School & Behavioral Health Partnerships:

A Resource Guide

Developed by:

[Logo of Arizona Department of Education]  [AHCCCS Arizona Health Care Cost Containment System]
Welcome

The Arizona Department of Education (ADE) and the Arizona Health Care Cost Containment System (AHCCCS) are pleased to provide this mental health resource guide for principals, other education administrators, school mental health professionals and anyone who wishes to be a voice that promotes the need for school mental health resources in Arizona. In it, you’ll find clear, concise information and tools that will help connect educational leaders and behavioral health providers, define expectations and roles for each, provide guidance for handling a behavioral health crisis, and help your community respond to a suicide. All of these resources are intended to increase students’ access to the mental health care system.

AHCCCS, the state’s Medicaid agency, provides health care services to more than two million Arizona residents, and covers more than half the births in our state. In 2017, the Arizona State Legislature prioritized funding for mental health in public and charter schools and renewed that funding again in 2018. AHCCCS encouraged health providers to partner with schools and provide services on campus. The result was a remarkable 300 percent increase in services provided to Arizona’s students in just two years.

Additionally, our two state agencies manage Project AWARE, a grant-funded effort to bring suicide prevention and mental health resources to schools and are jointly providing guidance to public and charter schools who are implementing the Mitch Warnock Act. The law requires all school staff who work with students in 6th through 12th grade to be trained in an evidence-based suicide prevention training. AHCCCS has vetted and approved a list of training courses and works with schools to implement and track the new training requirement.

We are thankful for this ongoing, collaborative work between state leaders and agencies because it means that more students and their families are receiving much needed mental health care. We welcome your feedback or further questions, and we thank you for your dedication to Arizona’s students!

Regards,

Jami Snyder

Kathy Hoffman, MS, CCC-SLP

Director at Arizona Health Care Cost Containment System

Superintendent of Public Instruction
Purpose of this Guidance

Schools and behavioral health providers often serve the same students and families. However, their unique systems require a diverse set of skills to ensure they are effective, accessible, and equitable when supporting students. Each system approaches care and intervention from a lens that is unique to their field. The language, leadership hierarchy, decision making structure, and gate keepers are different enough to cause confusion, but similar enough that the potential for positive impact is high.

Terminology can be confusing between the education and mental health system and this will be addressed within the context of this document. To begin, AHCCCS and other insurance carriers define behavioral health services as services that include access to both mental health and substance use treatment. However, in the educational settings, “behavioral” typically refers to how a student is acting and the types of behaviors they are displaying in the classroom and other areas of the campus. Changing a student’s behaviors may or may not require access to behavioral health services.

To keep matters simple for this resource guide, the term “mental health” will be used throughout to refer to services that address students’ mental health and substance use. Addressing student mental health not only increases student success and well-being but also positively affects the school climate, school safety and outcomes for the whole school community.

Comprehensive school mental health provides an array of supports and services that promote positive school climate and increase school safety through the use of a tiered approach that addresses the prevention, intervention and treatment of mental health concerns in school-age children.

Schools who partner with community-based mental health providers make these services more accessible to their students and families and increase the school’s ability to provide an equitable, safe, and supportive learning environment that promotes academic success.

Public health research overwhelmingly supports the efficacy and positive impact of school-based health. The table shows some outcomes schools can expect and where these services overlap/intersect with current school priorities. In essence, schools that partner with community-based providers save lives.

This is why ADE and AHCCCS are excited to jointly provide this resource. It is intended to assist school district and behavioral health providers in creating a seamless partnership that supports Arizona’s youth and families.

Partnerships between schools and community-based providers connect directly to the resiliency of our communities. They make it possible to meet the unique needs of our students and provide the ongoing support to their families. These partnerships are based on the understanding that no one system can meet all of these needs. The comprehensive school mental health approach strives for continuous collaboration, allows for fluidity in the implementation of services, and places student voices at the center of the work. As with other services, comprehensive school mental health services tend to be fluid and are best implemented through ongoing collaborations with youth families, school personnel and mental health providers. Note: This document does not constitute legal advice.

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What is Mental Health?

The American Foundation for Suicide Prevention defines mental health as “a state of mental, emotional, and cognitive health that can impact perceptions, choices and actions affecting wellness and functioning.” Mental health exists on a continuum (see Fig. 1). Fluctuations along this continuum can be part of typical youth development or may indicate a chronic condition that may benefit from professional attention. 2 Mental health conditions include depression, anxiety disorders, post-traumatic stress disorder (PTSD), and substance use disorders as well as others. Mental health can be impacted by the home and social environment, early childhood adversity or trauma, physical health, and genetics.3

The Mental Health Continuum

Currently, most western health care systems do not utilize a wellness model. A wellness model frames mental health care as a preventative activity with health impact similar to regular brushing and flossing. The stigma of mental health as mental illness or disease is very much present in modern times. Families may be reluctant to engage in mental health services or school-based supports for a variety of reasons. Families want to help their children but may need help to unpack preconceived ideas about mental health, mental illness, and need modeling from other adults to normalize fluctuations in mental health with the same empathy and understanding as physical health and illness. As an educator or school mental health professional it is our job to normalize the conversations around mental health and to reduce the stigma of mental health for our youth and families.

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Role of Mental Health Professionals on a School Campus

The role of a mental health professional employed by a school is to help students succeed in an academic environment. There are multiple types of school mental health professionals, each with unique training and education. Their roles may overlap at times, but each provides a distinct type of support. School mental health professionals may be a school social worker, school counselors, school psychologists, etc. Arizona’s strong commitment to local decision-making means that the roles may vary between district/charter schools based on community needs and available supports. For further information on professional role descriptions please visit the following professional organizational websites:

1. American School Counselor Association: [www.schoolcounselor.org](http://www.schoolcounselor.org)

Community-based providers do not provide the same services as school mental health professionals and support staff. They **are not intended to duplicate the role of school mental health or support staff.** Instead, they provide individualized clinical treatment for children and families in a setting proven to increase the student’s ability to access these services. It is also important to note that although both fields use the term counselor, they have different job duties in a mental health versus education setting. The role of a community-based provider is to provide clinical support. Clinical interventions aim to reduce the severity and duration of mental health challenges impacting the child’s ability to meaningfully engage in activities of daily life. Success in the academic environment is only one goal of community-based mental health support. Fig. 2 illustrates how school and community mental health professionals might work together to achieve the best outcomes for students.

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Considerations for Collaboration

Form a team:

An effective team is the core component to successful implementation of school and community mental health partnerships. Teams set expectations for interventions and data collection, and develop procedures to assess and address student needs at individual, small-group, classroom, and whole-school levels. District school mental health teams organize efforts across schools to ensure consistent standards of support are met districtwide. Comprehensive school mental health teams should include multiple disciplines, community members and the community-based providers. This approach will ensure that all aspects of the student’s mental health and educational needs are represented in the decisions made by this team.

When partnering with a community-based provider it is important to understand that clinical directors have significant say in programming. The decisions about programming are based on organizational policies, federal and state funding requirements, insurance considerations, and staffing availability. Clinical directors are responsible for using these criteria to determine what services can and will be provided on a school site. The school on-site administrator and the community provider’s clinical director can set the tone for how a collaboration will work. Community-based provider’s school teams usually consist of a small number of professionals and they have very limited staffing. Discuss staffing up front so that capacity of all team members and ability to deliver services is clearly communicated.

Research community service options:

• Learn who the providers are in your area:
  † Are they along the bus line?
  † Do they offer services in home, on campus, and/or via telehealth?
  † What types of funding do they accept for service: private pay, Medicaid (AHCCCS), Tribal (IHS) insurance, private insurance, all or some of the above?

• Learn the different types of services they offer:
  † Do they offer family services?
  † What types of treatment do they offer and where (e.g in home, in school, virtual)?
  † Do they offer services in Spanish or other languages? Do they have bi-lingual clinicians?
  † Do they offer medication management?
  † Do they offer crisis support?
  † What is the referral process?

• Learn the current wait times for services:
  † At the beginning of each semester, call every referral line for every provider in your area and attempt to navigate the enrollment process. This is often the biggest barrier to service for families.
  † Tip: Get the name of the agency staff and contact information for future calls.

Develop an agreement with community-based providers:

It is recommended that collaboration begins with developing a standard Memorandum of Understanding (see Appendix 1) with community-based partners. The MOU should contain roles and responsibilities of team members to ensure that there are no overlap or gaps in services provided to students. Partnerships require a great deal of collaboration and time is extremely limited; success begins with shared understanding of processes and language. The document School Mental Health Quality Guide: Teaming offers evidenced based practices, concrete examples and questions to assist school sites in forming, developing and implementing effective teaming strategies.

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6 Link: www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Teaming-1.27.20.pdf
Start by clearly defining the roles and responsibilities of the community mental health provider and school staff.

- **Who will be the lead point of contact?** When, where, and how often will student sessions be held? **Who communicates with families?** How will you collaborate and who will be invited?

- Clinicians that provide onsite services must have appropriate space that is confidential and routine.

Determine what type of approval is necessary in order for the partnership to move forward. This may look different across Arizona due to our many education options and local control policies. Entering into contracts and MOUs usually, but not always, involves coordination with the District Administration or requires Governing Board Approval.

**Facilitate parent and family engagement:**

Adults play a key role in the mental health and wellness of students. Their collaboration with the comprehensive mental health team will be vital to the outcomes and effectiveness of any school-based program. The resource *Authentic and Proven Family Engagement Strategies* provides strategies for engaging families by leading with equity and developing trusting relationships with your school community. By listening to and working with your community, school leadership teams can develop joint strategies for working with families. Relationships with caregivers are critical. Educators that develop trusting relationships find that families feel more confident to make decisions about their student’s access to care and that families develop an understanding of how to collaborate with the school and why including the school in their student’s care will help improve outcomes. Discuss with families what measures you take to protect privacy.

**Protect student and family privacy:**

**Health Insurance Portability and Accountability Act (HIPAA) and FERPA:** Sharing of information is important for successful partnerships, but many school leaders feel hesitant to pursue relationships with mental health providers due to concerns or lack of understanding of the privacy requirements of HIPAA and FERPA. Through collaboration with local partners, these barriers can be addressed to ensure equitable and stigma-free access to care.

The document *HIPAA and FERPA Laws: A School Mental Health Navigation Tool for A School Mental Health Navigation Tool for Pacific Southwest States* provides Arizona-specific requirements regarding privacy in a school setting.8

**Parent / Guardian Consent:** Parent/guardian consent is mandatory and must be obtained before a referral can be sent to any community-based mental health provider. Some families may be reluctant to allow student information to be shared and may be reluctant to engage in services at all. This is a typical response due to the stigma surrounding mental health that continues to impact access for our most vulnerable children and youth. The comprehensive school mental health team should work with parents and community leaders to understand the specific barriers they face and develop guides to address those concerns and stigmas within your community.

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Integrating Services

Identify and refer students in need:

The mental health system and the education system have historically operated in isolation. This becomes apparent when mental health and education support teams begin to collaborate. Key terminology for collaboration such as “screening” or “referral” have different meanings and interpretations in individual systems.

### Key Terms to Know

The words “referral” and “screening” mean different things to educators and mental health providers. For the purpose of this document, the following definitions are used to describe these processes and represent the use of terms in an education setting.

Referral: An informal or formal process of connecting a student to a specific mental health related intervention(s). Not all referrals for mental health support on a school campus go to a community-based provider. However, if connecting to an outside provider for support, parent or Guardian consent is required by law and must be obtained before a referral can be sent to any community-based provider.

Screening: A non-clinical tool or process employed with an entire population, such as a school’s student body, a group of students, such as one grade level, or classroom. The purpose of screenings can be to identify students at risk, to identify student strengths and needs or to inform team decision making about needed supports. Screening can be universal, targeted to specific groups or individual students.

Although outside the scope of this guide, it is important to note that not all students will require the support of a community-based mental health provider. **Partnerships with community providers are just one component of a larger system of interventions for students that benefit from this level of support.** A referral for community-based clinical support is appropriate only for the students with the highest level of need and is **rarely** an appropriate first step. A multi-tiered system of support model (MTSS) is an effective and evidence-based strategy to develop scaffolded interventions for routine classroom behavior concerns or developmentally appropriate changes in mood.

When a student is actively suicidal and the immediate safety of the student or others is at-risk (such as when a weapon is in the possession of the student), school staff should call local crisis response number or 911 immediately. Always provide mental health crisis information to families, along with an explanation of when and how to call if the situation becomes life threatening. It is critical to have upfront and realistic conversations with families, otherwise families can feel put on the back burner with waitlists and little access to alternatives.

For more information on specific suicide prevention policies and sustainable practices to put in place at your district or charter, see appendices three “Arizona Model Suicide Prevention Policy”.

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9 [https://www.azleg.gov/ars/36/02272.htm](https://www.azleg.gov/ars/36/02272.htm)

Enrolling in community-based mental health services:

Community-based mental health providers are responsible for the treatment plans. This process typically includes consent, intake, assessment, treatment, and discharge plans. Before services can begin, community-based providers will complete an intake and needs assessment with the student and their guardian/parents. The provider will go over possible treatment options and have the parents sign the consent for treatment. A treatment plan and goal setting meeting determine the type, duration, and intensity of service. Treatment needs may change over time and progress is monitored through regular Child & Family Team (CFT) meetings. The school team may be asked to attend CFT meetings to develop support for the student.

Delivery of services:

Community-based mental health providers use a variety of methods and measures to provide services in a school partnership. The following are a few examples:

Clinic or Home-Based Services: While it is common for referrals to begin at school, the services take place in a clinical or home setting. Depending on the needs of the child, they may be assigned to a case manager or a clinic team and may be regularly re-evaluated.

On site services: Community-based mental health providers may maintain a space on campus to see clients. School and community provider team should set a location and office hours through a memorandum of understanding. Provider shall complete intakes, assessments, and deliver services on site. This partnership does not have significant interaction with school support staff members although it may involve regular interaction with front office staff to check in and call students from class.

Integrated on site clinic services: Community-based mental health providers and school districts/charters enter into an agreement where a comprehensive referral and care system is developed. The community provider acts as an independent contractor, with a designated space (determined by school administration) where they provide services to students. These providers can be involved in school team meetings and have regular interaction with key school site staff, primarily in the area of case staffing and support.

Virtual/Telehealth Services: Telehealth is the use of digital technology, like computers, telephones, smartphones, and tablets, to access health care services remotely. AHCCCS members who cannot travel to an office can use these devices from their homes to attend healthcare appointments with their providers. Telehealth can make access to health care more convenient, saving time and transportation costs.
On Campus Meeting Space Guidelines

If intake or ongoing services will take place on your school campus, **HIPAA requires a confidential meeting space.**

- Free of cross and pass through traffic
- Walls are thick so sound does not travel, walls go from floor to ceiling, room has a door, and window coverings are used while meetings are in session.
- Sound stays inside the meeting space.
- If passes are used to ‘call’ students from class, they cannot state the reason for the session.

**Funding:**

Mental health partnerships with AHCCCS-contracted mental health providers should never require a direct financial commitment from schools in Arizona\(^1\). It is **never** the schools’ responsibility to determine the insurance eligibility of a student. Students in Arizona can receive funding for mental health services through a variety of options and can work directly with a local provider to combine a variety of funding streams, **regardless of their ability to pay.** Even families that have not traditionally qualified in the past may now qualify for new streams of funding in Arizona. Encourage families to work with the community-based providers to explore expansions to private insurance coverage and AHCCCS eligibility. The following are options that may be available to families:

- Private insurance
- Block grant funding
- Sliding scale payment fees
- Private community-based assistance counseling
- Medicaid benefits
- Tribal Health Insurance

**To Learn More:**

The Coalition for Community Schools and the National Association of School Psychologists outline **nine key elements necessary for creating and sustaining effective partnerships** to improve student mental health, physical health, and overall wellness.\(^2\)

The School Health and Performance Evaluation System, or the **SHAPE System**, helps educators measure the quality and sustainability of their mental health programs as well as their level of trauma responsiveness. Assessment results are linked directly to a resource library specific to your school needs\(^3\).

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\(^1\) Non-AHCCCS contracted or Tribal Health providers may offer alternatives not addressed in this reference document.

\(^2\) Link: [https://shape.3cimpact.com/overview](https://shape.3cimpact.com/overview)

\(^3\) Link: [https://www.theshapesystem.com/](https://www.theshapesystem.com/)
Relevant Statutes

ARS 15-120 (https://www.azleg.gov/ars/15/00120.htm)

Suicide prevention training; approved materials; posting; immunity; spending classification

All school personnel who interact with students in grades 6-12 must receive approved evidenced based suicide prevention training in suicide prevention once every three years.

ARS 15-160 (https://www.azleg.gov/ars/15/00160.htm)

Student identification cards; suicide prevention; contact information required

By July 1, 2021 all identification cards issued to students in grades 9-12 shall have national and/or local suicide prevention phone numbers printed or affixed on them.

ARS 15-104 (https://www.azleg.gov/ars/15/00104.htm)

Mental health screening; consent; form; exemption

Parental consent is required before a school site can complete a non-clinical mental health specific screener.

ARS 36-2272 (https://www.azleg.gov/ars/36/02272.htm)

Consent of parent required for mental health screening or treatment of minors; exception; violation; classification; definition

Parental consent is required before clinical mental health screening can take place on a minor in any setting.

SB1523 - Jake’s Law

In 2020, the Arizona legislature passed Senate Bill 1523, establishing the Children’s Behavioral Health Services Fund. This $8 million fund is to be administered by AHCCCS and will provide behavioral health services to uninsured/underinsured students who are referred for services by an educational institution and who have written parental consent to obtain the behavioral health services. AHCCCS will distribute the funding to the Regional Behavioral Health Authorities (RBHAs), which will then contract with local behavioral health service provider agencies. These agencies will create agreements with public and charter schools to provide services on and off of school campuses. AHCCCS is currently developing policies and procedures for this behavioral health service delivery, in partnership with stakeholders.

This bill further requires mental health providers to survey parents whose children were referred for, and/or received, behavioral health services as the result of a referral from an educational setting. This survey will ask students’ and families’ satisfaction level with the referral process, the overall provision of services, and the availability and selection of providers. It will also ask whether the recipients would opt-in to receive services again in the future. AHCCCS will compile the survey.
A student in my classroom is having a mental health crisis (possibly including suicidal thoughts). What do I do?

If you have a school-based mental health professional, they should be the point of contact. If not, you should have a clear point of contact on your campus. If your school doesn’t have a policy or contact identified, get the attention of another adult nearby. Call the front desk or send a student to another classroom and ask for immediate assistance. **The student should not be left alone at any time during this process.** Have an adult walk the student to a safe location and call the local crisis line. They will assess the situation and determine next steps.

**Crisis lines in Arizona:**

- Maricopa County served by Mercy Care: **1-800-631-1314 or 602-222-9444**
- Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties served by Arizona Complete Health - Complete Care Plan: **1-866-495-6735**
- Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties served by Steward Health Choice Arizona: **1-877-756-4090**
- Gila River and Ak-Chin Indian Communities: **1-800-259-3449**
- Salt River Pima Maricopa Indian Community: **1-855-331-6432**
Appendix 2
Sample Memorandum of Understanding

[District/Charter] and [Community Based Provider Name Here]

The Parties of this Memorandum of Understanding (MOU) are [District/Charter and [Program Name Here], hereinafter collectively referred to as the Parties.

Purpose:
The purpose of this agreement is to establish roles and responsibilities of the Parties to develop and implement a comprehensive school mental health system (CSMHS) that utilizes the strengths and expertise of school and community-partnered professionals.

CSMHS are defined as school-community partnerships that provide a multi-tiered system of mental health supports (MTSS) to support students, families and the school community. “Mental health services” include activities, services and supports that address social, emotional and behavioral well-being of students, including substance use.

Roles and Responsibilities:
The Parties agree to the following roles and responsibilities.

Responsibilities of [Program Name Here]

1. Actively participate in school mental health team(s) to support effective school-community collaboration that promotes:
   • well-defined roles and responsibilities of team members (with structures in place to avoid duplication of efforts),
   • data sharing,
   • data-based decision making,
   • seamless services and supports across tiers,
   • integration of mental health and other academic supports
   • Define the effective referral processes.

2. Provide mental health screening, assessment and services, to include [customize services below]

   **Tier 1 - Mental health promotion services and supports (Tier 1):** are mental health-related activities, including promotion of positive social, emotional, and behavioral skills and wellness, which are designed to meet the needs of all students regardless of whether or not they are at risk for mental health problems. These activities can be implemented school-wide, at the grade level, and/or at the classroom level.

   - Universal mental health screening
   - Social Emotional Learning (SEL) activities
   - School climate activities
   - Positive behavioral expectations and rules/Classroom management
   - Bullying prevention
   - Restorative Practices
   - Mental health literacy for students
   - Mental health literacy for families/caregivers
   - Mental health literacy for teachers/school staff
   - Teacher/staff consultation to promote mental health of all students
Tier 2 - Selective services and supports (Tier 2) to address mental health concerns are provided for groups of students who have been identified through needs assessments and school teaming processes as being at risk for a given concern or problem. When problems are identified early and supports put in place, positive youth development is promoted, and problems can be eliminated or reduced. Sometimes these are referred to as mental health “prevention” or “secondary” prevention services.

- Progress monitoring of students identified as “at-risk” and those receiving services
- Social skills training/coaching
- Group therapy for students identified as at-risk of developing mental health problems
- Teacher/staff consultation for students identified as at-risk of developing mental health problems

Tier 3 - Indicated services and supports (Tier 3) to address mental health concerns are individualized to meet the unique needs of each student who is already displaying a particular concern or problem and displaying significant functional impairment. Sometimes these are referred to as mental health “intervention” or “tertiary” or intensive services.

- Progress monitoring of students identified with mental health problems and those receiving services
- Individual treatment for students with mental health problems
- Group treatment for students with mental health problems
- Family therapy to support students with mental health problems
- Psychiatric evaluation
- Case management
- Teacher/staff consultation for students identified with mental health problems and those receiving services
- Peer support/navigation services for students identified with mental health problems and those receiving services
- Family peer support/navigation support services for families of students identified with mental health problems and those receiving services
- Facilitate transitions to and from community agencies and programs (e.g., mental health providers, psychiatric hospitals and day programs, juvenile services, child welfare)

3. For all of above services, utilize evidence-based services and supports14, as available. When evidence-based interventions are not available for intended population, selected interventions should be based on promising/best practices and should be evaluated for program impact.

4. Collect and report data that documents [customize data elements below]:

- Clinician productivity
- Program and intervention impact on student/school psychosocial and academic functioning
- Student/family satisfaction and engagement

5. Ensure the complete confidentiality of any and all identifying student and family information gathered in the performance of this agreement. The information gathered, used and developed shall not be provided to any other party without the express written approval of individual(s) authorized to give consent for release of information.

6. Meet federal, state and local regulations required of community mental health providers, including those stipulated by the Health Insurance Portability and Accountability Act (HIPAA).

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14 Evidence-Based Services and Supports are programs, services or supports that are based directly on scientific evidence, have been evaluated in large scale studies and have been shown to reduce symptoms and/or improve functioning. For instance, evidence-based services and supports are recognized in national evidence-based registries, such as the Substance Abuse Mental Health Services Administration (SAMHSA), National Registry of Evidence-based Programs and Practices (NREPP), Blueprints for Healthy Youth Development, and Institute of Education Sciences (IES) What Works Clearinghouse (WWC). A full continuum of evidence-based services and supports within a school includes behavioral health promotion, selective prevention, and indicated interventions.
Responsibilities of [District/Charter]

1. Identify school(s) for service that demonstrate readiness and a commitment to hosting a community mental health provider to support a multi-tiered system of mental health support (MTSS)

2. Identify district and school point of contact to facilitate successful integration of community mental health provider into school(s) and to address any concern.

3. Provide mental health screening, assessment and services, to include [customize services below]

   **Tier 1 - Mental health promotion services and supports (Tier 1)** are mental health-related activities, including promotion of positive social, emotional, and behavioral skills and wellness, which are designed to meet the needs of all students regardless of whether or not they are at risk for mental health problems. These activities can be implemented school-wide, at the grade level, and/or at the classroom level.

   - Universal mental health screening
   - Social Emotional Learning (SEL) activities
   - School climate activities
   - Positive behavioral expectations and rules/Classroom management
   - Bullying prevention
   - Restorative Practices
   - Mental health literacy for students
   - Mental health literacy for families/caregivers
   - Mental health literacy for teachers/school staff

4. Teacher/staff consultation to promote mental health of all students - Provide confidential space in school(s) that includes access to a locked file cabinet and mechanism for communicating with families and other providers (e.g., phone, computer, Internet access).

5. Facilitate inclusion and active participation of community partners in school mental health teams that utilize best practices in teaming:

   - Well-defined roles and responsibilities of teams and team members, with structures in place to avoid duplication of efforts
   - System to evaluate existing team structures, with existing team continuation and new establishment only as necessary
   - Overarching school shared purpose and shared goals ACROSS teams
   - Unique goals for distinct teams
   - Teams and team members understand and support each other’s purpose and work
   - Teams and team members have a process/procedure to ensure frequent and consistent communication
   - Teams and team members address any confidentiality barriers to facilitate regular information sharing across and within teams

6. Create data-based decision models and referral processes that promote early identification and intervention for students.

7. Considerations for special populations (e.g., English Language Learners)
Independent Contractor:
In providing services to [District/Charter] students, [Program Name Here] shall at all times operate as an independent contractor and shall have no authority to make any arrangements or incur any liabilities on behalf of the Board.

Duration and Termination:
This Agreement is for the period beginning Month/Day/Year to Month/Day/Year. Either party may terminate this Agreement for non-performance after first giving written notice of breach to the other party and an opportunity for the other party to cure the non-performance within fifteen (15) days of the receipt of written notice.

Insurance and indemnification
[Community-based provider] shall purchase and maintain during the term of any resulting agreement:

1. **Commercial General Liability Insurance**: of at least $5,000,000 combined single limit coverage written on an occurrence basis covering all premises and operations, and including Personal Injury, Independent Contractor, Contractual Liability and Products and Completed Operations. The Board of Education of [District/Charter] and all of its agents and employees shall be named as an additional insured, which must be shown on insurance certificates furnished to [District/Charter].

2. **Worker’s Compensation Insurance**: benefits as required by Arizona law to include Employers’ Liability coverage with limits of at least $100,000 each accident, $100,000 each employee disease, and $500,000 disease policy limit.

3. **Professional Liability Insurance**: with limits of at least $1,000,000 each occurrence and $3,000,000 aggregate.

[Community-based provider] shall indemnify and hold harmless the Board, its employees, servants, and agents against all liabilities, loss, charges and expenses, including court costs and attorney’s fees, resulting from the failure of [Community-based provider], its employees, servants, and agents, to faithfully and competently perform its obligations hereunder or arising from or caused by [Community-based provider]’s provision of services.

Whole Agreement:
This MOU contains the entire agreement between the parties with respect to the subject matter set forth herein but may be modified with the written consent of both parties.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their authorized representatives.

By: Superintendent, [Name of District or Charter]

By: Executive Director, XX Mental Health Agency
Appendix 3

Arizona Model School District Policy on Suicide Prevention Intervention

Purpose: This model school district policy on suicide prevention is to assist Arizona school districts with protecting the health, safety, and well-being of all students. Information provided by the Centers for Disease Control and Prevention indicates that:

In 2017, suicide was the second leading cause of death in the U.S. among young people ages 10-19. On average, a young person dies by suicide every hour and 25 minutes. For every young person who dies by suicide, an estimated 100-200 youth make suicide attempts. As such, it is an imperative for school districts to have policies and procedures in place to prevent, assess the risk of, intervene, and respond to youth suicidal behavior.

In 2019 the State of Arizona passed the Mitch Warnock Act (ARS 15-120)\(^{15}\) that specifies requirements for training in suicide awareness and prevention for school guidance counselors, teachers, principals and other school personnel who work with pupils in grades six through twelve beginning in the 2020-2021 school year. Districts are encouraged to include the provisions of ARS 15-120 in their suicide prevention policy.

The model suicide prevention policy presented in this document includes best practices using the American Foundation for Suicide Prevention publication: Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources as the main reference\(^{16}\). (afsp.org/our-work/education/model-school-policy-suicide-prevention/)

AHCCCS and ADE respect that school districts vary in many ways and that this model policy will not meet all needs. It is, however, intended to provide a foundation for tailoring a School District Policy on Suicide Prevention.

\(^{15}\)www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/15.00120.htm

The model policy is organized as follows:

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**Purpose**

Protecting the health, safety, and well-being of students aligns with **SCHOOL DISTRICT NAME**’s mandates and is an ethical imperative for all school personnel working with youth. Where it is impossible to predict when a crisis will occur, preparedness is necessary. Prevention policies and procedures can help to deter suicide and schools and school personnel are key to prevention.

The purpose of this policy is to assist **SCHOOL DISTRICT NAME** to protect the health and well-being of all students by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicidal behavior. The language and concepts covered by this policy are applicable for education levels K-12.
SCHOOL DISTRICT NAME should:

- Recognize that physical and mental health are integral components of student outcomes, both educationally and beyond graduation
- Recognize that suicide is a leading cause of death among young people
- Recognize they have an ethical responsibility to take a proactive approach in preventing deaths by suicide
- Acknowledge the school’s role in providing an environment that is sensitive to individual and societal factors that place youth at greater risk for suicide and helps to foster positive youth development and resilience
- Acknowledge that comprehensive suicide prevention policies include prevention, intervention, and postvention components

This policy pairs with other policies supporting the overall emotional and mental health of students and to ensure safe school environments:

PLACEHOLDER FOR DISTRICT TO LIST OTHER RELEVANT POLICIES

Scope

This suicide prevention policy:

- Covers actions that take place in the school, on school property, at school-sponsored functions and activities, on school buses or vehicles and at bus stops, and at school-sponsored out-of-school events where school staff are present.
- Applies to the entire school community, including educators, school and district staff, students, parents/guardians, and volunteers.
- Covers appropriate school responses to suicidal or high-risk behaviors that take place outside of the school environment.

Definitions

At-Risk: Suicide risk exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention by the school and the district.

A student who is defined as high-risk for suicide is one who:

- Has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset of potential mental health conditions or a deterioration of mental health.
- May have thoughts about suicide, including potential means of death, and may have a plan.
- May exhibit behaviors or feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain.

A student at high-risk for suicide would necessitate a referral, as documented in the procedures in this policy. The type of referral, and its level of urgency, shall be determined by the student’s level of risk according to this local district policy.
It is important for school districts to be aware of student populations that are at elevated risk for suicidal behavior based on various factors.

- Youth Living with Mental and/or Substance Use Disorders
- Youth Who Engage in Self-Harm or Have Attempted Suicide
- Youth in Out-of-Home Settings
- Youth Experiencing Homelessness
- American Indian/Alaska Native (AI/AN) Youth
- LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) Youth
- Youth Bereaved by Suicide
- Youth Living with Medical Conditions or Disabilities

**Crisis Team:** A multidisciplinary team of administrative staff, mental health professionals, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention, response and recovery. Crisis Team members:

- Often include someone from the administrative leadership, school psychologists, school counselors, school social workers, school nurses, school resource officer, and others including support staff and/or teachers.
- These professionals have been specifically trained in areas of crisis preparedness and take a leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports.
- Crisis team members who are mental health professionals may provide crisis intervention and services.

**Mental Health:** A state of mental, emotional, and cognitive health that can impact perceptions, choices and actions affecting wellness and functioning. Mental health conditions include depression, anxiety disorders, post-traumatic stress disorder (PTSD), and substance use disorders. Mental health can be impacted by the home and social environment, early childhood adversity or trauma, physical health, and genes.

**Risk Assessment:** An evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated school staff (e.g., school psychologist, school social worker, school counselor, or in some cases, trained school administrator). This assessment is designed to elicit information regarding the student’s intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

**Self-Harm:** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm behaviors can be either non-suicidal or suicidal. Although non-suicidal self-injury (NSSI) lacks suicidal intent, youth who engage in any type of self-harm should receive mental health care. Treatment can improve coping strategies to lower the urge to self-harm, and reduce the long-term risk of a future suicide attempt.

**Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
**Suicide Risk Factors:** Characteristics or conditions that increase the chance that a person may attempt to take their life. Suicide risk is most often the result of multiple risk factors converging at a moment in time. Risk factors may encompass biological, psychological, and/or social factors in the individual, family, and environment. The likelihood of a suicide attempt is highest when factors are present or escalating, when protective factors and healthy coping techniques have diminished, and when the individual has access to lethal means.

**Suicide Attempt:** A self-injurious behavior for which there is evidence that the person had at least some intent to die. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings, such as a wish to die and a desire to live, is a common experience with most suicide attempts. Therefore, ambivalence is not a reliable indicator of the seriousness or level of danger of a suicide attempt or the person’s overall risk.

**Suicidal Behavior:** Suicide attempts, injury to oneself associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one’s life.

**Suicidal Ideation:** Thinking about, considering, or planning for self-injurious behavior that may result in death. A desire to be dead without a plan or the intent to end one’s life is still considered suicidal ideation and shall be taken seriously.

**Suicide Contagion:** The process by which suicidal behavior or a suicide completion influences an increase in the suicide risk of others. Identification, modeling, and guilt are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides within a community.

**Suicide Postvention:** A crisis intervention strategy designed to assist with the grief process following suicide loss. This strategy, when used appropriately, reduces the risk of suicide contagion, provides the support needed to help survivors cope with a suicide death, addresses the social stigma associated with suicide, and disseminates factual information after the death of a member of the school community. Often a community or school’s healthy postvention effort can lead to readiness to engage further with suicide prevention efforts and save lives. The following link indicates a best practice postvention methodology recommended by AHCCCS:

[https://www.sprc.org/comprehensive-approach/postvention](https://www.sprc.org/comprehensive-approach/postvention)

**Responsibility for Policy Implementation**

A district-level suicide prevention coordinator shall be appointed by the superintendent or designee. The district suicide prevention coordinator and building principal shall be responsible for planning and coordinating implementation of this policy for the school district.

Each school principal shall designate a school suicide prevention coordinator, and who will be responsible in the coordinator absence, to act as a point of contact in each school for issues relating to suicide prevention and policy implementation. This should be your school social worker, if you have one on campus, or other school-based mental health professional. Otherwise, this may be a trained staff person on campus.

All staff members shall report students they believe to be at-risk for suicide to the school suicide prevention coordinator or appropriate school mental health professional if the coordinator is unavailable.

**Policy Publication and Distribution**

This policy shall be reviewed and distributed annually (PLACEHOLDER FOR DISTRICT TO INSERT SPECIFIC DATES) and be included in all student and teacher handbooks, and on the school website. All school personnel are expected to know and be accountable for following all policies and procedures regarding suicide prevention.
Professional Development for School Personnel
As required by the Mitch Warnock Act, beginning in the 2020/2021 school year, all school staff who interact with students from grade 6-12 must take an evidence-based best practice suicide prevention training once every three years. For more information on approved, evidence-based trainings visit:

https://www.azahcccs.gov/AHCCCS/Initiatives/suicideprevention/training_for_schools.html

For more information on trainings visit: https://www.azed.gov/wellness/aware

Training for Students, Families, and Community
The above referenced evidence-based suicide prevention trainings are also suggested by the District for raising awareness and building suicide prevention skills for students, families, and community.

PLACEHOLDER FOR DISTRICT TO INSERT INFORMATION ABOUT DEVELOPMENTALLY APPROPRIATE, STUDENT-CENTERED EDUCATION MATERIALS THAT MAY BE USED IN K-12 HEALTH CLASSES AND OTHER CLASSES AS APPROPRIATE.

Assessment and Referral
When a student is identified by a peer, educator or other source as potentially suicidal — i.e., verbalizes thoughts about suicide, presents overt risk factors such as agitation or intoxication, an act of self-harm occurs, or expresses or otherwise shows signs of suicidal ideation — the student shall be seen by a school-based mental health professional, such as a school psychologist, school counselor, school social worker, within the same school day to assess risk and facilitate referral if necessary.

Educators shall also be aware of written threats and expressions about suicide and death in school assignments. Such incidences require immediate referral to the appropriate school-employed mental health professional. If there is no mental health professional available, a designated staff member (e.g., school nurse or administrator) shall address the situation according to district protocol until a mental health professional is brought in.

A school’s crisis response plan shall address situations when school personnel need to engage law enforcement. When a student is actively suicidal and the immediate safety of the student or others is at-risk (such as when a weapon is in the possession of the student), school staff shall call 911 immediately.

Parental Notification and Involvement
The principal, designee, or school mental health professional shall inform the student’s parent or guardian on the same school day, or as soon as possible, any time a student is identified as having any level of risk for suicide or if the student has made a suicide attempt (pursuant to school/state codes, unless notifying the parent will put the student at increased risk of harm).

Following parental notification and based on initial risk assessment, the principal, designee, or school mental health professional may offer recommendations for next steps based on perceived student need. These can include but are not limited to, an additional, external mental health evaluation conducted by a qualified health professional or emergency service provider.

When a student indicates suicidal intent, schools shall attempt to discuss safety at home, or “means safety” with parent or guardian, limiting the student’s access to mechanisms for carrying out a suicide attempt e.g., guns, knives, pills, etc. In addition, during means counseling, which can also include safety planning, it is imperative to ask parents whether or not the individual has access to a firearms, medication or other lethal means. Lethal means counseling shall include discussing removal of firearms and unused prescription

Staff will also seek parental permission, in the form of a Release of Information form, to communicate with outside mental health care providers regarding the student’s safety plan and access to lethal means. At minimum, staff will share a list of community resources and crisis contact lines, to the parent/guardian to access services, if needed.
Re-Entry Procedure
For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), whenever possible, a school-based mental health professional, the principal, or designee shall meet with the student’s parent or guardian, and if appropriate, include the student to discuss re-entry. A designated staff person shall periodically check-in with the student to help with readjustment to the school community and address any ongoing concerns, including social or academic concerns.

In-School Suicide Attempts
In the case of an in-school suicide attempt, the physical and mental health and safety of the student are paramount. In these situations:

- First aid shall be rendered until professional medical services and/or transportation can be received, following district emergency medical procedures
- School staff shall supervise the student to ensure their safety
- Staff shall move all other students out of the immediate area as soon as possible
- The school-based mental health professional or principal shall contact the student’s parent or guardian.
- Staff shall immediately notify the principal or school suicide prevention coordinator regarding the incident of in-school suicide attempt
- The school shall engage the crisis team as necessary to assess whether additional steps should be taken to ensure student safety and well-being, including those students who may have had emotional or physical proximity to the victim
- Staff shall request a mental health assessment for the student as soon as possible.

Since self-harm behaviors are on a continuum of level and urgency, not all instances of suicidal ideation or behavior warrant hospitalization. A mental health assessment, including a suicide risk assessment, can help determine the best treatment plan and disposition.

Out-of-School Suicide Attempts
If a staff member becomes aware of a suicide attempt by a student that is in progress in an out-of-school location, the staff member shall:

- Call 911 (police and/or emergency medical services)
- Inform the student’s parent or guardian
- Inform the school suicide prevention coordinator and principal

If the student contacts the staff member and expresses suicidal ideation, the staff member shall maintain contact with the student (either in person, online, or on the phone) and then enlist the assistance of another person to contact the police while maintaining engagement with the student.
After a Suicide Death: POSTVENTION

The crisis response team, led by a designated crisis response coordinator, shall develop a crisis response plan to guide school response following a death by suicide. This plan may be applicable to all school community related suicides whether it be student (past or present), staff, or other prominent school community member.

Step 1: Get the Facts
Step 2: Assess the Situation
Step 3: Share Information
Step 4: Avoid Suicide Contagion
Step 5: Initiate Support Services
Step 6: Develop Memorial Plans
Step 7: Postvention as Prevention

PLACEHOLDER FOR DISTRICT TO INSERT DISTRICT APPOINTED CRISIS RESPONSE COORDINATOR

External Communication

The school or district-appointed spokesperson shall be the sole media spokesperson. Staff shall refer all inquiries from the media directly to the spokesperson. The spokesperson shall:

• Keep the district superintendent and school crisis response coordinator informed of school actions relating to the death
• Prepare a statement for the media, which may include the facts of the death, postvention plans, and available resources — the statement shall not include confidential information, speculation about victim motivation, means of suicide, or personal family information

PLACEHOLDER FOR DISTRICT TO INSERT DISTRICT APPOINTED SPOKESPERSON

Sample Language for Student Handbook

Protecting the health and well-being of all students is of utmost importance to SCHOOL DISTRICT NAME.

The school board has adopted a suicide prevention policy which will help to protect all students through the following steps:

• Students will learn about recognizing and responding to warning signs of suicide in friends, using coping skills, support systems, and seeking help for themselves and friends.
• This curricular content will occur in all health classes throughout the school year, not just in response to a suicide, and the encouragement of help-seeking behavior will be promoted at all levels of the school leadership and stakeholders
• Each school or district will designate a suicide prevention coordinator to serve as a point of contact for students in crisis and to refer students to appropriate resources
Students will have access to national resources that they can contact for additional support, such as:

**National Prevention Lifeline:** 1-800-273-TALK (8255) suicidepreventionlifeline.org

**The Trevor Lifeline:** 1-866-488-7386 thetrevorproject.org/get-help-now

**Trevor Lifeline Text/Chat Services, available 24/7** Text “TREVOR” to 678-678

**Crisis Text Line:** Text TALK to 741-741 crisistextline.org

**Parental & Family Engagement**

Parents and guardians play a key role in youth suicide prevention, and it is important for the school district to involve them in suicide prevention efforts. While parents and guardians need to be informed and actively involved in decisions regarding the student’s welfare, the school mental health professional should ensure that the parents’ actions are in the best interest of the student (e.g., when a student is LGBTQ and living in an unaffirming household). Parents and guardians who learn the warning signs and risk factors for suicide are better equipped to connect their children with professional help when necessary. Parents and guardians should be advised to take every statement regarding suicide and a wish to die seriously and avoid assuming that the student is simply seeking attention. There are commercially available videos and programs to help train parents in recognizing suicide warning signs.

**Importance of School-Based Mental Health**

Access to school-employed mental health resources and access to school-based mental health supports directly improves students’ physical and psychological safety, academic performance, cognitive performance and learning, and social/emotional development. Having these professionals as integrated members of the school staff empowers principals and administrators to more efficiently and effectively deploy resources, ensure coordination of resources, evaluate their effectiveness, and adjust supports to meet the dynamic needs of their student populations. See Part 1 of the *School & Behavioral Health Partnerships Guide* released by Arizona Department of Education and Arizona Health Care Cost Containment System.

**Messaging and Suicide Contagion:**

Research has shown a link between certain kinds of suicide-related media (including social media) coverage and increases in suicide deaths. Suicide contagion has been observed when the number of stories about individual suicides increases, or when a particular death is reported in great detail. The coverage of a suicide death being prominently featured in a media outlet or on social media, or headlines about specific deaths being framed dramatically have also been observed to contribute to suicide contagion.

Research also shows that suicide contagion can be avoided when the media reports on suicide responsibly, such as by following the steps outlined in “Recommendations for Reporting on Suicide” at ReportingOnSuicide.org, as well as through the National Association for School Psychologists media guideline: Responsible Media Coverage of Crisis Events Impacting Children and Youth.

Schools should strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student’s family and friends. Refer to the American Foundation for Suicide Prevention’s After a Suicide: A Toolkit for Schools resource.

Finally, it is important for schools to encourage parents and guardians to monitor student social media pages after a death by suicide.
Crisis: when is calling the crisis line the right answer?
Crisis services are provided to any individual in Arizona, without expense. If you are worried about a person’s mental health, call the crisis line. The person on the call will help direct next steps. Neither you nor the individual in question will be billed for this service.

Crisis lines in Arizona:

- Maricopa County served by Mercy Care: **1-800-631-1314** or **602-222-9444**
- Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties served by Arizona Complete Health - Complete Care Plan: **1-866-495-6735**
- Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties served by Steward Health Choice Arizona: **1-877-756-4090**
- Gila River and Ak-Chin Indian Communities: **1-800-259-3449**
- Salt River Pima Maricopa Indian Community: **1-855-331-6432**
Appendix 4

Arizona Model School Mental Health Referral Policy

In order to access and utilize the funding that is included through SB 1523, The Children’s Behavioral Health Services Fund, schools must develop policy related to the referral of students for mental health services. These policies must be publicly vetted through a public comment period and posted on schools’ websites. Additionally, any school who wishes to access and utilize the funding provided through SB 1523 must provide students’ families with the opportunity to opt-in or opt-out to participate in the referral process on an annual basis. Finally, it is further required that students who have received a referral for mental health services be offered the opportunity to participate in a survey related to the referral process, and experience with the services received. This survey will be provided by the behavioral health provider.

This template serves as a resource for schools to assist in the development of policy which meets the minimum requirements to access funding through SB1523. Schools do not have to use this template and may develop their own policy.

SB1523 Policy Template:

Example Purpose Statement: In conformance with SB 1523, this policy establishes a process to ensure parents are provided an opportunity to opt-in for their child to receive referrals to a mental health provider on an annual basis. Ensures that parents are provided an opportunity to furnish feedback related to the referral process, availability of services and providers, and their experience with receiving mental health services as the result of the referral. Outlines the process for identification of participating mental health providers, to be posted on schools’ websites for public access. Finally, the Policy will create a process to conduct a survey of parents whose children were referred to and received mental health services. For funding requirements, refer to AHCCCS AMPM 320-T2.

Example Referral Process:

A School District Governing Boards/Charter School Governing Body must develop a method by which parents/guardians are able to opt-in or out of the mental health referral process annually. An example consent document has been included for reference. Schools may personalize and utilize this form, or a form of their own in order to obtain parent/guardian consent prior to making a referral for mental health services for a student.

(School District Governing Boards/Charter School Governing Body to include specific opt-in or out process here).

School District Governing Boards/Charter School Governing Body must develop and implement a referral pathway for students who have opted-in, and have been identified as needing mental health services. The following link is a resource available to schools to develop an effective referral system, see Chapter 1, page 17. Figure 1.1; SMHRP Toolkit Introduction for detailed description http://www.esc-cc.org/Downloads/NITT%20SMHRP%20Toolkit%2011%202015%20FINAL.PDF.

(School District Governing Boards/Charter School Governing Body to include specific referral pathway information here)

Monitoring: (School District Governing Boards/Charter School Governing Body to include specific referral tracking process here)
Example Survey Information:
Parents/Guardians of students referred for mental health services as a result of a referral will be invited to complete a survey about the referral process and their satisfaction with the services and providers of services received. This survey will be conducted through the mental health provider working with the student. The survey will include the following elements at minimum:

Whether the parent opted into the program
Whether the parent was notified before the referral took place
Whether the mental health services were appropriate to meet the students’ needs
Whether the parent is satisfied with the choice of mental health service providers
Whether the parent intends to opt into a program again in the following school year

Example Consent for BH Services Referral:

(School Name)

Consent to Referral for Services

________________________ School strives to support children and families by utilizing all resources made available to the school. As such, ______________________ School has a partnership with ___________________________ (mental health agency) for services to assist children and families with challenges that arise and may interfere with the full academic and life success of children. These services may include assessment of services recommended, social skills training or coaching, individual/group therapy, family therapy, substance abuse counseling, home visits, or monitoring of child progress.

We believe that your child, ______________________ would benefit from a referral for services from one of our partner agencies. The services will be either free-of-charge or will be based upon your ability to pay. Your child’s participation in any services will remain confidential.

If you have further questions, please feel free to contact ____________________________.

Consent/Non-Consent for Services for my child

[ ] YES, my child can be referred for services to one of the schools’ partner agencies

[ ] NO, my child cannot be referred for services to a partner agency

Printed Name of Parent/Guardian __________________ Signature of Parent/Guardian __________________ Date __________________