NYC Community School Mental Health Work Plan

For each assigned Community School, fill in Lead CBO funded mental health services.

School Year:	**Completion Date:**
School DBN(s) & Name:	**School Contact(s):**
Lead CBO:	**Lead CBO Contact(s):**
Budget Per Provider:	**Co-located School DBN(s):**
Campus Enrollment:	**School Enrollment:**

Targeted Interventions (See Partnership Guidebook for service types)	**Contracted Mental Health Provider**	**Start Date**	**End Date**	**Work Tasks** (Include: staff details, setting/location, clinical interventions/curriculum used)	**Intervention Goal(s)** (Why a service is being implemented)	**Intervention Objective(s)** (How we will measure impact)	**Target Number of Participants, Type of Participant(s) & Frequency**
EXAMPLE: Treatment	*Ex: ABC Agency*	*Ex: 9/2021*	*Ex: 6/2022*	*Ex: 1 Full time clinician will provide individual counseling to 9-12th graders who are identified by the guidance team and teachers. Treatment will be provided virtually and in person. Clinician will incorporate CBT, DBT and Trauma interventions.*	*Ex: To support students who are experiencing mental health challenges that impact their functioning.*	*Ex: Reduction in symptoms associated with trauma exposure evidenced by less school incidents for enrolled students.*	*Ex: At least 15 students will be seen every week.*
Selective Interventions	**Contracted Mental Health Provider**	**Start Date**	**End Date**	**Work Tasks**	**Intervention Goal(s)**	**Intervention Objective(s)**	**Target Number of Participants, Type of Participant(s) & Frequency**
Universal Interventions	**Contracted Mental Health Provider**	**Start Date**	**End Date**	**Work Tasks**	**Intervention Goal(s)**	**Intervention Objective(s)**	**Target Number of Participants, Type of Participant(s) & Frequency**

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