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## Office of Student Services Sheffield-Sheffield Lake City Schools

The Sheffield-Sheffield Lake City Schools partner with several mental health, prevention, and intervention practices & agencies in effort to support students and families in our community.

Firelands Counseling & Recovery Services (based in Amherst) is a partner which supports prevention, education, and consultation of mental health services for the Sheffield Schools.

**Consultation** is a process where a student (and/or family) can work with a mental health counselor to determine the type of support needed for a child. The levels of support range from very short-term to more ongoing care.

### Included in this packet:

- **Consultation Handout**- Explanation and description handout
- **Guidance: Youth Ohio Scales**- This is a screening questionnaire used to help gather information on emotions and behaviors
  - Parents should fill out the Parent Rating-Short Form P
  - Students should fill out the Youth Rating-Short Form Y (if Ages 12-18)
- **Individual Consultation Participation Consent & Release**- Allows Firelands Counseling to work with you and your child.

Ohio Scales & the Participation Consent form can be returned to your child's school counselor or school social worker.

Consultation services are funded by the Lorain County Board of Mental Health. There is no cost to families for the consultation service/process.

Questions regarding services, or request for additional information or assistance, can be directed to Andrew Smith, LISW-S, our school district social worker, at 440-949-4213 or by email at [asmith@sheffieldschools.org](mailto:asmith@sheffieldschools.org)

## CONSULTATION

Consultation is used when attempting to determine the appropriate level of care needed for a student. "Level of Care" is in reference to the safest and least restrictive option given the needs of an individual. An example would be if you have a cold, you would not expect to be hospitalized. The process for consultation includes a meeting with the parents, with the student, and also with school staff. Both the parent and student (12+) will complete an Ohio Scales form. The Ohio Scales is a brief questionnaire that will assess severity of concerns as well as the student's current ability to function. This will assist in determining the level of care needed for the student. Once the student is referred to a service, the therapist doing the consultation will remain involved until the student is linked with the appropriate service. The process is individualized depending on the needs of the child.

### Process:

- *Meeting with parent – Ohio Scales*
- *Meeting with student – Ohio Scales if over 12*
- *Meeting with school – Teachers, Principal, etc.*
- *Meeting to discuss recommendations*

### Potential Level of Care Options:

Prevention – This could come in multiple forms. It could be adding to a prevention group. It could also be meeting briefly.

Outpatient – This would open the student with the agency. The location would be determined based upon the needs of the student and recommendations of the therapist.

Outpatient + CPST – This would open the student with the agency. The location would be determined based upon the needs of the student and recommendations of the therapist. Case management services would be added, which includes home and school appointments.

Intensive Services – This would refer the student to a different agency for IHBT services. IHBT is more intensive, which could include appointments multiple times a week and for longer durations. This would also occur in multiple settings, including at home. The alternative option would be ICT, which is similar but for co-occurring mental health and alcohol/drug.



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

**P**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Child's Grade: \_\_\_\_\_

ID#: \_\_\_\_\_  
 Completed by Agency \_\_\_\_\_

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. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	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

(Add ratings together) Total \_\_\_\_\_

**Instructions:** Please circle your response to each question.

- Overall, how satisfied are you with your relationship with your child right now?
  - Extremely satisfied
  - Moderately satisfied
  - Somewhat satisfied
  - Somewhat dissatisfied
  - Moderately dissatisfied
  - Extremely dissatisfied
- How capable of dealing with your child's problems do you feel right now?
  - Extremely capable
  - Moderately capable
  - Somewhat capable
  - Somewhat incapable
  - Moderately incapable
  - Extremely incapable
- How much stress or pressure is in your life right now?
  - Very little
  - Some
  - Quite a bit
  - A moderate amount
  - A great deal
  - Unbearable amounts
- How optimistic are you about your child's future right now?
  - The future looks very bright
  - The future looks somewhat bright
  - The future looks OK
  - The future looks both good and bad
  - The future looks bad
  - The future looks very bad

**Total:** \_\_\_\_\_

**Instructions:** Please circle your response to each question.

- How satisfied are you with the mental health services your child has received so far?
  - Extremely satisfied
  - Moderately satisfied
  - Somewhat satisfied
  - Somewhat dissatisfied
  - Moderately dissatisfied
  - Extremely dissatisfied
- To what degree have you been included in the treatment planning process for your child?
  - A great deal
  - Moderately
  - Quite a bit
  - Somewhat
  - A little
  - Not at all
- Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.
  - A great deal
  - Moderately
  - Quite a bit
  - Somewhat
  - A little
  - Not at all
- To what extent does your child's treatment plan include your ideas about your child's treatment needs?
  - A great deal
  - Moderately
  - Quite a bit
  - Somewhat
  - A little
  - Not at all

**Total:** \_\_\_\_\_

<b>Instructions:</b> 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 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



**Ohio Mental Health Consumer Outcomes System**  
**Ohio Youth Problem, Functioning, and Satisfaction Scales**  
 Youth Rating – Short Form (Ages 12-18)

**Y**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Grade: \_\_\_\_\_

ID#: _____ Completed by Agency _____
---

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. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	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

(Add ratings together) Total \_\_\_\_\_

**Instructions:** Please circle your response to each question.

- Overall, how satisfied are you with your life right now?
  - Extremely satisfied
  - Moderately satisfied
  - Somewhat satisfied
  - Somewhat dissatisfied
  - Moderately dissatisfied
  - Extremely dissatisfied
- How energetic and healthy do you feel right now?
  - Extremely healthy
  - Moderately healthy
  - Somewhat healthy
  - Somewhat unhealthy
  - Moderately unhealthy
  - Extremely unhealthy
- How much stress or pressure is in your life right now?
  - Very little stress
  - Some stress
  - Quite a bit of stress
  - A moderate amount of stress
  - A great deal of stress
  - Unbearable amounts of stress
- How optimistic are you about the future?
  - The future looks very bright
  - The future looks somewhat bright
  - The future looks OK
  - The future looks both good and bad
  - The future looks bad
  - The future looks very bad

**Total:** \_\_\_\_\_

**Instructions:** Please circle your response to each question.

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

**Total:** \_\_\_\_\_

<b>Instructions:</b> 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

**(Add ratings together) Total** \_\_\_\_\_

## INDIVIDUAL CONSULTATION PARTICIPATION CONSENT AND RELEASE

As was discussed with you by your school counselor or school social worker, your child has been referred to a counselor from Firelands Counseling & Recovery Services who can assist in determining if mental health services may be beneficial to your child and, if so, what type of services would be most beneficial. In order to make this determination, the consultant from Firelands Counseling would collect information from you, speak with your child, observe them in the classroom if necessary, talk with the school staff that knows your child best. Some screening tools may be used to help make the best recommendations. After this information is collected, you will receive a call from the Firelands Counselor or School Social Worker who will explain the recommendations. If mental health services are recommended for your child and you wish to follow these recommendations, the Firelands Counselor and School Social Worker will help to connect you with the right service. Some services are available directly at school.

These individual consultation services will be provided at no cost to the participant or family. This service is not a mental health assessment. Rather, it is a screening that is for the sole purposes of (1) identifying if mental health services are needed and (2) if so, making sure that you can connect your child to the needed service. Personal information or records obtained by the consultant from Firelands Counseling & Recovery Services will be kept secured and private.

Name of student _____	Name of Parent/Legal Guardian _____
Parent/Legal Guardian Phone Number: _____	Best time to call: _____
Parent Email: _____	
Please provide the name of any school staff who could help the consultant better understand your child's needs: _____	

Your signature will authorize your student to participate in the School Based Individualized Consultation Program.

Signature of Parent/Legal Guardian <del>X</del> _____	Date _____
Signature of Student _____	Date _____
Student Services Signature _____	Date _____

### ..... CONSENT FOR RELEASE OF INFORMATION

Re (Student Name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ of \_\_\_\_\_  
(name) (relationship)

the above named student, hereby authorize Firelands Counseling & Recovery Services, the mental health agency providing School Based Consultation services to the Sheffield-Sheffield Lake City Schools, to share information & maintain records about the above named client with Sheffield-Sheffield Lake City Schools/Student Services for coordination of services. I understand that the Consent for the Release of Information expires at the end of the current school year unless otherwise indicated herein. I also understand that I may revoke this Consent for Release of Information at any time by stating in writing with the date and my signature and delivering it to the School Based Services consultant from Firelands Counseling & Recovery Services. I recognize that if I revoke my consent, this does not include any information which has already been shared between the time that I gave permission to share information and the time it was cancelled. I understand that my signing or refusing to sign this consent will not affect services that I am eligible for. The information disclosed is in accordance with federal and state confidentiality rules; Federal regulation (42 CFR part 2) prohibits re-release of drug and alcohol information without specific written consent.

Signature of Parent/Legal Guardian <del>X</del> _____	Date _____
Signature of Student _____	Date _____
Student Services Signature _____	Date _____