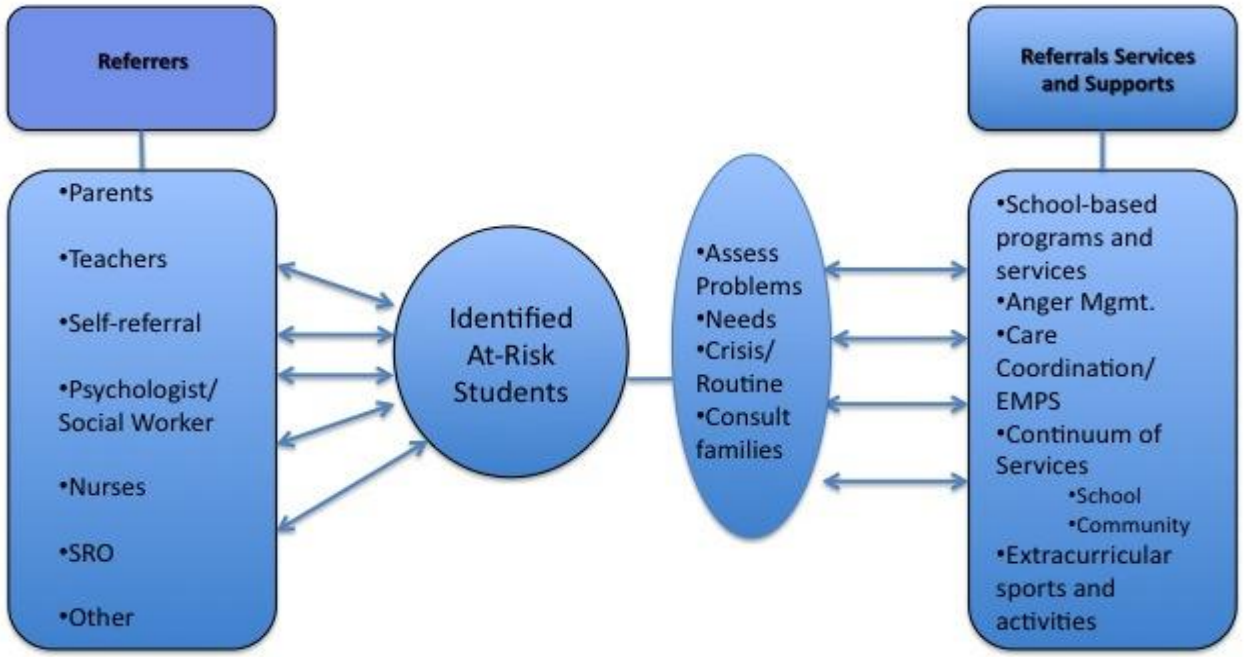
Data Collection and Evaluation: SBDI creates a longitudinal implementation record that guides future replication efforts. Data elements are collected from schools and from the local EMPS providers to document the impact of SBDI on participating schools. Data elements of interest include, but are not limited to: number of referrals to mental health/juvenile justice services; demographic characteristics of referred youth; description of services received; diversion from juvenile justice to community-based programs and services; satisfaction with SBDI. Outcomes and data collection are described in more detail in Section II on Implementation.

Mission Statement

The mission of the Connecticut School-Based Diversion Initiative is to reduce the number of youth with mental health needs who are referred from the schools to the juvenile justice system, and instead, link these youth to appropriate services and supports that will meet their needs and help them be successful adults.

Screening and Acceptance

We conceptualize the screening and acceptance process as one that is centered on the school as a central access point for students with mental health needs. One of the goals of SBDI is to facilitate better collaboration between schools and communities, increase utilization of school- and community-based services, and ultimately provide better service to students with mental health needs. Screening and acceptance to our initiative is based on the following conceptual model:



Conceptual Model of SBDI/EH Partnership and Data Collection J.Vanderploeg & C.Hayling, 2010

The above model is useful as a framework for understanding the role of this initiative within a specific school and community. However, each school and community will have its own unique set of referrers and referral services and supports that are identified in collaboration with the project coordinators.

Referral and Acceptance Process

As depicted in the model above, students with mental health needs are typically identified by school staff, but also by parents and community members. They are subsequently referred to the SBDI. At this point, school professionals (e.g., guidance counselors, school psychologists, administration) meet to identify primary presenting problems using resources and consultation provided by SBDI staff members. Parents are included in this process, along with any existing service providers. Next, a core group of SBDI collaborators convenes to:

1.) Discuss primary needs among students and their families who have been referred
2.) Identify available resources
3.) Make appropriate referrals
4.) Follow-up on all service referrals to ensure timely linkage
5.) Monitor treatment outcomes

The Emergency Mobile Psychiatric System is the primary mobile mental health crisis provider in the state of Connecticut. As such, they provide rapid response and crisis stabilization services to the community, including schools. EMPS is referenced throughout this manual; however, other appropriate service providers are utilized in collaboration with schools depending on available community resources. Using EMPS as an example, once the EMPS team arrives at a school they request that school professionals and families work together in order to accept the family for services:

- Information (regarding the student's history, and the events of the crisis)
- An attempt to contact the parent(s) and request permission as well as presence at the school, if possible
- Time to make a thorough evaluation
- Space to talk, often with parent and child separately
- At times, supervision of the student while clinician talks to parent
- School staff to remain in building (if school day is ending) until the evaluation is completed
- Support and security in escalated situations
- Support if ambulance is called
- Understanding if there are privacy or confidentiality issues

The following issues are considered when developing a clinical intervention plan:

- What level of treatment is appropriate?
- Where can those services be obtained?
- What can be accomplished in six weeks by EMPS?

- How will EMPS, the school, and the family handle transitions between educational, community and service settings?
- Medication issues
- Parent concerns
- Group versus individual modalities
- Need for specialized treatment: e.g., eating disorders, sexualized behaviors

The Screening and Assessment Procedures consist of the Ohio Scales for Youth, Parents, and Agency Workers. Also, samples of the Statewide Crisis Plan, the EMPS Crisis Intake forms, are completed upon referral (See Appendix A).

EMPS screening and assessment instruments examine a number of domains that can be part of similar efforts in any community. Assessed domains may include the following:

- Emotional/behavioral difficulties
- Emotional/behavioral functioning and strengths
- Presenting problems
- Current guardianship and residence
- Legal history
- Medical history
- Risk and protective factors
- Mental status
- Suicidality/Self-harm
- Substance abuse

See Appendix B for a full description of the EMPS practice model.

SECTION II:

IMPLEMENTATION: BUILDING A COLLABORATIVE DIVERSION INITIATIVE

Section II Overview

This section provides you with a step by step guide for implementing a SBDI. First, you will find the process of implementing an initiative along with a summary table based upon the CT-SBDI. Second, we present the process of implementation in three phases. In **Phase I**, the initial steps are discussed in detail with a sample **Memorandum of Agreement (MOA)**, **Needs Assessment Survey** and **Focus Group Protocol**. The **EMPS Policies and Procedures for Referrals After First Contact** are also included in **Phase I** as they describe process by which students are linked to services. It is important to be familiar with these aspects of available services in your area when building an initiative of this kind. **Phase II** describes the process of active implementation, which is the process of delivery the training and consultation to schools and communities. Finally, **Phase III** details the process of data collection and reporting. It is important to note that this model should be used as a guide rather than a "roadmap," be sure to adapt it as appropriate in your respective schools and communities.

The **"lessons learned"** portion of this section provides the reader with insight to the particular experiences of the CT-SBDI during the pilot year with implications for future implementation. Section II concludes with **Program Database and Outcome Monitoring Procedures,** which outlines the process of managing SBDI data and calculating outcomes with reference to the "data dictionary" found in Appendix D.

Process/Implementation

This initiative involves schools, mental health providers, juvenile justice and law enforcement personnel, community members, and state agency partners. Participating school districts are selected based upon 1) Interest, 2) Need, and 3) Capacity. The term "interest" refers to a school administration's desire to participate in the SBDI. In the context of the CT-SBDI, "need" refers to a school's relative need for a diversion initiative based upon rates of referral, and mental health crises in the school. Finally, exploring the level to which a school is able to meet the demands of the initiative in terms of personnel, data collection, training time, and deliverables assesses "capacity".

In general, it makes sense to work with schools that have an existing infrastructure because they will find it easier to incorporate this type of initiative. In Connecticut, we have been fortunate to identify districts with existing Positive Behavior Support curricula, and Wraparound initiatives, and implement the current project in a manner that builds off of these strengths and resources. The following table details the recommended implementation process for the CT SBDI.

Implementation Table

Phase I: Planning and Implementation

- Meet with State agencies and funders to establish goals and expectations
- Select participating schools based upon: Interest, Need, Capacity
- Develop core collaborative group comprised of school personnel, one or more community-based mental health providers, SBDI staff, law enforcement, juvenile probation, child welfare, and existing programs or initiatives occurring in the school
- Build collaborative relationships to sustain the initiative

Phase II: Active Implementation

- Identify target audience for school based training (email list, regular communication, flyers/newsletters for advertisement, developing incentives for participation)
- Schedule and conduct needs assessment (identify needs and interests for training)
- Identify training dates
- Develop training menu
- Identify, procure, and schedule community trainers to map onto training curriculum
- Baseline data collection

Phase III: Wrapping Up

- Continue data collection
- Engage in ongoing feedback loop and make modifications
- Develop and present year-end reports

Phase I in Detail for CT SBDI

- The SBDI is a coordinated effort between the Connecticut Judicial Branch's Court Support Services Division and Department of Children and Families and the Child Health and Development Institute of Connecticut/Connecticut Center for Effective Practice. Key leaders from each agency met to discuss the plans and expectations for the initiative prior to beginning the active implementation phase of this initiative.

- It is important to meet with school and community leaders to prepare them for participation and outline goals and expectations. We met with school officials in each school district as well as Superintendents, Assistant Superintendents, mental health providers, leaders from each community collaborative, and participants in the Wraparound initiative during the first two to three months of the initiative.

- Memoranda of Agreement (MOAs) were developed between EMPS providers and the participating school districts. The MOAs specified goals, activities, roles, responsibilities, and expectations for this initiative. In one community, the leaders believed this to be the first MOA ever developed between the largest mental health provider in the community and the public school district. In the other district, the MOA renewed and revised an existing MOA that was several years old. MOAs developed for this project were shared with the CT Department of Children and Families; the state agency in charge of funding and managing most of the publicly funded children's mental health and child protection services in the state. DCF plans to use these MOAs as templates for other communities.

- We believe that the time taken to build collaboration between schools and mental health providers is important, and sets up a foundation for a sustainable relationship that can support continued work in this area.

- In addition to the mental health providers, we sought to establish relationships between the local law enforcement/juvenile justice community and the school districts. In our preliminary assessment, we found that police provide some support to schools during behavioral health crises, and depending on the circumstances, police support may increase the likelihood for juvenile justice involvement or emergency department utilization. Working with local law enforcement can be challenging. In one school district, we reached out on a number of occasions to local police. In one phone conversation, police reported to SBDI coordinators that no amount of training would change department protocol and practice, which involved an immediate transport to the emergency department in the event of a behavioral health crisis call from the schools. Sustained effort and early engagement with law enforcement is required in order to ensure their participation in work of this kind.

- juvenile probation department in the area. Officials from this department agreed to partner with us and train staff on changes in juvenile law, intersections between probation, juvenile justice, and mental health, and addressing the service needs of children and families who are involved or at-risk for involvement with the juvenile justice system.

- Some schools have School Resource Officers (SROs) who are constables employed by the School District to provide on-site school support to manage disciplinary, behavioral health, and law enforcement concerns. SROs can be helpful as partners by attending and providing trainings, when appropriate. In the CT SBDI, SROs partnered with us on the initiative, however, they faced logistical challenges to full participation; the only times offered by the school for trainings were during the after-school hours, at which time SROs were required to patrol school grounds. Despite this barrier, their awareness of the initiative and limited participation establishes a foundation for continued collaboration.

- Together the relationships between the school, community collaboratives, and law enforcement are focused on sustainability and the improvement of student outcomes.

Memorandum of Agreement –SAMPLE

The purpose of developing MOAs between schools and community-based providers is to establish relationships that are guided by clear roles and expectations. MOAs are appropriate to establish agreements among the major partners in the initiative. At minimum, they should be developed between the school(s) and a major community-based mental health provider but also between schools and other community-based organizations that serve as key partners in the initiative.

Below is a sample of an MOA used between a school and their local EMPS provider.

This document serves as a Memorandum of Agreement ("MOA") between [Community Provider] and [School/District] and has been developed for the following purposes:

- To develop a uniform process to identify and refer children and adolescents who are in psychiatric crisis to the [Community Provider];
- To reduce unnecessary psychiatric emergency department visits among children and adolescents with behavioral health concerns;
- To reduce suspensions, expulsions, detention, police contact and other juvenile justice involvement among children and adolescents with behavioral health concerns;
- To enhance communication and coordination between [Community Provider] team and [School/District] for children and adolescent in mental health crisis.
- To promote earlier identification of children and adolescents with behavioral health problems and support timely linkage to needed supports and services.

The aim of the program [EMPS in this case] is to provide a community-based crisis stabilization service to children and families in the least restrictive setting possible, and support their transition to ongoing treatment services, as appropriate.

CLIENT ELIGIBILITY

- Any child from 0 to 18 years of age, and any youth over the age of 18 who is still in high school;
- Child must be in a behavioral health crisis;
- Child must be attending Bridgeport Public Schools

[Community Provider] agrees to the following:

- Have mobile EMPS available to respond in person to crisis calls from [School District];
- Respond by offering telephone support Monday through Friday 8:00 p.m. to 8:00 a.m. through the EMPS 24 hour centralized access number (211);
- Respond to all requests for service by [School] within 45 minutes;
- Offer [School] students brief in-school crisis stabilization services with appropriate follow-up services;
- Develop a child-specific crisis plan within the episode of care and share that plan with the family, school staff, treatment providers, and other relevant parties upon execution of a proper release from the parent or guardian;
- Provide case management service linkages to children and families referred by the schools;
- Collaborate and maintain close communication with the appropriate educational staff to develop an effective plan of care for each individual client referred for [Community Mental Health] services;
- Provide quarterly training to identified educational staff members in the [School District] on crisis assessment and management, and crisis safety planning.

[School/District] agrees to:

- Contact [Community Provider] when a child or adolescent is determined to be experiencing a psychiatric or behavioral health crisis and can benefit from in-person crisis stabilization services;
- Collaborate with [Community Provider] staff as needed to develop community-based plans for children and adolescents receiving [Community Provider] services;
- Provide space for [Community Provider] clinician(s) to meet with the student and provide educational staff support to [Community Provider] clinician as needed.

Both parties agree to:

- Designate a person(s) from each agency to participate in quality review as it relates to the terms of this agreement;
- Collaborate to develop shared crisis safety planning processes and procedures;

This memorandum of agreement will remain in effect unless any party wishes to terminate the agreement, or the [Community Provider] is no longer in operation. Both parties agree to provide 30 days notice in advance of terminating this agreement.

_____	_____
Executive Director Date	Superintendent Date
[Agency Name]	[Name of School]

Addendum
The Connecticut School Based Diversion Initiative

The MOA above outlines a general agreement between [School/District] and [Community Provider] for meeting the needs of children with behavioral health needs, and remains in effect until one or both parties wish to modify or terminate the agreement. The purpose of this addendum is to specify roles and expectations pertaining to the Connecticut School Based Diversion Initiative ("initiative"). The agreements reached in this addendum are intended to remain in effect only until the end of the initiative.

The Connecticut School Based Diversion Initiative is a component of the John D. and Catherine T. MacArthur Foundation Models for Change Mental Health/Juvenile Justice Action Network. The initiative is a collaborative effort between the Judicial Branch Court Support Services Division and the Department of Children and Families and will work in conjunction with the existing federally funded Connecticut Family and Community Partnership Wraparound Project in the [Community Provider] Collaborative. Investigators at the Connecticut Center for Effective Practice will coordinate the School Based Diversion Initiative.

The primary goal of the initiative is to reduce the number of children and youth with mental health needs whom schools refer to the juvenile justice system. A summary of the initiative deliverables includes:

- Ensure school participation (e.g., organize participation of one school; prepare for participation; conduct needs assessment; facilitate MOA development)
- Integrate youth, family, and community participation (e.g., solicit and organize meaningful youth and family participation)
- Provide training to school staff (e.g., organize and schedule training; develop and ensure delivery of a training curriculum; integrate with Wraparound training curriculum; provide training stipends to school personnel)
- Provide data collection, quality assurance, and formal evaluation of projects goals and outcomes (collaborate with schools and EMPS providers on data collection and sharing; collaborate with DCF and CSSD on data collection and sharing; develop databases; analyze results; write reports)

[School] has been selected as the demonstration site in the [District] and the EMPS team from [Community Provider] will be the primary behavioral health provider agency in the Bridgeport community.
[Community Provider] agrees to:

- Work with the Connecticut Center for Effective Practice and [School] to accomplish project deliverables.

- Be available to facilitate in-service trainings to educate [School] staff on crisis assessment and referral practices and effective utilization of EMPS services; maintain consistent working relationships with educational staff.
- Work with the Connecticut Center for Effective Practice to design and ensure data collection to assess the impact of the school-based mental health-juvenile justice diversion initiative for students from [School]. Specific data elements include:
    - Number of referrals from [School] to EMPS
    - Demographic characteristics of referred youth (e.g., age, gender, race/ethnicity, history of juvenile justice involvement, etc.)
    - Number/proportion of [School] referrals accepted into EMPS program
    - Description of EMPS services received (e.g., number of EMPS visits, location of visits, type of intervention(s) provided)
    - Number and type of EMPS referrals and linkages to other programs or services (e.g., home-based services, outpatient services, hospital inpatient, juvenile justice, etc.)
    - Satisfaction with implementation of the School Based Diversion Initiative and its effects on student outcomes

[School] agrees to:

- Work with the Connecticut Center for Effective Practice and CGC-GB to accomplish project deliverables.
- Work with CCEP to ensure participation of school personnel in training activities
- Collaborate with CGC-GB to adopt and implement new practices in crisis assessment and referral; adhere to recommendations on the effective utilization of EMPS services; maintain consistent working relationships with CGC-GB staff.
- Work with the Connecticut Center for Effective Practice to design and ensure data collection to assess the impact of a school-based mental health-juvenile justice diversion initiative.
    - Number and type of behavioral health crisis incidents in the school
    - Number/proportion of behavioral health crises resulting in calls/referrals to law enforcement or juvenile justice
    - Number/proportion of behavioral health crises resulting in calls/referrals to EMPS
    - Satisfaction with implementation of the School Based Diversion Initiative and its effects on student outcomes.

Needs Assessment Survey

Note: The CHDI\CCEP researchers work collaboratively with schools and communities to best address their needs and interests. As such, the following needs assessment and focus group protocol were created as a means of introducing the project and examining the interest and capacity for learning within the schools. Summative reports are then created and findings are discussed with the school in the process of developing the plan for the year.

The following brief survey is part of a needs assessment being conducted at your school. The goal of this needs assessment is to determine how your school identifies youth with juvenile justice and behavioral health needs and refers them for services. Investigators from the Connecticut Center for Effective Practice are coordinating this project in conjunction with the Judicial Branch's Court Support Services Division and the Department of Children and Families. The initiative is funded by a grant from the MacArthur Foundation.

Your answers to this survey and to the needs assessment focus group will be combined with others' responses and reported only in aggregate. Your participation is strictly voluntary and you are free to discontinue participation at any time.

Your Title: _____

Please rate the degree to which you disagree or agree with the following statements:

	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
I know which youth at our school have juvenile justice and mental health needs					
I understand *when* it is appropriate to refer a child for mental health services					
I understand *where* it is appropriate to refer a child with mental health needs					
Children in this school who have mental health needs are likely to be referred to the juvenile justice system					
Juvenile justice/detention is the right setting for youth who have mental health needs					
Available services in this community are well-coordinated and well-integrated with our school					

Please continue to the next page

	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Our school has clear policies and guidelines about *mental health emergencies/crises*					
Our school has clear policies and guidelines about *routine mental health referrals*					
Children in this school who have mental health needs are receiving the right services					
I understand the role and function of the Emergency Mobile Psychiatric Services (EMPS) program in this community					
I understand the role and function of Care Coordinators in this community					
I have a good understanding of the other mental health services and supports available in this community					
I feel prepared to competently address the role of race, ethnicity, and culture in the education, mental health, and juvenile justice systems					
I am comfortable making a referral for mental health services					
Mental health providers and my school communicate well with each other after a referral for services has been made					
This school collaborates well with law enforcement/SROs when it comes to kids with mental health needs					
I am interested in receiving further training in the following areas, as they relate to juvenile justice, mental health, and our school…					
…recognizing mental health needs					
…the principles of the Wraparound approach to service delivery					
…a uniform crisis planning approach between EMPS and my school					
…crisis de-escalation strategies for the classroom					
…effective collaborations with EMPS and care coordination					
…effective collaborations with law enforcement					
…the impact of race, ethnicity, and culture on the mental health and juvenile justice systems					
…engaging parents of youth with mental health needs in educational and mental health interventions					

Needs Assessment Focus Group Protocol

1. What are the most common behavioral health concerns that occur in the school?

2. What is the current process for managing a behavioral health problem or crisis? Are there specific policies and procedures in place to guide this?

3. How do you distinguish between mental/behavioral health needs and acting out behavior that warrants police involvement?

4. How are children with behavioral health needs currently referred for services?

5. Following referral, to what extent do behavioral health providers (including EMPS) follow-up with the school?

6. To what extent are police or law enforcement personnel involved in helping manage behavioral health crises? Are children ever arrested after displaying acting out behavior?

7. To what extent are EMPS providers involved when a child has a behavioral health emergency? What makes it more likely that they will provide a mobile response? what makes it less likely?

8. In what ways are parents or caregivers involved when a behavioral health emergency occurs?

9. What are the current gaps in knowledge or skill development that affect school personnel in managing behavioral health issues?

10. To what extent are you knowledgeable about the mental health services that are available to children in your area?

11. In what trainings would you like to participate in order to learn more about managing behavioral health problems in the school?

12. What would make you more likely to participate in trainings such as the ones discussed today?

Phase II

- Baseline data elements were collected from the school administration prior to program implementation. Data related to the number of school incidents/crises, school demographics, arrest rates, and mental health service utilization were collected.

- A great deal of effort was devoted to developing and implementing a training curriculum for school staff, with great success. The first step in this process was to conduct needs assessments in both schools in order to identify training needs and interests among school staff and to enhance buy-in for the initiative from the key participants as identified by the school administration. The needs assessment methodology integrated qualitative and quantitative data collection. Reports were prepared for each School District summarizing the findings and these findings were used to guide development of the training curriculum and to further shape the goals and activities of the initiative (see Appendix C for a sample Needs Assessment Report). One aspect of these reports was a Training Menu that outlined training content areas and a training calendar for the year. Core and elective training modules were delivered. The core training elements that were shared in both schools included:

    - Recognizing Mental Health Symptoms in Children
    - Effective Collaboration with EMPS
    - Parent Involvement in School Interventions
    - Changes in Juvenile Law
    - Overview of the CT Behavioral Health System
    - Uniform Crisis Prevention Planning
    - Effective Collaboration with Police and Law Enforcement
    - Classroom Behavior Management and Crisis De-Escalation
    - Multicultural Competence and School-Based Mental Health

- Trainings can be incentivized in a number of ways including financial compensation, SBDI paraphernalia (i.e., canvas bags, portfolios, etc.), and resources related to juvenile justice and mental health in schools. School staff members may also receive copies of resources that describe how to design and implement school-based mental health programs or strategies for enhancing social-emotional learning. The CT SBDI has utilized existing school means of publicity and marketing to inform school staff of upcoming trainings, including such strategies as public announcements, notices in teacher/mental health professionals' boxes, intranet emails, and placement on the school calendar.

- Ideally, the training aspect of the SBDI will be integrated with the formal professional development curriculum for the school or district; therefore, trainings and programmatic

activities can be held during pre-determined and contractually required professional development times. Alternatively, schools may only be able to commit to scheduling training that occurs during the after school hours, and those trainings may be voluntary. In such circumstances, it is important to identify incentives that will ensure that school professionals consistently attend. For example, project coordinators may want to consider snacks, prizes, CEUs, privileges within the school (e.g., access to the best parking spot for one month), or other incentives in order to overcome any logistical or implementation challenges.

- Whenever possible, project coordinators should utilize trainers that are drawn from the communities in which the schools are located. This increases the relevance of the material for school professionals and helps enhance the sustainability of the initiative after formal project implementation ends. In the early implementation phase of the initiative, project coordinators work with school administrators to identify relevant community-based mental health and juvenile justice service providers. Often, these agencies employ staff members that are qualified to provide the trainings that become part of the curriculum. By identifying individuals and agencies in the community with content expertise that is relevant to the school, and building these relationships throughout project implementation, schools will be able to draw on these individuals and agencies as resources in future years after completion of the formal project.

Phase III

- During the last phase of implementation, project coordinators should work with schools and the collaborative group of stakeholders to review goals, accomplishments, barriers and facilitators to implementation, and key outcomes. Sustainability should be discussed, including strategies for ensuring that training will continue past active implementation and how coordination and agreements between the school and various community partners can be maintained over time. The present manual can be helpful in guiding this process.

- Throughout implementation, monthly meetings with the core school personnel should be held to review progress. In addition, project coordinators should meet regularly with state agencies to report findings and obtain feedback. This process allows for ongoing modification and improvement of the initiative, and is essential when installing a project of this nature.

- One of the major aspects of this initiative is reporting. Year-end reports are generated by the SBDI researchers and presented to state funders and schools for review. Data related to diversion, mental health intervention, and training evaluation are presented and discussed in terms of their implications for the future.

Lessons Learned for Implementing SBDI

In our experiences implementing SBDI in Connecticut, we have discovered several helpful tips and lessons learned that can be beneficial in replication efforts. Seven examples of lessons learned are described in detail below, including:

- Pre-Implementation Capacity Building
- Select schools based on interest, need, and capacity
- Understand school logistics
- Identify the pre-existing infrastructure
- Identify a school champion
- Reduce confusion between SBDI and other programs
- Understand the difference between urban and suburban districts

- **Pre-Implementation Capacity Building**. Working with schools can be a complicated process involving multiple layers of administration and oversight. Thus, installing a new initiative often is a process and project coordinators should not expect to be able to begin implementation in a very short timeframe. The first few months of the project are spent building awareness and support for the initiative, selecting participants, identifying resources and community stakeholders, and developing program strategies. The remainder of the year is spent implementing the plan that was developed in the first few months. Whenever possible, the project timeline should include this pre-implementation or start-up time to accommodate the need to address these challenges.

- **Select schools based on interest, need, and capacity.**
    - **Interest:** Schools that are nominated for participation by an external source such as a Superintendent or an external committee can be resistant to full participation and cooperation. Project coordinators are encouraged to send out one to two page informational sheets describing the basic elements of the initiative, to schedule meetings and have discussions about the project, and ultimately select a school or schools that demonstrate internal interest in the initiative.
    - **Need:** Need for a program of this kind can be defined as having high rates of behavioral health concerns, high rates of students on probation, or frequent arrests. If a school is interested in the project but has not demonstrated a need then the initiative will fail to prevent, or divert, youth from negative outcomes (i.e., arrests, probation, incarceration). Using existing data to demonstrate need can be helpful, including the number of law enforcement and mental health referrals, the number of students with SED designation, substance abuse concerns, or high arrest rates.
    - **Capacity:** Schools must also have the capacity, or readiness, to take on a new initiative. A school that has interest and need, but is not able or willing to release

school professionals for training, is not a good candidate for the initiative. School administrators, teachers, and other professionals must be willing to devote additional time to the initiative for training and must be willing to collect and report data to evaluate its effects. Project coordinators are encouraged to have open discussions with school administrators to ensure that the practical and logistical needs of the initiative can be met throughout the active implementation phase.

- **Understand school logistics**. One of the difficulties of the initiative was managing the achievement of deliverables while working within the challenges of the school calendar and workday relative to the calendar and workday of other participating agencies. During the school day, many school staff members are teaching and interacting with students and are typically unavailable for meetings or training, although school administrators tend to have more flexible schedules. After-school hours can be more convenient for meetings and training, but often are limited to 2 or 3 hour blocks. Most school personnel are not available during the summer months, which can place the initiative on a forced hiatus. We found it helpful to identify the available professional development days well ahead of time and schedule trainers into those days as soon as possible. Traditional half day or full day training modules often must be creatively adapted to fit the logistics of the school environment; for example, by splitting a four hour training into a pair of two-hour blocks.

- **Identify the pre-existing infrastructure**. Most schools have already done some work to meet the needs of students with behavioral health concerns. Upon selecting a school, it is important to quickly identify the group of school personnel who have already worked on behavioral health and juvenile justice issues and meet with them to determine in what way this initiative can further consolidate their work and offer enhancement. For example, some schools have implemented the Positive Behavior Support program or have participated in a demonstration of Wraparound. These schools tend to be good candidates because the teams of school professionals that already are in place can continue to work on the issues of interest for SBDI. Project coordinators are encouraged to meet with the individuals that oversee training initiatives and also talk with the Student Assistance Team, or similar groups of school professionals that review critical incidents, discuss disciplinary action, and/or discuss how to meet the social, emotional, and behavioral needs of students.

- **Identify a school champion**. It is important to enlist the support of individuals that will be the champions for the initiative. This individual or group of individuals will notify other school staff, identify resources, and help make logistical decisions. One question to consider is whether the school champion is an administrator or someone with direct experience providing special services such as a guidance counselor or a school social worker. Administrators are effective at scheduling meetings, creating top-down buy-in, and ensuring that the right people are in the right place at the right time. School social workers have experience in direct service delivery and have content knowledge about behavioral health

and juvenile justice issues. This makes them excellent resources because they understand the broader context and importance of the work. We learned that pairing an administrative champion with a social work or guidance department champion is an effective approach to ensuring that the deliverables are achieved.

- **Reduce confusion between SBDI and other programs.** Although it is important to identify pre-existing infrastructure and build off of existing programs, sometimes school professionals can experience confusion among multiple programs or initiatives. For example, in Connecticut, the first year of SBDI was linked with a dissemination of high-fidelity Wraparound in the surrounding communities. Although this offered many advantages, some school professionals remained confused throughout the year about the goals of the SBDI initiative relative to those of Wraparound. Simple steps such as "branding" the initiative with a unique SBDI logo has helped raise visibility of the initiative in the school and build support for the work.

- **Understand differences between urban, suburban, rural districts.** The Connecticut SBDI has worked with urban and suburban districts, and with middle and high school professionals. Every experience working with a school district is likely to be very different from the last. For example, urban school districts often experience disproportionate rates of behavioral health and juvenile justice referrals relative to other school districts. In some communities, urban school districts have many programs and initiatives in place, but they can be fragmented. As a result, project coordinators will benefit from working with these schools to consolidate and integrate SBDI with other initiatives in a culturally competent manner. Sometimes, suburban school districts can be better resourced with lower referral rates than urban districts, but behavioral health needs can be unrecognized and the incidents that exist can be severe in nature. It is important that project coordinators are mindful that emotional and behavioral needs exist in every school and that school professionals require training and support to meet those needs. Furthermore, a good assessment of the types of needs that exist within each school is essential for planning a response initiative.

Program Database and Outcome Monitoring Procedures

CCEP/CHDI researchers create, manage, and analyze all databases related to the School Based Diversion Initiative. In order to avoid duplication, CCEP researchers work to integrate the SBDI data collection and reporting needs with existing data collection requirements among participating schools.

Data collection and analysis is important at all stages of implementation. During the pre-implementation phase, baseline data are collected at the school and community level to assess need for the initiative. The needs assessment survey and focus group provides valuable information for program planning and identification of training needs. After each training, evaluations are collected to determine whether key learning objectives were achieved and to modify the training curriculum as needed.

To assess changes in key outcomes, several data elements are collected at baseline and following program implementation. Data are collected to assess changes in teachers' knowledge, attitudes, and skills related to managing behavioral and juvenile justice concerns. School- and child-level indicators are collected at baseline and after the program to assess the effectiveness of the initiative for diverting youth from juvenile justice involvement toward community-based services and supports. School-level indicators are collected to determine initiative impact, and include such indicators as the number of arrests and the number of referrals to community-based services and supports.

In addition, qualitative data are collected throughout program implementation in order to document services delivered, the barriers and facilitators to program implementation that were encountered, and helpful tips for replicating the program. Many of these qualitative implementation data points are summarized in this manual.

Data Collection recommendations are described below. These recommendations can be viewed as guideline for program evaluation efforts. Each program coordination team should work closely with their funders and with the schools and communities in order to tailor an evaluation that meets their specific needs.

1. **School and Community Characteristics**: It is important to establish the need for the initiative by collecting school and community level data that assesses the kinds of events that targeted by the initiative. For example:
    a. Enrollment and demographic characteristics of student population

b. Percentage of students receiving free/reduced lunch
c. Percentage of students currently involved with the juvenile justice and/or the mental health service systems
d. Number of emergency crisis calls for behavioral health (past year)
e. Number of arrests (past year)
f. Percentage of students with IEP/SED status
g. Characteristics of teachers and other school professionals
h. Percentage of students proficient in reading and math
i. Community level crime and poverty statistics

2. **School Needs Assessment:** Each school should be part of a needs assessment at soon after they agree to participate. This can be helpful for identifying and responding to the unique needs of each school and community served. In our initiative, we employed surveys and focus groups during the needs assessment. The needs assessment should end with the completion of a report that is delivered to funders and to the school summarizing key findings. Recommended areas of inquiry include the following:
    a. Teacher/school staff attitudes, knowledge, and skills related to youth with mental health and juvenile justice needs
    b. School policies and procedures regarding routine and emergency mental health situations
    c. School professionals' knowledge, use, and perspectives about community-based mental health and juvenile justice services and supports
    d. Knowledge of and comfort level concerning issues of race, ethnicity, and cultural diversity
    e. Lines of communication within the school concerning students with mental health and/or juvenile justice needs
    f. Training needs and interests

3. **Training Evaluation Data**: After each training, participants are asked to complete an evaluation form that assesses whether key learning objectives were achieved. This information is used to make modifications to the training curriculum, as needed.

4. **Changes in Teachers' Knowledge, Attitudes, and Skills**: Teachers are asked to complete a measure at baseline and following the initiative that assesses knowledge, attitudes, and skills related to managing the needs of students with mental health or juvenile justice needs.

5. **Student-Level Indicators**: Each of the schools that participate in the program receives a database that meets the student-level data collection needs of the project. In addition, a "data dictionary" is provided to each school that outlines each variable

and provides an operational definition. The following are helpful indicators for assessing the student-level impacts of the initiative:

a. Demographic characteristics of children (and their families) referred to the initiative
b. Prior involvements with mental health or juvenile justice systems (type of involvement, dates of involvement)
c. Date and description of presenting problem or incident leading to referral
d. Did incident result in arrest? Did the initiative facilitate a diversion from arrest?
e. Behavioral health referrals made following incident or presenting concern (type of referral, date of referral)
f. Did the child/family actually receive referred services? (type, date)
g. School professionals' satisfaction with community response

6. **Documenting Programmatic Activities:** Project coordinators are encouraged to track attendance at all meetings in order to determine how often programmatic activities were held and the number of types of school professionals and community members that participated.

The MacArthur Cross-Site Evaluation team has developed process/implementation and outcome questions that can be helpful for guiding the evaluation and assessing the effectiveness of the diversion initiative, although program coordinators may find it helpful to go beyond these questions to assess additional outcomes.

Process/Implementation Outcomes

Outcome 1: Develop a manual for school-based implementation that can be used to facilitate program replication.

Outcome 2: Increase collaboration as a result of the development of the necessary agreements and linkages among the agencies/systems that are involved in the program.

Outcome 3: Increase understanding of program components and available services through the provision of training to key school-based staff, and other staff involved with the new program as necessary.

Outcome 4: Implementation of the school-based mental health response program in identified pilot sites.

Program/Youth Outcomes

Outcome 1: Youth with mental health needs in the pilot site schools will be referred to the school-based mental health response program.

Outcome 2: Youth who meet program eligibility criteria are accepted into the program

Outcome 3: Youth accepted into the program will receive needed mental health services.

Outcome 4: Key personnel will express satisfaction with the impact of the program.

Reporting

All of the above indicators should be summarized in mid-year and end of year progress reports. It is also helpful to regularly review data indicators that can be examined more regularly if such indicators can help project coordinators and stakeholders make decisions about how best to modify the program in order to meet existing needs.

SECTION III: TRAINING CURRICULUM

Overview

The training curriculum is among the core objectives of our initiative. Trainings are offered to school teachers, school administrators, mental health professionals, families, and other community stakeholders, with the goal of increasing the knowledge base around effectively meeting the needs of youth with mental health needs, and reducing inappropriate referrals to juvenile justice. It is important to collaborate with schools to identify relevant trainings, thus, the needs assessment can be used to assess interest in suggested training areas and gather information on additional areas of interest.

Once the training menu is developed, the school provides their approval, and dates are set for either after school professional development, or school in-service days. Subsequently, community providers and experts come to the school or to an agreed upon location to deliver trainings. This approach serves a dual purpose 1). Trainers become more familiar with their area school personnel, and school personnel develop contacts in the area of children's mental health. 2). This approach supports our long-term goal of sustainability and systemic change. In the event that no one in the immediate community is available, we seek to recruit trainers in other nearby areas.

Training Curriculum

The training curriculum for the 2009-2010 school year consisted of the following topics:

- Overview of Connecticut School-Based Diversion Initiative
- Overview of Connecticut Behavioral Health System
- Recognizing Mental Health Problems in Children
- Uniform Crisis Prevention Planning and Response
- Updates and Changes in Juvenile Law
- Becoming a Multiculturally Competent Practitioner
- Increasing Collaboration with the Emergency Mobile Psychiatric System
- Understanding and Increasing Empathy for Families with Mental Health Needs
- Classroom Management and Crisis De-escalation

Each of the following one page summaries provide: 1). An Overview of the Presentation, 2). Learning Objectives, 3). An Outline of the Presentation.

Connecticut School-Based Diversion Initiative:
Overview

In this first training module, the project coordinators introduce the project to the school professionals and community members in attendance. The funding source, goals for the project, needs assessment data, and community resources are reviewed.

Learning Objectives:

The trainers seek to increase knowledge on:

1. The key partners funding and coordinating the initiative
2. The fundamentals of the School-Based Diversion Initiative
3. Understanding the Needs Assessment Data

Outline of Presentation

I. Introduction
   a. Founding principles
   b. Advisory group
   c. Funding sources
II. Overview of SBDI Goals
III. Review of Needs Assessment
   a. What was assessed
   b. Overview of Findings
   c. Recommended Professional Development
IV. Linking to Community Resources

Presenter Notes:

- This training is meant to provide an overview of the initiative.
- Be sure to provide ample time for questions and answers.
- This presentation is typically the first opportunity to describe the project to training participants, take care to allay concerns and take this opportunity to obtain ideas and expectations from the audience.
- This is a great training for special INCENTIVES!

Overview of Connecticut Behavioral Health

A representative from the Connecticut Department of Children and Families delivered an overview of the state behavioral health network as it relates to youth and families with mental health needs. The purpose of this training was to increase school personnel's knowledge of the state of Connecticut's behavioral health system. Topics related to budget, services, and upcoming changes were discussed, with particular emphasis on the role of school personnel in improving youth access to services.

Learning Objectives:

As a result of this training, trainees will have a better understanding of the:

1. Current status of behavioral health in the state
2. Levels of service in the state
3. Major statewide Initiatives

Outline of Presentation

I. Current Status
   a. Good News
   b. Bad News
   c. Need for Service
      i. Child Protective Services
      ii. Adolescent Substance Abuse
      iii. Mental Health

II. Service Array
   a. CT Behavioral Health Partnership

III. Levels of Service
   a. Prevention
   b. Community Based
   c. Intensive Community Based
   d. Emergency/Crisis Services
   e. Group Home
   f. Residential
   g. PRTF/Sub-Acute
   h. Hospital Level Care

IV. Program Management

V. Major Initiative

Presenter Notes:

- State and community partnerships are the lifeblood of the CT-SBDI. Therefore, a central goal of this initiative is to increase coordination efforts between schools and the existing behavioral health system.
- We have found that school personnel are not always aware of the services, practices, and policies that exist. This presentation should give a "big picture" view and then identify specific linkages for teachers, administrators, and school mental health providers.

Recognizing Mental Health Problems in Children

This training provided teachers, administrators, and school mental health staff with critical information related to effectively recognizing child mental health symptoms in schools. The presenter discussed a variety of topics as outlined below, and concluded with questions and answers.

Learning Objectives:

The trainer sought to increase knowledge in the areas of:

1. Potential Causes of Mental Health Problems
2. Typical Adolescent Development
3. Recognizing Signs of Mental Health Difficulties in Children

Outline of Presentation

I. Introduction
   a. Critical Issues in School Health
   b. Child Mental Health Statistics
   c. Cost of Untreated Problems
II. Overview of the Impact of Adverse Childhood Experiences?
III. Typical Adolescent Development
IV. Recognizing Mental Health Symptoms in Children
V. Signs that May Indicate the Need for Help
VI. Causes of Mental Health Disorders
VII. Common Mental Health Disorders
VIII. The myth of the "Bad Kid"
IX. Sources of Hope
X. Resources

Presenter Notes:

- Although school professionals do not need specific diagnostic criteria, gaining a basic understanding of mental health symptoms and their causes is essential for this training.
- The goal is to aid school personnel in making better referral decisions for youth with mental health needs.
- Presentations should focus on increasing the fund of knowledge based upon empirical research.
- The use of "non-examples" is also particularly useful in this training (e.g., a temper tantrum after failing a test does not equate to Conduct Disorder).

Uniform Crisis Prevention Planning and Response

This two-part training was designed to bolster school personnel knowledge of best practices related crisis prevention and response. The training was very interactive and allowed time for role-plays, group work, and video.

Learning Objectives:

As a result of this training, participants will be stronger in the following areas:

1. Creating an Individualized Plan
2. Recognizing Informal/Formal Networks of Support
3. Maintaining School Safety

Outline of Presentation

I. Value Base
II. Steps for Developing an Individualized Plan
    a. Crisis
    b. Safety Plan
    c. Important Factors
    d. Child and Family Team
III. Natural/Informal Supports and Community Resources
IV. Positive Support and Indicators
V. Negative Risk Factors
VI. Assessing Safety
VII. Crisis Intervention
VIII. Crisis Planning
IX. Proactive Safety Plans
X. Reactive Crisis Plans
XI. What to do After the Plan is Developed

Presenter Notes:

- This training works best as a 3-4 hour in-service with the following elements:
    - Lecture
    - Video presentation
    - Group Work and presentation
    - Question and Answer
    - Role Play
- The task at hand for the presenter is to present the material in such a way that both teachers and mental health professional gain pertinent information related to their specific roles within a comprehensive training model.

Updates and Changes in Juvenile Law

A representative from the Connecticut Court Support Services Division delivered training on the Connecticut juvenile justice system. The goal of the training was to help school personnel become more familiar with the system. This training emphasized the appropriate utilization of the Department of Juvenile Justice and the implications of youth involvement.

Learning Objectives:

This training seeks to increase knowledge in the following areas:

1. The types of cases the court handles
2. Current child law
3. The role of schools in the process

Outline of Presentation

I. Six types of Juvenile Court Cases
   a. Delinquency
   b. Family with Service Needs
   c. Youth in Crisis
   d. Uncared for Petition
   e. Abuse/Neglect
   f. Emancipation
II. Who Is Considered a "Child"?
III. Current Laws
IV. Confidentiality
V. Appropriate Referrals
VI. School Expectations
VII. Goal of Probation
VIII. CT Court Statistics
IX. Emerging Strategies

Presenter Notes:

- In order for this training to be maximally effective, we recommend that the trainer be familiar with the school referral process and current utilization of the juvenile justice system.
  - This will often involve preparatory work on the part of the initiative in order to equip the trainer with the necessary information.
- It would be best if the trainer limited the information to that which is most relevant for school personnel, as the topic is quite dense.

Becoming A Multiculturally Competent Practitioner

The goal of this training was to increase the multicultural awareness, knowledge, and skill of school-based professionals, with particular emphasis on working with students with mental health needs. The training included role-plays, two video clips, a lecture, and an interactive quiz, among other elements.

Learning Objectives:

The trainer sought to increase competence in the following areas:

1. Awareness of one's own culture, biases, and beliefs
2. Knowledge of major constructs of multiculturalism
3. Skills related to creating a culturally affirming school environment, recognizing cultural differences, and intervening competently

Outline of Presentation

I. Introduction of the Topic
   a. Broadening the discussion to include:
      i. Race
      ii. Ethnicity
      iii. Culture
      iv. Class
      v. Language
      vi. Religion
      vii. Sexual Orientation/Gender
II. Three major areas of competence
   a. Awareness
   b. Knowledge
   c. Skills
III. What is Multiculturalism?
IV. Cultural Competence Continuum
V. Attitudes and Biases
VI. The Importance of Knowledge of one's self and others
VII. Putting competence into skilled practice
VIII. Role Plays
IX. Question and Answer

Presenter Notes:

- This training is useful to all school professionals regardless of the demographic makeup of the student body. The training increases knowledge, awareness, and skills when working with youth from all backgrounds.
- The presenter should have a broad base of knowledge in this particular area, and focus on allaying fears and anxieties that often come up when discussing such topics (e.g., declare the room a "safe space" for growth and understanding).
- During question and answer it trainers must reinforce tolerance and encourage participants to engage in the process of moving to more advanced stages of cultural competence, while allowing participants to appropriately share their experiences and perspectives.

Emergency Mobile Psychiatric Service (EMPS)

The purpose of this training was to increase school personnel's knowledge of the role of EMPS, including the referral process, what constitutes a crisis, and the appropriate ways to utilize the service. The presentation also focused on the role of EMPS in the referral of youth to more intensive/ comprehensive services in the state of Connecticut.

Learning Objectives:

The purpose of this training was to:

1. Increase overall knowledge of EMPS mission and purpose
2. Expand knowledge of referral process including specific disorders that may result in behavioral crises
3. Improve decision making ability related to using the system

Outline of Presentation

I. Introduction of the Topic
   a. Critical Issues in School Health
   b. Recent Changes in EMPS
   c. The History of EMPS
II. What is the Emergency Mobile Psychiatric Service?
III. Who Can Access EMPS?
   a. Hours
   b. Eligibility
IV. EMPS & Schools
V. EMPS as an Alternative to the Emergency Department
VI. EMPS as an Alternative to the Police Department
VII. What is a Crisis?
VIII. What to Expect…
   a. During the Call
   b. Upon Arrival of the Team
IX. Addressing Barriers to EMPS Involvement
   a. Parent consent
   b. Parental presence
   c. Confidentiality
X. Knowing when to Call
XI. Advantages of Calling EMPS
XII. Resources and Follow-up

Presenter Notes:

- As mentioned throughout this manual, EMPS happens to be an innovative CT-based psychiatric mobile response team that draws on existing community resources to improve the continuum of care for youth and families in crisis.
- This training helps schools understand how to best utilize the service. It would likely be helpful if the identified psychiatric emergency responders in your community present their practices and policies to help improve collaboration and referrals.

Understanding and Increasing Empathy for Families with Mental Health Needs

Parents and Teachers as Allies is a two-hour teacher in-service, developed by educators and mental health professionals at NAMI in Connecticut, to help school professionals identify the key warning signs of early-onset mental illnesses in children and adolescents. It focuses on specific, age-related symptoms of mental illness in youngsters. The program is intended to provide an educational tool for mainstream teachers and for advancing mutual understanding and communication between families and school professionals.

The presentation brings together a panel consisting of a parent of a child with mental health needs, an adult who is living with mental illness, and an educator who has experience in identifying mental health needs among children and adolescents. The panel of presenters engages in discussions with the training participants and distributes a number of helpful resources.

Learning Objectives

As a result of this training, participants were able to better:

1. Recognize signs of early-onset mental illnesses in children and adolescents as seen at home and at school
2. Understand the role of the educator as a trained classroom observer who aids in, but does not make, diagnoses
3. Understand family reactions to mental illnesses and guidelines for helping families, while building a capacity for empathy and understanding
4. Recognize that early intervention and treatment leads to better educational outcomes
5. Obtain a number of helpful resources for parents and school professionals

Outline

I. Presentation by a parent of a child with behavioral health needs
II. Presentation by an adult who recalls their own experiences with mental health concerns during their school years
III. Presentation by an educator who has experience identifying and managing behavioral health needs among students
IV. Group discussion and question and answer
V. Distribution of community resources

Presenter Notes:

- Empathy and capacity building are among the chief foci of this training. We found that the attitudes and beliefs appeared to shift after this session. Therefore, it is beneficial to offer this module early in the training schedule.
- Project coordinators should consult with their local chapter of NAMI for presenters and/or resources to support this training. If no such organization exists in your community, work with your existing resources to build a panel of individuals with personal and professional experiences with adolescent mental health.

Classroom Management and Crisis De-escalation

This training focused on equipping school personnel with pragmatic means of managing classroom behaviors effectively, and deescalating crises. The trainer provided tips for verbal intervention, prevention, and provided context for difficult youth behaviors. Further, this training focused on specific ideas related to improving curriculum and instruction, and classroom climate.

Learning Objectives

The purpose of this training was to:

1. Increase overall knowledge of classroom behavior management techniques
2. Increase overall knowledge of crisis de-escalation techniques
3. Broaden knowledge of instructional practices related to students with mental health needs

Outline

I. Limit setting
II. Verbal interventions tips and techniques
III. Rational detachment
IV. Paraverbal communication
V. CPI verbal escalation continuum
VI. Listening actively
VII. Information delivery
VIII. Student work
IX. Organization
X. Starting a lesson
XI. Conducting a lesson
XII. Ending the lesson
XIII. Instructional strategies and classroom accommodations for the ODD student
XIV. Educational implications
XV. Instructional strategies

Presenter Notes:

- Concrete examples from school teaching staff are particularly effective during this training.
- It is important to survey the audience throughout this presentation to gain valuable information about their current beliefs and practices.
- If schools have a PBS (positive behavior support) model (or one similar) in place, it will be important to integrate those elements into this presentation. One could invite a school coordinator of such programs to co-facilitate this training.

Training Evaluation

It is important to collect training evaluation data at the conclusion of each module. This can help assess the effectiveness of trainings and help project coordinators determine if modifications are needed in the future. Calculating mean scores for each item as well as a total mean score aggregated across all items best summarizes the results.

See Appendix E for a sample training evaluation used in Connecticut.

Conclusions

This manual represents the accomplishments and lessons learned as a result of MacArthur Foundation funding. In one year we were able to develop a new program, select participating schools, reach agreements, implement a comprehensive training program, build linkages between schools and the mental health provider community, accept referrals from schools, collect data that demonstrates need and impact, and begin to prepare for dissemination of this program in additional schools. SBDI facilitated linkages to the EMPS program in order to divert youth from juvenile justice involvement. We demonstrated that youth who were referred to EMPS differed from other youth that experienced behavioral health incidents during the school year. These are important findings for informing the refinement of our program.

We believe these are important successes for a one-year program that was developed from scratch; yet, we believe that SBDI has the potential to have an even larger impact given all the lessons learned and the capacity that has been built. The most pressing challenges that affected SBDI were the rapid implementation of the program in a shortened timeframe and the timing of the school calendar including the summer break as well as availability of sufficient training time outside of regular school hours. Despite these challenges, this program can be an effective approach to working with schools so that they can more effectively meet the needs of children with mental health needs, and their families.

List of Partners

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APPENDICES

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

Y

Youth Rating - Short Form (Ages 12-18)

THIS SECTION TO BE COMPLETED BY AGENCY

Program Name: _____ **RU:** _____ **ID#:** _____

Please check one: ☐ Admission ☐ 6th session ☐ 60 days ☐ Discharge

If not completed, please indicate reason: ☐ Youth/Parent Unavailable ☐ Language Issue ☐ Youth/Parent refused to complete ☐ Literacy Issue

Name: _____ Date: _____ Grade: ____

Date of Birth: _____ Sex: ☐ Male ☐ Female Race: _____

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Lying	0	1	2	3	4	5
8. Can't seem to sit still, having too much energy	0	1	2	3	4	5
9. Using drugs or alcohol	0	1	2	3	4	5
10. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
11. Skipping school or classes	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

FOR CLINIC USE ONLY

E ☐ 1-8 D ☐ 9-11 I ☐ 12-20

(Add ratings together) Total _____

NAME OF CLINICIAN SCORING FORM _____

-OVER-

entered by: _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your life right now?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied

2. How energetic and healthy do you feel right now?
   1. Extremely healthy
   2. Moderately healthy
   3. Somewhat healthy
   4. Somewhat unhealthy
   5. Moderately unhealthy
   6. Extremely unhealthy

3. How much stress or pressure is in your life right now?
   1. Very little stress
   2. Some stress
   3. Quite a bit of stress
   4. A moderate amount of stress
   5. A great deal of stress
   6. Unbearable amounts

4. How optimistic are you about your future right now?
   1. The future looks very bright
   2. The future looks somewhat bright
   3. The future looks OK
   4. The future looks both good and bad
   5. The future looks bad
   6. The future looks very bad

Total: _____

NOT TO BE DONE AT AI .SION

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. How much are you included in deciding your treatment?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
3. Mental health workers involved in my case listen to me and know what I want.
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
4. I have a lot of say about what happens in my treatment.
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all

Total _____

Y

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

January 2000 (Youth-2)

(Add ratings together) Total _____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales
Parent Rating - Short Form

P

THIS SECTION TO BE COMPLETED BY AGENCY

Program Name: _____ **RU:** _____ **ID#:** _____

Please check one: ☐ Admission ☐ 6th session ☐ 60 days ☐ Discharge

If not completed, please indicate reason: ☐ Youth/Parent Unavailable ☐ Language Issue ☐ Youth/Parent refused to complete ☐ Literacy Issue

Child's Name: _____ Date: _____ Child's Grade: ____

Child's Date of Birth: _____ Child's Sex: ☐ Male ☐ Female Child's Race: _____

Form Completed By: ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Other: _____

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Lying	0	1	2	3	4	5
8. Can't seem to sit still, having too much energy	0	1	2	3	4	5
9. Using drugs or alcohol	0	1	2	3	4	5
10. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
11. Skipping school or classes	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

FOR CLINIC USE ONLY

(Add ratings together) Total _____

E ☐ 1-8 **D** ☐ 9-11 **I** ☐ 12-20

NAME OF CLINICIAN SCORING FORM _____

-OVER-

entered by: _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied

2. How capable of dealing with your child's problems do you feel right now?
   1. Extremely capable
   2. Moderately capable
   3. Somewhat capable
   4. Somewhat incapable
   5. Moderately incapable
   6. Extremely incapable

3. How much stress or pressure is in your life right now?
   1. Very little
   2. Some
   3. Quite a bit
   4. A moderate amount
   5. A great deal
   6. Unbearable amounts

4. How optimistic are you about your child's future right now?
   1. The future looks very bright
   2. The future looks somewhat bright
   3. The future looks OK
   4. The future looks both good and bad
   5. The future looks bad
   6. The future looks very bad

Total: _____

NOT TO BE DONE AT ADMISSI

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied

2. To what degree have you been included in the treatment planning process for your child?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all

3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all

4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all

Total: _____

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few	Some Troubles	OK	Doing very well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

January 2000 (Parent-2)

(Add ratings together) Total _____

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales

W

Agency Worker Rating - Short Form

THIS SECTION TO BE COMPLETED BY AGENCY

Program Name: _____ **RU:** _____ **ID#:** _____

Please check one: ☐ Admission ☐ 6th session ☐ 60 days ☐ Discharge

If not completed, please indicate reason: ☐ Youth/Parent Unavailable ☐ Worker Unavailable ☐ Language Issue ☐ Youth/Parent refused to complete ☐ Worker refused to complete ☐ Literacy Issue

Child's Name: _____ Date: _____ Child's Grade: ____

Child's Date of Birth: _____ Child's Sex: ☐ Male ☐ Female Child's Race: _____

Form Completed By: ☐ Case Manager ☐ Therapist ☐ Other: _____

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Lying	0	1	2	3	4	5
8. Can't seem to sit still, having too much energy	0	1	2	3	4	5
9. Using drugs or alcohol	0	1	2	3	4	5
10. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
11. Skipping school or classes	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

FOR CLINIC USE ONLY

(Add ratings together) Total _____

E ☐ 1-8 D ☐ 9-11 I ☐ 12-20

NAME OF CLINICIAN SCORING FORM _____

-OVER-

entered by: _____

ROLES: Enter the number of days the youth was placed in each o the following settings during the past 90 days. (For example, the youth may have been in a detention center for 3 days, a group home for days and with the biological mother for 80 days.)

_____	Jail	_____	Foster Care
_____	Juvenile Detention Center	_____	Supervised Independent Living
_____	Inpatient Psychiatric Hospital	_____	Home of a Family Friend
_____	Drug/Alcohol Rehabilitation Center	_____	Adoptive Home
_____	Medical Hospital	_____	Home of a Relative
_____	Residential Treatment	_____	School Dormitory
_____	Group Emergency Shelter	_____	Biological Father
_____	Residential Job Corp/Vocational Center	_____	Biological Mother
_____	Group Home	_____	Two Biological Parents
_____	Therapeutic Foster Care	_____	Independent Living with Friends
_____	Individual Home Emergency Shelter	_____	Independent Living by self
_____		**90**	***Total for the two columns should equal 90***

Markers:

School Placement _____

Current Psychoactive Medications:

_____

_____

_____

Arrests

Suspensions from school _____

Days in Detention _____

Days of School Missed _____

Self-Harm attempts _____

Instructions: Please circle the number corresponding to the designated youth's current level of functioning in each area	Extreme Troubles	Quite a Few	Some Troubles	OK	Doing very well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

January 2000 (Parent-2)

(Add ratings together) Total _____

WheelerClinic
fostering positive change

EMPS CRISIS INTAKE

Place Client Label Here

211 Call Date/
Episode Start Date &Time ☐☐.☐☐.☐☐ ____ a.m. /p.m.

Date of Intake/
EMPS First
Contact Date/Time ☐☐.☐☐.☐☐ Arrival Time: ____ a.m. / p.m. Departure Time: ____ a.m. / p.m.

Assigned Clinician Name & Staff # _____ ____ Agency: (please circle) N.B. 4 Htfd 5 W Htfd 6 Meriden M

Client Name: _____ Male: ☐ Female: ☐ DOB: _____ Age ___ SS#: _____
(Last, First, Middle)

Primary Caretaker _____ Rel to Client: _____ Phone: _____ Alt. # _____

Address: _____ City: _____ State: ____ Zip Code: _____

Person's Present at Intake: _____

Presenting Crisis/Reason for Evaluation (Include name and age of youth, who referred, why referred and place of assessment):

History of presenting problems:

Who does client reside with ? _____

CARETAKER (S) / GUARDIANSHIP Legal Guardian (s) ? _____

	Name:	Address:	Phone:	Alt. Phone:	Comments:
Father's:					
Mother:					
Kinship Caretaker:					
Foster Parent (S):					

EDUCATION

School:	Primary Contact:	Town/City:	Phone:	Grade	Spec Ed. Y/N	Ever Retained? Y/N	Grade(s)
					☐☐	☐☐	

LEGAL AND SOCIAL SERVICES:

Agency	Past Year or Age	Current Date Started	Current Contact Name	Contact Number
DCF				
Court Involvement				
Other				

CLIENT BEHAVIORAL HEALTH TREATMENT

(Community Based)

Level of Care	Past Year or Age	Current Date Started	Agency/Facility	Current Contact Person(s) and Number
Outpatient				
Extended Day				
IOP/PHP				
In-Home TX Type				
In-Home TX Type				

(Out of Home)

	Facility/Location	Year/Age	Duration	Reason for Referral
Inpatient				
Inpatient				
Inpatient				
Residential/GH				
Residential/GH				
Other				

MEDICAL INFORMATION

Primary Care Physician ? Y N Name: _____ Clinic: _____ Phone: _____

Last physical exam date ? _____

Does client have pain that interferes with functioning ? Y N If yes, Pain Brochure given to client: ☐ Do you see a doctor for your pain ? Y N

Does the client have any current medical problems ? Y N If yes, list _____

Is the client pregnant ? Y Denies N/A _____

Is the client breast feeding or lactating ? Y N
(ask if client age 12 or over)

List

Does the client have any history of seizures, head injuries, lead exposure ? Y N _____

List

Does the client have any history of other serious medical problems, or any past medical treatment procedures ? Y N _____

_____

Is the client overweight/underweight ? Y N If yes, Nutrition Brochure given to client ☐

Does client have an eating disorder ? Y N If yes,

Is the client allergic to any medications ? Y N _____

Developmental Milestones: On-Time ☐ Delays: ☐ Describe: _____

_____

Does client/family practice alternative medicine or faith healing ? Y N

Is client currently taking OTC meds ? Y N

Is client currently taking dietary or herbal supplements ? Y N

Please list all prescription medications, over the counter medications and herbal/dietary supplements below:

Name	Current Dosage	Current Frequency	How is it taken	Date Started	Compliant	Prescriber

During the past 4 weeks:

How much physical pain has the client had:

☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

How much trouble is client experiencing doing regular daily activities due to health reasons ?

☐ Not at All ☐ A Little ☐ Some ☐ A Lot ☐ Can't do it

How much does the client's health limit his/her ability to:

	Not at All	A Little	A Lot
Carry or lift objects:	☐	☐	☐
Climb several flights of stairs:	☐	☐	☐
Walk several blocks:	☐	☐	☐

How much has physical or emotional health problems interfered with normal social activities with family, friends, or others?

☐ Not at All ☐ A Little ☐ Moderately ☐ A Lot ☐ Extremely

Are you currently being treated for any of the above ? Y N If Yes, by whom: _____

Do you currently have any spiritual supports ?

_____

How would you identify your religious denomination?

_____

Family History of Mental Illness, Suicidality, Substance Abuse, Legal Involvement, or Other Risk Factors

Client Risk Factors	Denies	School	Community	Home	Details
Physical Aggression					
Extreme recklessness, agitation, impulsivity, or other dangerous destructive behavior					
Sexual acting out					
Running away					
Fire setting					
Eating Disorders					
Gang association					
Victim of bullying					
Other illegal activities					
Trauma/Abuse/Neglect					
Problem Gambling *If yes, See Youth Gambling Screen*					
Other					

MENTAL STATUS

I. APPEARANCE:

A. DRESS
- ☐ Casual
- ☐ Formal
- ☐ Disheveled
- ☐ Weather Appropriate
- ☐ Age Appropriate

B. GROOMING
- ☐ Well-Kempt
- ☐ Unkempt
- ☐ Meticulous
- ☐ Poor
- ☐ Other: _____

C. COORDINATION
- ☐ Typical for Age
- ☐ Clumsy
- ☐ Awkward
- ☐ Other: _____

D. MANNERISMS
- ☐ None Noted
- ☐ Gestures
- ☐ Tics
- ☐ Other _____

Chronological Age _____ Apparent Age: Younger As Stated Older

E. SPEECH:
- ☐ Normal Rate
- ☐ Slow
- ☐ Rapid
- ☐ Pressured
- ☐ Normal Volume
- ☐ Soft
- ☐ Loud
- ☐ Yelling
- ☐ Clear
- ☐ Slurred
- ☐ Mumbled
- ☐ Lisps
- ☐ Unintelligible
- ☐ Other: _____
- ☐ Spontaneous
- ☐ Hesitant
- ☐ Stuttering
- ☐ Typical Amount
- ☐ Uses Few Words
- ☐ Has a Lot to Say
- ☐ Non-Verbal
- ☐ Selectively Mute
- ☐ Logical
- ☐ Illogical
- ☐ Perseverations
- ☐ Tangential
- ☐ Vague
- ☐ Circumstantial

F. AFFECT/FACIAL:
- ☐ Appropriate to Mood
- ☐ Inappropriate to Mood
- ☐ Appropriate to Content
- ☐ Inappropriate to Content
- ☐ Consistent
- ☐ Labile
- ☐ Relaxed
- ☐ Tense
- ☐ Anxious
- ☐ Full-Range
- ☐ Constricted
- ☐ Blunted/Flat
- ☐ Other _____

II. BEHAVIOR

A. ATTITUDE
- ☐ Open
- ☐ Defensive
- ☐ Guarded
- ☐ Withdrawn
- ☐ Dissociative
- ☐ Friendly
- ☐ Distrustful
- ☐ Paranoid
- ☐ Suspicious
- ☐ Hostile
- ☐ Cooperative
- ☐ Resistant
- ☐ Engaging
- ☐ Instigative
- ☐ Seductive
- ☐ Other _____

B. BOUNDARIES
- ☐ Appropriate
- ☐ Invasive
- ☐ Inappropriate

C. PSYCHOMOTOR
- ☐ Within Typical Range
- ☐ Decreased
- ☐ Increased
- ☐ Agitated

II. THOUGHTS/COGNITION

A. PROCESS
- ☐ Logical
- ☐ Goal Directed
- ☐ Tangential
- ☐ Loose
- ☐ Circumstantial
- ☐ Blocked

B. PERCEPTIONS
- ☐ Normal
- ☐ Hallucinations
- ☐ Visual
- ☐ Tactile
- ☐ Auditory

Command: Y N

Describe: _____

C. CONTENT
- ☐ Normal/Appropriate
- ☐ Odd/Bizarre
- ☐ Obsessions/Fixations

Describe: _____

- ☐ Delusions

Describe: _____

D. ESTIMATED COGNITIVE ABILITIES
- ☐ Generally Below Average
- ☐ Generally Average
- ☐ Generally Above Average

E. MEMORY

Remote:	☐ No impairment	☐ Problem	_____
Recent	☐ No impairment	☐ Problem	_____
Immediate	☐ No impairment	☐ Problem	_____

F. ORIENTATION

Time Y N
Place Y N
Person Y N

G. SENSORY ISSUES _____

H. THREE WISHES: 1. _____ 2. _____ 3. _____

IV. MOOD

Current Mood _____ Overall Mood in the Last Month _____

Describe Any Recent Changes in Mood _____

Does the client or caretaker describe any changes in:

Sleep ↑ ↓	Nightmares ↑ ↓	Energy level ↑ ↓	Self Esteem ↑ ↓	Impulsivity ↑ ↓
Appetite ↑ ↓	Pleasure ↑ ↓	Hopelessness ↑ ↓	Anxiety ↑ ↓	Compulsions or Rituals ↑ ↓
Irritability ↑ ↓	Worries ↑ ↓	Weight ↑ ↓	Lability ↑ ↓	Concentration ↑ ↓
		____ lbs in _____		Social Interactions ↑ ↓

V. HARM to Self and Others (see Risk Assessments)

Child/Adolescent Suicidality / Self-Harm Assessment

Each Item must be completed, leaving no blanks on the form

1 Current/Recent History (wishes, threats or actions to kill or harm self in last 30 days) Denies ☐

Date	Describe	Level of Risk	Intervention

2. Past History (wishes, threats or actions to kill or harm self longer than 30 days ago) Denies ☐

Date/Age	Describe	Level of Risk	Intervention

4. What function does self-harm and/or suicidality play for the client ? N/A ☐

Emotional Expression of:

☐ Anger ☐ Boredom
☐ Sadness ☐ Jealousy
☐ Hurt ☐ Being Overwhelmed
☐ Guilt ☐ Fear
☐ Shame Other _____

Function:

☐ Escape
☐ End Emotional Pain
☐ Engagement/Re-Engagement of Others
☐ Get Help For Self
☐ Bring Attention to "unspeakable" situation
☐ Self-Soothe
☐ "Feel something"
☐ Avoidance
Other _____

5. What does client believe happens when people die ? What does he/she believe would happen if he/she died ?

_____

6. Risk Factors for Suicidality ☐ None

☐ Inadequate Family Support
☐ Recent Separation/Losses
☐ Poor impulse control
☐ Family History of Suicidal Behavior
☐ Current Substance Abuse
☐ History of Previous Attempts
☐ Access to Lethal means (i.e. guns, drugs, etc.
☐ Recent Suicide of Peer or Meaningful Person
☐ Issues related to Sexuality
☐ Psychosis with Command Hallucinations
☐ Lack of concern with Consequences
Other severe stressors _____

7. Current Plan to Harm Self or Commit Suicide: Yes Denies Describe plan and time line:

_____

_____

A. How lethal is plan ? _____

B. Does the client believe the plan to be lethal ? Yes No

8. Means Does the client have the means to carry out the above plan ? N/A ☐ Denies Yes

Describe: _____

9. Current Intent to Harm Self or Commit Suicide Denies Yes Describe: _____

A. Client has current thoughts of harming/killing self with no intent to act upon thoughts.

B. Client intends to harm self but denies intent to kill self.

C. Client states he/she will carry out a plan to kill self. Describe time line: _____

10. Is the client future oriented ? Yes No

11. Summary of Risk and Lethality

_____

_____

_____

Child/Adolescent Homicidality / Harm to Others Assessment

Each Item must be completed, leaving no blanks on the form

1. Current/Recent History (wishes, threats or actions to kill or harm others in last 30 days) Denies ☐

Date	Describe	Level of Risk	Intervention

2. Past History (wishes, threats or actions to kill or harm others longer than 30 days ago) Denies ☐

Date	Describe	Level of Risk	Intervention

4. What function do wishes or actions to harm others play for the client ? N/A ☐

Emotional Expression of:

☐ Anger ☐ Boredom
☐ Sadness ☐ Jealousy
☐ Hurt ☐ Being Overwhelmed
☐ Guilt ☐ Fear
☐ Shame Other _____

Function:

☐ Escape
☐ End Emotional Pain
☐ Engagement/Re-Engagement of Others
☐ Get Help For Self
☐ Bring Attention to "unspeakable" situation

☐ Self-Soothe
☐ "Feel something"
☐ Avoidance
☐ Retribution
Other _____

5. What does client believe would happen if he/she harmed others ?

_____

6. Risk Factors for Homicidality ☐ None

☐ Inadequate Family Support
☐ Recent Separation/Losses
☐ Poor impulse control
☐ Family History of Homicidal Behavior
☐ Current Substance Abuse
☐ History of Previous Attempts
☐ Access to Lethal means (i.e. guns, drugs, etc.
☐ Issues related to Sexuality
☐ Psychosis with Command Hallucinations
☐ Lack of concern for consequences
Other severe stressors _____

7. Current Plan to Harm Others Denies Yes Describe plan, timeline, intended victim, and whether victim is aware of plan:

_____

_____

A. How lethal is plan ? _____

B. Does the client believe the plan to be lethal ? Yes No

8. Means Does the client have the means to carry out the above plan ? N/A ☐ Denies Yes

Describe: _____

9. Current Intent to Harm Others Denies Yes Describe: _____

A. Client has current thoughts of harming others with no intent to act upon thoughts.

B. Client intends to harm others but denies intent to kill others.

C. Client states he/she will carry out a plan to kill others.

10. Summary of Risk and Lethality

_____

_____

_____

Client Substance Abuse Assessment

FAMILY SUBSTANCE ABUSE:

Is there any family history of substance use/abuse ☐ Y ☐ N Reported by: _____

Describe (inc. hx, what is used, who uses, and the impact of substance abuse in family:)

_____

_____

_____

_____

_____

CLIENT SUBSTANCE ABUSE HISTORY

DRUG	Denies Hx	Has Tried	Regular Use	Age of 1st Use	Peak Use (Amt/Freq)	Use in Past Month	Additional Information
Alcohol							
Caffeine							
Cigarettes/Nicotine							
Marijuana							
Cocaine/Crack							
Opiates (heroin, morphine, codeine, methadone, Vicodin, Percocet, etc.)							
Hallucinogens (acid, mushrooms, Ecstasy, PCP, Ketamine, Salvia)							
Amphetamines (Ritalin, Dexedrine, Crystal Meth)							
Barbituates/Sedatives (Ativan, Klonopin, etc)							
OTC (drugs/inhalents)							

CLINICAL FORMULATION

Please give a description of the client's unique presenting picture that supports the diagnosis and treatment approach.

Psychiatric Diagnosis - DSM IV:

Axis I

☐☐☐.☐☐ *(Primary)* _____

☐☐☐.☐☐ *(Secondary)* _____

☐☐☐.☐☐ *(Additional)* _____

☐☐☐.☐☐ *(Additional)* _____

☐☐☐.☐☐ ***(Rule Out)*** _____

Axis II

☐☐☐.☐☐ *(Primary)* _____

☐☐☐.☐☐ *(Secondary)* _____

Axis III *(General Medical Condition):*

☐ None	☐ Arthritis	☐ Asthma	☐ HIV	☐ Obesity
☐ Chronic Pain	☐ Cystic Fibrosis	☐ Eating Disorder	☐ Neurological Disorder	☐ Visual Impairment
☐ Hepatitis	☐ Lupus	☐ Mobility Impairment	☐ Traumatic Brain Injury	☐ Other-specify below:
☐ Pregnancy	☐ Postpartum	☐ Sickle Cell	☐ Cardiac Problem	_____
☐ Type II Diabetes	☐ Type I Diabetes	☐ Hearing Impairment	☐ Cancer	

Axis IV (Psychosocial & Environmental Problems):

- ☐ Problems with primary support group. *Specify:* _____
- ☐ Problems related to social environment. *Specify:* _____
- ☐ Educational problems. *Specify:* _____
- ☐ Occupational problems: *Specify:* _____
- ☐ Housing problems. *Specify:* _____
- ☐ Economic problems. *Specify:* _____
- ☐ Problems with access to health care services: *Specify:* _____
- ☐ Problems related to interaction with the legal system/crime. *Specify:* _____
- ☐ Other psychosocial and environmental problems. *Specify:* _____

Axis V (GAF)

	Low																			High
☐ *Current*	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	99
☐ Highest *Past Year*	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	99

Ohio Scales

	Child	Parent	Worker
Problem Severity	☐☐ E ___	☐☐ E ___	☐☐ E ___
Hopefulness	☐☐ D ___	☐☐ D ___	D ___
Satisfaction	☐☐ I ___	☐☐ I ___	I ___
Functioning	☐☐	☐☐	☐☐

Reason Codes for Not Completing Ohio's
- 1 = Family Refused
- 2 = Language Issue
- 3 = Literacy Issue
- 4 = Family Unavailable
- 5 = Child 11 or younger *(Youth scales only)*

Client and Family Strengths

Client's Recreation/Leisure Interests/Activities ?

Disposition/Next Steps

Intake Clinician *(Signature and Degree)* Date ☐☐.☐☐.☐☐

Supervisor *(Signature and Degree)* Date ☐☐.☐☐.☐☐

Psychiatrist *(Signature if required)* Date ☐☐.☐☐.☐☐

COMPLETE PAGE 11 IF CLIENT HAS HUSKY MEDICAID INSURANCE

PLEASE ANSWER THE QUESTIONS IN THE BOX BELOW IF THE CLIENT HAS HUSKY MEDICAID INSURANCE

Client Label

1. Is this a new admission to outpatient services within your Agency/Practice ☐ Yes ☐ No
2. Is Member being discharge from higher level of care within your Agency/Practice ☐ Yes ☐ No
3. Ethnicity: Is the client of Hispanic/Latino Origin? ☐ Yes ☐ No
4. Referral Source:
   ☐ Self/Family Member ☐ Hospital ED ☐ Managed Service System ☐ PCP/Medical Provider ☐ Step Down Intermediate LOC
   ☐ Community Collaborative ☐ CT BHP ASO ☐ Step Down Inpatient LOC ☐ Other BH Provider ☐ School ☐ DCF
   ☐ DMR ☐ DHMAS ☐ Court Ordered ☐ Legal ☐ Other
5. Has the member had previous mental health/substance abuse treatment within the past 6 months? ☐ Yes ☐ No
   If yes, check one or both ☐ Mental Health ☐ Substance Abuse
6. Are there identified family members or significant others involved in the members treatment and recovery? ☐ Yes ☐ No
7. If yes, are any of the above family member's /supports receiving their own mental health or substance abuse treatment? ☐ Yes ☐ No
8. Have you obtained consent to contact:
   a. School: ☐ Yes ☐ No ☐ Denied
   b. Medical Provider ☐ Yes ☐ No ☐ Denied
   c. Previous BH tx provider: ☐ Yes ☐ No ☐ Denied ☐ N/A
   d. BH tx providers for family member or significant other: ☐ Yes ☐ No ☐ Denied ☐ N/A
9. Who is the lead case management provider:
   ☐ No CM Provider ☐ DCF Enhanced Care Coordinator ☐ DMHAS Case Manager
   ☐ DCF Case Worker ☐ CC *Systems of Care/Collaborative)*
10. Is the client on currently on psychiatric medication ? ☐ Yes ☐ No
11. Is a psychiatric mediation evaluation or medication management visit indicated? ☐ Yes ☐ No
12. Does the client have co-occurring mental health and substance use conditions? ☐ Yes ☐ No ☐ Not assessed
13. If the member is involved with the legal system, please select all that apply ☐ Juvenile Justice ☐ Probation ☐ Parole ☐ Other Court
14. Have you provided information regarding peer support or self-help options? ☐ Yes ☐ No
15. Client has SED ? ☐ Yes ☐ No ☐ Unknown
16. Co-Occurring Disorder? ☐ Yes ☐ No ☐ Unknown
17. Living Situation ?
    ☐ Independent Living with support ☐ Jail/Correctional Facility ☐ FC (Therapy/Profess) ☐ Crisis Stabilization Residence ☐ FC (standard)
    ☐ Group Home ☐ Homeless ☐ Residential Treatment Center ☐ Psychiatric Residential Treatment Facility
    ☐ Safe Home ☐ Shelter ☐ Private Residence
18. Has the child/youth been arrested within the past 12 months ? ☐ Yes ☐ No ☐ Unknown
19. Has the child/youth been suspended/expelled within the past 12 months ? ☐ Yes ☐ No ☐ Unknown

CHILD GUIDANCE CENTER OF GREATER BRIDGEPORT, INC
180 FAIRFIELD AVENUE
BRIDGEPORT, CT 06604

EMERGENCY MOBILE PSYCHIATRIC CRISIS PROGRAM
1-866-242-7818
CRISIS PLAN

Date/*Fecha*: _____

Name of Child/Adolescent Evaluated: _____
(Nombre del niño/adolescente evaluado)
Name of Parent/Guardian: _____
(Nombre del padre/tutor)
Name of Crisis Clinician: _____
(Nombre del terapista de crisis)
Date/Location of Assessment: _____
(Fecha y sitio de la evaluación)
Presenting Problem: _____
(Problema identificado)

The following crisis plan is agreed to by the clinician and the parent/guardian:
(Con el siguiente plan se ha llegado de comun acuerdo entre el terapista/padre o tutor)

__ Immediate Hospitalization, as follows: _____
(Hospitalización inmediata)_____
Include specific transportation and admission information
(Incluya información especifica acerca de el medio de transporte y admisión)

__ Call the Crisis Line (1-866-242-7818) if any of the following occur:
(*De ocurrir alguna de las circumstancias indicadas aqui abajo favor de llamar a la linea de crisis al 1-866-242-7818)*

_____

_____

__ Referral to other agencies/programs as follows: _____
(Referido a otras agencias/programas)
_____

__ Next appointment with clinician: _____
(Proxima cita con el terapista)

__ Other measures to maintain stability, as detailed below: _____
(Otras medidas para mantener la estabilidad, como se indicada abajo)

_____

_____ _____
Parent/Guardian Crisis Clinician

10-7-03

08-07-07

CHILD GUIDANCE CENTER OF GREATER BRIDGEPORT

EMERGENCY MOBILE CRISIS / CDCP
SCREENING / INDIVIDUALIZED CRISIS ASSESSMENT / TREATMENT / DISCHARGE PLAN

SCREENING

Date: _____ **Time:** _____ **Day of Week:** S M T W T F S

Program? ___ EMPS ___CDCP **Language?** Eng / Spa / Other: _____

Prev. Case? Y N **ID#:** _____ **When?** _____

Program? _____ **Clinician?** _____

Referring Person: _____ Title: _____

Agency: _____ Phone: _____

CHILD: _____ DOB: _____ Age: ___ Sex: ___

Parent / Guardian: _____ Legal Status: _____

Address: _____

Telephone #s: Home: _____ Work: _____ Cell: _____

School/Daycare: _____ Grade: _____ Special Ed? Y N

Pediatrician: _____ Tel.#: _____

Insurance: Med / Com Company: _____ ID#: _____

DCF Involvement: Y N Worker: _____ Tel#: _____

Location / Status of Child Now: _____

Location of Parent Now: _____

Nature of Crisis *(Precipitant, Previous Similar Instances, etc):*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Problem Areas?

Sleep: Y N _____

_____

Energy/Motivation: Y N _____

_____

Appetite: Y N _____

_____

Substance Abuse: Y N _____

_____

Harmful to Self: Y N _____

_____

Danger to Others: Y N _____

_____

Hallucinations: Y N _____

_____

Fire Setting: Y N _____

_____

Destroying Property: Y N _____

_____

Stealing: Y N _____

_____

Arrests/Court Case: Y N _____

_____

Running Away: Y N _____

_____

School Issues: Y N _____

_____

Social Issues: Y N _____

_____

Phys./Sex. Abuse: Y N _____

_____

Exposure to Violence: Y N _____

_____

Other Trauma: Y N _____

_____

_____

08-07-07

Current Medical Issues: _____

_____

Currently in Treatment? Other agencies involved with family? *Details. Has this provider been contacted? Can they meet the needs of the child/family? If not, why not?*

_____

_____

Brief Treatment History including Medications: _____

_____

_____

Family's / Caller's Preferred Time & Location: _____

Screener's Notes: *(Attempts to contact parent/guardian. Screener in agreement w/ family's preferences? Safety Instructions given to family pending assessment? Etc.)*

_____

_____

_____

Screener: _____ **Time Completed:** _____

Clinician Assigned to Assessment: _____

Assessment Date & Time: _____ **Place:** _____

Assessment within 30 min. of screening? Y N

If not, why? ___ Parent Pref. ___ Other: _____

Mobile Assessment? Y N

If not, why? ___ Parent Pref. ___ Other: _____

Notes / Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

08-07-07

TREATMENT PLAN

CRISIS STABILIZATION INTERVENTIONS

PROBLEMS	INTERVENTIONS
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Family's Reaction to the Above Crisis Intervention Plan:

_____

_____

_____

_____

Modifications in Plan Following Conference with Family:

_____

_____

_____

_____

Actions Taken by Clinician to Implement Plan:

_____

_____

_____

_____

_____
Clinician

_____
Date

08-07-07

DISCHARGE PLAN

Child: _____

Presenting Problems: _____

_____

_____

_____

_____

Interventions: _____

_____

_____

_____

_____

Treatment Goals *(Achieved/Not Achieved)*: _____

_____

_____

_____

_____

Admissions GAF: _____ **Discharge GAF:** _____

Discharge Plan: _____

_____

_____

Community Linkage: _____

_____

_____

_____
Clinician

_____
Date

Data Entered? Yes No

Appendix B
Description of EMPS Practice Model

Scope of Work

The responsibility of the selected EMPS contractor is the provision of the EMPS to all towns located within their catchment area. The contractor must provide all staffing, office space, equipment, materials, supports, and resources necessary to meet the performance requirements of the EMPS Service either directly or through limited sub-contract arrangements. The selected provider must provide all resources necessary for in-home, in-school, or other community based response as well as the ability to respond telephonically and/or at their offices.

Service Components

Hours of Operation

- The EMPS contractor must retain the capacity to receive and immediately respond to crisis calls/inquiries for crisis intervention, 24 hours a day, seven days a week, 365 days per year.
- The EMPS contractor must maintain capacity for mobile response between the hours of 9:00 AM to 10:00 PM, Monday through Friday, and 1:00 PM to 10:00 PM on Saturday, Sunday, and Holidays.
- Within those hours requiring mobile response capacity, the EMPS contractor must retain the ability to respond to multiple calls within the same time frame and the flexibility in staffing to respond effectively to predictable peak periods of demand.
- During the hours of 10:00 PM to 9:00 AM, Monday through Friday and 10:00 PM to 1:00 PM on Saturdays, Sundays, and Holidays, the EMPS contractor must respond immediately by phone, or in person, to all calls requiring crisis intervention.

Mobile Responsivity

- A minimum of 90% of EMPS responses must be mobile, consisting of the immediate dispatch of staff to the client home, school, or other community based setting.
- While there may be exceptional circumstances in which a mobile response is not the preferred method of responding, the EMPS program is designed to be mobile.
- The implementation of a central call system will screen out and respond to requests for information and non-emergent requests for service thus increasing the percentage of calls received by local EMPS providers that will require a mobile response.
- A response to the home or school demonstrates provider commitment, builds rapport, has superior ecological validity in comparison to office based interventions, and provides the practitioner with more information with which to intervene effectively. Such interventions also remove barriers associated with transportation.
- Individuals or families that prefer an office based response at a later time may be best served through referral for urgent access to the local Enhanced Care Clinic rather than an EMPS emergency crisis intervention.
- In those cases where a mobile response is contra-indicated due to safety or risk issues, a call to 911 for police involvement or facilitation of a hospital ED admission is recommended.

Time Frames for Responsivity

- EMPS provider agencies must maintain 24 hour ability to be immediately "conferenced" in to calls received by the central call center and determined to require an immediate emergency crisis response.
- EMPS clinician's are expected to be on site in the home, school, or other community setting within 45 minutes of their receipt of the call.

- An initial crisis plan must be developed with the family whenever possible, within the course of the initial intervention and a copy provided to all participants prior to the end of the intervention. The initial crisis plan should be provided to other key players (therapist, school staff, coach, etc.) with appropriate consent w/in 1 business day of development.
- Initial follow-up with the child/family must occur within one week of the initial crisis intervention or sooner if clinically indicated. Whenever possible, follow-up should be provided by or include a community provider in a position to provide ongoing care, or by the EMPS staff if no care provider has been engaged.

Follow-up Care

- Follow-up care to support continued crisis stabilization, strengthening of supports, and linkage to ongoing services and supports is a required and critical element of EMPS.
- The goals of follow-up care are the support of continued stabilization and linkage to ongoing care. Linkage should be accomplished and follow-up transitioned to ongoing care by a community provider as soon as possible. The pursuit of goals more appropriately addressed through ongoing therapy or in-home service should not occur within the EMPS intervention.
- While follow-up care is critical, EMPS teams must maintain a balance between maintaining capacity for mobile response to initial crises and providing sufficient follow-up care to support continued stabilization and linkage.
- From the point of the initial crisis response, the duration of follow-up care should not exceed 6 (six) weeks. In rare cases where extended follow-up may be required, the EMPS provider must request permission for an exemption from the follow-up time-limitation from the assigned DCF manager of EMPS.
- Follow-up care must conform with the principles and practices of the system of care including family driven, youth guided, community based, linguistically and culturally competent, strength based, and promoting the use of informal community based supports.

Crisis Planning

- The crisis plan must conform to the structure and approach described by Grealish (2006) in The Comprehensive Guide to Crisis Intervention Planning.
- Each crisis plan should include kinship, natural, and family supports to the extent possible
- An initial crisis plan must be developed for each case served and continually updated throughout the course of the EMPS intervention.
- The crisis plan must be in writing, contained in the client record, and copies provided to the family and key resources (with appropriate consent). .

Staffing and Team Composition

- All EMPS hours that require a mobile response (9-10 M-F & 1-10 S,S & Hol. = 4276 hours annually), must be staffed by a dedicated EMPS Team or teams of clinicians.
- 80% or more of the members of the EMPS teams providing coverage during the hours of mobility must work at least half-time within the EMPS program.
- EMPS programs may use part-time and/or per diem staff to augment their coverage of the hours of mobility and/or to cover non-mobile hours.
- All clinicians working with the EMPS team must be licensed or license eligible for independent practice as a clinical psychologist, clinical social worker, marriage and family therapist, licensed professional counselor, or licensed alcohol and drug counselor. Exceptions to these clinician credentialing requirements may be allowed with prior approval from DCF for bilingual/bicultural clinicians.

- All EMPS Programs must provide access to a psychiatrist for psychiatric assessment, psychiatric consultation, and short-term medication management that is sufficient to meet the needs of staff, children, and families.

Training

- During the 1st year of implementation, the EMPS provider must provide all required training to all members of the EMPS team (including subcontractors, if any).
- In subsequent years, training will be provided by the DCF contracted training and quality assurance vendor.
- Training must include at a minimum the following;
    - Crisis Assessment and Intervention
    - Suicide Assessment and Prevention
    - Violence Assessment and Prevention
    - Principles and practices of the System of Care
    - Crisis Planning
    - Strength based assessment and care planning
    - Identification and use of natural supports
    - Traumatic stress and trauma informed service provision
    - Orientation to the CT Behavioral Health Service System
    - Culturally and linguistically competent care
    - Working with foster families and the behavioral health needs of children in foster care
    - Parent Support and behavior management
    - Training in standardized risk assessment and treatment protocols

Relationships with Emergency Departments (EDs)

- Each EMPS provider must collaborate with and maintain relationships with the EDs within their service area. EMPS providers must also establish relationships with EDs outside their service area that serve a significant number of children and youth from within their service area.
- The relationship with each ED will be demonstrated by the following;
    - An MOU outlining roles and responsibilities of each party
    - Outreach to high sources of referral to the ED to facilitate diversion from the ED
    - Collaboration with each ED to facilitate rapid discharge of ED patients to the community via the provision of education/consultation regarding diversion options and by follow-out/follow-up care by the EMPS provider
    - Willingness of the EMPS provider to provide on-site consultation at the ED

Relationships with Schools

- Each EMPS provider must work to establish relationships with each school system within their service area paying special attention to those schools that have a history of a high rate of ED referral and/or EMPS utilization
- The relationship with the school is designed to facilitate appropriate utilization of EMPS services as an alternative to ED referral

Relationships with Law Enforcement

- Each EMPS provider must work to establish/maintain relationships with each Police Department within their service area paying special attention to those departments that have a history of a high rate of ED referral and/or EMPS utilization

- The relationship with police is designed to:
    - Facilitate cooperation in those cases where a police escort may be required or advisable during the course of an EMPS response
    - Facilitate increased utilization of EMPS in those cases where police respond to calls where EMPS intervention may be a better alternative to ED referral or arrest.

Relationships with the Foster Care System

- Each EMPS provider must work to establish/maintain relationships with entities involved in the management and provision of foster care services and organizations that advocate on behalf of foster parents and foster children. These relationships should include DCF Foster Care and Adoption Service Units (FASU), foster care provider agencies, and foster parent advocacy and support organizations.
- The purpose of the relationship with Foster Care is to promote increased utilization of EMPS by foster families leading to a decrease in ED visits and foster care disruptions.
- The linkage with Foster care is predicated on the following facts;
    - Children in foster care have higher rates of serious emotional disturbance than the average child and higher than similarly disadvantaged groups
    - Behavioral health crises that occur within foster homes can lead to placement disruption if the crisis is not adequately managed and the child/family is not linked to appropriate services and supports.
    - Children who experience multiple foster home placements and/or are removed as a result of behavioral health crises occurring in the home show some of the poorest long-term health, educational and behavioral health outcomes of all children in the child welfare system.
    - Children in foster care and their foster care families who are supported in managing crises in a timely manner and linked to appropriate services have better short-term and long-term outcomes.

Other Key Relationships

In addition to those relationships outlined above, each EMPS provider must develop/maintain relationships and active involvement with the following:

- All local Systems of Care within their service area
- All local managed service systems within their service area
- All DCF local offices within their service area
- All Enhanced Care Clinics
- Key service providers including outpatient, extended day treatment, intensive outpatient, intensive in-home, respite, mentoring, care coordination, crisis stabilization, sub-acute, and psychiatric inpatient providers.
- Key community resources that are likely to be a significant source or point of access for natural and informal supports that may be of value to families in crisis
- CT Behavioral Health Partnership network management, ICM, & Peer Staff

Data Collection and Quality Improvement

- Each EMPS provider must collect and submit data to DCF and/or DCF contracted providers for the purpose of quality improvement.
- EMPS providers must maintain the capacity to transmit or input data via electronic submission of batch files and/or web-based systems. Final specifications will be determined upon contracting with the QI and Training Vendor

Multicultural and Linguistically Competent Training and Service Delivery

The selected contractor must have the ability to: a) provide culturally and linguistically competent training for their staff members; and b) assure multicultural competence in the implementation of EMPS. Bi/Multilingual and/or cross-cultural communication capabilities are required for service delivery especially in those areas where there are significant numbers of non-native English speakers who are likely to seek service from EMPS. The preferred method of insuring culturally competent care is the hiring of bilingual or multilingual EMPS clinicians. Limited use of interpretive services is permitted, where no bilingual staff is available.

Statement on Sub-contracting

For the procurement of the EMPS System, the department discourages the use of subcontracts to deliver EMPS service to sub-areas of the proposed service area or for other substantial components of the EMPS service unless the applicant can clearly demonstrate why the proposed subcontracting relationship is essential and will contribute to significantly improved care. While the use of sub-contracts for defined sub-areas of the larger service area are not prohibited, the burden will be upon the applicant to demonstrate why they are necessary and/or will result in improved care. In the case of two applications with relatively equal merit on all other components, the department is more likely to select the applicant that has demonstrated the capacity to deliver the service without the use of sub-contractors. The discouragement of the use of subcontractors for specific sub-areas of service delivery does not preclude the appropriate use of subcontracts for components such as training, interpretation/translation, psychiatric consultation or other limited components of EMPS service provision.

Appendix C
Sample Needs Assessment Report

School-Based Diversion Initiative: Needs Assessment Findings

[---] High School

July 6, 2010

Report prepared by:

Charlayne C. Hayling, Ph.D.
Jeffrey J. Vanderploeg, Ph.D.

Child Health and Development Institute of Connecticut, Inc.
Connecticut Center for Effective Practice

Introduction
On May 28, 2010, a needs assessment was conducted with [School] in Connecticut, facilitated by Jeffrey Vanderploeg, Ph.D. and Jeana R. Bracey, Ph.D. of the Connecticut Center for Effective Practice (CCEP). The needs assessment was an initial step in the implementation phase of the School Based Diversion Initiative (SBDI) funded by the MacArthur Foundation. The primary aim of the project is to develop a statewide school-based diversion program in Connecticut. [School] was selected as a year two site for this initiative.

Prior to the needs assessment, investigators from CCEP worked closely with John Chapman from the Connecticut Judicial Branch, school psychologist -----, Principal -----, and Vice Principals ------- and ------- among other integral school staff – to discuss implementation goals of the project and review the MOU.

Methods
Dr. Vanderploeg provided a brief introduction and overview to the school-based diversion initiative and described the rationale for the needs assessment. Following this introduction, questions were answered, consent for participation was obtained from those in attendance, and a 24-item survey developed by Dr. Vanderploeg was distributed (attached). The survey took approximately five minutes to complete. Upon completion of the survey, a semi-structured focus group was conducted, guided by a protocol developed by Dr. Vanderploeg (attached). The focus group took 45 minutes to complete.

Participants
In an effort to serve as a liaison between the school and community to better serve the needs of students, 71 school and community personnel participated in the needs assessment focused group, and 59 completed and returned the needs assessment. The group was diverse in terms of job title and background. At least one staff member in the following self-identified positions was in attendance:

School Counselor
Special Education Teacher
Classroom Teacher
School psychologist
School Support Staff

Findings

Mental Health Services Survey Findings

A brief survey was developed to assess perceptions of mental health needs within the school setting, school responses to mental health needs and emergencies, available services in the school and community, perceptions of collaboration, and training interests. We are not aware of any scientifically designed and psychometrically sound surveys of this kind; thus, a brief survey was designed specifically for this needs assessment. Participants were asked to respond to each of the 24 items on a 5-point Likert-type scale (1 = "Strongly Disagree", 5 = "Strongly Agree"). Mean scores approaching the maximum of 5.0 suggest strong agreement with a statement whereas mean scores approaching the minimum mean score of 1.0 suggest strong disagreement with a statement. Fifty-nine participants returned completed surveys. The results are presented in Table 1.

Table 1. Results of Mental Health Services Survey

Item #	Item Description	Mean Rating
1	I know which youth at our school have juvenile justice and mental health needs	2.7
2	I understand *when* it is appropriate to refer a child for mental health services	3.5
3	I understand *where* it is appropriate to refer a child with mental health needs	3.2
4	Children in this school who have mental health needs are likely to be referred to the juvenile justice system	2.7
5	Juvenile justice/detention is the right setting for youth who have mental health needs	2.1
6	Available services in this community are well-coordinated and well-integrated with our school	2.9
7	Our school has clear policies and guidelines about *mental health emergencies/crises*	3.5
8	Our school has clear policies and guidelines about *routine mental health referrals*	3.5
9	Children in this school who have mental health needs are receiving the right services	3.2
10	I understand the role and function of the Emergency Mobile Psychiatric Services (EMPS) program in this community	2.4
11	I understand the role and function of Care Coordinators in this community	2.4
12	I have a good understanding of the other mental health services and supports available in this community	2.7
13	I feel prepared to competently address the role of race, ethnicity, and culture in the education, mental health, and juvenile justice systems	3.0
14	I am comfortable making a referral for mental health services	3.4
15	Mental health providers and my school communicate well with each other after a referral for services has been made	3.4
16	This school collaborates well with law enforcement/SROs when it comes to kids with mental health needs	3.5
	I am interested in receiving further training in the following areas, as they relate to juvenile justice, mental health, and our school	
17	…recognizing mental health needs	3.8
18	…the principles of the Wraparound approach to service delivery	3.7
19	…a uniform crisis planning approach between EMPS and my school	3.7
20	…crisis de-escalation strategies for the classroom	4.0
21	…effective collaborations with EMPS and care coordination	3.8
22	…effective collaborations with law enforcement	3.8
23	…the impact of race, ethnicity, and culture on the mental health and juvenile justice systems	4.0
24	…engaging parents of youth with mental health needs in educational and mental health interventions	4.0

Despite its brevity and the small sample size (N=59), the survey suggested several important themes.

- On Item 1, most staff members on average did not report a strong opinion related to their awareness of students with juvenile justice and mental health needs in the school; though many seemed to disagree with this statement (mean= 2.7). This trend was somewhat consistent throughout the portion of the assessment related to knowledge, awareness, and school practices (Items 1-16).

- Staff tended toward neutrality around having knowledge of the appropriate time and place(s) to refer students with mental health needs (Items 2 and 3).
- With regards to item 4, personnel did not endorse an overall strong feeling about whether students with mental health needs at [School] are likely to be referred to the juvenile justice system (mean = 2.7).
- Personnel reportedly tended to agree more with items related to the clarity of school policies related to child mental health (Items 7 and 8).
- Staff did not express definitive opinions on items 14 (mean = 3.4), 15 (mean = 3.4), or 16 (mean = 3.5). Nevertheless, they reportedly tended to agree that they were comfortable making referrals for mental health services, communicate well with each other related to mental health crises, and that they collaborate effectively with SROs related to students with mental health needs.

Items 17 through 24 asked respondents to indicate whether they were interested in receiving further training in a few potential content areas. It is important to note that a key objective of the focus groups that took place later in the day was to identify potential training interests. Thus, some training content areas were not represented in the survey portion of the needs assessment.

- The findings suggest that school personnel were at least moderately interested in all the content areas listed. Out of a maximum mean score of 5.0, all training content areas were at or near 4.0, indicating relatively strong interest in each area.
- Staff demonstrated the strongest interest in trainings related to crisis de-escalation, multicultural competence, and engaging parents (mean = 4.0).
- The lowest mean scores were obtained for training in the principles of wraparound service delivery (mean = 3.7) and uniform crisis planning approach between the school and EMPS (mean = 3.7). Again, scores near 4.0 still indicate relative interest in these content areas.

Focus Group Findings

School personnel in attendance identified a number of areas of concern related to better serving the needs of students with mental health needs at [School]. Many of the areas of focus appeared to be related to effective collaboration with community-based mental health, distinguishing mental health crises from juvenile justice issues, and the logistics of policies and practices. Due to budgetary concerns in the district, the school will no longer have resource officers next school year. This topic raised concern related to effectively managing crises at [School] next year. School personnel reported significant concerns related to systemic challenges within the state's behavioral health system. Topics related to zoning, "turf wars," and quality of care were discussed as their student population represents a region, rather than a specific town or city. In addition, personnel expressed interest in collaborating in a more culturally competent manner, especially with Spanish speaking families (e.g., bilingual consent forms).

IDENTIFYING NEEDS; POLICIES AND PROCEDURES

School personnel in attendance identified several presenting concerns that might lead to an office referral, a behavioral crisis, or a juvenile justice referral. School staff initially identified mostly externalizing, or acting out, behaviors as particularly problematic in their school. They included: aggression/anger, and bullying. This is significant because these types of behaviors are most likely to result in a juvenile justice or law enforcement referral. Staff also cited substance abuse and internalizing disorders like anxiety and depression as problematic. The topic of students who pride themselves on being "social outcasts" was also mentioned as an area of concern for this generation of youth.

It is important to note that school staff also identified many strengths and resiliencies demonstrated by youth even though questions were intended to determine the types of problematic behaviors that might trigger a mental health or juvenile justice referral.

Reaching Agreement on What Constitutes a Crisis

Staff reported that they always utilize the resources within the school before involving any outside personnel. These resources reportedly include: the SAT (Student Assistance Team), guidance counselor, and school psychologist. When asked, "How do you distinguish mental health needs and need for police involvement?" members of the group replied that they seek feedback on questions related to home life, grades, and the student's feelings. Police involvement is said to depend on the amount of disclosure and the immediate threat of danger. Staff reported that they try to "think outside the box," as much as possible and that they have had "some successful, some not so successful [school based] interventions." The presence of clear policies and guidelines, regarding responses to mental health concerns and emergencies, remained unclear during the focus group.

SERVICES

Child Guidance of [Town] and 211/EMPS at [Lead Mental Health Agency] were identified as the points of contact most often utilized by personnel at [School]. Staff reported that information is commonly not communicated once referrals are made, and that the sole responsibility is generally placed on the school to do the follow-up and build the relationships with collaboratives, which can be challenging. One staff member said that they have difficulty finding out if custody has changed and that they "don't see a lot of coordination from agencies, I guess they're overwhelmed too." With regards to the CT behavioral health system, staff stated, "It's not a system and it's not a system that works." The overall sentiment was that the staff perceives the system as different parts working in isolation. There were apparent strong feelings related to the ability of the current behavioral health system to meet the needs of the students most effectively. The role of SBDI in creating stronger linkages between schools and community collaboratives was explored in relation to this concern.

IDENTIFYING NEEDS AND GAPS

Training Content

The above findings suggest that school personnel are deeply committed to their students and to their own professional development, all in the interest of enhancing learning and creating a safe and supportive school environment where students can learn to become productive citizens. School staff endorsed interest in recommended training topics along with the following areas of interest:

- typical adolescent development including a focus on the brain
- ways for schools to better increase the likelihood of student engagement
- key indicators of mental illness related to development and brain development (diathesis-stress model)
- transition to young-adult services
- what triggers might lead teens joining dangerous groups (e.g., gangs, and supremacist groups)
- serving students with sexual obsessions
- serving students with risky dating behaviors
- effectively addressing sexual development
- making better home-school connections—learning about the home environment and potential stressors without being intrusive

Importantly, school staff said they were motivated to participate in training because it will be beneficial for their students, because they want to learn how to better manage the classroom in an effort to enhance learning, and to enhance their ability to cope with these challenges. Many staff members recognized the great work that teachers and other staff were already doing to manage the behaviors of difficult students. There was considerable agreement that further training in these areas could only benefit and supplement their already excellent work in this area. Finally, the group introduced the idea of giving CEUs as an incentive for participation. They also reported that trainings on NEASC days may decrease participation, and is therefore not recommended.

RECOMMENDATIONS

In response to the needs assessment survey and focus group findings, the following recommendations for training and collaboration were developed for the coming year:

Core Training Menu with Electives

- Recognizing Mental Health Symptoms in Children
- Understanding and Increasing Empathy for Families with Mental Health Needs
- School-based Multicultural Competence
- Effective Collaboration with EMPS
- Effective Collaboration with Care Coordination
- Uniform Crisis Prevention Planning
- Effective Collaboration with Department of Juvenile Justice
- Adolescent Psychological Development (elective)
- Improving Home/School Coordination (elective)
- Increasing School Engagement/Decreasing Problem Behavior (elective)

Collaboration

- Regular meetings (at least monthly) with school administrators and data collection team to discuss the progress of the initiative and necessary modifications
- Regular meetings among key community stakeholders (e.g., Youth Services Bureau, Child Guidance Clinics, Police, Juvenile Probation, etc.) focused on mental health and juvenile justice to improve school and community collaboration
- Participation in scheduled PTO meetings to foster parent engagement
- Increased cultural responsiveness efforts, specifically related to addressing language barriers (e.g., developing bilingual outreach efforts).

Appendix D
Data Dictionary for Student-Level Data Collection

Label	Description	Categories
student_id	School's ID number for this child	N/A
st_age	Child's age	Enter age in years
st_gender	Child's gender	1=male 2=female
ethn_hisp	Hispanic ethnicity?	1=yes 2=no
race_white	Caucasian or White?	1=yes 2=no
race_black	African-American or Black?	1=yes 2=no
race_amindian	American Indian or Alaskan Native?	1=yes 2=no
race_asian	Asian?	1=yes 2=no
race_haw_pi	Native Hawaiian or Pacific Islander?	1=yes 2=no
race_other	Other race?	1=yes 2=no
	Other race description	Please describe race
school_name	School name (enter number 1 through 3)	1=Marin School 2=JFK Middle 3=Joseph A. DePaolo Middle
incid_date	Date of incident	Please enter in format: mm/dd/yyyy
incid_descrip	Incident description	Please enter description of incident
called_911	Was 911 and/or local law enforcement called?	1=yes 2=no
st_arrested	Was the child arrested?	1=yes 2=no
juv_prob_inv	Prior to incident, was child involved in juvenile probation?	1=yes 2=no
mental_health_inv	Prior to incident, was child involved in mental health system?	1=yes 2=no
dec_callparent	Was the child's parent called?	1=yes 2=no
dec_call211_emps	Was 211 called in order to access local EMPS team?	1=yes 2=no
dec_ref_lawenf	Was a call made to 911, local law enforcement, or was a School Resource Officer called in to respond to this crisis?	1=yes 2=no
dec_call_amb	Was an ambulance called to respond to this crisis?	1=yes 2=no
dec_call_mental_health	Was a direct call placed to a mental health provider (other than EMPS)?	1=yes 2=no
dec_ret_class	Was the child returned to class, on the same day,	1=yes

	after the incident?	2=no
dec_other	Were any other decision(s) made other than those above?	1=yes 2=no
dec_other_descr	Please describe the other decision(s) made in reponse to this incident.	1=yes 2=no
emps_mobile	If 211/EMPS was called, did EMPS make a mobile, in-person response to the school?	1=yes 2=no
emps_satisfied	If EMPS was involved, were you satisfied with their response and assistance with this crisis?	1=yes 2=no
school_ref_wrap	Was the child referred directly to the Wraparound project, via the local Community Collaborative?	1=yes 2=no

Appendix E

School-Based Diversion Initiative Training Evaluation

Date of Lecture/Activity:_____

Title of Lecture/Training:_____

1. The content of the training was thorough, useful and appropriate to your level of training/experience:

Unsatisfactory	Fair	Good	Excellent	Outstanding
1	2	3	4	5

2. The readings, materials, visual aids and syllabus were clear, useful, helpful and relevant to the topic.

Unsatisfactory	Fair	Good	Excellent	Outstanding
1	2	3	4	5

3. The instructor's overall teaching ability was:

Unsatisfactory	Fair	Good	Excellent	Outstanding
1	2	3	4	5

4. Overall, I would rate this training as:

Unsatisfactory	Fair	Good	Excellent	Outstanding
1	2	3	4	5

5. This training provided information that I believe can improve the quality of services for children and families.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

6. This training was worthwhile.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

7. This training offered an opportunity for me to share my experiences.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

8. I was able to have my questions related to child/adolescent mental health answered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

9. This training should have been shorter

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

10. This training should have been longer

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

COMMENTS:_____