INTAKE AND ASSESSMENT

DESCRIPTION

The intake process occurs once a student has been referred for school mental health services and it has been determined that the student a) meets criteria for service, and b) demonstrates a willingness to participate. The intake generally includes an orientation to services, collection of insurance and demographic information, as well as a comprehensive mental health assessment. The mental health assessment collects all pertinent information (e.g., social and family history, behavioral or emotional problems, psychiatric history)

RATIONALE

The intake procedure is necessary to collect clinical, demographic, and contact information and to orient the student to the services. It should be easy to access and help reduce barriers to care. A thorough assessment helps to identify the nature of a presenting problem, how it interferes with the students' home and school lives, and how to proceed with a course of treatment.

The following guidelines offer recommendations to schools, stakeholders, and school mental health providers on the process of intake and initial assessment.

RECOMMENDATIONS

Pre-intake

1. Consult with the state's policy regarding whether a guardian's authority is needed to initiate services.

2. Consider whether it is appropriate, given the client's circumstance, for a family member/guardian to be present during the intake process.

3. Consider sending a pre-intake packet to student and/or guardian including a reminder letter, information about the school mental health program, what to expect during the intake, and any paperwork to fill out before the appointment.

4. Consider a brief talk on the phone before the intake with the family about presenting problems in the student, ways therapy might help, and initial steps that the family can take before the appointment.

5. Make a reminder call the day before the appointment.

6. Determine whether initial assessment is a component of the intake or if it occurs at the following session.

Intake

1. Discuss confidentiality, privacy, and mandated reporting laws with the student/family at intake.

2. Outline school mental health provider's areas of expertise and what services may be provided.

3. Ensure all paperwork is signed at intake.

4. Elements of a standard intake form include:

    - Patient identifying data: (name, date of intake, date of birth, gender, age, social security number)
    - Parent/guardian contact and employment info
    - Emergency contact
    - Insurance information
    - Primary language spoken
    - Ethnicity
    - Family living situation
    - School placement information (grade, homeroom)
    - Special education services or Individualized Education Plan
    - Usual grades achieved
    - Collateral contacts (social worker, primary care physician, Guardian Ad Litem, mentor, probation officer etc.)
    - Involvement (current or past) with Social Services
    - Involvement with child protective services or juvenile justice
    - Past therapists and dates of service

Mental Health Assessment

1. Interview student to obtain the following information:

    - Client identifying data
    - Parent/guardian identifying data
    - Date of assessment
    - Medications taken
    - Language
    - Ethnicity
    - Referral source
    - Risk and protective factors
    - Other agency involvement:
    - Presenting Complaint(s):
    - History of Presenting complaint(s):
    - Past psychiatric/treatment history
    - History of suicidal ideation, homicidal ideation, substance abuse, eating disorder or any self injurious behavior
    - Psychosocial/Family Information
    - Family Psychiatric History
    - Developmental History/Functioning
    - Medical information
    - Mental Status Exam
    - 5 Axis Diagnoses (include DSM-IV #):
    - Referrals made:
    - Prognosis
    - Treatment Plan

2. Include additional methods of gathering information, including:

    - An observation of the student and student/family relations
    - Contacts with multiple informants (e.g., parent or caregiver, others family members, teachers, previous school mental health providers, other agencies involved) to understand the student better and obtain information that the student may not have (e.g., name of medication, contact information of other providers, family psychiatric history)

REFERENCES

Grier R, Morris L, Taylor L. Assessment strategies for school-based mental health counseling. *Journal of School Health.* 2001; 71(9):476-9.

New Mexico Assembly on School-Based Health Care and New Mexico Department of Health, Office of School Health. (n.d.). SBHC Mental Health Client Intake Summary. In *Opening a School-Based Health Center, A How-To Guide for New Mexico SBHC Coordinators,* First Edition. p.162. Retrieved from http://measbhc.org/uploads/sbhc_nmmanual_oct2005.pdf

The University of Maryland's Center for School Mental Health (2008). *School Mental Health Quality Assessment Questionnaire (SMHQAQ) Quality Indicator Power points, Indicators 28, 31*. Retrieved from http://www.schoolmentalhealth.org/Resources/Clin/QAIRsrc/QAQPP.

RESOURCES

http://measbhc.org/uploads/sbhc_nmmanual_oct2005.pdf
Opening a School Health Center: A How-To Guide; information on intake (p.162) and assessment (p.155).

http://www.healthinschools.org/static/hs.aspx
A sample data collection form (connected to a biennial physical exam)

http://www.schoolmentalhealth.org/Resources/Clin/PsychologicalAssessmentforClinicians7.28.08.pdf
Handout for teachers on what a psychological assessment is and how and when to refer a student