# CENTER MENTAL HEALTH CONSULTANT

**Pre-Compliance Assessment Questions**

This form should be completed by the CMHC. If the center has more than one CMHC, then the CMHCs should collaboratively complete this form. Please provide responses to the following questions **1 week prior** to the health specialists’ arrival on center for the Health and Wellness Compliance Assessment. **Responses should be typed.**

The purpose of the compliance assessment is to **verify** and **clarify** compliance with PRH requirements and applicable laws, as well as to highlight program qualities and strengths. Please coordinate with the Health and Wellness Director to ensure all information (e.g., data, forms, materials, logs, surveys, specific student health records) necessary to support your responses is available for the review.

Complete for each CMHC:

|  |  |  |
| --- | --- | --- |
| **CMHC Name:** |  | **CMHC Name:** |
| **CMHC Subcontractor Agency:**  (note if self-held or agency name) |  | **CMHC Subcontractor Agency:**  (note if self-held or agency name) |
| **Phone number(s):** |  | **Phone number(s):** |
| **E-mail:** |  | **E-mail:** |
| **Date of Hire:** |  | **Date of Hire:** |
| **Schedules on center:**  (Please list days/hours) |  | **Schedules on center:**  (Please list days/hours) |
| **Type of license & license renewal date:** |  | **Type of license & license renewal date:** |
| **If CMHC does not meet the** [**PRH minimum staff qualifications in Exhibit 5-3**](https://prh.jobcorps.gov/Management%20Services/5.2%20Personnel/Related%20Sub%20Requirements/Exhibit%205-3%20Minimum%20Staff%20Qualifications.pdf%22%20/t%20%22_blank)**, has a one-time waiver been submitted and approved by the National Office?**  Yes  National Office waiver approval date: \_\_\_\_\_\_\_\_\_  Do not have waiver.  N/A |  | **If CMHC does not meet the** [**PRH minimum staff qualifications in Exhibit 5-3**](https://prh.jobcorps.gov/Management%20Services/5.2%20Personnel/Related%20Sub%20Requirements/Exhibit%205-3%20Minimum%20Staff%20Qualifications.pdf%22%20/t%20%22_blank)**, has a one-time waiver been submitted and approved by the National Office?**  Yes  National Office waiver approval date: \_\_\_\_\_\_\_\_\_  Do not have waiver.  N/A |
| **Are you on call during the evening and/or weekends?** ☐ Yes ☐ No |  | **Are you on call during the evening and/or weekends**? ☐ Yes ☐ No |

1. Name and title of person completing this form:
2. Please complete the table below:

|  |  |
| --- | --- |
| 1. Total number of appointments (e.g., initial evaluations, returns or walk-ins) seen by **CMHC (s) per month on average** |  |
| 1. Total number of appointments seen by intern(s) per month on average (if applicable) |  |
| 1. Have you submitted any recommendations of denial as part of applicant file review in the last 12 months? | Yes  No |

1. In what way does your mental health and wellness program use an **Employee Assistance Program Model (EAP)?**
2. How are **no-shows for scheduled appointments** documented? What is the process for following up with students who no-show for scheduled appointments?
3. Complete the table below for **psychotropic medication monitoring:**

|  |  |
| --- | --- |
| Does the CP/NP/PA refer students to you? | Yes  No |
| Do you refer students to the CP/NP/PA for medication evaluation? | Yes  No |
| Do you participate in the monthly medication review conducted by the CP and HWD? | Yes  No |
| Do you discuss concerns about specific students with the CP? | Yes  No |
| Are there regular case conferences with TEAP specialist, counseling, and other appropriate staff based on individual student needs? | Yes  No |
| Is the on-center referral and feedback system documented in the SHRs? This includes feedback to the referral source. | Yes  No |
| Brief explanation of any answers from the table above if needed: | |

1. Explain how you **collaborate with the TEAP specialist** for short term counseling of students with co-occurring conditions. Include how this collaboration is documented.
2. What is the process for managing **urgent or emergency mental health situations** on center? Do you provide on-call services during the evening and/or weekends? Provide the names community resources including local hospital(s), crisis stabilization units, mobile crisis teams, etc. that are used to manage mental health emergencies
3. Describe the process for managing **referrals to off-center mental health professionals or agencies** for ongoing treatment or specialized services. Provide the names of the community professionals or agencies that you regularly refer students to. How is care coordination with off-center professionals and agencies documented?
4. Explain your involvement in the **applicant file review** process. How is the process documented? What assessment forms do you use to make a recommendation of denial?
5. Explain your involvement in the **disability accommodation process** for applicants and students with disabilities.
6. Explain your center’s process for reviewing **Social Intake Forms (SIFs).** How is the information from the SIF used?
7. Explain how and when you conduct **intake assessments** of students referred to you.
8. Explain how you are involved in the process of assessing and making recommendations about a **medical separation with reinstatement rights (MSWR)** for students with mental health conditions. Include how the student is educated on what steps are required to return from a MSWR and the expectations of stabilization before their return
9. Please complete the table\* below:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Do you do a **1-hour presentation** on the Mental Health and Wellness Program with **all new students during** **CPP?**  *Please have materials or notes available to review.* | | | | | | Yes  No | |
| Does the CPP presentation include information about basic skills in identifying and responding to a mental health crisis and include information about resources such as 988 and the Job Corps Safety Hotline? | | | | | | Yes  No | |
| List **annual center wide** mental health promotion and education activity(ies). If none, check this box: ☐ | | | | | | | |
| Event Name | | Event Description | | | Month and Year | | |
|  | |  | | |  | | |
|  | |  | | |  | | |
|  | |  | | |  | | |
| List any **psycho-educational skill-building groups** on center | | | | | | | |
| Group Name | | | | Facilitator (e.g. counselor, intern, CMHC) | | | |
|  | | | |  | | | |
|  | | | |  | | | |
|  | | | |  | | | |
| List any **mental health staff training** that you or your interns have conducted(may include adolescent growth and development). If none, check this box: | | | | | | Month and Year |
|  | | | | | |  |
|  | | | | | |  |
|  | | | | | |  |
| Are you **involved with other programs** on center? Mark below. | | | | | | |
| SART | Yes  No | | Recreation | | | Yes  No |
| HEALs | Yes  No | | Residential Living | | | Yes  No |
| SGA | Yes  No | | Other: | | | |
| Y2Y | Yes  No | | Other: | | | |
| Are you familiar with your **regional mental health specialist?** | | | | | | Yes  No |
| How many **regional teleconferences** have you attended in the past 12 months? | | | | | |  |

*\*write any additional events, etc. under question 15 below*

1. Describe any unique, innovative, or promising practices of the center’s Mental Health and Wellness Program. Include information on internship programs here if applicable.