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The Georgia Apex Program Annual Evaluation Report

July 1, 2016–June 30, 2017

Prepared by The Center of Excellence for Children's Behavioral Health

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Executive Summary

In partnership with the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), the Center of Excellence for Children's Behavioral Health (COE), housed in the Georgia Health Policy Center at Georgia State University, conducted an evaluation of the second year of the Georgia Apex Program and provided technical assistance to each of the community-based mental health providers, hereafter referred to as fundees. The program created partnerships between local schools and the fundees to provide school-based mental health (SBMH) services in an effort to increase access to mental health services for children and youth, provide for early detection of children and adolescent mental health needs, and increase coordination between fundees and the local schools and school districts they serve. Utilizing both quantitative and qualitative data collection and analyses, the evaluation measured program performance, identified technical assistance needs, and investigated facilitators and barriers to programmatic success and sustainability. The following report details the measures and methods utilized for the evaluation and provides a summary of the results for the second program year.

Monthly progress reports (MPRs) were utilized to gather aggregate data for referrals, utilization, and billing of SBMH services, as well as information on activities to support ongoing coordination and collaboration between the fundees and the school partners. These school-level reports provided information about each of the program goals. In the second year, the 29 fundees reached 2,822 students who had not previously received mental health services. The program served an average of 235 first-time students each month. Students were largely served in the school setting, with over 40,044 services provided in schools over the second year. Providers began serving 147 schools in August 2016 and increased steadily to serve a total of 210 schools by May 2017.

Of the 203 schools served by providers during the second year, 99 were elementary, 55 were middle, 39 were high, and 10 were alternative schools. To increase access to services, fundees continue to be encouraged to serve Title I schools, and 92.1% of schools were, in fact, designated Title I schools. Further, 48.1% of schools had Positive Behavioral Interventions and Supports (PBIS) or other mental health programs in place before or during the second year of Apex. Of the 213 schools reporting geographic data, 76% of schools were located in rural areas, 15.5% in suburban areas, and 8.4% in urban areas.

The COE used the Mental Health Planning and Evaluation Template (MHPET) to evaluate partnerships and collaborations. Fundees provided a self-report of their efforts in connecting with school partners in September 2016 and May 2017. Overall, fundees report on average that policies and procedures that support sustainable SBMH partnerships are "somewhat in place." Mean scores are higher at follow-up (May 2017) across all 11 questions, or partnership attributes. Fundees

Year 2 by the Numbers

- **29** fundees
- **203** schools served
- **92%** retention rate of schools from year 1 to year 2
- **2,822** students who had not previously received mental health services
- **235** average number of first-time students served each month
- **21** average number of students served per school
- **40,044** services provided in schools

most frequently report improvements in the Stakeholder Involvement (36%) and Identification, Referral, and Assessment (33%) dimensions.

The Apex Year-End Survey helps to compile critical contextual information about the schools served, implementation of the programs, and successes and challenges related to billing, sustainability, and collaborative relationships. Qualitative data from survey responses were analyzed for common themes that contributed to programmatic successes and challenges. Common challenges included care management organization requirements (billing, credentialing requirements for staff, timely authorization for services), difficulties in scheduling time with students during the school day, and lack of support and investment from leaders within the fundees and school partners. Common successes were also noted, including integration into partnering schools, improved coordination and communication between providers and school staff, and increased access to services for students otherwise not receiving needed help. Activities that were helpful to move fundees toward sustainability within schools were participating in school events, serving as a resource to school staff (training, crisis intervention, lunch-and-learns), providing quality care to the students, and using data to demonstrate the benefits of Apex programming.

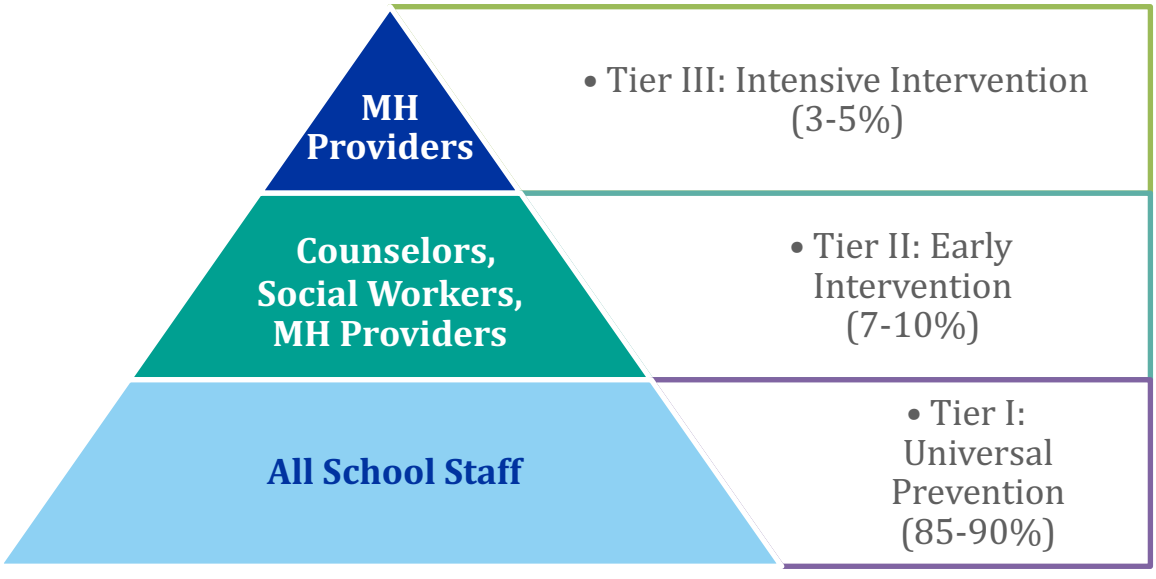
The following report describes the methods and measures used and the activities included in the second year, and discusses some of the growth and increased reach of Apex programming from year 1 to 2. The results may serve to inform future program guidance and implementation, identify facilitators to sustainability at the local level, and aid in assessment of related policies and funding opportunities. Additionally, evaluation results from year 2 can serve as evidence to help fundees tell their programmatic story.

Introduction

Mental health needs are common among today's school-aged children and youth. An estimated one in five children under the age of 18 has a diagnosable mental health disorder.[1, 2] These concerns, if left unaddressed, can cause children and youth to struggle to succeed by impairing academic performance, inducing maladaptive behavioral patterns that lead to truancy and disciplinary action, and creating cumulative, long-term detrimental impacts. Despite a great need for mental health services for children and youth, an estimated 75%-80% of those who require services do not receive them.[3] Barriers to accessing needed services include lack of health coverage, stigma associated with mental health, limited availability of services, and transportation issues.

School-based mental health (SBMH) services are a growing avenue to increase access to mental health care, provide preventive care, and provide for the early detection of mental health needs. The Georgia Apex Program aligns with other types of SBMH support programs, like Positive Behavioral Interventions and Supports (PBIS). This framework is represented in Figure 1. Most students' needs can be met on Tier I, universal supports and services, like PBIS. About 7%-10% of students require more targeted services and can have their needs met on Tier II with early intervention services (such as at-risk youth or other targeted prevention services). However, about 3%-5% of students, represented on Tier III, have a higher level of need that requires clinical intervention. The Georgia Apex Program was designed to meet the needs of these students requiring intensive intervention by facilitating placement of mental health providers in schools.

Figure 1: The Apex Triangle



Students requiring more intensive mental health interventions can also find support through the System of Care, a spectrum of effective, community-based services and supports to help children at risk for behavioral health challenges function at home, in school, and throughout life.[4] The state of Georgia has made significant investments in the System of Care for children with severe emotional disorders over the past few years. The goal of the System of Care is to provide community-based, culturally competent, family- and youth-driven care for youth and children in need of behavioral health services. In order to create a System of Care that meets the needs of Georgia's families, the state has dedicated funding and has applied for federal grant funding to support community mental health providers in serving this population.

SBMH programs are an important part of the System of Care, as they promote access to mental health services, increase early identification of mental health needs, and provide interventions for children in need of behavioral health services. Based in the school setting, these programs provide a continuum of behavioral health care to students and their families, including crisis support and ongoing therapy for more severe conditions and needs. Furthermore, such programs foster collaboration between and across systems, an important component of the System of Care. The System of Care wraps services around the child and family to provide care in the most appropriate, community-based, and culturally competent setting.

In addition to the Georgia Apex Program, Project AWARE (Advancing Wellness and Resilience in Education) and Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) are also helping to address the mental health needs of students within schools in Georgia. Project AWARE is a five-year Substance Abuse and Mental Health Services Administration (SAMHSA) grant that was awarded to the Georgia Department of Education (DOE) in September 2014. Currently implemented in three school districts, Project AWARE provides training in Youth Mental Health First Aid and focuses on developing processes and procedures for connecting youth and families to community-based mental health services. Additionally, the Department of Public Health (DPH) has received funding for Project LAUNCH, which promotes and supports early mental health screening and assessment for children ages 0-8. In recent years, Georgia DOE has worked to expand implementation of PBIS programs to districts and schools throughout the state. These programs are integral parts of the Georgia System of Care and have opened the door for mental health providers and schools to come together to address children's behavioral health needs by increasing the accessibility of care. The collaborative investment made into the System of Care by child-serving agencies in Georgia has ultimately increased the availability and reach of behavioral health services in schools in the state.

In the pilot year of the Georgia Apex Program, the 2015-2016 school year, the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD),

Division of Behavioral Health, Office of Children, Young Adults, and Families, provided funding support to 29 fundees to coordinate with their local schools and respective school districts to provide SBMH services. The goals of the Apex program are to:

- Increase access to mental health services for children and youth;
- Provide for early detection of children and adolescent mental health needs; and
- Increase coordination between community mental health providers and their local schools and school districts.

In partnership with DBHDD, the Center of Excellence for Children's Behavioral Health (COE), housed in the Georgia Health Policy Center at Georgia State University, provided technical assistance to each of the Apex fundees and conducted a program evaluation.

Over the course of the first year, fundees were able to reach 2,419 students who had not previously received mental health services. The program served an average of 944 students each month. Students were largely served in the school setting, with over 20,000 services provided. By the end of the first year, the fundees maintained active partnerships with 136 schools throughout the state. Challenges to program implementation as cited by fundees were related to family engagement and unclear referral processes, while program success centered on increased coordination and communication between fundees and schools. Data analyses from year 1 provide evidence that the program made significant progress toward the three goals of increased access, early detection, and increased coordination between fundees and their local schools.

Given the positive results and community feedback from the pilot year, DBHDD, partnering again with the COE, who was tasked to provide technical assistance and program evaluation, continued funding the same providers for a second year, with the expectation of sustained progress in reaching the program goals and further expansion of SBMH services throughout the state.

Evaluation goals outlined for year 2 include to:

- Demonstrate the program's ability to meet intended goals/outcomes;
- Identify facilitators and challenges to sustainability and replication; and
- Serve as foundational information for programs to tell their stories.

The following report details the measures and methods utilized for the evaluation of year 2 and provides a summary of the results.

Measures and Methods

The COE applied a mixed-methods approach to the evaluation of the second year of the Georgia Apex Program. The evaluation incorporates both primary and secondary qualitative and quantitative data to assess fundee efforts toward achieving the three Apex program goals and to demonstrate expansion of service provision within their regions.

Monthly Progress Reports

The monthly progress report (MPR) was completed by all fundees participating in the Apex program. The MPR is designed to measure program development and to help fundees and DBHDD identify opportunities for technical assistance that strengthen the program's ability to facilitate improved outcomes for the students and families served.

In partnership with DBHDD, the COE created an electronic data collection survey using an online survey administration tool. A link to the MPR was emailed to all Apex fundee contacts on the first day of each month during the program period. Fundees were given 15 days to complete and submit this survey report detailing information from the previous month. The Apex evaluation team at the COE provided support for questions or concerns related to the technical input of fundee data and the interpretation of the data items requested. Quantitative data submitted for this report were analyzed using statistical software. Qualitative data were analyzed for common themes and explored in depth across fundees. A copy of the tool is available in Appendix A.

Mental Health Planning and Evaluation Template

The COE utilized selected items from the Mental Health Planning and Evaluation Template (MHPET; Appendix B) to assess fundee efforts to sustain and increase coordination between themselves and their partner school(s) as they enhanced an existing or developed a new SBMH program. The MHPET is a free online tool developed by the National Assembly of School-Based Mental Health Centers, in conjunction with the Centers for School-Based Mental Health. Further discussion of the MHPET can be found under Goal 3, page 17.

Apex Year-End Survey

Fundees were asked to complete the Apex Year-End Survey in June 2017. This survey collected information about the schools served, services provided, billing practices, program characteristics, provider presence, and integration within schools. Open-ended questions helped to identify successes and challenges of

program implementation and sustainability. Responses were reviewed for common themes. Additionally, fundees were asked to report on the partnerships they created and maintained for year 2 of Apex. A copy of the year-end survey is provided in Appendix C.

Parent Survey

The Georgia Apex Program Parent/Guardian Survey is a 14-item instrument designed to explore the parents' perspectives on how receiving services through Apex has impacted the behavioral health of their children. During family meetings, fundees administer this survey to the parents of students receiving SBMH services through Apex. Parents are asked a variety of questions related to their children's functioning since joining the Apex program, including satisfaction with the services the child has received, the child's ability to handle daily life, and improvement in work and/or school. Items are scored using a five-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). The scores from the parent survey were summed to create a composite score of the child's level of functioning as perceived by the parent. These scores were then analyzed along with the number of reported days in Apex services to see whether the program had an impact on child functioning. A copy of the parent survey is provided in Appendix D.

Findings Overview Apex Program Year 2

Students Served and Program Characteristics

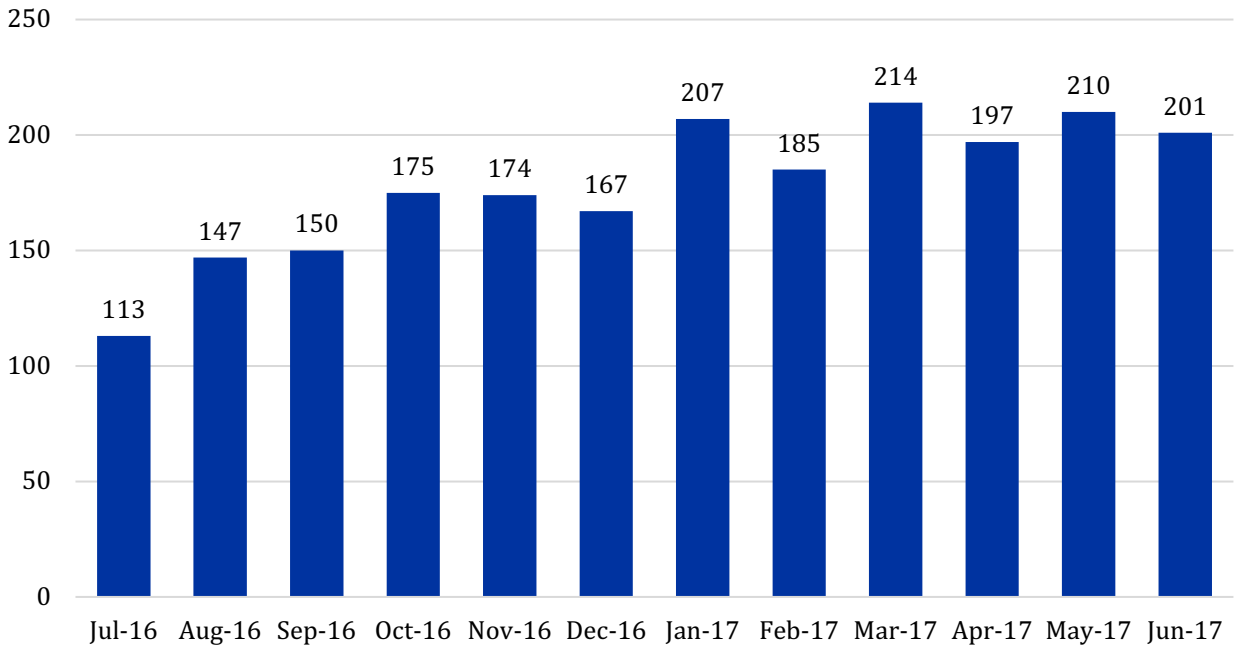
The findings presented in this report are reflective of data from a variety of sources. There were a total of 293 schools reported via the MPRs submitted in year 2. Of these, 79 schools were not reported on by the fundees in the year-end survey. These reporting discrepancies could be due to the strengths or nature of the partnerships, and whether they were sustained throughout the school year. As a result of the varied reporting of schools, there were a total of 214 schools represented on the year-end survey. In order to provide descriptive information about the schools served by Apex fundees, publicly available data from the Georgia DOE and the Governor's Office of Student Achievement (GOSA) were aligned with schools reported on in the year-end survey. Information about enrollment, Title I status, and school type was obtained for a total of 203 schools from the year-end survey. The number of schools for which the following information is presented is represented in the title for clarity. Additionally, the table in Appendix E further details the number of schools served by data source.

Number of School Partners and Enrollment

Over the course of the second year, fundees were encouraged by the funder to continue serving in schools where they had formed strong collaborations and were also challenged to forge new partnerships (see Figure 2). The number of schools served during year 2 steadily increased and ultimately ranged between two and 36 schools for each fundee. The average number of schools served by fundee for year 2 was 10, however several partnerships did not result in sustained service delivery. School partnerships were lowest during the summer before the second school year in July 2016 (113 schools) and highest in March 2017 (214 schools).

By the end of year 2, fundees reported active partnerships in 203 schools on the year-end survey. These schools represent a total enrollment of 141,355 students for the 2016-2017 school year, which means that over 140,000 students potentially had access to SBMH services through the Apex program (see Figure 8, page 15).

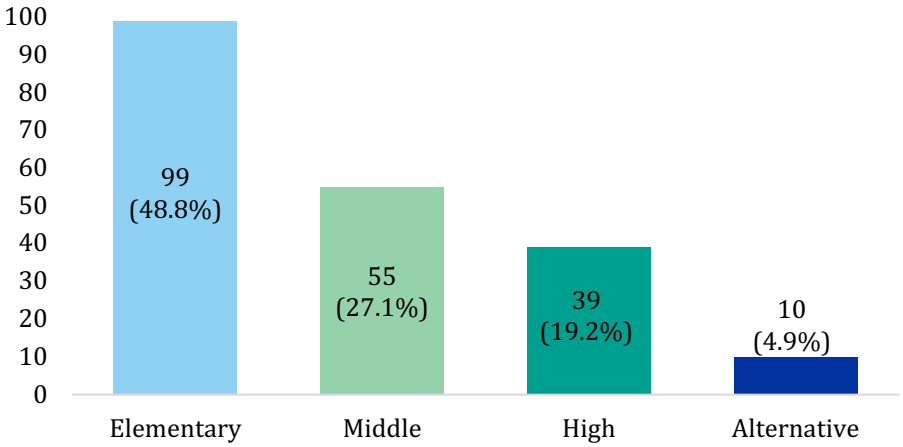
Figure 2: Number of Schools Served Monthly [a]



[a] Data Source: Monthly progress reports (MPRs)

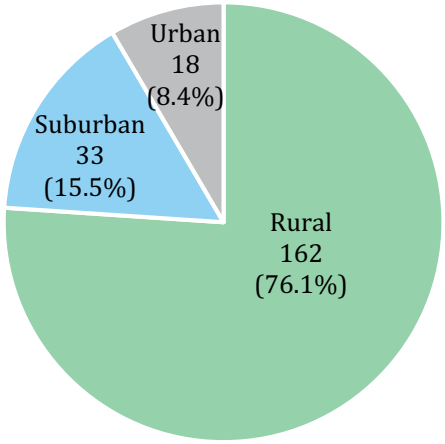
Almost half of the schools served by Apex fundees in year 2 were elementary schools (48.8%). Additionally, 5% of schools were considered "Alternative" schools. According to the Georgia DOE, alternative schools and programs are an option for students who may require innovative or creative structured alternatives to a traditional education setting.[5] These schools and programs include combined school types, special education centers, and alternative schools (see Figure 3).

Figure 3: Type of School Served by the Apex Program (N=203)[b]



Additionally, fundees reported on the geography and surrounding landscape of their partner schools. The majority (76.1%) of schools served by Apex fundees were located in a rural setting (see Figure 4).

Figure 4: Geography of Apex Schools (N=213)[c]

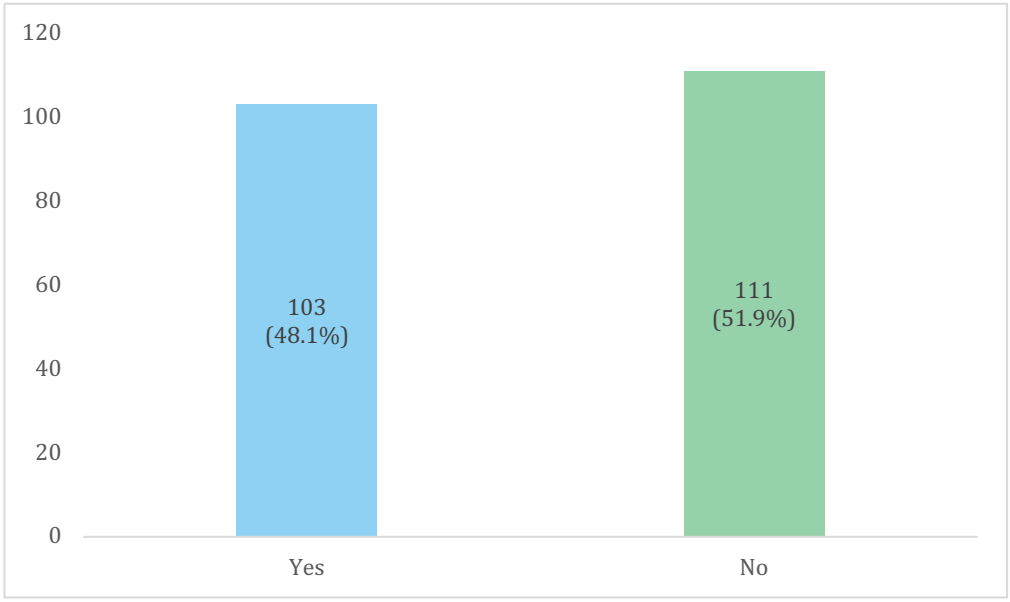


[b] Data Source: Apex Year-End Survey merged with GOSA and DOE data
[c] Data Source: Apex Year-End Survey (missing values=1)

SBMH Programs and Title I Status

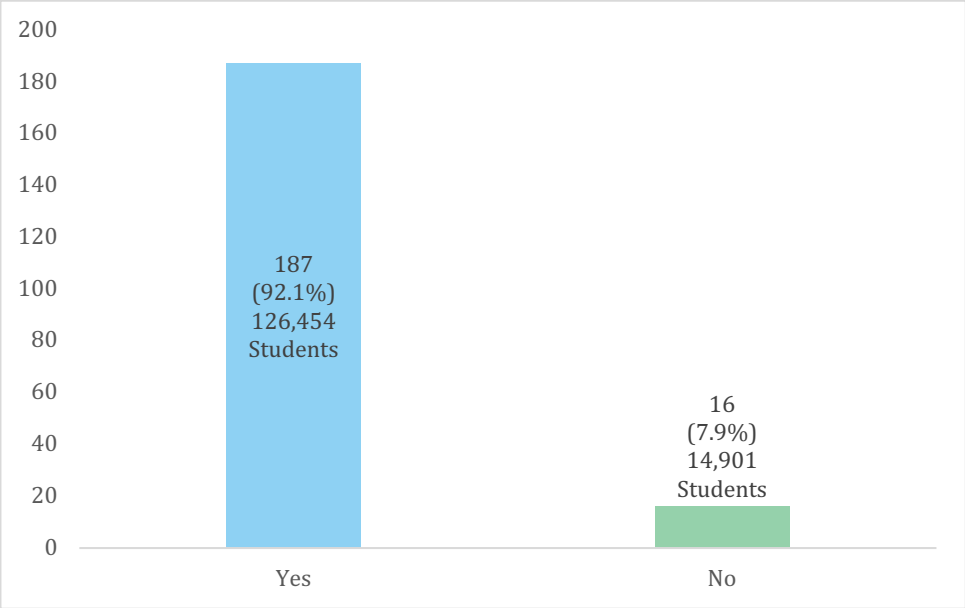
To meet the program goal for early detection, fundees have continued to be encouraged by the funder to consider elementary and middle school partners, and to prioritize schools with unmet needs. In year 1, fundees were encouraged to partner with schools that had previously implemented PBIS programs to ease integration into the school setting. Integration with schools that already have some form of SBMH programs can also facilitate program sustainability, as school leadership may be more receptive to the demonstrated value of offering these services in their districts. Although this was not a requirement in year 2, 103 out of the 214 schools reported on in the year-end survey had either PBIS and/or other SBMH programming before Apex (see Figure 5). Additionally, fundees were urged to consider school partners with Title I status in an attempt to have a greater impact on students with lower resources and greater potential for having unmet needs. In year 2, 92.1% of partner schools were Title I schools (see Figure 6). These schools represented a total enrollment of 126,000 students from low-income or low-resource backgrounds who had access to SBMH services.

Figure 5: Schools With SBMH or PBIS Prior to Apex Program Participation (N=214)[d]



[d] Data Source: Apex Year-End Survey

Figure 6: Schools and Enrollment With Title I Status (N=203)[e]



Goal 1: Increased Access to Mental Health Services

One of the goals of the Apex program is to increase access to mental health services for children and youth, particularly for those who are in need of services and not receiving them. Over the course of the second year, the program served an average of 1,937 students each month, more than double the monthly average from year 1 (926 students).

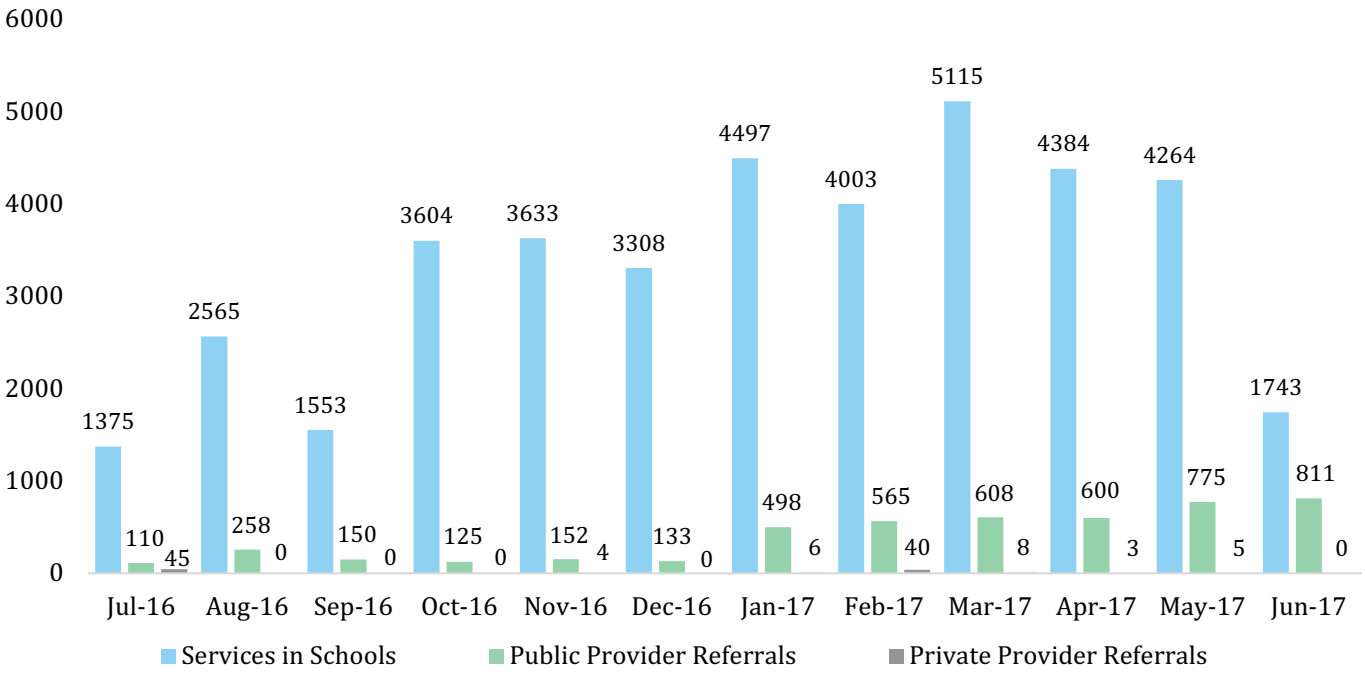
The vast majority of services were provided in the school setting, consistent with the purpose of the Apex program.

The number of services provided in schools and the number of referrals made to public providers almost doubled from year 1 to year 2. In total, 40,044 services were provided in schools (compared to 22,640 from year 1) and 4,785 referrals were made to public providers (compared to 2,468 in year 1).

[e] Data Source: Apex Year-End Survey merged with GOSA and DOE data

Referrals made to private providers decreased from 270 in the first program year to 111 in the second. A potential reason for this decrease could be the development of summer programming or continued use of school space during breaks ensuring continuity of services within schools. Another plausible reason could be lack of insurance coverage by private providers — therefore fundees are more likely to refer to public providers. Additional reasons can be further explored in future analyses. Services and referrals for all students served in year 2 are represented in Figure 7.

Figure 7: Total Services and Referrals for All Students[f]



Goal 2: Early Detection of Mental Health Needs

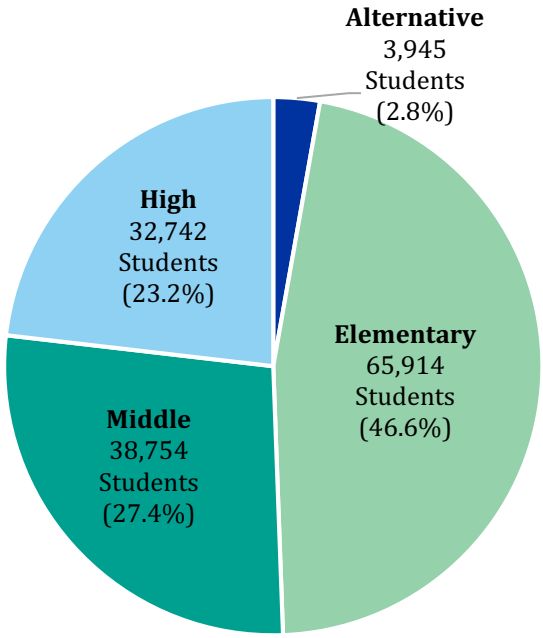
Another program goal is to increase early detection of mental health needs. Fundees were encouraged to partner with elementary and middle schools to identify needs and make services available to students at a younger age. As noted earlier, the 29 fundees partnered with a total of 99 elementary schools, 55 middle schools, 39 high schools, and 10 alternative schools over the course of the 2016-2017 school year (see Figure 3).

[f] Data Source: Monthly progress reports

The Apex program provided access to services for 65,914 students in elementary schools, 38,754 students in middle schools, and 32,742 in high schools, for a total of over 140,000 students (see Figure 8).

During the course of the program, the maximum number of schools fundees attempted to partner with in a one-month period was 214 (see Figure 2).

Figure 8: Type of School Served by the Apex Program and Enrollment (N=203)[g]



The number of first-time students served decreased, overall, for January through June. This decrease may indicate that the providers encountered fewer students with first-time need during these months, while concurrently serving a greater number of students overall (see Figure 9). Additionally, first-time referrals were made to Apex providers for a total of 2,822 students who had not previously received mental health services through Apex for a monthly average of 235 first-time students served. Five thousand nine hundred forty-two (5,942) total services were provided in school and 828 referrals were made to public providers for first-time students. The number of services and referrals provided to first-time students

[g] Data Source: Apex Year-End Survey merged with GOSA and DOE data

only follows a similar seasonal pattern as the number of students served, with a demonstrated decrease from the middle (February) toward the end of the school year (June) (see Figure 10)

Figure 9: Number of Students Served, Total and for the First Time by Month[h]

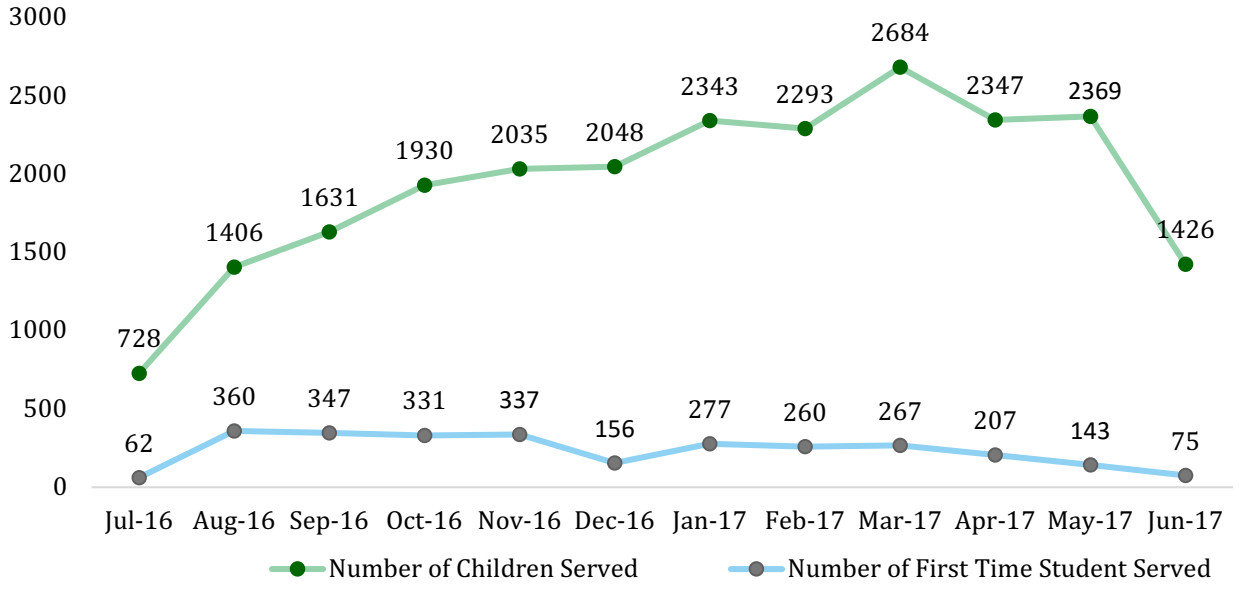
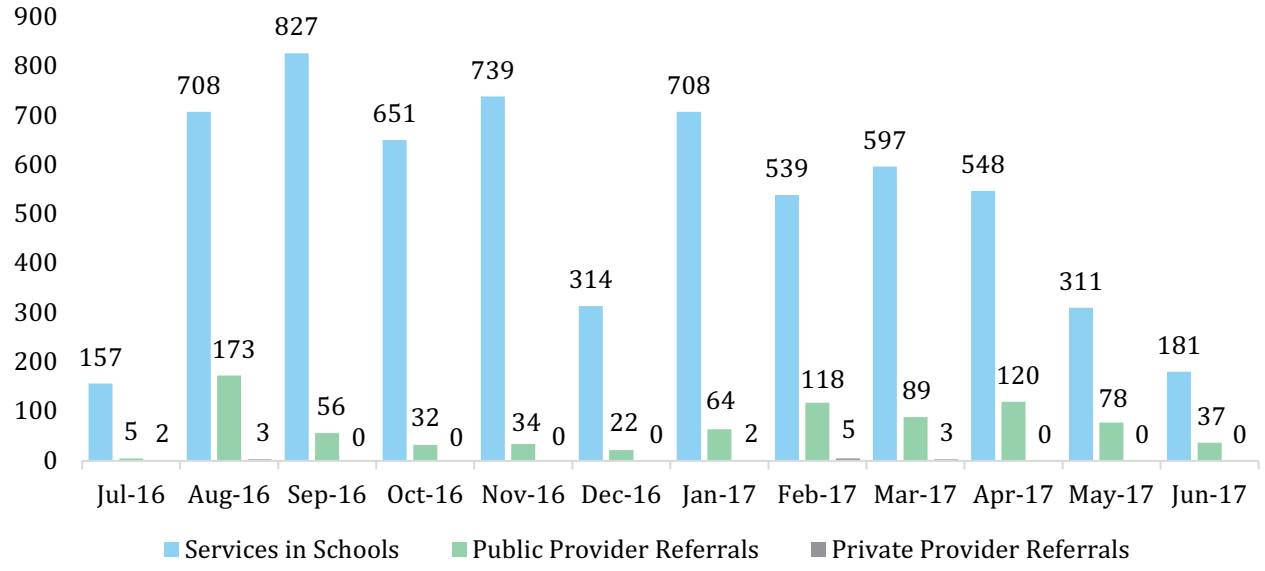


Figure 10: Services and Referrals for First-Time Students by Month[i]



[h] Data Source: Monthly Progress Reports
[i] Data Source: Monthly progress reports

Goal 3: Increased Coordination Between Mental Health Providers and Schools

Strong partnerships between schools and mental health providers are essential to promoting the sustainability of SBMH programs. As such, fundees have continued to make intentional efforts to foster close relationships in the second year of the Apex program. The third goal of the Apex program is to increase collaboration and coordination between community mental health providers and the local schools and districts in which they serve. Strong partnerships provide the foundation for infrastructure that can be maintained should there be a negative shift in funding. An adapted version of the MHPET was employed to examine fundee and school partner efforts at creating and fostering partnerships and infrastructure to support SBMH services. Qualitative questions were also administered to fundees in the year-end survey to assess the key elements that contribute to sustainable partnerships.

Mental Health Planning and Evaluation Template

The MHPET assesses school mental health programs across eight dimensions based on item-level responses:

- Operations;
- Service delivery;
- Stakeholder involvement;
- School coordination and cooperation;
- Staff and training;
- Community coordination and cooperation; and
- Identification, assessment, and referral.

An abbreviated version of the MHPET incorporating one to two questions per dimension was added to the September and May MPRs. Survey scores were compared across the two survey administration periods. For both the September 2016 (baseline) and May 2017 (follow-up) surveys, an average was calculated for each MHPET question by school. Question-level responses were analyzed to assess changes in fundees' perceptions of the level to which policies and procedures are in place to support the sustained relationship between the fundee agencies and their school partners. Baseline and follow-up survey means were compared between levels of school attributes using paired t-tests.

The MHPET scale ranges from 1 to 6, with 1 meaning the item was not at all in place, 2 through 5 meaning the item was somewhat in place, and 6 meaning the item was fully in place. Twenty-four fundees completed baseline MHPET surveys for 148 schools in September 2016. Follow-up MHPET surveys were completed for 210 schools in May 2017. Matched survey results were analyzed for 132 school partnerships. Overall, fundees report on average that policies and procedures that support sustainable SBMH partnerships are "somewhat in place." Mean scores are

higher at follow-up across all 11 questions or partnership attributes. Paired t-tests indicate that the changes in mean scores as a whole are significant at $p < .001$.

Table 1: MHPET Overall Mean Survey Scores (N=132)[j]

Dimension	Question	September Average (T1)	May Average (T2)
Operations	1.There are clear protocols and supervision for handling students' severe problems and crisis (e.g., suicidal ideation, psychosis)	4.83	5.25
	2. Mental health services adhere to clear policies and procedures to share information appropriately within and outside of the school and to protect student and family confidentiality.	5.41	5.65
Stakeholder Involvement	3. Families are partners in developing and implementing services.	4.55	5.08
	4. Teachers, administrators, and school staff understand the rationale for mental health services within their school and are educated about which specific barriers to learning these services can address.	4.42	4.87
Staff & Training	5. Mental health staff receives training and ongoing support and supervision in implementing evidence-based prevention and intervention in schools.	4.83	4.88
	6. Mental health staff receives training, support, and supervision in providing strengths-based and developmentally and culturally competent services.	4.92	5.11
Identification, Referral & Assessment	7. Mental health service providers and the school have adopted a shared protocol that clearly defines when and how to refer students.	5.08	5.43
Service Delivery	8. A range of activities and services, including schoolwide mental health promotion, prevention, early intervention, and treatment services, are provided for youth in general and special education.	3.92	4.60
School Coordination & Collaboration	9. Mental health staff develops and maintains relationships and participates in training and meetings with educators and school-employed mental health staff (*if applicable*)	4.66	4.83
Community Coordination & Collaboration	10. Servicers are coordinated with community-based mental health and substance abuse organizations to enhance resources and to serve students whose needs extend beyond scope or capacity.	4.42	4.63
Quality Assessment & Improvement	11. A stakeholder-informed mental health quality assessment and improvement (QAI) plan is implemented that includes measures of consumer satisfaction, individual student outcomes (e.g., measures of behavioral or emotional health), and school-related outcomes (e.g., attendance, behavior, academic performance).	3.64	4.00
Overall Mean		**4.61**	**4.94**

[j] Data Source: Monthly progress reports for September 2016 and May 2017

Changes in the level of implementation of partnership dimensions were assessed. The majority of providers report no change in the level of dimension implementation on the follow-up survey compared to the baseline survey. The percentage of providers who rate the dimension level of implementation higher on the follow-up survey ranged between 20% and 36%. Fundees most frequently report improvements in the Stakeholder Involvement (36%) and Identification, Referral, and Assessment (33%) dimensions. Conversely, the percentage of providers who rate dimension level of implementation lower on the follow-up MHPET survey than at baseline ranged between 7% and 20%. Twenty percent of fundees report a lower level of implementation in the Community Coordination and Collaboration (19.7%) and School Coordination and Collaboration (16.7%) dimensions (see Table 2, below).

Table 2: Changes in Level of Implementation of Partnership Attributes (N=132)[k]

Dimension/Question		Percent Improved (a)	Percent Declined (b)	No Change
Operations	Q1	29.6%	10.6%	59.8%
	Q2	28.7%	16.7%	54.5%
Stakeholder Involvement	Q3	36.4%	12.9%	50.8%
	Q4	23.5%	6.8%	69.7%
Staffing & Training	Q5	23.5%	14.4%	62.1%
	Q6	25.0%	11.3%	63.6%
Identification, Referral & Assessment	Q7	33.3%	11.4%	55.3%
Service Delivery	Q8	28.0%	12.1%	59.8%
School Coordination & Collaboration	Q9	23.5%	16.7%	59.8%
Community Coordination & Collaboration	Q10	23.5%	19.7%	56.8%
Quality Assessment & Improvement	Q11	20.5%	15.2%	64.4%

(a) Change in score from "Not at all in place" to "Somewhat in place" or "Somewhat in place" to "Fully in place"
(b) Change in score from "Fully in place" to "Somewhat in place" or "Somewhat in place" to "Not at all in place"

[k] Data Source: Monthly progress reports for September 2016 and May 2017

Publicly available data from the Georgia DOE and the GOSA were utilized to examine the relationship between several school-level characteristics (school type, geography, presence of SBMH services prior to Apex implementation, and presence of PBIS prior to Apex implementation) and MHPET total baseline and follow-up mean scores. Of the 132 schools that had completed both the baseline and follow-up MHPET surveys, 15 schools did not have DOE or GOSA publicly available data. Therefore, the total number of schools assessed in the following analysis was 117.

Table 3 results demonstrate differential improvements in MHPET mean scores by school type (e.g., elementary, middle, high, and alternative), geography, and whether or not schools had SBMH or PBIS programs in place prior to Apex. Specifically, follow-up scores significantly improved, compared to baseline, for partnerships with both elementary and high schools, schools located in rural settings, and schools that did not have SBMH or PBIS programs in place prior to Apex. Improvements within middle schools were also observed, though not at statistically significant levels. Follow-up survey mean scores decreased from baseline survey mean scores among partnerships with schools located in urban and suburban areas.

Schools without SBMH and PBIS in place prior to Apex improved on most dimensions of the MHPET and yielded statistically significant results.

While schools that did have SBMH or PBIS prior to Apex did not produce statistically significant results, follow-up survey mean scores did increase from baseline. The lack of significance could be attributed to the sample size or to the possibility that schools with no SBMH or PBIS prior to Apex had opportunity to make greater gain.

Table 3: Mean Scores for MHPET Overall Survey by School-Level Attributes (N=117)[1]

School-Level Attributes	Baseline Mean	Follow-Up Mean	Difference in Means
School Type			
Elementary	4.69	5.01	0.32*
Middle	4.60	4.77	0.17
High	4.30	4.92	0.62**
Alternative	5.30	4.34	-0.95
Geography			
Rural	4.61	5.09	0.48**
Urban	4.66	3.80	-0.86
Suburban	4.61	4.49	-0.12
SBMH Prior to Apex			
Yes	4.30	4.72	0.42
No	4.71	4.95	0.24*
PBIS Prior to Apex			
Yes	4.71	4.94	0.23
No	4.53	4.86	0.33*

*p < .05 **p < .01

Year-End Survey

Fundees were asked to complete a year-end survey in June 2017. This survey collected information about the schools served, services provided, billing practices, program characteristics, and successes and challenges of program implementation. The surveys yielded quantitative and qualitative data about program characteristics, implementation, and sustainability. Additionally, fundees reported on the partnerships they created and maintained for year 2. Responses were reviewed for common themes. Fundees completed year-end surveys for 214 schools total, although there were missing values for some of the measures presented below.

School Partnerships

Each Apex fundee determined how best to implement its program based on its local community. Implementation strategies varied between fundees, but all involved creating or strengthening partnerships with local schools, principals, superintendents, or school boards. Some fundees formed partnerships with local school districts to determine at which schools to implement Apex programming, and

[1] Data Source: Monthly progress reports for September 2016 and May 2017 merged with GOSA/DOE and Apex Year-End Survey Data

others utilized data from the Georgia DOE to identify potential school partners and approached the individual school.

According to the year-end survey, 4,372 unique students were served across 201 schools in year 2.[m] This is an average of about 21 students served per school in year 2. Fundees reported they attempted to partner with an average of 12 schools across year 2, with about 10 of those attempts on average reported as turning into successful partnerships. The average number of schools each fundee served by the end of year 2 according to the year-end survey was 14. Included in this average are schools that the fundees had been serving since year 1 of the program. In total, 58% of the schools reported in the year-end survey were served by Apex in year 1 (n=125). Additionally, fundees indicated that they had a previous relationship with 72% (n=153) of the schools reported on the year-end survey, suggesting that the fundees are intentionally establishing relationships and developing partnerships with schools before providing direct services to students, which helps build a strong foundation for program sustainability.

Data Tracking and Sharing

Fundees reported utilizing a variety of strategies to gather and share data related to student improvement and academic performance. The majority of fundees are not collecting data independent of COE's evaluation. However, fundees are collecting data in partnership with schools and school systems, predominantly school outcomes data related to grades, attendance, and behavior. Fundees reported tracking attendance in 55% of schools and tracking any measure of academic performance in 59% of schools. Notably, fundees are tracking information related to behavior disruptions for their students for 70% of the schools reported. This is significant, as behavior disruptions are one way for behavioral health providers to understand if their services are having an impact on child functioning. Of the 129 schools for which fundees track academic performance, almost 100% (n=127) of those schools report data on grades. Fundees only collect information related to grade point average (GPA) for 14% of schools and track scores on the Georgia Milestone Assessment (GMA) for 11% of schools. Other sources of academic data reported by fundees include teacher reports and local data from an individual school's reporting systems. In order to collect data associated with the frequency and impact of services as well as service provision, one fundee added a school field on the admission form, which allowed further data queries.

Fundees were asked with whom they share this data to demonstrate the impact of their programs to garner community support. Fundees reported they shared data with mental health agency leadership for 76% of their schools and with individual school leadership in 61% of schools. Fundees share data with either community leadership or school district leadership in less than 25% of schools. Of the fundees

[m] Data Source: Apex Year-End Survey with 13 missing values

who do interact with community and school district leadership, the sharing of both data and success stories has been the most common strategy to demonstrate the benefits of Apex programming. Fundees present at various community partner meetings and school board meetings as well as resource fairs and outreach events. Additionally, they are sharing their data with local clubs such as the Lions or Rotary. Broadening the audience with which fundees are demonstrating the impact of their program to include business leaders can help to diversify funding. Having school district and community buy-in is an important aspect of planning for sustainability of the Apex program. One fundee reported that sharing data at a community service board meeting inspired a board member to provide grant funding to support summer camp activities.

School Integration and Provider Presence

Integration of services and provider presence varied across fundees and within schools. In the majority of schools (70%), providers regularly attended school meetings. Providers had a school email address in 25% of schools, and a school badge in 29% of schools. One-third of the providers reported "other" ways of integrating into the schools, such as hosting lunch-and-learns for school staff, participating in PTA meetings, and attending resource fairs and field days. Additionally, in 75% of the schools served, providers reported they had a private office space for providing services, with 14% reporting having a shared space. Office space is crucial for providers to be able to serve students in a confidential manner. Providers lacking a designated (private or shared) space identified alternative options such as conference rooms, copy rooms, and empty classrooms.

Fundees also reported on the types of providers serving in each school. More than half of year 2 schools were staffed by providers with a BSW (bachelor-level social worker) and just over one-third of schools were staffed by providers with an LPC (licensed professional counselor) certification. Comparatively fewer schools were staffed by a provider with LAPC[n] (28%), LMSW (18%), LCSW (17%), and/or MSW (11%) certifications. Less than 10% of schools were staffed with an RN[o] (8%), psychologist (7%), or LMFT (5%). Across all schools with complete data for the year-end survey (202 schools), just under one-third (30%) were staffed by only those providers who were not licensed, meaning that in 70% of year 2 Apex schools, at least one licensed provider was on staff providing Apex services.

Provider presence in the school is categorized by days per week and by hours per day. However, it is difficult to estimate the average number of hours per week the providers were present in an individual school due to the phrasing of the question on the survey. In 96% of schools, fundees reported that providers were present at

[n] Licensed associate professional counselor, licensed master social worker, licensed clinical social worker, master social worker

[o] Registered nurse, licensed marriage and family therapist

least one to at most five days a week. Only three schools had a provider serving less than one hour per day, per week. Only eight schools had providers serving less than one day per week (see Table 4).

Table 4: Provider Presence in Schools by Days per Week and Hours per Day (N=214)

Provider Days per Week	Provider Hours per Day			
	<1 hour	1-4 hours	5-8 hours	Total
<1 day	3	5	0	8
1-2 days	0	41	65	106
3-5 days	0	9	91	100
Total	3	55	156	214

Fundees were also asked to report on the staffing details for each school they served in including how many full- and part-time staff members were dedicated to each individual school (see Table 5).

Table 5: Provider Staffing in Schools by Type (Full-Time and Part-Time) (N=213)[p]

Staff Type	Frequency of Number of Staff per School			
	<1 (including 0)	1	2-5	>5
Full-Time	54	80	73	15
Part-Time	139	53	8	14

There were a variety of inconsistencies in the data reported by fundees, thereby making it somewhat difficult to accurately determine the actual number of staff allocated to the schools. Future analyses will reflect more accurate data as the questions related to staffing have been revised to represent a more accurate understanding of the therapist's allocation of time. Excluding outliers, the following patterns were observed: The most frequent response to the question about how many full time providers were dedicated to the individual school was one (n=80, 38%). Additionally, 70% of the schools reported having one to three providers serving students (n=152). Of the 75 total schools reported as having any part-time staff, 61 had between one and five providers (81%).

Challenges to Billing and Financial Sustainability

The challenges related to billing as reported by fundees on the year-end survey may subsequently impact financial sustainability for programs. Fundees frequently cited the care management organization's (CMO's) processes and procedures, lack of credentialed staff, and insurance-related issues as primary billing challenges. The CMO's requirements and criteria related to obtaining authorization and securing

[p] Data Source: Apex Year-End Survey with one missing value

reimbursement were noted as most challenging across all fundees. Furthermore, fundees report the time and process to receive authorization for services as cumbersome and laborious. Due to increased caseloads and crisis situations that require immediate attention, fundees reported often being delayed in submitting documentation. Some fundees designate administrative staff to help support timely submissions. Since many insurance carriers only reimburse if services are provided by fully licensed clinicians and many fundees employ associate licensed clinicians, billing private insurance is an added challenge. Fundees also report the inability of private insurance to collect copays within the school setting as a barrier. This limitation presents additional challenges to fundees, as parents do not always communicate insurance information or notify fundees if there is a lapse in coverage, resulting in more reimbursement delays. These challenges may necessitate the need for fundees to take proactive steps in participating on private and CMO insurance panels in order to advocate for the option of billing for SBMH services regardless of clinician status and to work toward adding schools as appropriate venues for delivering support services.

Fundees report instructional time and testing schedules as additional challenges in billing and long-term financial sustainability, as providers have limited hours in the day to meet with students, which results in less billable time.

The time spent on activities critical for school buy-in such as school engagement, integrating into the school culture, and supporting staff and administrators are nonbillable. Fundees report that Apex funding has been crucial in offsetting the cost associated with nonbillable activities. In the absence of Apex funding, these significant activities that are crucial for onboarding new schools and continuing to support existing school partners would make sustainability difficult.

Challenges to the Sustainability of the School Partner Relationship

Overall, fundees report positive relationships with school partners, especially when fundees take the time to embed themselves within schools and participate in, as well as contribute to, school activities. However, some fundees reported a lack of support from school administrators as a challenge for sustaining the Apex partnership. Fundees also state that turnover within schools makes it difficult to implement programming and to maintain consistent investment in the program on behalf of the school partners. Additionally, stable staffing among the providers is important as well. Feedback from the year-end survey conveys how difficult it is to maintain rapport and trust with the school partners and students if providers are constantly

changing. Fundees report activities such as providing trainings to school staff on mental health awareness, hosting lunch-and-learns for parents to understand mental health stigma, and participating in numerous school events help to promote successful collaboration. However, these activities are nonbillable services.

Facilitators in Creating Financial Sustainability

The greater number of referrals into the program means increased productivity and greater opportunity to bill for services. Fundees report they have employed creative strategies and solutions to increasing referrals. Many fundees added summer camps and activities throughout the summer to increase their availability and accessibility to students in what have historically been less active months. Many fundees have initiated offering therapeutic group services as another way to provide outreach. Fundees report that being present at all school activities increases the visibility of the program and services. While this presence is helpful in creating financial sustainability, it is also a challenge, given that participating in school activities is nonbillable time. Fundees also reflected on the importance of seeking support from community partners and businesses as a strategy toward financial sustainability since providing SBMH services to students benefits the entire community.

Facilitators in Sustaining Relationship with Schools

The qualitative responses to the year-end survey revealed more detail about the nature of implementing and improving school partnerships than the previously reviewed quantitative data. The clear majority of fundees support the notion of "embedding themselves within the school's culture." Participating in activities such as developing PBIS curriculum and individualized education plan meetings; attending family nights, parent orientations, and open houses; hosting lunch-and-learn events; and providing training opportunities for administrators and staff are some of the examples of how fundees are embedding themselves. Fundees also report it is important to have a consistent presence at schools in order to provide quality care. Maintaining a dependable schedule of the days and hours spent in schools contributes to perceptions of reliability, which fundees have indicated as being important to school staff. Additionally, frequent and effective communication with staff and administrators helps sustain the relationship with the school partners. Using data to demonstrate the value of services and positive outcomes for students bolsters relationships with schools.

Facilitators in Sustaining Relationships With Community Partners

Participating in community collaborative meetings such as Local Interagency Planning Teams (LIPT), Family Connection, and similar endeavors has been important for fundees to increase awareness and knowledge of the program. As fundees report, visibility within the community is critical to sustaining relationships with community partners. Sharing data with community partners has been a successful strategy for many fundees to obtain buy-in, demonstrate the value of Apex programming, and solicit investment.

Marketing Activities

Printed material in the form of brochures, postcards, and flyers, as well as product marketing (pens, stress balls, water bottles), are some examples of how fundees are marketing their programs. Many are also creating videos, participating in radio interviews, writing articles for the local newspaper, and making appearances on local TV programs. Fundees are representing Apex at school and at community events in addition to hosting events dedicated to educating the larger community about mental health awareness.

Apex Program Goals for Year 3

The goals of the Apex providers for year 3 aligned with five main themes (see Table 6). The most notable goal was to expand Apex schools within their regions.

Table 6: Year 3 Goals for Apex Program as Identified by Fundees

- Expand Apex services to more schools
- Increase parent engagement
- Ensure sustainability of providers
- Collect/share more data
- Increase engagement with community partners

The strongest theme, which cuts across all the questions related to sustainability on the year-end survey reported by fundees, is the significance of the activities that are nonbillable. Fundees report that activities such as providing trainings to school staff on mental health awareness, hosting lunch-and-learns for parents to understand mental health stigma, and participating in numerous school events such as open houses or curriculum nights contribute to building lasting rapport with school partners. Equally important for fundees is being visible in the community to market the program in an effort to increase community collaboration and diversify funding. These nonbillable activities are crucial to the sustainability of the relationships and programming. In the absence of Apex funding, fundees are extremely concerned with how they would cover the cost of these activities and the implications of not engaging in them.

Parent Survey and Student Outcomes

Throughout the year, fundees administered surveys to the parents of children in Apex services. The survey asked questions about the child's functioning since joining the Apex program, including "Overall I am satisfied with the services that my child has received," "My child is better at handling daily life," and "My child is doing better in school and/or work." The survey consists of 14 items, scored from 1

(strongly disagree) to 5 (strongly agree). The survey is designed to show how receiving services through Apex impacts the behavioral health of the child as reported by the parent. The parent survey is administered to parents in the fundee clinic, at the point when their children are being assessed with the Child and Adolescent Needs and Strengths (CANS) questionnaire. The CANS assesses exposure to trauma, needs, and strengths through the following domains: Life Functioning, Child Risk Behaviors, Acculturation, Child Behavioral/Emotional Needs, Traumatic Stress Symptoms, Traumatic/Adverse Childhood Experiences, Child Strengths, Substance Use, Caregiver(s) Needs and Strengths. Within each domain is a set of items which uses a four-level rating system and is designed to translate assessment into action based on varying levels of strengths and needs presented within an individual child. The CANS assessment is intended to be administered every 90 days as a tool to track progress over time. The parent survey also asks about how long the child has been in Apex services. The MPRs include information about how many children received a CANS assessment each month, as well as how many were eligible for a reassessment, how many were reassessed, and how many had a score that indicated improved functioning in that reassessment.

Results of the parent survey can help inform whether Apex services are positively impacting children's functioning. Across the year, only 92 parent surveys were completed (including information about the length of time in Apex services). The average score across all 14 items on the parent survey was 4.07, indicating relatively high agreement with the statements regarding the child's improved functioning (as perceived by the parent). Additionally, when the scores are summed across all of the items, there is a weak but statistically significant relationship between improved child functioning and length of time in Apex services ($R=.188$, $p<.1$). This suggests that the Apex services are having an impact on children's behavior and are helping providers meet the needs for these children.

The CANS data also support the findings of the parent survey around improved functioning for Apex students. In total, 2,798 students completed a CANS assessment across all providers for year 2. Additionally, 2,185 students were eligible for a CANS reassessment throughout the year. Of the students across the entire year who were eligible for a CANS reassessment and received one (n=1,095), 74.6% showed an improved CANS score (n=817).[q] While only 1,095 students received a CANS reassessment, which accounts for about one-fourth of all reported unique students served, this is still an impressive proportion of students showing improvement. Collectively, this information suggests that the Apex program is effective at improving behavioral health for children. The longer students remain in services, the more likely they are to demonstrate improvement both in their behaviors at home as interpreted by the parents and as reported by their providers through the CANS assessment.

[q] Data Source: Monthly progress reports

Additional Findings from Year 1 to Year 2

School Retention

During the first year of Apex, the fundees served a total of 155 schools, while in year 2 of Apex, the fundees served a total of 283 schools, as indicated by the submission of at least one MPR during either evaluation year.

One hundred forty-two (142) of the schools served in year 1 were also served in year 2, representing a 92% school retention rate across the first two years of Apex implementation.

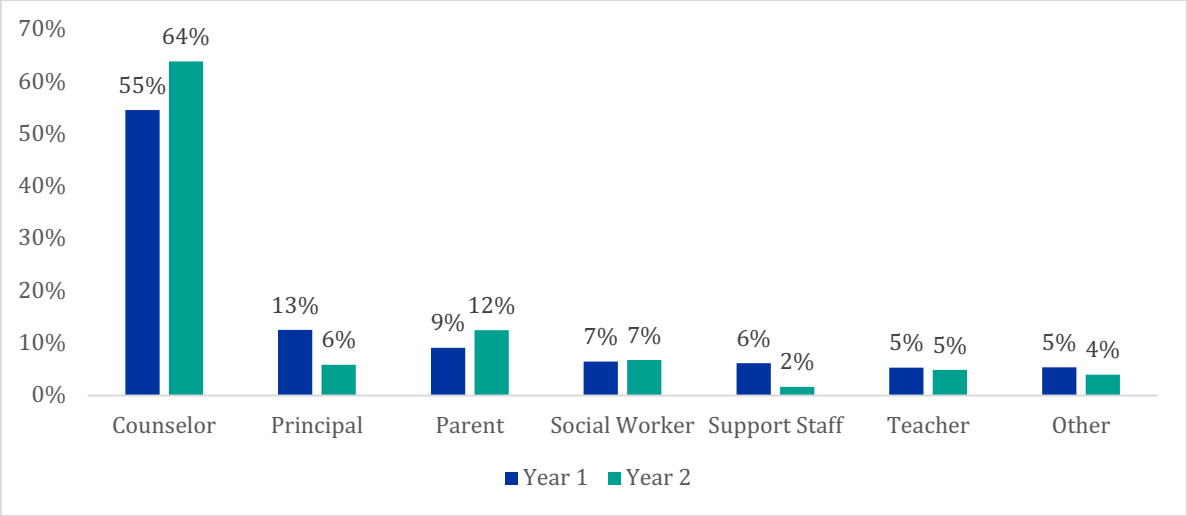
Stated alternatively, 13 of the 155 schools served in year 1 were not served in year 2. During year 2, 141 new schools were served that were not served during year 1. Across both years, a total of 296 unique schools were served:

- 142 schools were served in both years;
- 13 schools were served in year 1 but not year 2; and
- 141 schools were served during year 2 but not year 1.

Diversification of Referrals

One important indicator of the implementation of SBMH services is the network of referrals that place students into care. A diversity of referrals potentially indicates a high integration of community partners into the schools. The referral network for the first two years of Apex is displayed in Figure 11 below. During year 1 of Apex, a total of 6,114 referrals for SBMH services were made across 155 schools. During year 2, a total of 11,377 referrals were made to Apex fundees across 283 schools. In both years, counselors represented the majority of referrals to Apex (55% in year 1 and 64% in year 2). All other sources accounted for less than half of the total percentage of referrals during both years. This could be partially due to internal school-level protocols and processes around referring to Apex providers.

Figure 11: Apex Program Referral Sources From Year 1 to Year 2[r]



Increased Access to Service Across Years

As Apex fundees received continued funding across implementation years, one important consideration is the expansion of services within schools over time. An important question for consideration is, Within schools served during both years, did the number of students served increase? We answered this question by comparing the overall number of students served, as well as the number of first-time students served across both years. We specifically compared these two measures during the beginning of the school years (September) and the end of the school years (May). That is, school-level data from September of year 1 were matched with September of year 2, while May of year 1 was matched with May of year 2.

Seventy-seven (77) schools were matched for September of year 1 and year 2, and 105 schools were matched for May of year 1 and May of year 2. As displayed in Table 7, during September of year 1, 302 students were served across the 77 matched schools. By the beginning of year 2, the number of students served across the same schools rose to 977. On average, about nine more students were served in each of the matched schools in year 2. The difference in the number of students served was statistically significant and represents a large effect size. During the end of the school year for year 1, a total of 1,136 students were being served across the 107 matched schools. In year 2, 1,365 students were being served across the same schools. Accordingly, between the end of years 1 and 2, about two more students on average were being served in each of the matched schools. This result was also statistically significant but represents a small effect size. The results of the analysis indicate that in school partnerships that were continued between both years, the

[r] Data Source: Monthly progress reports

gain in the number of students served was much higher at the beginning of the school year compared to the end of the school year.

Table 7: Differences in Number of Students Served Across Years[s]

Time	Number of Matched Schools	Number of Students Year 1	Number of Students Year 2	Raw Difference	Mean Difference	Effect Size
Beginning of School (September)	77	302	977	+ 675	+ 8.64 ***	Large
End of School (May)	107	1136	1365	+ 227	+ 2.14 *	Small

Analysis consisted of two-tailed dependent t-test. Effect sizes derived from Cohen's *d*.

Location of Services During the Summer Months

The locations of services provided during June of both program years are outlined below in Table 8. During June of year 1, a total of 876 students were served. Any one student could receive multiple services during a reporting month, so the total number of services provided is greater than the number of students served. During June of year 1, despite the drop in the total number of students served, almost all services received occurred in the school setting (87%). In the summer of year 2, although more students overall were served (n=1,426), comparatively fewer services were received in the school setting (54%). The drop in the percentage of summer services from year 1 to year 2 appears to be driven by a shift in the percentage of services provided by a public community provider. During June of year 1, 13% of services were provided by a public community provider, while in June of year 2, this percentage rose to 25%.

Table 8: Location of Services in June of Year 1 and 2[t]

	Total Number of Students Served	School Setting	Home	Other	Referred to Public Community Provider	Referred to Private Community Provider	Total Number of Services
June 2016	876	1905	N/A	N/A	276	13	2194
June 2017	1426	1743	288	371	811	0	3213

[s] Data Source: Monthly progress reports
[t] Data Source: Monthly progress reports

Distribution of Billing in Year 2

The distribution of billing sources among students served in September and May of year 2 is displayed in Table 9. At both time points, the distribution remains largely the same. Almost one-third of students at each time point received services that were billed to WellCare. Peach State, Amerigroup, and private insurance also accounted for a large share of the billing sources for students receiving Apex services. Relatively few services received by students were billed to DBHDD or an "other government" source. In September 2016, 59 students (3.64% of total students served that month) received services that were not billable, while in May 2017, 117 students (4.94% of total students served that month) received services that were not billable.

Table 9: Billing Sources at Beginning and End of Apex Year 2

	Total	Private Insurance	Amerigroup	Medicaid	DBHDD	Other Govt	Amerigroup 360	WellCare	Peach State
Sep 2016	1621	97 (5.98%)	285 (17.58%)	175 (10.80%)	61 (3.76%)	25 (1.54%)	25 (1.54%)	509 (31.40%)	371 (22.89%)
May 2017	2369	108 (4.56%)	461 (19.46%)	256 (10.81%)	101 (4.26%)	66 (2.79%)	23 (0.97%)	747 (31.53%)	470 (19.84%)

Summary and Conclusions

Facilitators to Program Success

Fundees cite school integration and provider presence in schools as key components to program success. The more a provider can embed himself into the culture of the school and participate in as well as contribute to school events, the more it results in additional buy-in from the schools. Increasing visibility within the schools by hosting learning/training opportunities and serving as an advocate for the importance of mental well-being in the larger community also contributes to program success.

Barriers to Program Success

While fundees continued to meet the program goals of Apex in year 2, they did experience some barriers to program success. Most notably, fundees reported on barriers related to a lack of support from school administrators, challenges with seeing youth due to instructional time and testing schedules, and factors related to billing insurance. Lastly, perhaps the barrier most frequently cited by fundees is

related to the essential consultation services fundees engage and the lack of billability.

Conclusion

Georgia DBHDD's Apex program provided funding to 29 community-based mental health provider organizations to integrate mental health providers into local school settings. By the end of the second year, the providers coordinated services with at least 214 schools throughout the state and provided over 40,000 services in the school setting. Of the children served, more than 2,800 students were receiving services for the first time from Apex fundees. The program continues to make significant progress toward the three goals of increased access, early detection, and increased coordination between community mental health providers and their local schools.

Findings from the evaluation indicate that in Georgia, funding to build infrastructure for SBMH programs contributes to increased coordination between community mental health providers and local schools, specifically in the areas of stakeholder involvement and staff training. This increase in collaboration and coordination also supports early identification and access to, and delivery of services to, students and families who need them most. Schools without SBMH in place prior to Apex improved on most dimensions of the MHPET, while schools that did have SBMH prior to Apex also showed improvement, although not statistically significant.

Lessons learned from two years of implementation, specifically engaging with fundees through consultation with technical assistance providers, peer-to-peer learning opportunities such as the System of Care Academy or the Peer Learning Seminar, and collecting both quantitative and qualitative data have resulted in a more informed understanding about best practices of an SBMH model in Georgia and critical components to sustainability. Data collection for year 3 will not only enable monitoring of progress toward reaching Apex goals, but it can also include the school voice in assessing the partnership and collaboration efforts in implementing Apex in schools through focus groups. Technical assistance will focus on helping to facilitate conversations and implementation of factors necessary to position for sustainability both individually and collectively across all fundees. Additionally, more data will be collected and analyzed to assess how well the program is achieving the program goals outlined in this report and the difference made by the program on student-level behavioral health outcomes.

Georgia has made a considerable investment in supporting the mental well-being of its youth by placing SBMH programming in schools through programs like Apex, Project AWARE, and Project LAUNCH. With the inclusion of children's mental health in the federal government's Every Student Succeeds Act (ESSA), and the Individuals

with Disabilities Education Act (IDEA) legislation and regulations, the national dialogue surrounding SBMH services has been elevated. Such dialogue will help to facilitate further multistakeholder engagement and serve as an opportunity to strategize funding opportunities. The Georgia System of Care plan drafted by the Interagency Director's Team also supports SBMH and expansion of services throughout the state. Evaluation findings from the Apex program will continue to inform program planning, implementation, and funding.

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Georgia APEX — School-Based Mental Health Monthly Monitoring Report

Name of Organization: (drop down box)
Phone: _____
School Name: (drop down box; OTHER option)

Name of Person Submitting Report: _____
Date Report Submitted: _____
Targeted Grades to Receive SBMH Services at School: _____

Information gathered through this report aligns with Georgia Apex Program objectives. It is understood that you may not have activities in all areas every month. Please enter N/A for measures that are not applicable within a given reporting period.

Objective 1: Provide greater access to mental health services for students.

a. *Indicate the total number of students referred for school-based mental health (SBMH) services by referral source in the current reporting period: Note: totals in the table below may exceed the total number of unique students reported in Objective 1b. above, as a student may receive or be referred for more than one service in a given reporting period.*

Referral Source	No. of Students
Teacher	
Counselor	
Social Worker	
Principal	
Nurse	
School Support Staff	
Parent	
Other	
Total	

b. *Indicate the total number of **unique** students who received services from the SBMH provider during the current reporting period:* _____

c. *Indicate the number of students who received services (including screening, evaluation or treatment) from the SBMH provider by service type in the current reporting period. (Totals in the table below may exceed the total number of unique students reported in Objective 1b. above, as a student may receive or be referred for more than one service in a given reporting period.):*

Service Type	Provided in School Setting	Provided in Home	Provided Other Setting	Referred to Community Provider		Total Students
				Public Provider	Private Provider	
Behavioral Health Assessment						
Diagnostic Assessment						
Crisis Intervention						
Psychiatric Treatment						
Community Support Individual Services						
Individual Outpatient Services (i.e., therapy session)						
Group Outpatient Services						
Family Outpatient Services						
Other Services						
Total						

d. *Of the __ unique students who received services from the Apex provider(s) during the current reporting period, for how many students were you able to bill the following sources? PLEASE NOTE: The total number of students for whom you have billed should not exceed the number of unique students served.*

Payer	No. of Students
Private insurance	
Amerigroup	
Amerigroup–Georgia Families 360	
WellCare	
Peach State	
Medicaid/PeachCare Fee-for-Service (i.e., DCH)	
DBHDD Fee-for-Service	
Other government (e.g., Medicare, Tricare, State Health Benefit Plan, etc.)	
Other	
Total	

e. *Please indicate the number of students in the following categories as they relate to CANS assessments during this reporting period.*
   1. *Number of students who received a baseline CANS assessment:*
   2. *Number of students eligible for a CANS reassessment:*
   3. *Number of students eligible for a CANS reassessment who received one:*
   4. *Number of students who received a CANS reassessment and had an improved CANS score (as compared to baseline/intake):*

Objective 2: Provide for early detection of students' mental health needs.

a. *Of the total number of students referred (as reported in Objective 1a.), indicate the number of students receiving a first-time referral for mental health services in the current reporting period. (First-time referral information may be gathered during the intake interview with the student's parent/legal guardian.):*

Referral Source	No. of Students
Teacher	
Counselor	
Social Worker	
Principal	
Nurse	
School Support Staff	
Parent	
Other	
Total	

b. *Of the total number of first-time referred students reported in Objective 2a., indicate the total number of **unique** students who received services from the SBMH provider during the current reporting period: _____*

c. *Indicate the number of first-time referred students who received services (including screening, evaluation, or treatment) from the SBMH provider by services type in the current reporting period. (Totals in the table below may exceed the total number of unique students reported in Objective 2b. above, as a student may receive or be referred for more than one service in a given reporting period):*

Service Type	Provided in School Setting	Provided in Home	Provided Other Setting	Referred to Community Provider		Total Students
				Public Provider	Private Provider	
Behavioral Health Assessment						
Diagnostic Assessment						
Crisis Intervention						
Psychiatric Treatment						
Community Support Individual Services						
Individual Outpatient Services (i.e., therapy session)						
Group Outpatient Services						
Family Outpatient Services						
Other Services						
Total						

d. *Is there any additional information that was not captured in the previous questions that you would like to share? If so, please record it in the space below.*

Appendix B: Mental Health Planning and Evaluation Template (MHPET)

Adapted Mental Health Planning and Evaluation Template (MHPET) for the Georgia Apex Program

For the following questions, please select the number that best reflects the degree to which the item is implemented at the school using the 1 to 6 scale:

- *1 indicates the item described is not at all in place. For those items that have multiple components, meeting none of the components would merit a 1.*
- *6 indicates the item described is fully in place. For those items that have multiple components, meeting all of the components would merit this rating.*

Your rating should honestly reflect the present status. Avoid the positive bias common in self-rating methods (i.e., rating services higher than actually exist).

Domain	Statement	1	2	3	4	5	6
Operations	1. There are clear protocols and supervision for handling students' severe problems and crises (e.g., suicidal ideation, psychosis).						
	2. Mental health services adhere to clear policies and procedures to share information appropriately within and outside of the school and to protect student and family confidentiality.						
Stakeholder Involvement	3. Families are partners in developing and implementing services.						
	4. Teachers, administrators, and school staff understand the rationale for mental health services within their school and are educated about which specific barriers to learning these services can address.						
Staff & Training	5. Mental health staff receives training and ongoing support and supervision in implementing evidence-based prevention and intervention in schools.						
	6. Mental health staff receives training, support, and supervision in providing strengths-based and developmentally and culturally competent services.						
Identification, Referral & Assessment	7. Mental health service providers and the school have adopted a shared protocol that clearly defines when and how to refer students.						
Service Delivery	8. A range of activities and services, including schoolwide mental health promotion, prevention, early intervention, and treatment services, are provided for youth in general and special education.						
School Coordination & Collaboration	9. Mental health staff develops and maintains relationships and participates in training and meetings with educators and school-employed mental health staff.						
Community Coordination & Collaboration	10. Servicers are coordinated with community-based mental health and substance abuse organizations to enhance resources and to serve students whose needs extend beyond scope or capacity.						
Quality Assessment & Improvement	11. A stakeholder-informed mental health quality assessment and improvement (QAI) plan is implemented that includes measures of consumer satisfaction, individual student outcomes (e.g., measures of behavioral or emotional health), and school-related outcomes (e.g., attendance, behavior, academic performance).						

Apex Year-End Survey 2017

Name of your organization: {drop down box}

Over the course of the 2016-2017 school year, how many schools has your organization attempted to partner with? {numeric response only}

How many of those partnerships resulted in providing school-based mental health services in the school? {numeric response only}

How many schools does your organization currently serve? {numeric response only}

Note: "Serving" in a school is defined as providing outpatient behavioral health services at the school site. Providing only crisis services to a school should not be considered "serving" a school.

Individual Schools and Program Descriptions

The following questions are about the individual schools you are currently serving through the Apex Program. These questions will be repeated to allow for entry of responses for each individual school partner. Please complete all questions for each individual school served.

1. Information about the school:
    a. Name of School (enter one only — drop down)
    b. Did your agency serve this school during Apex year 1, 2015-2016?
    c. Prior to Apex, were school-based mental health services (SBMH) available in this school?
    d. Prior to Apex, did the school implement Positive Behavior Intervention and Supports (PBIS)?
    e. Prior to Apex, did the school provide any other behavioral health services?
        i. If yes, please name/describe
    f. In what type of area is the school located?
        i. Rural
        ii. Urban
        iii. Suburban
    g. Please list any other school-based health services offered at this school:
    h. Outside of the SBMH program you implemented, how accessible are children's behavioral health services in the community?
        i. Very accessible
        ii. Somewhat accessible
        iii. Somewhat inaccessible
        iv. Very inaccessible
    i. Do you collect the following data for this school? Check all that apply:
        i. Attendance
        ii. Behavior disruption
        iii. Academic performance
            1. If Yes: What data do you use to assess academic improvement? Check all that apply:
            __Grades,
            __GPA,
            __Georgia Milestones Assessment System,
            __Other (text entry)

j. Please describe any barriers you have experienced in collecting school data. {text box}
k. Please describe any successful strategies you have used to access and collect school data. {text box}
l. Please identify key staff who helped to access this data within the school.
m. Please indicate below who you share this data with. Check all that apply:
__School partner/leadership
__School district
__Community leadership
__Mental health leadership
__Other (text entry)
n. Please describe any barriers you have experienced in sharing this data. {text box}
o. Please tell us about any other special characteristics of the school:

2. Students Served
a. What grades did the program serve?
i. All
ii. Some grades (list):
b. How many unique students were served at this school during year 2 of Apex, 2016-2017? {numeric response only}

Service Characteristics

1. Number of full-time employees dedicated to this school and their credentials {numeric response only}

2. Number of part-time employees dedicated to this school {numeric response only}

3. Credentials of provider(s) at this school. Check all that apply:
__BSW
__MSW
__LMSW
__LCSW
__LAPC
__LPC
__Psychologist
__LMFT
__RN
__Other (text):

4. Presence at the school:
a. How many days per week was the provider present at this school?
i. Less than one day per week
ii. One to two days per week
iii. Three to five days per week
b. Of the days present, how many hours per day was the provider present?
i. Less than one
ii. One to Four
iii. Five to Eight

c. Where, in the school, was the provider located?
    i. Private office
    ii. Shared space
    iii. The provider was not located in the school (other, text box).
d. Please describe any ways in which the mental health provider was integrated with the schools.
    - Provider had school email address
    - Provider had school badge or ID card
    - Provider attended staff and/or committee meetings
    - Other: (text box)

Implementation Lessons

1. Prior to the 2016-2017 school year, was there a previous relationship between your organization and this school?
    i. If yes, skip to **Sustainability Lessons.**
    ii. If no, please describe how this relationship was formed.
    b. Please describe the process you used for forming community partnerships and any challenges experienced in this area.
    c. Please describe how helpful the following local stakeholders were to the implementation process.
        i. Local school superintendent(s)
        ii. School principal(s)
        iii. School social worker(s)
        iv. School counselor(s)
        v. School resource officer(s)
        vi. Other (text box)
    d. Were there any challenges associated with the integration of the mental health providers and the school? If yes:
        i. What were the challenges?
        ii. How were they addressed?
        iii. Were they resolved?

2. Please describe any success stories or things that worked well during program implementation in this school.

3. Please describe any challenges associated with program implementation in this school.

Sustainability Lessons

The following questions are about billing, sustainability, and strategic planning moving forward with the Apex program.

1. Did you bill for any of the school-based services provided during the year?
    a. For what percentage of **services** (approximately) are you able to bill a third-party payer (Medicaid, CMOs, or private insurance)?
        i. None
        ii. 0-25%
        iii. 26-50%
        iv. 50-75%
        v. 75-90%
        vi. 90-100%
    b. Please describe any challenges to billing for Apex services: {text box}

2. What challenges can you identify to the:
    a. Financial sustainability for this program? {text box}
    b. Sustainability of the relationship with the school partners? {text box}

3. Are there any things that you have found to be helpful in creating:
    a. Financial sustainability for this program? {text box}
    b. Sustainability of the relationships with the schools? {text box}
    c. Sustainability of relationships with community partners? {text box}

4. Did you apply for and/or receive any other supplemental funding (federal, state, DOE, foundations)?
    a. If yes: Please describe:

5. How could you or have you demonstrated the benefits of SBMH services to your community and to other potential funders?

6. Please describe any marketing activities that you have undertaken for the Apex program.

7. Other than the information required in your monthly progress reports and reported in this survey, did you collect any data on your own, or in partnership with the schools or school systems, to determine program outcomes?
    a. If yes: please describe.

8. Is there anything else that you would like to share about the implementation of Apex at new schools that has not been covered?

9. Please describe three goals that you have for the Apex program in your service area for year 3.

You have now finished the survey. Thank you for your time and effort in completing this survey. If you have any questions or concerns, please contact Dimple Desai by email at ddesai@gsu.edu or by phone at 404-727-0346.

Appendix D: Parent Survey

Georgia Apex Program Parent/Guardian Survey

Organization Name: _____
School Name: _____
Number of Days that Student has been in Apex Services: _____

Please respond to the questions about your child and family since receiving School-Based Mental Health Services.

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
1. Overall I am satisfied with the services that my child has received.						
2. My child is better able to do things he or she wants to do.						
3. My child is better at handling daily life.						
4. My child gets along better with family members.						
5. My child gets along better with friends and other people.						
6. My child is doing better in school and/or work.						
7. My child is better able to cope when things go wrong.						
8. I am satisfied with our family life right now.						
9. My child's symptoms are not bothering him/her as much.						
10. My child is able to see the same behavioral health provider when school is not in session.						
11. I can spend more time at work since my child can receive behavioral health services while at school.						
12. I am more equipped to respond to my child's symptoms.						
13. I have improved in my ability to advocate for the needs of my child.						
14. I know how to access appropriate resources for my child.						

Please complete and mail back to:
Georgia Apex Evaluation Team
55 Park Place
8th Floor
Atlanta, GA 30303

Data Source	Number of Schools	Referenced in Report	Notes
Monthly Progress Reports	293	School Characteristics Additional Findings from Year 1 to Year 2	Duplicative reporting for 10 schools served by two providers at least one time throughout year 2; 283 individual schools reported
	283	Additional Findings from Year 1 to Year 2	Duplicative reporting for 10 schools served by two providers at least one time throughout year 2; 283 individual schools reported
	261	School Characteristics	32 schools without a monthly report since March 2017, partnerships not sustained through the end of the year
	241	School Characteristics	20 schools with either one report only in May or June 2017 (new partnerships) or between two and four reports with a recent report in April, May, or June (new partnership and/or developing relationship)
Year-End Survey	214	Figure 5: Schools with SBMH or PBIS Prior to Apex Participation, Year 2 Year-End Survey: School Partnerships Year-End Survey: Data Tracking and Sharing Year-End Survey: School Integration and Provider Presence	Total schools reported by fundees on year-end survey. Three of the schools reported on the year-end survey had two fundees serving in them, for a total of 211 individual schools.

Year-End Survey + Public Data	203	Figure 3. Type of School Served by Apex Program, Year 2 Figure 4: Type of School Served by the Apex Program by Enrollment, Year 2 Figure 6: Apex Year 2 Schools and Enrollment With Title I Status, Year 2 Figure 8: Geography of Apex Schools, Year 2 (1 missing value) School Characteristics	11 schools from the year-end survey do not have publicly available data
MHPET	132	Table 1. Overall Mean Survey Scores Table 2. Changes in Level Implementation of Partnership Attributes	Twenty-four fundees completed baseline MHPET surveys for 148 schools in September 2016. Follow-up MHPET surveys were completed for 210 schools in May 2017. Matched survey results were analyzed for 132 school partnerships.
MHPET + Public Data	117	Table 3: Mean Scores for Overall Survey by School-Level Attributes	Of the 132 schools that had completed both the baseline and follow-up MHPET surveys, 15 schools did not have DOE or GOSA publicly available data.