A large, close-up photograph of a young person's face, showing their eyes, nose, and mouth. The person has dark, curly hair and is looking directly at the camera with a neutral expression. The image is framed by a thick, wavy orange border at the top and bottom. The background of the image is dark, making the person's face the central focus.

**Supporting Children's
Mental Health in Georgia Schools:
How Three School-Based
Mental Health Providers
Serve Students**

June 2020



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FOREWORD

Never before has the need for access to mental health services been so great nor so apparent. The onset of the coronavirus pandemic brought with it not only situational circumstances lending themselves to mental health challenges, but also an amplification of mental health service obstacles that existed long before COVID-19 complicated our world. The combined impact of these factors makes the release of this report, *Supporting Children's Mental Health in Georgia Schools: How Three School-Based Mental Health Providers Serve Students*, and the release of Georgia Statewide Afterschool Network's *Behavioral Health Needs in Afterschool & Summer Programming: Equipping Programs to Support Georgia's Youth*, all the more appropriate.

For years prior to the pandemic, Georgia struggled to meet the mental health needs of children and youth. **Two in five children aged 3 to 17 have trouble accessing the mental health treatment and counseling they need.** Pediatric psychiatrists are, historically, in short supply. Schools have been the primary referral source to juvenile courts, yet years of attention paid to fulfilling a U.S. Department of Justice consent decree pertaining to services for adults with developmental disabilities and behavioral health challenges have somewhat impinged upon potential resource and policy development for youth. However, increasing instances of self-harm and suicide by Georgia's children over the last decade caught the attention of policymakers at all levels, and thus began a change in course.

This paradigm shift is ongoing and has been marked by deep exploration of root causes of child and adolescent

behaviors, as well as impressive political will to address an array of inadequacies and ineffective elements within child-serving environments. Recent policy developments across child-serving sectors convey a more widespread understanding of the roles that access to screening and treatment, technology, positive school climate, food and safety, as well as family and community play in a child's academic success.

In fact, government's desire to succeed in providing mental health services for children seems to be a recurring theme in the countless pandemic press conferences, soundbites, strategy discussions, and virtual meetings amongst state and local agencies, child-serving nonprofit organizations, and academic institutions. Heightened public appreciation for centrally located services raises up what many in the pediatric mental health space already knew: **mental health supports and services are essential**; they must be easily accessible; and **they must exist as part of the greater whole of healthy child development, in schools, at home, and in the community.**

As coronavirus mitigation continues, all but isolating children and families from in-school and out-of-school routines and services, all the while adding anxiety and confusion to what was once a more predictable and accessible world, this report offers both guidance for the future and hope. By gleaning information and perspective from these in-depth interviews in the context of Georgia's "new normal," we have the opportunity to design a mental health service delivery future that is sleeker, more efficient, and more effective. And as children and youth emerge from sheltering in place, we will need this roadmap more than ever.

SERVING GEORGIA'S CHILDREN DURING COVID-19

How Providers Pivoted

To adapt to a rapidly changing landscape, providers quickly shifted to telehealth through both phone and video calls, as well as expanding their scope to provide multidisciplinary services to communities, including:

- [Delivering services by bus](#), bringing treatment within walking distance of students' homes;
- Employing Certified Peer Specialists to create social media content with mental health support and resources; and
- Providing food to families in need.

How Georgia Responded

Following federal allowances, state agency leaders and policymakers took action to preserve and promote access to services and supports in our state through telehealth. Voices developed a [COVID-19 Response and Policy Recommendations Dashboard](#), which outlines what our child-serving agencies are doing to mitigate the challenges presented by the pandemic as well as lays out recommendations for actions not yet taken.

What Providers Need

In addition to the recommendations outlined in this report, providers recently identified support needed to successfully adapt to this new environment and continue serving families well:

- Streamlined processes to authorize short-term crisis-counseling services by health insurance companies;
- Flexible support from health insurers for telehealth services, such as longer time frames for approvals;
- Maintain the recent changes made to telehealth provision, policy, and practice beyond the public health emergency; and
- The state's adoption of streamlined Medicaid eligibility determination policy and practices to reduce the number of uninsured children. Georgia has approximately 220,000 uninsured children, most of whom are eligible for Medicaid or PeachCare - a reality that puts great strain on the financial sustainability of community providers.

ACKNOWLEDGEMENTS

Voices for Georgia's Children would like thank Dr. Nikia Scott for conducting the in-depth interviews with each school-based mental health provider. For generously sharing their time to make this research possible, we would like to say special thanks to the three school-based mental health providers interviewed for this report: Aspire Behavioral Health and Developmental Disabilities Services, CarePartners of Georgia, and View Point Health. And many thanks to the Georgia Department of Behavioral Health and Developmental Disabilities, Georgia State University's Center of Excellence for Children's Behavioral Health, and the Georgia Department of Education for their contributions to this report. Without each of you, this work would not have been possible.

Executive Summary

One in six children aged 2 to 8 years old, nationwide, has a diagnosed mental, behavioral, or developmental disorder. During the 2018-2019 school year, nearly **80,000** Georgia students in sixth through 12th grade reported having seriously considered attempting suicide. In Georgia, two in five children have trouble accessing the mental health treatment they need. It is evident that Georgia's students could benefit from mental health support where they can easily access it — at school. School-based mental health programs provide a continuum of behavioral health care to students and their families,¹ thereby mitigating transportation challenges, continuity-of-treatment issues, and, often, misbehavior within the school itself.

In 2015, Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) created the Georgia Apex Program (Apex), a school-based mental health pilot, to increase the availability of mental health services in Georgia's elementary and middle schools. While a few school-based mental health programs were present in Georgia prior to Apex, the successful implementation of the pilot created a pathway for the state to scale up programs in every region by providing grants to fund clinicians' school-based work. As of publication of this report, Apex has expanded to more than 430 schools in approximately 100 counties. As the state, philanthropy, and local districts continue to invest in such programs, understanding factors that contribute to a school-based mental health program's success, as well as the obstacles that providers face in delivering these critical services, can make such investments most effective and help children grow healthy and strong.

This report captures the findings of, and makes recommendations based on, in-depth interviews with three long-standing school-based mental health providers in different regions of Georgia, with varied funding sources.

Key Findings

Generally, school-based programs are staffed with licensed and associate-level clinicians, on-site from one to five days per week. Many practitioners serve multiple schools and are funded via a blend of insurance (primarily Medicaid/ PeachCare for Kids®) and private and government grants, the latter of which can be used to support nonbillable, comprehensive interventions to serve an entire school population. Leveraging insurance billing and flexible grant funding for program implementation and sustainability are key for success, as are school buy-in and provider flexibility.

Once a child is referred to a provider (most often by teachers and school counselors), clinicians obtain verbal consent from the student's parent or guardian prior to assessment or treatment. Parents and students are required to meet with the clinician in person for the initial assessment, where written consent is then obtained. All providers in this sample deliver three-tiered system supports, in addition to services after school and over the summer. Without exception, Tier 3 interventions (e.g., individual therapy) make up the majority of their workload, followed by Tier 2 interventions (e.g., group therapy), and then by Tier 1 (e.g., teacher trainings or schoolwide activities). Of interest is the effectiveness of such comprehensive school-based mental health, which results from increased opportunities to identify students' needs and intervening early, preventing or offsetting further decline or complications. Comprehensive programs also increase the chances that misdiagnoses are avoided, particularly for students who may initially appear to have a mental health disorder but are actually experiencing another challenge — such as family instability, lack of access to food, or vision or hearing trouble. Additionally, these providers conduct home visits, provide crisis support, and manage medication as part of their treatment. Telemedicine for treatment and medication management, as well as home delivery of medication, are employed by some as necessary to help the families they serve.

Despite far-reaching service provision and heavy caseloads, however, clinicians report that their greatest burden is paperwork — either requesting treatment authorization from insurers or completing documentation required for billing. Committed parental involvement can also be elusive, by virtue of competing family or work priorities, or simply a lack of transportation.

Barriers to success include some of the same challenges as non-school-based pediatric mental health care, namely:

- Workforce shortage, salary constraints, and clinician burnout
- Blurred roles in schools and extra demands on clinicians' time outside of service provision
- Lack of student transportation for afterschool and summer services
- Mental health stigma and generational barriers
- Limited parental involvement

Based on these findings, Voices for Georgia's Children offers the following select recommendations for different audiences in three key areas. A comprehensive list of all recommendations can be found on pp. 25-27.

Support School-Based Mental Health Program Success through Funding and Other Means:

- Extend telemedicine reimbursement provisions to support increasing access (including summer services) and family engagement. Providers need to be reimbursed to provide these services.
- Streamline Medicaid eligibility determination policy and practices to reduce the number of uninsured children. Georgia's high rate of uninsured children, most of whom are eligible for Medicaid or PeachCare, puts a great strain on the financial sustainability of community providers.
- Regularly publish outcomes, including clinical and educational measures, of state-funded school-based mental health programs.
- Build on the momentum of investment in school-based mental health by supporting comprehensive and integrated school-based health, such that students whose physical challenges are manifesting as behavioral problems can be properly diagnosed and treated.
- Leverage the Interagency Directors Team, System of Care State Plan, and other established channels to continue to strengthen coordination and collaboration between the Georgia Department of Education and DBHDD to increase comprehensive school-based mental health programs and reduce stigma.
- Ensure consistent reimbursement and tracking of school-based mental health services by Care Management Organizations.
- Continue to look for ways to reduce the administrative burden of insurance billing, such as by streamlining the authorization process, lengthening authorization periods, and making medical necessity determinations more transparent and consistent.
- Increase peer-to-peer opportunities for youth and families, e.g., integration of Sources of Strength, existing local chapters Federation of Families for Children's Mental Health into school-based mental health programs.

Explore incorporation of Certified Peer Specialist "Ys" and "Ps" (youth and parents), staffed at Community Service Boards, into school-based mental health programs.

Grow and Protect the Qualified Workforce:

- Explore reasonable alternatives to the state salary schedule such that state behavioral health professionals are competitive in their field.
- Ensure degree pathways for behavioral health professions in technical colleges, four-year colleges and universities, and graduate schools around the state.
- Leverage Apex to develop a pipeline of graduating school-based mental health professionals.
- Study the feasibility of mobilizing school counselors, school psychologists, and school social workers with clinical licensure to provide therapeutic services in schools.

Boost Partnerships with Schools:

- Providers and schools: Evaluate program success in partnership, and collaborate to develop valuable measures that address the interests of various stakeholders.
- Providers: Develop partnerships with schools to gain buy-in. Identify schools' needs, and consider facilitating school/community awareness activities for initial access to schools. Track and share outcomes data with schools to show the success of school-based mental health programs.
- Providers: Develop partnerships with afterschool or summer learning programs at the schools served by school-based mental health programs to broaden access to services and build on positive environments for students.
- Providers: Consider working with Regional Education Service Agencies, School Climate Specialists, and school Positive Behavioral Interventions and Supports (PBIS) coordinators.

Our research shows that there are distinct methods providers have found effective in establishing and operating a school-based mental health program successfully. Their insight and experience may prove useful for other providers and schools as they aim to create or expand programs. Such moves have potential to dramatically improve outcomes for Georgia's children, as school-based mental health programs increase school attendance, support a positive school climate, reduce escalation of disciplinary incidents, and provide support for families when they may not receive it elsewhere.

Introduction

Children, like adults, suffer from mental health disorders, and early diagnosis and treatment can dramatically improve their outcomes.² The timing of intervention is critical: one in six children aged 2 to 8 years old has a diagnosed mental, behavioral, or developmental disorder, and half of all serious mental illness cases start by age 14.³ In Georgia, nearly half of all middle and high school students reported feeling depressed, and nearly one-third reported experiencing intense anxiety within the last month.⁴

However, child and adolescent mental health needs often go unmet. More than 40 percent of children aged 3 to 17 have trouble accessing the mental health treatment and counseling they need. Barriers to access include a lack of health coverage, limited availability of services, transportation issues, stigma associated with mental illness, and a lack of available providers. Additionally, the state suffers a severe shortage of child and adolescent psychiatrists, with only 7.5 professionals per 100,000 children.⁵

Sadly, these unmet needs can have tragic consequences. Suicide is the second-leading cause of death for children aged 10 to 24 in Georgia.⁶ In 2019, more than 61,000 Georgia students in sixth through 12th grades reported harming themselves, nearly 40,000 reported attempting suicide, and nearly 78,000 reported having seriously considered attempting suicide.⁷ Almost 70 percent of youth in Department of Juvenile Justice long-term facilities have a mental health diagnosis severe enough to require ongoing treatment.⁸ While these statistics are startling and clearly demonstrate a need for intervention, these behavioral health concerns can stem from a variety of challenges that a child faces. In fact, among Georgia's students who have seriously considered attempting suicide within the last year, the most commonly cited reason was "family reasons."⁹ Therefore, it is critical that in order to improve the mental well-being of our children, the child-serving system must not only provide access to mental health services, but it must also work to identify — and where possible, address — contributing factors such as a lack of access to food, unstable housing, poverty, violence in the home or community, family instability, and other nondiagnosable challenges.

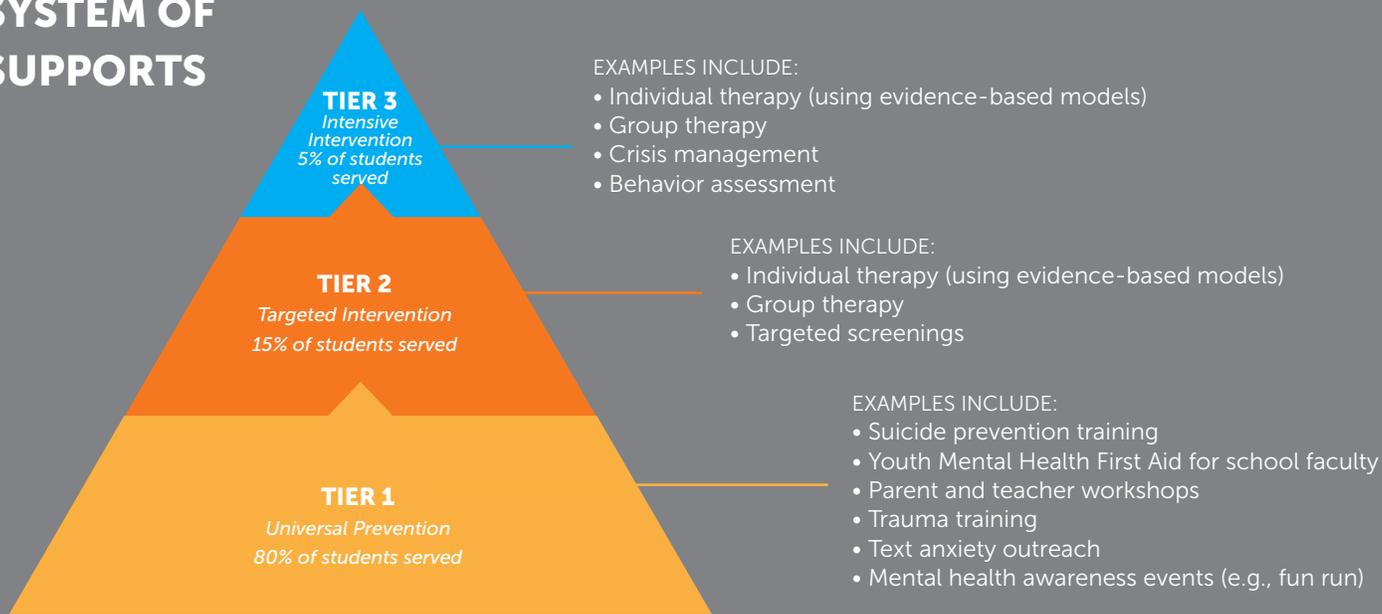


As the public institution that reaches most of Georgia's children, the education system is well-positioned to provide children with access to mental health services and supports. School-based mental health programs provide a continuum of behavioral health care to students and their families and are based in a school setting.¹⁰ Additionally, comprehensive school-based mental health (SBMH) provides a great benefit to schools in the form of improved school climate and academic performance, reduced need for special education, decreased disciplinary incidents, and higher rates of graduation.¹¹

MULTITIERED SYSTEM OF SUPPORTS

One of the most common frameworks that guide the provision of school-based mental health is the Multitiered System of Supports (see Figure 1). Each tier is described as follows, with service/support examples:

MULTITIERED SYSTEM OF SUPPORTS



TIER 1 UNIVERSAL PREVENTION

Services target the entire school population, for example, schoolwide programs that promote positive behavior and school climate such as mental health awareness events and teacher trainings. Typically, these interventions adequately serve or address the needs of about 80 percent of the school population.¹⁴ Tier 1 interventions/universal prevention activities play a critical role in overall program success and sustainability, and positively affect school climate by bringing mental health into the conversation with students and teachers. Providers of these services can be school counselors or teachers, or mental health providers or social workers.

TIER 2 TARGETED INTERVENTIONS

Services target a subset of students in a school who are at risk of developing mental health concerns. Examples of these services include social skills training or short-term counseling. Typically, only about 15 percent of the school population needs this level of support.¹⁵ Given the nature of the services and the at-risk clientele, providers of these services are school counselors, social workers, or mental health providers.

TIER 3 INTENSIVE INTERVENTIONS

Services target high-risk students and are highly individualized, for example, long-term counseling, group therapy, and personalized intervention plans. Typically, only about 5 percent of the school population needs this level of support.¹⁶ Providers of these services are behavioral health providers or social workers.

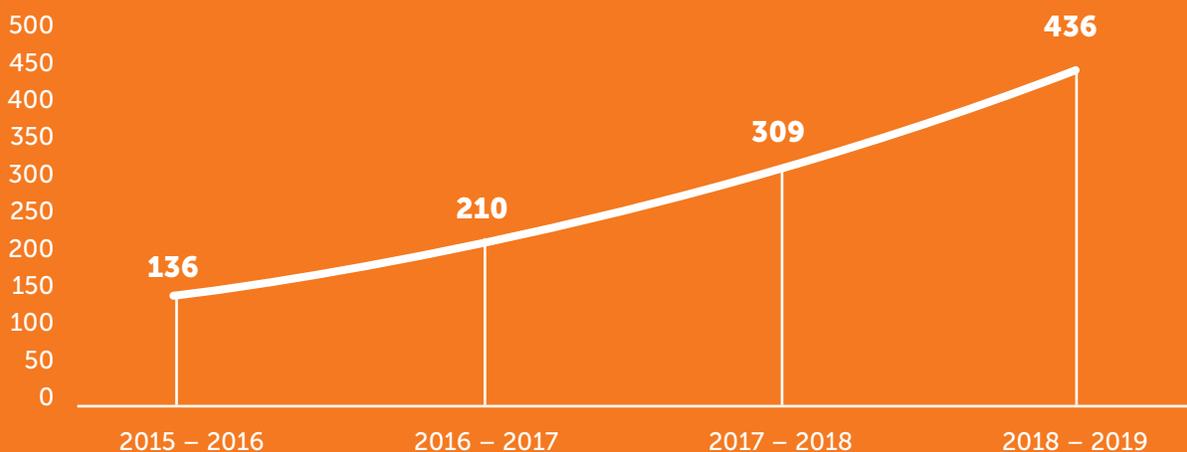
The state has significantly invested in increasing access to school-based mental health for Georgia’s children over the past five years. In 2015, Georgia’s Department of Behavioral Health and Developmental Disabilities (DBHDD) created the Georgia Apex Program (Apex), a pilot initiative designed to increase behavioral health services available in schools. A year later, DBHDD converted Apex to a program, and it has now expanded to more than 430 schools. Apex allowed Georgia to drastically scale up access to services across the state. In just four years, from 2015 to 2019, Apex funding recipients nearly tripled the number of schools served through school-based mental health programs. (See Figure 2 below.) In 2019, \$8.4 million in one-time funds were allocated in the Amended Fiscal Year 2019 state budget to expand Apex further. Apex creates partnerships between Community Service Boards (CSBs) and other community-based providers with local schools, and provides grants to fund behavioral health clinicians’ work in schools. This focus on clinical work means Apex prioritizes supporting students in Tier 3; however, providers are directed to support teachers and administrators through Tier 1 interventions, and to support students across all three tiers.

REPORT INTERVIEWEES

This report captures the results of in-depth interviews with three of the state’s leading school-based mental health providers: View Point Health (View Point), an Apex funding recipient and CSB located in Norcross; Aspire Behavioral Health and Developmental Disabilities Services (Aspire), an Apex funding recipient and CSB located in Albany; and CarePartners of Georgia (CarePartners), a private, non-Apex-funded provider located in Swainsboro. (Only three providers were interviewed – any reference to “the providers” refers only to these three organizations.) In Summer 2019, Voices began interviewing each agency’s school-based mental health clinicians and supervisors, as well as school administrators and counselors at one to two schools where each provider serves. The interviews were conducted at each provider’s main office as well as on-site at the schools. Additional interviews were conducted in Spring 2020. In addition to the information gathered in interviews, we reviewed organizational materials such as annual survey results and outcomes data, and captured information through school tours and provider presentations at local school-based mental health forums.

FIGURE 2

NO. OF SCHOOLS SERVED BY THE GEORGIA APEX PROGRAM



**View Point Health
Norcross, GA**

- Community Service Board
- Began SBMH in 2007
- Apex funding
- 22 schools/757 students served in 2018-2019 school year

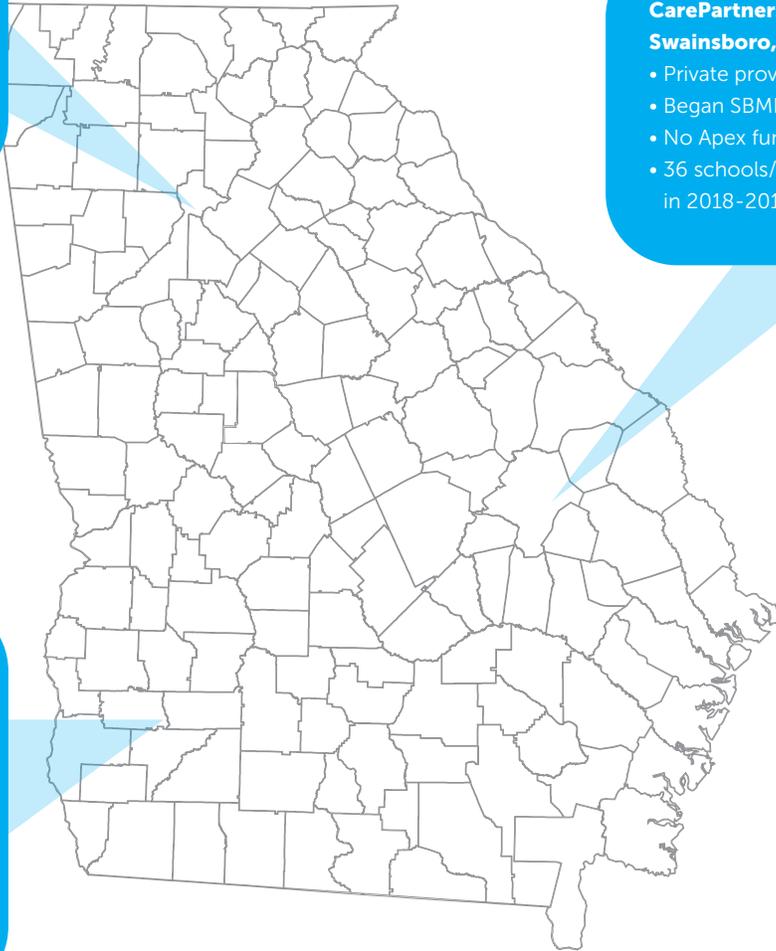
**CarePartners of Georgia
Swainsboro, GA**

- Private provider
- Began SBMH in 2003
- No Apex funding
- 36 schools/376 students served in 2018-2019 school year

**Aspire Behavioral Health and
Developmental Disabilities
Services**

Albany, GA

- Community Service Board
- Began SBMH in 2013
- Apex funding
- 57 schools
(20 Apex-supported)/614 students served 2018-2019 school year



The size of the agencies' school reach varies — from 22 to 57 schools, serving 376 to 757 students — as does the nature of their geographical regions — from rural to suburban. Between the three providers, they serve primary, elementary, middle, and high schools; alternative schools; and one public college.

The providers were selected for interviews because they are geographically diverse and established leaders in the field of school-based mental health. It is important to note that additional programs have demonstrated success and that these providers are a sample of established leaders in the

field. Given that the state has continued to invest in Apex, and the program has supported an unprecedented increase in access to school-based mental health services in Georgia, two CSBs that are a part of Apex were chosen for research. However, we also included CarePartners of Georgia, a private provider that is not a part of Apex (but is a part of the DBHDD core provider network), to better understand how an independent school-based mental health program operates.

Findings

School-based mental health providers shared detailed information about how they operate, what they need to provide high-quality behavioral health services, how service provision works, and what helps them succeed.

PROGRAM STRUCTURE

STAFFING AND SUPERVISION

Clinicians provide services at the schools anywhere from one day per week to full-time during the school year, and manage caseloads of approximately 90 students each. Only one clinician is assigned at each school, although that one clinician may split their time to serve more than one school in the course of a week. With total staff sizes — including clinicians and other staff — ranging from 20 to 30 people, the three providers experience overall turnover rates of roughly 15 percent to 30 percent. CarePartners has the lowest turnover rate (16 percent) of the three agencies. Of note, as a private provider, CarePartners is not bound to the state salary schedule. As quasi-governmental organizations, CSBs pay according to the state salary schedule; private providers are not required to follow the state salary schedule, and therefore have more flexibility in the salaries they can offer.

The providers offer associates the supervision required for licensure at no cost. This includes individual and group

supervision, both of which are conducted weekly for one hour each. All three agencies retain associate-level clinicians on staff after they become licensed, to the greatest extent possible. At Aspire, newly licensed clinicians are eligible to apply for the federal loan forgiveness program if they sign a two-year contract with the provider upon licensure. [See Appendix C for more on staffing, supervision, and the physical spaces used for service provision.](#)

PROGRAM EVALUATION

All three providers reported conducting program and outcome evaluation activities; however, each to a different extent. All three providers measure individual student outcomes using the Child and Adolescent Needs and Strengths (CANS) assessment tool, as well as progress against individualized treatment plan goals (e.g., goals related to grades, discipline, or absenteeism). Aspire and View Point participate in the statewide evaluation of Apex, conducted by the Center of Excellence for Children’s Behavioral Health (COE) in the Georgia Health Policy Center at Georgia State University. The COE captures monthly, quarterly, and annual data on a wide variety of metrics from all mental health agencies that participate in the Georgia Apex Program, and analyzes and reports programmatic and outcomes data, yearly, in aggregate for the entire state. CarePartners, which is not a part of Apex, conducts a more limited evaluation of its school-based mental health work without any outside support. It tracks number of schools and students served, as well as the number of services provided in each school. CarePartners also measures the overall success of their program through quarterly parent and school personnel satisfaction surveys, and yearly or biannual parent and school personnel focus groups. On an individual-patient level, like the other providers, CarePartners clinicians use typical clinical tools to measure student functioning: CANS before and during service provision (as well as before

TABLE 1. Select Staffing Metrics, by Agency

| | Aspire | CarePartners | View Point |
|--|--------|--------------|------------|
| Staff size | 30 | 20 | 21 |
| Ratio of associates to licensed clinicians | N/A | 2 to 3 | 1 to 2.1 |
| Turnover rate | 33% | 16% | 20% |
| Caseload | 90 | 90 | N/A |
| Waitlist for services | No | No | Yes |

PROVIDERS' FUNDING BREAKDOWN

FIGURE 3

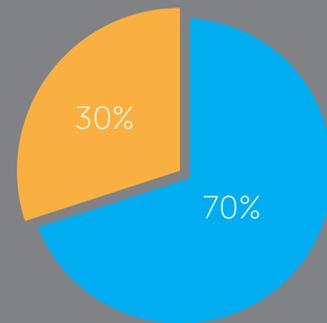
discharge), and student progress against case management plans. CarePartners reports that over the last 10 years, these surveys have shown yearly average satisfaction ratings over 90 percent for their school-based mental health services, including telemedicine. [See Appendix D for more on program evaluation.](#)

FUNDING AND BILLING

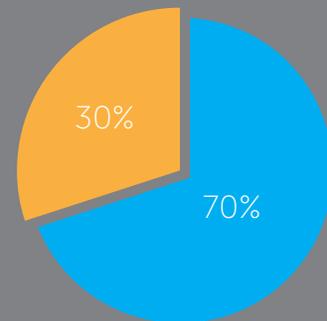
The providers use a mix of funding sources to support operations and multitiered supports. (See Figure 3.) All clinical services with an authorization from the insurance provider — for example, direct therapeutic or wraparound services like medication management — are billed to insurance, most often Medicaid. In order to obtain authorization from insurance providers, the provider must prove that the service is medically necessary. The easiest way to demonstrate this is through a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders-5, or a DSM-5 diagnosis. (Examples of DSM-5 diagnoses include autism spectrum disorder; attention deficit disorders; intellectual disabilities; major depressive disorder; generalized anxiety disorder; obsessive-compulsive disorder; and eating, learning, and sleeping disorders.)

Providers report difficulty billing school-based services to private insurance and that such services are routinely denied; typically, in their experience, services must take place in a clinic to be reimbursed. Billing to Medicaid also has its challenges. One provider reported that roughly 20 percent of the students they serve lose PeachCare eligibility over the course of the year, often as a result of the family not being able to pay their monthly premium. The provider reported that it can take three to five months to have benefits reinstated for these children. Providers also reported

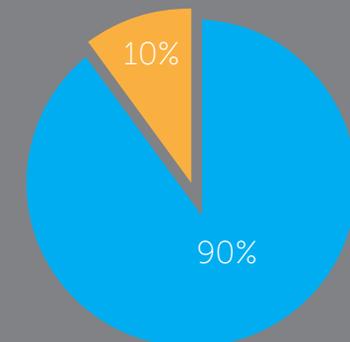
Aspire Funding Sources



View Point Funding Sources



CarePartners Funding Sources



■ Paid for by Insurance ■ Paid for by Grants

- At Aspire and View Point, 30 percent of clinicians' time is paid for by grants (Apex and others), which support staff time dedicated to nonbillable services, such as crisis calls for non-Apex-enrolled students, and operational costs, such as personnel, equipment, facility costs, and program evaluations.
- **CarePartners, which does not receive Apex funding, relies more heavily on insurance reimbursements (namely Medicaid) than the other providers do.** CarePartners receives a grant from Bulloch County Schools to serve students who do not have Medicaid, and sometimes schools pay for medication delivery and other wraparound services that are not billable to insurance.

*According to DBHDD, when a clinician can bill for **60%** of their services, their position becomes sustainable, and they can engage in other nonbillable services with the remainder of their time.*

BILLABLE TIER 1 ACTIVITIES

Some Tier 1 activities can be billed to insurance, such as:

- Development and monitoring of behavior plans
- Developing and monitoring classroom-management systems
- Coordinating care concerning symptoms and behaviors at home
- Development of anger management and conflict mediation skills in the classroom

that in recent years, some students on Medicaid through Supplemental Security Income (SSI) (which provides for children with a disability) have lost their benefits. In some cases, the family is told that the child no longer qualifies for the benefit, even though the provider reports that their diagnosis or diagnoses are for lifelong disorders (i.e., autism, bipolar). Such denials also result when a family does not complete their renewal paperwork on time or when the family claims not to have received a renewal notification (and thus did not submit the required paperwork). The providers report that denial of SSI benefits is usually permanent, unless the family seeks a legal appeal; still, the courts sometimes uphold the denial. In addition, providers report that a lack of similar prior authorization criteria across the Care Management Organizations — which administer Medicaid and PeachCare programs for children's coverage — makes obtaining authorizations challenging (e.g., a service may be more easily billable to one Care Management Organization but not to another).

While some Tier 1 and Tier 2 activities (e.g., school climate-related activities and mental health training for teachers) can be billed to insurance, most of these services will not be billable, and thus other sources of funding — such as grants — play a critical role in supporting their provision.

(When services are not billable to insurance it is because medical necessity according to insurers cannot be proven. This is often because the children being served do not have a mental health diagnosis.) However, as programs mature, providers often become savvier about identifying and billing for the billable Tier 1 and Tier 2 services.

Providers can receive grants through Apex; the school districts where the program works; private foundations; and federal sources, such as Title I, Title II, or Title IV funds, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, Individuals with Disabilities Education Act funding, and more. (See Figure 4.) School districts themselves are sometimes eager to work with the provider to find additional sources of funding that would expand school-based mental health at their schools. For many Tier 1 interventions, DBHDD (through Apex and the Office of Behavioral Health Prevention



initiatives), the Georgia Department of Education (GaDOE), and the Georgia Division of Family and Children Services offer financial and other support, such as:

- Statewide suicide-prevention trainings for school personnel through Regional Education Service Agencies
- Youth Mental Health First Aid, for adults who interact with youth
- Sources of Strength training, a suicide-prevention program for youth
- Cross-training for schools and juvenile courts on fostering a positive school climate
- Universal mental health screeners for students in certain school districts, funded through a federal grant

Billing Administration

There is a significant amount of accounting and administrative work needed to support school-based mental health. Provider agencies are responsible for submitting requests for insurance authorization for students' services. **Despite heavy caseloads, clinicians reported being more overwhelmed by the administrative procedures, like completing paperwork for insurance authorization requests and documentation needed for billing services, than they are by service provision.** Authorizations last only three months and take 15 or more minutes to complete. Clinicians at one of the providers complete insurance authorizations themselves, which takes away from time to provide services. [See Appendix E for more on billing administration.](#)

SERVICE PROVISION

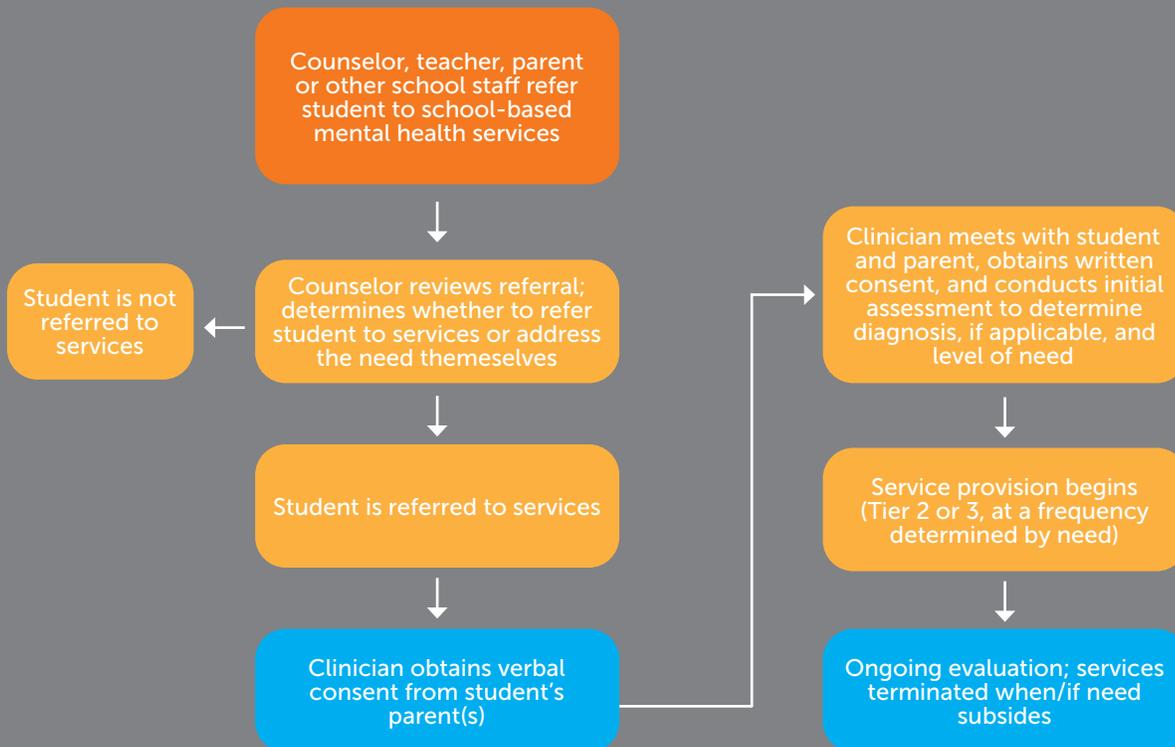
REFERRALS, PARENTAL CONSENT, AND ASSESSMENTS

Referrals are typically made by counselors, teachers, or other school staff based on observations of the child in the school environment. (See Figure 5 below.) Consistently, classroom disruption is reported as the leading cause of a referral, followed by academic performance and behavior in the larger school setting. The students who are unable to successfully manage their own behaviors or effectively interact with peers are among the first to be referred for services. Teachers often become overwhelmed by a child's externalizing behaviors (e.g., conduct) and look to school-based mental health services as a method to improve classroom behavior. This typically means asking the clinician for immediate assistance diffusing the crisis.

View Point described a system by which school personnel, parents, and students can refer a child for treatment by submitting a confidential form at the school's front office. The form, which notes the referral source (parent, teacher, etc.), asks the referral source to describe his or her observations and reason for the referral. Referrals are directed to the school counselor, who either assumes responsibility for addressing the need or determines it is appropriate for the clinician. Referrals are also made based on whether a student was previously diagnosed in a community-based service.

FIGURE 5

HOW STUDENTS ARE REFERRED TO SBMH SERVICES



MOST COMMON DIAGNOSES

(as reported by providers):

- Attention-Deficit Hyperactivity Disorder (ADHD)
- Anxiety
- Depression
- Adjustment Disorder
- Oppositional Defiant Disorder (ODD)

Once a child is referred to a provider, clinicians obtain verbal consent from the student's parent or guardian prior to assessment or treatment. Typically, obtaining verbal parental consent is not a burden and does not slow down service provision (though consistent parent involvement is sometimes a challenge, as discussed in the [Factors that Impact Program Success](#) section below). One agency did note that students are sometimes required to wait one month before receiving services and that this may be due to the delay caused by waiting for parental consent.

For the initial assessment, both parents and students are required to meet with the clinician in person, where written consent is obtained. The providers use evidence-based, structured diagnostic and behavior assessments that result in either a mental health or substance use disorder diagnosis (most likely requiring Tier 3 interventions), which includes all psychiatric diagnoses except intellectual disabilities and personality disorders, or the identification of a more general need, best addressed through the development of specific skills and behavioral strategies (i.e., Tier 2 interventions). Assessments are sometimes conducted by associate-level clinicians; in these instances, diagnoses are confirmed by a supervisor.

TREATMENT AND SUPPORTS

All providers interviewed provide multitiered system supports, including Tier 1, Tier 2, and Tier 3 services, in addition to services after school and over the summer (to varying degrees), and medication management. Very rarely, providers will refer students or families to outside providers, such as for in-home services. Aspire reports that such referrals account for less than 1 percent of all of their services; CarePartners states it makes up less than 5 percent of all services. This is sometimes the case when the student has a primary behavioral health provider outside of their school-based provider.

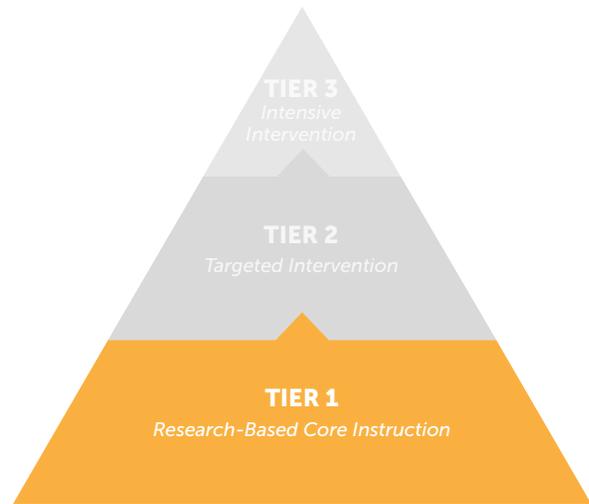
THE DATA

Referrals to services outside of the school setting or to another provider account for only

1% to 5%

of all services.

TIER ONE SERVICES



VALUE OF TIER 1 SERVICES

- School-based health clinicians can help parse out the root causes of a behavioral health challenge and whether it pertains to a mental health disorder. Behavioral concerns are not always manifestations of mental health conditions and can be instead related to vision impairment, learning disabilities, lack of food access, unstable housing, traumatic events, or a myriad of other challenges.
- Universal prevention services also help clinicians and school staff identify students who don't have obvious externalized behaviors but need greater levels of support. While disruptive behavior is the basis for the majority of referrals, for students with more internalized behaviors (e.g., social withdrawal), Tier 1 activities can increase communication around mental health and afford students who otherwise fly under the radar a space to discuss mental health.

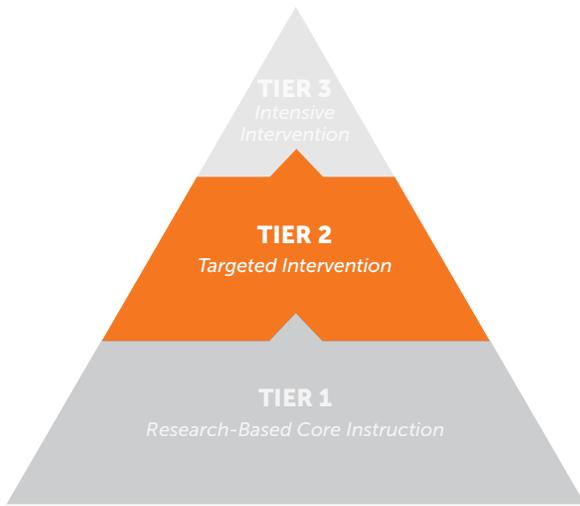
Tier 1 supports are provided to all of the schools that providers serve. Such services require collaboration with the school, and schools often cofacilitate these activities. Providers report that, generally, they make teacher trainings and schoolwide interventions available to schools and allow schools to decide whether or not to participate. Schools themselves sometimes host educational mental health-focused events (e.g., lunch and learns for school staff), and the providers offer support.

While Tier 1 services are critically important, high demands on teachers' time for state-mandated trainings and constraints on classroom time limit schools' availability for them. For example, Youth Mental Health First Aid training — an eight-hour training — is encouraged by DBHDD and offered by the providers, but the GaDOE requires teachers to participate in other mental health trainings (O.C.G.A. 20-2-1185). Because of this, teachers do not often choose to receive this additional in-depth training.

EXAMPLES

- Trainings for teachers, staff, and parents on:
 - Suicide prevention
 - Trauma
 - Youth Mental Health First Aid
 - Mental health classroom guidance lessons
- Tailored parent and teacher workshops
- Classroom observation
- Test anxiety outreach
- Mental health awareness events (e.g., health fairs, fun runs)

TIER TWO SERVICES



EXAMPLES

The Breakfast Club is a weekly one-hour morning group session held by View Point for a small group of kindergarten students where they rotate through stations that help develop communication and self-regulation skills.

Peer Mediation is a group developed by View Point that meets weekly and uses positive behavioral interventions.

Social Skills is another group held by View Point that meets twice weekly for an hour.

Tier 2 services are for at-risk students without a DSM-5 diagnosis. These make up a smaller portion of providers' service provision than Tier 3 services, as they are rarely billable to insurance. Tier 2 services include individual therapy, group therapy, and targeted screenings.

- At Aspire, early intervention services for at-risk or targeted students are offered to Apex-enrolled and nonenrolled students alike during the school year; consent is obtained in either case. (Students who are enrolled in Apex are those whose parents have both given consent and met with the clinician at school.) During the summer, these services are offered only to students who receive Apex services. [See Appendix F for more on summer services.](#)
- At CarePartners, individual therapy for at-risk students is provided at all of the schools they serve. Group therapy is conducted at 60 percent of schools, and targeted screenings are conducted at 73 percent of schools. CarePartners reported that group therapy sessions are hard to hold successfully in many of their schools due to stigma around mental health; in these cases, even if a student lacks a mental health diagnosis, individual sessions are held instead.
- At View Point, Tier 2 interventions make up nearly 30 percent of their service provision.

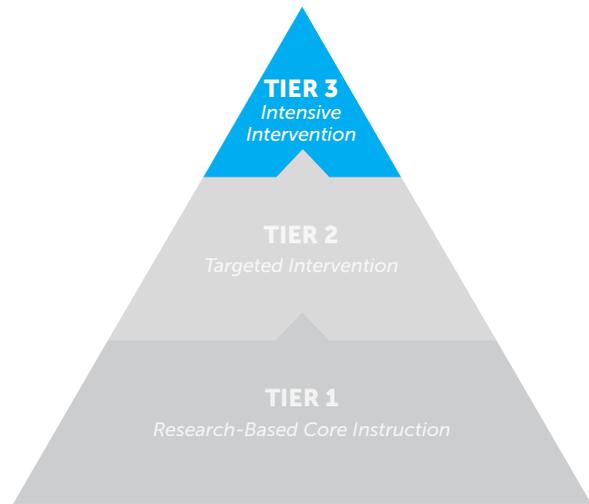
TIER THREE SERVICES

Tier 3 services, which are individualized, are provided to students with a DSM-5 diagnosis and are largely billable to insurance. These services include evidence-based interventions such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Solution-Focused Therapy, as well as play therapy, mindfulness, and art expression. Group therapy, crisis management, and behavior assessments are also considered Tier 3. Tier 3 interventions make up the bulk of the providers' work. This is particularly true at View Point, where Tier 2 and 3 services make up almost 100 percent of their work (nearly 70 percent is Tier 3, and Tier 1 services are rarely conducted).

- At Aspire, intensive intervention services include school-based mental health services, school- and community-based crisis protocol, and the Camp Apex summer program. Aspire uses a staff of Community Support Individuals to provide support to students who receive Tier 3 services if they have significant behavioral challenges and need support between biweekly individual sessions.
- At CarePartners, individual therapy, behavior assessments, and crisis management are conducted at all of the schools they serve.
- At View Point, intensive intervention services consist of individual therapy sessions for students with a diagnosis.

Tier 3 interventions are provided on a weekly, biweekly, or monthly basis, depending on the student's need and availability, as well as the availability of the clinician. Some students are seen as often as twice a week during particularly challenging periods.

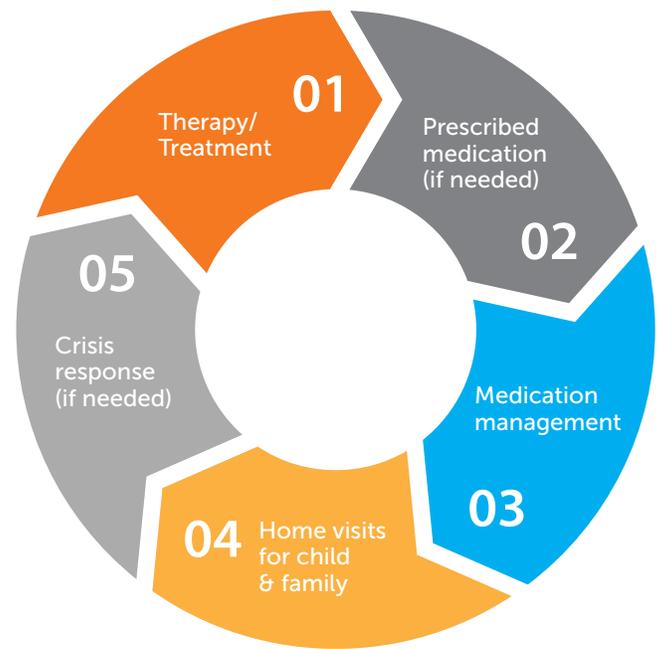
Like the frequency, the duration of services also depends on the student's need. View Point aims for treatment to "max out" at one semester, while at Aspire, many individual cases last the entire year. Aspire offers intensive intervention services to students and families year-round at participating Apex schools. When students are promoted from one school to another, like from elementary to middle, they will often be transferred to a clinician assigned to the new school.



The school setting does pose a unique issue. Because the clinician is located within the school, there is often an association between the academic calendar and the treatment timeline. The teacher, student, and student's family can come to expect that the student will receive treatment for the duration of the school year. However, treatment depends on the student's need and may not be needed for that length of time. When clinicians do attempt to terminate services with a student mid-school year, they are often quickly contacted by teachers and/or parents stating that the student has returned to their previous degree of functioning and again needs services. Continuing to strengthen school and provider partnerships and communication will help manage expectations and address this challenge.

EXAMPLES

- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy
- Solution-Focused Therapy
 - Group therapy
 - Crisis management
- Behavior assessments
 - Play therapy
 - Mindfulness
 - Art expression



Wraparound Services

Wraparound services help to ensure that students are able to access mental health services despite practical or logistical obstacles, providing impactful support for students and their families. All three providers deliver some combination of wraparound services that include medication management and afterschool and summer services. Lacking access to transportation sometimes poses a barrier to students' accessing afterschool and summer services, in which providers noted a drop in enrollment. [See the **Factors that Impact Program Success** section on page 19.](#)

Aspire and CarePartners offer home visiting, which is designed to give families the support they need to improve well-being. Home visits can include skills training, promotion of positive parenting practices, and education on child development, among other activities.

Aspire and CarePartners also provide crisis management services. View Point partners with the school districts they serve on crisis management, as the schools have strong protocols. CarePartners' 24/7 mobile crisis team has diffused approximately 90 percent of student crises; only 10 percent of students have needed hospitalization. CarePartners attributes its growth in part to its strong wraparound services like year-round medication management, medication home delivery, home visiting, and their 24/7 crisis-response team. [See more on wraparound services in **Appendix E**.](#)

Home visits include skill-building on topics like:

- Bedtime routines
- Eating habits
- Anger management
- Communication skills
- Mood tracking
- Resumé building (for parents)
- Employability (for parents)

TABLE 2. Wraparound Services Offered, by Agency

| | Aspire | CarePartners | View Point |
|-----------------------|--------|--------------|------------|
| Medication management | Yes | Yes | Yes |
| Telemedicine | Yes | Yes | Yes* |
| Home visiting | Yes | Yes | No |
| Crisis management | Yes | Yes | No |
| Afterschool services | Yes | Yes | Yes |
| Summer services | Yes | Yes | Yes |

*Prior to COVID-19, View Point did not provide telemedicine, but the provider began widely implementing telemedicine in Spring 2020.

7 FACTORS THAT IMPACT PROGRAM SUCCESS

BOOST SUCCESS

- Leveraging insurance billing and flexible grant funding
- School buy-in and provider flexibility to achieve it

HINDER SUCCESS

- Workforce shortage, salary, and burnout
- Blurred roles in the school and extra demands on clinicians' time
- Lacking student transportation (for afterschool/summer services)
- Stigma around mental health
- Limited parental involvement

THE DATA

86% of children who receive billable services from Apex clinicians are insured through Medicaid/PeachCare.

FACTORS THAT IMPACT PROGRAM SUCCESS

All three providers have expanded significantly in the past five years, serving five times as many schools than they did previously, on average. They all identified similar factors that impact program success, the most significant being the small size of Georgia's qualified behavioral health workforce who are interested in this difficult — though rewarding — work. Their hard-working, committed, and loyal staff have been central to their success.

The top seven factors that impact program success are as follows:

BOOST SUCCESS

Leveraging Insurance Billing and Flexible Grant Funding

A mix of funding sources is critical to school-based mental health program success. In thinking about the Multitiered System of Supports, students with the highest needs are served through Tier 3 interventions, which are clinical and require a student to have a diagnosis and are therefore generally reimbursed by insurance. However, Tier 1 and Tier 2 interventions, which are more preventive and do not require a medical diagnosis, are largely not reimbursable by insurance. While insurance provides a stable funding stream for high-needs insured children, other funding sources allow providers the flexibility to serve students who don't fall into this category: uninsured students, students whose insurance has lapsed or whose insurance doesn't cover the particular therapy, or students who do not have a diagnosable disorder but are nevertheless experiencing a true need for mental health services (e.g., students that have experienced death in the family, trauma, divorce, etc.). **When all three tiers are adequately provided, student needs can often be met before their needs become serious or life-threatening or the students develop a diagnosable disorder.**

Providers expressed that the flexibility of grant funding — which can come from state agencies, counties, or schools themselves — has allowed for more comprehensive service provision in all three tiers. Grant funding allows providers to serve students for whom they believe services are necessary, but which are not deemed "medically necessary" by insurers. It also allows programs to conduct schoolwide mental health events, train teachers on how to better

respond to students' needs in the classroom, and spend time building the relationships at schools necessary for effective service provision. All of this can help to meet the need of a student before it worsens and to contribute to a positive school climate. [See the **Recommendations** section on pp. 25 for tips for leveraging insurance billing and flexible grant funding.](#)

School Buy-In and Provider Flexibility to Achieve It

Consistently the providers emphasized the importance of school support to their success. Willingness on the part of the school — superintendents, principals, teachers, school counselors, and others — to allow the provider to come into the school, participate in school activities, and provide services to students is critical for many reasons, perhaps most importantly, referring students to the program. [See the **Recommendations** section on pp. 27 for tips for gaining and maintaining school support.](#)

Ample time and flexibility — and funding to support the clinicians' time — at schools is needed to build trust with teachers, counselors, and administrators to gain the support needed for service provision. CarePartners stated that their willingness to take on difficult cases and populations has led to the provider's growth. View Point stated that funding for a year of rapport building — during which clinicians would focus on providing many Tier 1 and Tier 2 services — would help them expand to additional schools.

Principals play a major role in school support. At View Point, word-of-mouth among principals led to their program's expansion to additional schools. At one school site, the success of View Point's program is directly linked to the clinician's positive relationship with the principal. This clinician was invited to participate in staff meetings and hiring procedures. In doing so, the clinician is regarded as part of the school's administration team, rather than an outsider providing services. Such relationships encourage program expansion. View Point reported that to expand Tier 1 services, they would specifically need greater principal support due to the level of collaboration with schools required for those activities.

Inversely, a lack of school support was described as the primary challenge to program growth at View Point. The provider reports there is the belief that academic achievement will diminish due to loss of instruction time

if students are enrolled in behavioral health services. View Point reports it has also had to address concerns about clinicians overstepping boundaries with school staff and ensuring that they feel supported. While Aspire does not have trouble gaining support within elementary and middle schools, they do struggle inside high schools, where both teachers and parents/caregivers believe graduation is the top priority and behavioral health needs fall to the wayside.

HINDER SUCCESS

Workforce Shortage, Salary, and Burnout

Providers identified the limited number of qualified workforce members who will accept the offered salary as a significant barrier. Georgia suffers from a shortage of behavioral health professionals, particularly in more rural areas of the state, where Aspire and CarePartners serve schools.¹⁵ CSBs are required to follow a state salary schedule. Private providers are not required to follow the state salary schedule, and therefore have more flexibility in the salaries they can offer. Further, the clinician roles demand fast-paced work and heavy caseloads, and clinicians often experience secondary trauma from treating students with severe trauma. Providers report that given the high caseloads, modest pay, and seriousness of the issues their clients face, it is easy for clinicians to feel burned out from school-based mental health provision. [See the **Recommendations** section on pp. 26 for tips for growing and protecting the workforce.](#)

Aspire experiences a turnover rate of approximately 33 percent. Staff there described a pattern of losing clinicians to jobs at schools where they serve, which offer higher pay without any additional credential requirement. CarePartners reported trouble retaining recent college graduates of mental health professions in rural Middle Georgia. Students who study in the region often don't choose to stay and work there after graduating. This poses a problem for the workforce pipeline in this area.

Blurred Roles in Schools and Extra Demands on Clinicians' Time

Clinicians are sometimes asked to participate in school activities and assume responsibilities outside of service provision (e.g., a therapy session), while they are also expected to be available for immediate response and support when a student needs it. This poses a challenge to service provision, especially when a clinician is only at the school for a short period each week or is managing a particularly

heavy caseload. While it is not the case in all schools, **some schools want an additional school counselor, but one who has clinical therapy knowledge and expertise and crisis-management capabilities. In these cases, teachers will send a student to the clinician’s office during a disruption or need, as they would use a school counselor’s office.** But in the current structure of school-based mental health programs, clinicians’ time at the schools is mostly scheduled with therapy sessions, and thus they are not available for this kind of real-time support.

These blurred roles result in programs billing fewer services – not because services are not in high demand, but because their time available for providing services that are “billable” is reduced as a result of extra demands. Billable time is important for program sustainability. Additionally, it leaves programs with weaker evidence to show that they need more time for service provision at these schools, despite persistent need.

Tensions can often be avoided, however, by developing a formal agreement between the school and the provider outlining responsibilities of the clinician. Other ways to address this include ensuring consistent communications between teachers and clinicians, hosting “lunch and learn” events at the school to discuss school needs and clinician roles, including a clear definition of the clinician’s role in the school in initial or recurring presentations to the school, or obtaining additional funding (perhaps from the school) to allow the clinician to have more time at the school.

Lacking Student Transportation (for Afterschool/Summer Services)

Transportation and distance to services pose a challenge for students to continue to participate in services offered over the summer, and for parents to complete intakes and initial visits. The majority of rural communities have no public transportation system, and Medicaid Non-Emergency Medical Transportation (NEMT) is not accessible enough to be reliably helpful to students during the summer. Providers reported that NEMT requires 72 hours of prior notice for most services to be scheduled, which conflicts with the acute nature of many mental health needs. In addition, it was reported that some transportation carriers require parents to accompany children, which can prove challenging for working parents.

Aspire serves many rural areas lacking transportation, which keeps kids from accessing the services they need. The provider reports that this accounts for a **30 percent to 40 percent drop in enrollment in summer services.** Aspire plans to contract with school transportation departments for their summer program in the future. Previously, CarePartners provided transportation for students and was able to bill this service to Medicaid where applicable. However, transportation must now be arranged through the school or a Medicaid NEMT provider. Clinicians at View Point will sometimes drive a student and their parent to the outpatient clinic for a psychiatrist appointment, if needed.

Even during the school year, two of the three providers (Aspire and CarePartners) find that lacking transportation is a hindrance to parental involvement and students’ access to afterschool services. Many families lack reliable transportation or the ability to drive. In some cases, multiple generations of a family have never driven and therefore are significantly limited in their family’s access to care. In rural areas, poorly developed roads pose another barrier. Families that live on dirt roads can find that roads are impassable following heavy rains. This can lead to extended school absences for all students within the home. If there is an extensive washout of the road that affects a number of families, a school may close until buses are able to resume pickups.

Even when services are successfully delivered in school, access to medication remains a barrier for many students. Some families live up to 15 miles from the nearest pharmacy and lack the transportation to get there. To mitigate this barrier, CarePartners delivers medication to many of the students they treat.

Stigma and Generational Barriers

Involving parents in the development and maintenance of the behavioral health treatment plan for their child is a critical aspect of effective treatment. Unfortunately, providers report that parents and caregivers sometimes perceive behavioral health professionals as judgmental or condescending, and thus can find it difficult to connect with the information being provided. In some areas, providers find generational illiteracy barriers that exacerbate general skepticism toward clinical services, in part due to processes and paperwork that are daunting and unfamiliar. In some rural areas, clinicians can meet resistance if they are not from the immediate area. In these cases, rapport-building

is critical, and they find it easier to provide services after the school counselor builds a relationship with the student (and student’s family).

Agencies also report that some parents are fearful of clinicians — specifically that they may involve Child Protective Services — and therefore parents refuse to engage. Families may not seek help due to the stigma around speaking to strangers about personal concerns (or their children’s personal concerns). Parents/caregivers may want clinicians to focus solely on the child and not on the parents/caregivers, even in cases where the parents should be involved. Overall, providers find deeper levels of stigma in rural areas than in urban ones, despite the generations of mental health care needs that can exist within a family. When these mental illnesses are left untreated, the family system becomes less of a support for the child.¹⁶

Generational poverty also limits the caregivers’ ability to direct attention and resources toward the child’s behavioral health treatment plan. Many of Georgia’s rural counties have historically been isolated from job opportunities and economic growth. Additionally, opportunities for upward mobility are limited. Clinicians sometimes find that parents must prioritize basic needs of food and shelter over mental health treatment. One agency reported that in some cases, families may “double up” within a home as an alternative to homelessness, a scenario that can add additional challenges to the environment for the child and increase the risk of abuse and neglect, as well as decrease access to parental support.

Investing time in building trust and sharing perspectives has proven an effective way to reduce stigma around mental health services. Aspire has found that mental health awareness events open to the community have reduced mental health stigma among parents and educators. These events include community trainings and community education events, such as an art festival and recovery project art show, a media campaign about their work, mental health-focused classroom guidance, and mental health awareness week involving school and community partners.

Limited Parental Involvement

While much of the service provision takes place without a parent present, nevertheless parents are a critical component of a child’s behavioral health care. A child’s family is typically his or her primary source of support, and families have the ability to contribute significantly to the child’s treatment by monitoring the child at home and communicating progress or challenges to the clinician. Together, families and clinicians can provide children with multiple levels of support to aid their recovery.

All agencies report challenges in involving parents in school-based mental health services. This is often due to a variety of factors. Parents cannot attend meetings because they are working long hours to afford the fundamental needs of their children (e.g., housing, food, health care). Additionally, lacking access to transportation, as discussed above, is another barrier to parents’ involvement.

Aspire expects to meet with parents of students who receive Tier 3 interventions monthly to ensure they are actively included in the child’s treatment plan. Separate sessions are often conducted with parents via a telemedicine session.



Discussion and Recommendations

Our in-depth interviews provide valuable insight into the factors that support and hinder the success of school-based mental health programs.

The findings support the idea that Multitiered Systems of Support work best when all of the three tiers' supports are engaged in serving the student population. Comprehensive school-based mental health enables the system to provide services to students with targeted, high-needs, as well as lower-level needs before the needs are exacerbated. Tier 1 interventions play a critical role in overall program success and sustainability, as they benefit all students and the school and help establish a positive school climate. And when schools have a positive school climate, school-based mental health services and other interventions are more likely to be effective. The information shared with teachers and other school staff, for instance through trainings on mental health or trauma, empowers those trainees to be additional facilitators of universal prevention activities, as well as gives them the ability to identify students with more internalized behaviors and connect them to support. School-based mental health care can also help to parse out behavioral concerns from others, like in cases where a child seems to have a behavioral disorder but it is actually a manifestation of another challenge — such as hunger, vision impairment, or another challenge that does not



require a mental health diagnosis. Misdiagnosing children with mental health diagnoses will not solve their behavioral health concerns.

The ability to braid and blend funding — leveraging insurance billing where possible, and integrating grant and school funding to support nonbillable activities — is critical to a program's overall success. If providers are providing supports in each tier, it likely means they are relying on funding from grants (Apex or others), schools, or the community for much of their Tier 1 and Tier 2 service provision, and on billing insurance for Tier 3 interventions (and possibly others). But the administrative capacity required for billing can be quite burdensome to programs and detract from time spent caring for students. Clinicians must request authorizations quarterly. Each authorization takes at least 15 minutes to complete. With an average caseload of 90 students, this is a major task. To the extent that providers can build their capacity to efficiently bill for services, this would benefit the program's sustainability. Efforts by insurers and managed care to streamline the billing process — and make medical necessity determinations more transparent and consistent — could greatly benefit school-based mental health program efficiency.

School-based mental health programs rely on qualified, highly motivated clinicians to manage a heavy caseload and serve students with severe or complicated challenges. The difficulty of this work requires a skilled professional who is committed to serving children despite myriad hurdles to

THE DATA



15 How many minutes it takes to complete each authorization



90 Average caseload of students

navigate — from finding a space to conduct therapy, to gaining the support of school personnel newly exposed to school-based services, to engaging a family who may not be well-versed in mental health, to conducting home visits or responding to crises after hours. Clinicians report encountering serious concerns, such as suicide ideation and deep trauma. It's no surprise, then, that clinicians experience burnout, including from secondary trauma that they face from the traumas in students' lives. In addition to the demanding work, school-based mental health programs typically offer lower salaries than alternative options in the field for qualified professionals. Private behavioral health providers are not required to follow the state salary schedule and therefore have more flexibility in the salaries they can offer. Providers need to make every effort to support clinicians how they can, given financial constraints on compensation. Given that two out of five children in Georgia have trouble accessing the mental health treatment they need, it is imperative that we support the workforce we have, seek ways to strengthen the workforce pipeline to grow the workforce, and think creatively about how we can engage additional staff (including school counselors, school psychologists, and school social workers) in providing mental health support for our state's children.

All providers agree that support from and integration into schools is essential, both for service provision and growing the program. School-based mental health provision requires a partnership with school staff at multiple levels: with the principal, to start and maintain a program, and enjoy meaningful access to teachers and students; with the teachers, who have the most time with students to make observations related to their well-being, and who may make referrals directly to the provider or to the counselor (who then may decide to refer the student to the provider); and with the counselors, who must trust the provider enough to make referrals where appropriate. When we imagine all of the ways a child interacts with the school system — from climbing onto the bus first thing in the morning, to a mid-day meal in the cafeteria, to outdoor play in the afternoon — it is clear that there are countless opportunities for any school staff member to observe a child's behavior and refer them to receive support. Clinicians' integration into the school ultimately helps children to get their needs met. Clinicians describe doing this by becoming familiar with the roles and responsibilities of various staff and faculty in the school,

THE DATA



2 out of 5 children in Georgia have trouble accessing the mental health treatment and counseling they need.

school language or jargon, and the students themselves. This requires time, funding to cover this nonbillable time, visibility, and a willingness to be creative in their service provision and participate in activities that may fall outside of traditionally clinical obligations. When successful, the clinician is a well-leveraged resource within the school community, serving students' needs (and potentially reducing disciplinary actions), alleviating teachers' burdens, and supporting a positive school climate.

In summary, **school-based mental health programs work best when they include Tier 1, 2, and 3 services to provide comprehensive support; are supported by a mix of funding sources, giving them flexibility to more nimbly address behavioral health challenges on a case-by-case basis; when they are staffed with a well-supported and qualified workforce; and when they enjoy supportive and collaborative partnerships with the schools in which they work.** Below we outline recommendations that would make these factors for success more widely accessible to school-based mental health programs throughout Georgia.

1. Support School-Based Mental Health Program Success through Funding and Other Means

State leadership and agencies:

- Extend telemedicine reimbursement provisions to support increasing access (including summer services) and family engagement. Providers need to be reimbursed to provide these services (as we recommend in the next section).
- Streamline Medicaid eligibility determination policy and practices to reduce the number of uninsured children. Georgia’s high rate of uninsured children, most of whom are eligible for Medicaid or PeachCare, puts a great strain on the financial sustainability of community providers.
- Regularly publish outcomes, including clinical and educational measures, of state-funded school-based mental health programs.
- Leverage the Interagency Directors Team, System of Care State Plan, and other established channels to continue to strengthen coordination and collaboration between the Georgia Department of Education and DBHDD to increase comprehensive school-based mental health programs and reduce stigma.
- Build on the momentum of investment in school-based mental health by supporting comprehensive and integrated school-based health, such that students whose physical challenges are manifesting as behavioral problems can be properly treated (and not misdiagnosed).
- Ensure consistent reimbursement and tracking of school-based mental health services by Care Management Organizations.

Providers and schools:

- Increase peer-to-peer opportunities for youth and families, e.g., integration of Sources of Strength, existing local chapters Federation of Families for Children’s Mental Health into school-based mental health programs. Explore incorporation of Certified Peer Specialist “Ys” and “Ps” (youth and parents), staffed at CSBs, into school-based mental health programs.
- Work together to submit community plans to draw down federal funding (e.g., Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, or Individuals with Disabilities Education Act funding). Leverage district and school-level funds (including PTA and foundation-raised funds) to support program costs.
- Include providers in school staff meetings and other administrative and support conversations.
- Consider investing in billing infrastructure to make better use of staff time (e.g., purchase billing software that automatically bills once necessary documentation is completed, outsource billing to an external vendor, hire in-house accounting staff, etc.).
- Consider continuing to leverage telehealth and other Health Insurance Portability and Accountability Act-compliant communication capacities to enhance access to services and improve service retention and continuity.

Medicaid managed care and insurers:

- Continue to look for ways to reduce the administrative burden, such as by streamlining the insurance authorization process and lengthening authorization periods. Consider making medical necessity determinations more transparent and consistent.
- Invest in school-based mental health programs as a way to manage children with high-needs/high-utilization, and prevent costly crisis and inpatient care.

2. Grow and Protect the Qualified Workforce

State leadership and agencies:

- Explore reasonable alternatives to the state salary schedule such that state behavioral health professionals are competitive in their field.
- Ensure there are degree pathways for behavioral health professions in technical colleges, four-year colleges and universities, and graduate schools around the state.
- Leverage Apex to develop a pipeline of graduating school-based mental health professionals.
- Study the feasibility of mobilizing school counselors, school psychologists, and school social workers with clinical licensure to provide therapeutic services in schools as part of school-based mental health.

Providers:

- Provide regular support specifically for clinicians to ease the burden and prevent burnout among providers (e.g., weekly appreciation activities, team-building, lunch and learns, workshops, secondary trauma training, and training for staff on how to best work in the school environment).
- Promote no- or low-cost, high-quality clinical supervision toward licensure.
- Offer incentives for credentialing. Promote federal loan forgiveness when the clinician becomes fully licensed, as an incentive.
- Maintain close relationships with local colleges for internships to foster the workforce pipeline.

Higher education institutions, including graduate schools:

- Incorporate certification and training opportunities on trauma-informed interventions.
- Incorporate training on completing necessary documentation for billing to Medicaid and other insurance providers.
- Technical College System of Georgia: Create a Registered Behavioral Technician program to strengthen the workforce pipeline and partner with schools to support increased training of existing classroom-based paraprofessionals.
- Partner with Apex providers to strengthen the workforce pipeline by offering high-quality supervision to graduate and postgraduate students for licensure. (For example, graduate school practicum placements can lead to postgraduate supervised positions.)

3. Boost Partnerships with Schools

Providers and schools:

- Providers and schools: Evaluate program success in partnership, and collaborate to develop valuable measures that address the interests of various stakeholders.
- Providers: Develop partnerships with schools to gain buy-in. Identify schools' needs, and consider facilitating school/community awareness activities for initial access to schools. Track and share outcomes data with schools to show the success of school-based mental health programs.
- Providers: Develop partnerships with afterschool or summer learning programs at the schools served by school-based mental health programs to broaden access to services and build on positive environments for students.
- Providers: Consider working with Regional Education Service Agencies, School Climate Specialists, and school Positive Behavioral Interventions and Supports (PBIS) coordinators.
- Bridge communication and knowledge gaps by holding regular meetings with providers, teachers, and staff and by providers regularly attending public school board meetings.
- Providers and school administrators: Meet biannually to evaluate service delivery through discussion and a stakeholder survey. This approach builds relationships and ensures that schools' expectations are being met or exceeded.

Conclusion

In Georgia, many children struggle to have their behavioral health needs met. Luckily, the state's investment in school-based mental health is working to address that problem head-on. At a time when suicide among youth is increasing and school safety is a major public concern, school-based mental health programs play a critically important role. Early diagnosis and treatment for a mental health diagnosis can dramatically improve outcomes in children's lives, and increased mental health awareness positively affects school climate. School-based programs,

if implemented well, can change the trajectory of children's lives in ways that not only benefit a child and their family's lives over the long term but that affect all of us, from reducing the burden on costly judicial and prison systems — systems that, too often, serve as a last resort for adults with mental illness — to educational and employment gains that benefit our economy.

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Appendix A

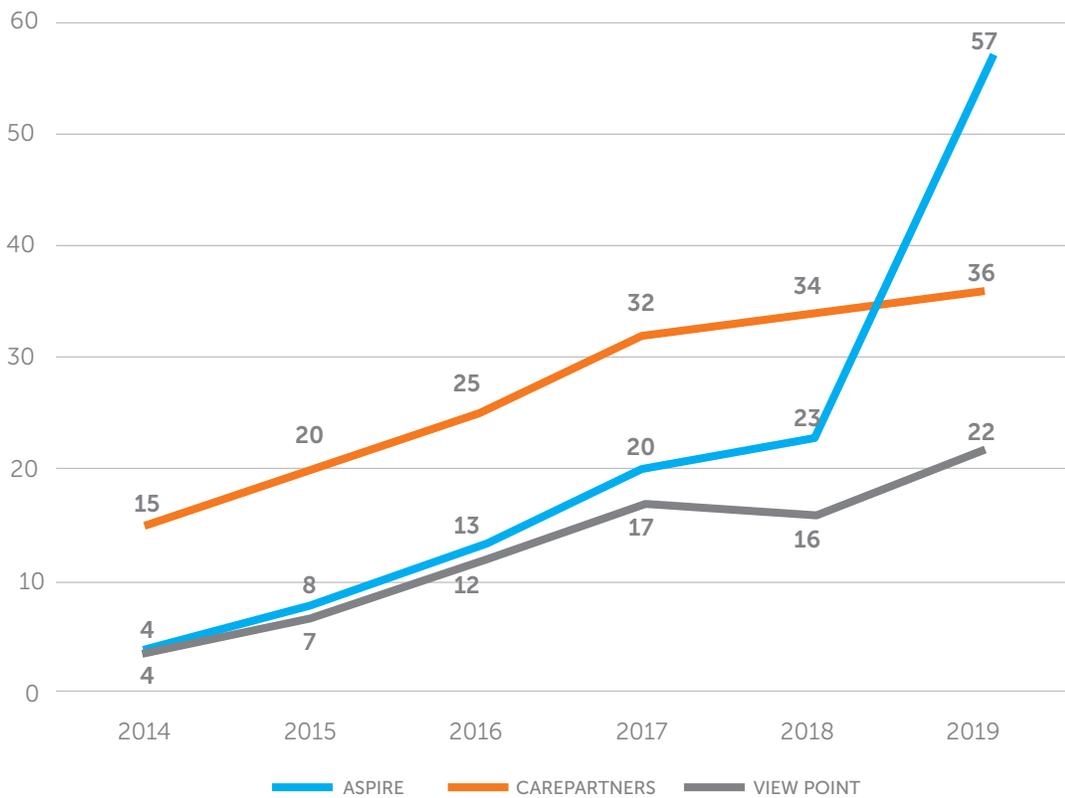
Provider Program Snapshot

| | Aspire | CarePartners | View Point |
|---------------------------------------|--------|--------------|------------|
| Community Service Board | Yes | No | Yes |
| Agency start | 1993 | 2003 | 1976 |
| SBMH start | 2013 | 2003 | 2007 |
| Apex funding recipient | Yes | No | Yes |
| No. of counties served | 8 | 3 | 3 |
| No. of schools served | 57 | 36 | 22 |
| No. of students enrolled in 2018-2019 | 614 | 376 | 757 |
| 1:1 ratio | Yes | Yes | Yes |
| Staff size | 30 | 20 | 21 |
| Ratio of associates to licensed | N/A | 2 to 3 | 10 to 21 |
| Turnover rate | 33% | 16% | 20% |
| Caseload | 90 | 90 | N/A |
| Waitlist for services | No | No | Yes |
| Use of telemedicine | Yes | Yes | Yes* |
| Off-site referrals | < 1% | < 5% | Rarely |
| Medication management | Yes | Yes | Yes |
| Afterschool services or program | Yes | Yes | Yes |
| Summer services or program | Yes | Yes | Yes |
| Home visits | Yes | Yes | No |
| Crisis management | Yes | Yes | Yes |

*Prior to COVID-19, View Point did not provide telemedicine, but the provider began widely implementing telemedicine in Spring 2020.

Appendix B

School-Based Mental Health Program Growth, Number of Schools Served



In the 2018-2019 academic year:

- Aspire enrolled **614** students in services
- CarePartners enrolled **376** students
- View Point enrolled **757** students

All three providers have expanded significantly in the past five years, serving five times as many schools than they did previously, on average.

Appendix C

Staffing and Supervision

Clinicians provide services at the schools anywhere from one day per week to full-time during the school year and manage caseloads of approximately 90 students each. Only one clinician is assigned at each school, although the one clinician may split their time to serve more than one school in the course of a week. With total staff sizes – including clinicians and other staff – ranging from 20 to 30 people, the three providers experience overall turnover rates of roughly 15 percent to 30 percent. CarePartners has the lowest turnover rate (16 percent) of the three agencies. Of note, as a private provider, CarePartners is not bound to the state salary schedule. As quasi-governmental organizations, CSBs are required to follow a state salary schedule. Private providers are not required to follow the state salary schedule, and therefore have more flexibility in the salaries they can offer.

All three agencies employ a mix of licensed and associate-level behavioral health professionals, including Licensed Professional Counselors (LPCs), Associate Professional Counselors (APCs), and Licensed Clinical Social Workers (LCSWs). Associate-level clinicians – who are in practicum training in graduate school, or have obtained master’s-level counseling/social work degrees and are working toward obtaining the supervised work experience required for licensure – provide direct services, including behavioral health assessments; crisis intervention services; and individual, group, and family counseling. Services provided by associates are reimbursed at a lower rate than those conducted by licensed clinicians. Given this, associates are well-positioned to provide Tier 1 and 2 interventions, like skill-building in small groups for students, teacher training, and mental health awareness events in the classroom.

The providers offer associates the supervision required for licensure at no cost. This includes individual and group supervision, both of which are conducted weekly for one hour each. At Aspire, if an employee resigns or is fired before licensure, they are obligated to pay back the cost of supervision at a rate of \$120 per hour.

All three agencies retain associate-level clinicians on staff after they become licensed, to the greatest extent possible. At Aspire, newly licensed clinicians are eligible to apply for the federal

loan forgiveness program if they sign a two-year contract with the provider upon licensure.

Once licensed, clinicians receive weekly or monthly supervision in both individual and group formats. An LCSW provides supervision for all social workers, and a Certified Provider Credentialing Specialist (CPCS) or LPC provides supervision for all licensed professional counselors. Other disciplines, like Marriage and Family Therapists (MFTs), are designated for supervision as needed.

In addition to the licensed and associate-level behavioral health professionals, Certified Peer Specialists (CPSs–Parent and Youth) and Community Support Individuals (CSIs) are also employed by some providers. Certified Peer Specialists provide engagement activities for students and their families, skills training and support groups for caregivers, and wellness recovery plan development. They also connect students and families to resources, and identify service gaps and remove barriers such that families are better supported. CSIs are paraprofessionals who similarly play an active role in service provision, meeting regularly with students and families for skill-building and case management, among other services. Services provided by both CPSs and CSIs are billable to insurance.

Physical Space

A dedicated space to provide services is important for success. Providers report that the size of the space varies across schools; however they are largely sufficient to accommodate sessions with students (and parents when necessary). At one Aspire school site, the clinician’s dedicated space has room for sensory stations, and one of the View Point sites has both a treatment room and a sensory room with different activities for students to address specific challenges. CarePartners’ clinicians have to be creative and flexible as space is limited at many of their school sites. When providers lack a dedicated space to provide care, they use the most discreet option available to them (e.g., a temporarily unused classroom or shared office). View Point reported that some of their schools lack additional physical space, which poses a barrier to expansion of their programs.

Appendix D

Program Evaluation

All three providers reported conducting program and outcome evaluation activities; however, each to a different extent.

Georgia Apex Program Statewide Evaluation

As mental health agencies participating in the Georgia Apex Program, Aspire and View Point participate in the statewide evaluation conducted by the Center of Excellence for Children's Behavioral Health (COE) in the Georgia Health Policy Center at Georgia State University. The COE captures monthly, quarterly, and annual data on a wide variety of metrics from all mental health agencies that participate in the Georgia Apex Program and analyzes and reports programmatic and outcomes data, yearly, in aggregate for the entire state.

As the Apex program has matured, so has the program evaluation. The first three years focused on understanding the penetration, number, and type of services delivered among and within schools, billing, and diagnoses served. In year four, the COE, in collaboration with DBHDD and Georgia Apex providers, worked to improve accuracy for overall programmatic outcomes – including clinical effectiveness.

Current Apex evaluation metrics include, but are not limited to:

- Number (and type) of schools served
- Number of services rendered (by tier)
- Number of students served (including number of first-time students)
- Referral sources (e.g., school counselor, parent)
- Diagnoses frequency
- Program setup/school integration
- Parent satisfaction
- Student functioning (utilizing the Child and Adolescent Needs and Strengths (CANS) tool)
- School outcomes — such as school climate, discipline incidents, and attendance

Additionally, school climate data collected by GaDOE through its Georgia Student Health Survey 2.0 has offered some quick gut-checks for the program. [The Apex Year 4 Annual Evaluation](#)

reports that on average, schools with the Georgia Apex Program alone or with Apex plus PBIS have better Climate Star Ratings and scores; lower incidence of violence, student discipline, out-of-school suspension, bullying, and harassment; and better personnel, student, and parent perception scores.

Other Evaluation Activities

As providers within DBHDD's network, all three providers measure individual student outcomes using the CANS assessment tool, as well as progress against individualized treatment plan goals — which may include social and/or academic goals (e.g., goals related to grades, discipline, or absenteeism). All providers also conduct continuous quality improvement (CQI) activities at their agencies, and two of the providers (Aspire and CarePartners) carry out CQI activities specific to their school-based mental health program services. View Point conducts similar school-based mental health program reviews; however, they are conducted separately from their organization's overall CQI activities. Another similarity between all three providers is that due to capacity, they do not regularly publicly report their organization's school-based mental health program evaluation findings — but rather share this information on an ad hoc basis with schools and key stakeholders.

Aspire's evaluation is carried out as part of its school-based CQI initiative, where Aspire reviews its own data submitted to the COE for the overall Apex evaluation, as well as clinical data (e.g., CANS and progress against individualized treatment plan goals), results of biannual key stakeholder surveys conducted with schools served, and mental health crisis data by school. These last data — including number of crisis calls from students in each school, and number of calls resulting in higher level of care — allow Aspire to assess their ability to help prevent crises through their school-based mental health programs. These data are not regularly published; however, they are shared on an ad hoc basis with relevant stakeholders, particularly when needed to garner support for their programs

View Point conducts its school-based mental health program review separately from its agency's CQI activities and has a

Appendix D

designated staff member to collect and analyze program data. View Point's school-based mental health program internal evaluation has a large focus on individual student clinical progress; however, the organization is looking to develop practical, meaningful ways to measure clinical outcomes at the aggregate level for their programs. In particular, because the results of Tier 2 early detection and prevention services, such as group therapy or brief student or teacher interventions, aren't captured in typical clinical reporting, View Point has started to explore its own ways to evaluate the impact of these services. Currently, they deliver and analyze pre- and post-tests for Tier 2 brief interventions and share results with key stakeholders and funders to underscore the value of investing in these nonbillable services. View Point also conducts reporting (using the same metrics they collect for the COE) for school districts on an ad hoc basis, or when trying to enter a new school.

CarePartners, which is not a part of Apex, conducts a more limited evaluation of its school-based mental health work, without any outside support. It tracks number of schools served, students served, as well as number of services provided in each school. On an individual-patient level, like the other providers, CarePartners clinicians use typical clinical tools to measure student functioning: CANS before and during service provision (as well as before discharge) and student progress against case management plans.

The latter is informed by student self-report; clinician observation; and clinician follow-up with teachers, school personnel, and family members. Due to a lack of time and resources, these clinical data are not aggregated and evaluated for CarePartners' school-based mental health programs as a whole. They are, however, provided to schools on an ad hoc basis, when requested by school leadership, or in select stakeholder meetings. Unlike the Apex providers, CarePartners does not track other nonclinical school outcomes (e.g., discipline, attendance, or academic metrics) for their program, though some of the schools that they serve track these outcomes on their own.

Two important ways CarePartners measures the overall success of their program is through their quarterly parent and school personnel satisfaction surveys, as well as yearly or biannual

parent and school personnel focus groups. These data are collected, analyzed, reviewed, and acted upon by CarePartners' internal CQI team. CarePartners reports that over the last 10 years, these surveys have shown yearly average satisfaction ratings over 90 percent for their school-based mental health services, including telemedicine. CarePartners believes that this high level of satisfaction is driven not only by quality of services, but also because their programs provide sorely needed children's mental health services, filling a broad, previously existing access gap.

Evaluation Challenges

While all providers noted the importance of school-based mental health program evaluation and outcomes reporting, they also reported facing various challenges to conducting it. For all provider agencies (particularly the one without Apex funds), a lack of sufficient staff time and resources to conduct evaluation activities was a barrier. Providers also reported difficulty in gathering data — noting trouble getting input from school staff and parents, or securing the regular release of highly protected school data.

One provider described how looking at overall agency results across different school systems can be particularly complicated, as school systems may define the same measure differently. For example, an "unexcused absence" may be defined by one system as missing the entire school day, by another as missing after lunch, or by another as missing one class. Additionally, the provider noted that mental health services are often very individualized, so showing the impact at an aggregate level, with aggregate-level data, can be difficult and may miss important pieces of what the services accomplish, or fail to account for distinctions like differences in lengths of services. Another provider noted that it remains challenging to find accurate measures that capture the benefit of prevention and early intervention activities for children without diagnosable conditions.

Regardless of the challenges, all providers agreed that program evaluation is extremely important for maintaining and gaining new buy-in from schools and other key stakeholders, and will continue to look for ways to improve upon their program evaluation activities.

Billing Administration

The accounting and administrative work that is needed to support school-based mental health is significant. Despite heavy caseloads, CarePartners staff stated that clinicians are more overwhelmed by the administrative procedures — like completing paperwork for insurance authorization requests and documentation needed for billing services — than they are by service provision. At Aspire, clinicians are responsible for submitting requests for insurance authorization for students' services, which takes away from their time to provide services. Aspire reported an increase in the frequency of authorizations required from insurance and an increase in the length of time it takes insurance providers to grant the authorization. Authorizations last only three months and take 15 or more minutes to complete.

The providers approach billing duties in different ways. At Aspire, an accounting department in-house largely handles accounting responsibilities, though the clinicians are tasked with handling insurance authorizations. Likewise, at CarePartners, in-house administrative staff review notes for codes and accuracy before sending it to their contracted billing agency; this takes an estimated 25 to 30 hours per week. At View Point, a clerical employee is tasked with billing through a Quality Assurance department, and a computer system bills automatically when documentation is completed.

Appendix F

Wraparound Services

Wraparound services help to ensure that students are able to access mental health services despite practical or logistical obstacles, providing impactful support for students and their families. All three providers provide wraparound services, such as medication management, and afterschool and summer services.

Medication Management and Telemedicine

Medication is often a part of a student's school-based mental health treatment plan. For these students, it is necessary that they are assessed and followed by a psychiatrist or psychiatric nurse practitioner to properly manage their treatment. Aspire and View Point provide these services daily through their outpatient clinic. Aspire uses telemedicine to provide medication management, due to a shortage of providers in Southwest Georgia.

Lacking internet bandwidth can pose a barrier to implementing telemedicine in areas without broadband capabilities. CarePartners uses telemedicine for medication management, as well as telepsychiatry, with the school acting as the presenting site. For these cases, CarePartners, which is located in a rural area of the state, contracts with a psychologist, psychiatrist, and psychiatric/family nurse practitioner in the closest neighboring city to provide the services. Parents are required to join these sessions remotely. The provider further accommodates students by delivering medication directly to the home or arranging for pharmacy delivery.

Until recently, View Point has been unable to utilize telemedicine with their school-based mental health programs due to schools' concerns about internet privacy. However, the provider quickly began implementing telemedicine in Spring 2020 in the midst of the pandemic.

Home Visiting

Home visiting is an intervention designed to give families the support they need to improve well-being. Home visits can include skills training, promotion of positive parenting practices, and education on child development, among other activities.

Aspire and CarePartners conduct home visits in certain cases. Aspire uses a staff of Community Support Individuals — whose activities are billable to insurance — to conduct home visits, which are focused on skill-building with parents. Such skills training could range from whole health and wellness skills (e.g., bedtime routines and eating habits), to coping skills (e.g., anger management skills, communication skills, mood tracking), or life skills (e.g., volunteering, resume building, employability skills). CSIs also play a major role in CarePartners' provision of home-based services, meeting with students and their families twice monthly to provide skills training, service coordination, and case management. View Point refers students' families to outside services when they are in need of home visits.

Crisis Management

Aspire and CarePartners provide crisis-management services, and View Point partners with the school districts that they serve on the districts' crisis management. View Point Apex staff are on one of the school district's crisis teams with school social workers.

CarePartners has a mobile crisis support team, where staff rotate being "on call" each week, and the on-call person will conduct home visits when needed. This means that CarePartners' patients rarely have to rely on the emergency room or inpatient hospital visits, as the crisis-support services offer de-escalation on-site and provide close follow-up in the wake of a crisis. Approximately one to two students per week needed crisis management support in the last year; only seven of these students needed to be hospitalized. In the remaining cases, the students' mental health needs were triaged following an assessment. Once triaged, the students and caregivers were given individualized crisis and safety plans and then were referred for mental health services and active follow-up. In the event that hospitalization is required, CarePartners makes daily contact with the student for 14 days following their release. There is a moderate amount of crisis need within the populations served by CarePartners, and this level of need increases during schools' state testing periods.

Appendix F

Afterschool and Summer Services

View Point provides afterschool services through a Mental Health Resiliency Support Clubhouse (funded and supported by DBHDD) twice a week for second- through fifth-graders, with a maximum enrollment of 60 students. Aspire also provides a Mental Health Resiliency Support Clubhouse afterschool program for six to nine months for students with a DSM-5 diagnosis. The program is focused on skill development for 6- to 15-year-olds. CarePartners provides afterschool services on a weekly basis, such as girls and boys groups for social-emotional skills and trauma coping skills. The exact services depend on the individual treatment plan but may take place in the home or community. These services are funded through a combination of insurance (i.e., Medicaid or PeachCare) and the grant that CarePartners receives from Bulloch County Schools.

The amount of available services as well as enrollment in services drops over the summer, though student needs typically do not. Particularly for students who need Tier 3 interventions and medication, this disruption of services can diminish their progress. The summer months are ideal times to utilize skill groups and nontraditional interventions, like activity therapies and field trips. But without access to transportation and, oftentimes, meals for students, attendance is reduced. Space is also an issue: some providers have access to their school sites over the summer, but others have access only to facilities in the county that are centrally located to their student population. Further, CarePartners reported that in some cases students stay with extended family away from home during the summer and are without treatment and medications for up to three months.

Aspire provides a six-week summer program, two days per week, as a part of their Apex program. Although they host a summer program in each of the 10 counties they serve in order to be closer to students' homes, participation still drops 30 percent to 40 percent from the school-year enrollment. The provider reported that access to transportation is a major barrier to summer program enrollment. Aspire plans to partner

and contract with school transportation departments next year to provide transportation to and from home for the six weeks during summer programming. This will be funded through their Apex grant.

View Point provides Tier 3 services over the summer at school and their outpatient clinic. They facilitate Boys and Girls Club activities and provide activity-based group therapy, field trips, and psychoeducation. The frequency of services varies on a case-by-case basis. View Point contracts with commercial car rental services for transportation and with the school for bus drivers to make summer services more accessible to students.

CarePartners provides a summer program three days per week, three hours per day, during May, June, and July. In counties where it is available, the provider partners with a feeding program to provide these services as these programs provide buses to bring students to and from the school for a free lunch. The curriculum targets social-emotional skill-building and a wellness recovery action plan. Services include recreational therapies (e.g., art therapy), experiential learning, exercise and outdoor activities, and leisure skill development.



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