

**CENTER OF EXCELLENCE FOR  
CHILDREN'S BEHAVIORAL HEALTH**  
integrating research, policy, and practice



# **The Georgia Apex Program Annual Evaluation Results**

July 2018–June 2019

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



## Executive Summary

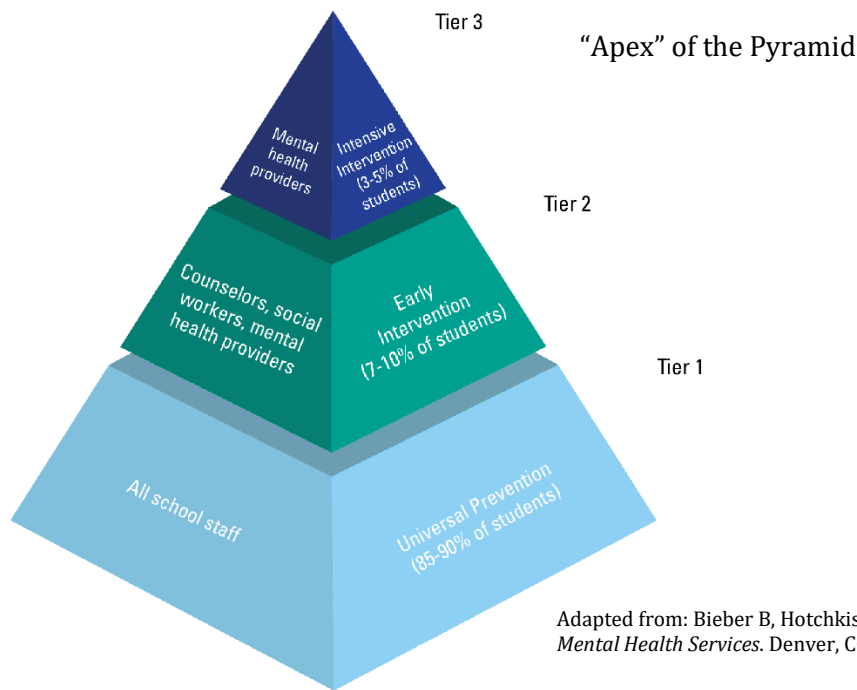
School-based mental health (SBMH) service delivery has become a successful strategy in increasing access to needed services for students in Georgia. The Georgia Apex Program, a partnership between community-based mental health providers and local school districts, with support from the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), is helping to address the mental health needs of Georgia students. The Center of Excellence for Children's Behavioral Health (COE), housed in the Georgia Health Policy Center at Georgia State University, provides program monitoring, evaluation, and technical assistance support to the community-based mental health providers and schools involved. The Apex program complements the Georgia Department of Education's (GaDOE) initiative to address the well-being of students through the implementation of Positive Behavioral Interventions and Supports (PBIS). Additionally, DBHDD and COE are working collaboratively with GaDOE to help identify shared measures to assess the impact of Apex on educational outcomes.

The program goals of Apex, conceptualized in 2015, continue to inform programmatic implementation and development. The program's three goals are as follows:

- Detection — Provide early detection of child and adolescent behavioral health needs;
- Access — Improve access to mental health services for children and youth; and
- Coordination — Promote increased coordination between Georgia's community mental health providers and local schools and school districts in their service areas.

The program promotes a multitiered approach to delivering services to students as conceptualized in Figure 1 (Colorado Department of Education, 2007; Costello-Wells, Ladrienne, Reed, & Walton, 2003; Fox et al., 1999). Apex funding helps to support building infrastructure and the placement of providers in schools. Providers prioritize delivering intensive intervention services to indicated youth represented in Tier 3, the top of the Apex pyramid. However, as providers integrate into schools, services are provided across all three tiers in collaboration with their school partners. This engagement with school partners helps to identify the appropriate referral process and identification of students in need of services. Providers engage in service delivery and rely on a variety of evidence-based practices (EBPs) to inform their work.

**Figure 1: Three-Tiered Approach to SBMH**



Adapted from: Bieber B, Hotchkiss & Palmer, B. (2007). *A Guide to School Mental Health Services*. Denver, CO: Colorado Department of Education.

Since its inception in 2015, the Apex program has supported partnerships with providers and over 500 schools across Georgia, provided first-time services to approximately 14,000 students, and delivered more than 212,000 services in schools. Increases from Year 1 (2015–2016 academic year) to Year 4 (2018–2019 academic year) provide evidence of program expansion as more schools and students are served, and more services are provided:

- Schools — 76% retention, 313% increase in schools served;
- First-time students — 124% increase in students receiving first-time services; and
- Services in schools — 295% increase in services provided in schools.

### Year 4 by the Numbers

- 31 Apex behavioral health provider agencies
- 562 schools involved; 436 schools reporting engaged partnership\*
- 5,419 students receiving first-time services
- 22,815 referrals made for SBMH services
- 89,642 services provided in schools
- 94% of parents surveyed reported being satisfied with the services their child received

*\* Engaged partnership is defined as three or more months of reported data.*

The reach of the Apex program continues to expand. At the end of Year 4, Apex services are present in 99 counties (62%), 110 school districts (61%), and 562 schools (25%) in Georgia. Engaged partnerships, indicated by three or more months of reported data, have been sustained with 436 schools.

Quantitative and qualitative data from the Year 4 evaluation of the Apex program indicate:

- Achievement of reaching the programmatic goals of access, early detection, and coordination;
- Providers are collaborating with schools to advance mental health promotion and prevention strategies by delivering services across all three tiers identified in the SBMH framework; and
- Apex schools report greater increases in a subset of measures related to school climate and greater decreases in school-wide discipline incidents, as well as bullying and harassment during Year 4, in comparison to the statewide average.

## Year 4 Findings

The current executive summary highlights findings for Year 4 of the Apex program and provides information on changes in program metrics over time (from Year 1 to Year 4). The findings presented include data from 31 Apex provider agencies. Additionally, the analyses reflect partnerships in *schools reporting three or more months of engaged activity* as reported through the Monthly Progress Report (MPR), as well as additional service and programmatic data collected on the Parent Survey, the Child and Adolescent Needs and Strengths (CANS) tool, the Mental Health Planning and Evaluation Template (MHPET), and the Year-End Survey (YES). The results are divided into findings related to program implementation and program outcomes. Furthermore, lessons learned as well as considerations for future evaluation efforts are discussed.

### *Program Implementation*

In an effort to be responsive to local needs and local solutions, Apex providers are given flexibility on how to implement programming and services. This flexibility supports local providers working with local educators to develop tailored programs that meet the unique needs of their respective communities.

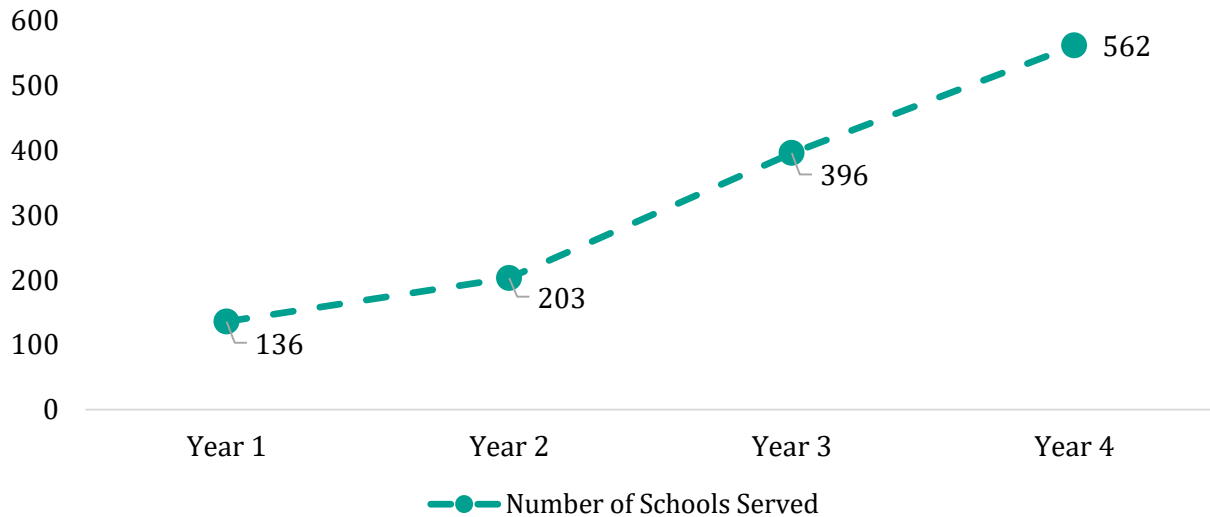
### *School Partners and Enrollment*

During Year 4 of the Apex program, 89,642 services were provided in 562 schools. Although 562 schools were touched by the Apex program, engaged school partnerships were maintained with 436 schools for Year 4. There are a variety of reasons why schools may not fall into the “engaged” category. For example, school partnerships are initiated throughout the program year, and some may still be in the start-up phase at the end of the reporting period.

The number of schools served monthly during Year 4 ranged from 278 to 419, with an average of 371 schools served monthly. The growth in schools served indicates the achievement of the programmatic goals of increasing access and sustaining coordination between schools and community-based mental health providers.

*There was a 78% annual growth rate in schools served from Year 1 to 4, representing a 313% increase overall (see Figure 2).*

**Figure 2. Growth in Schools Served by the Apex Program**



Elementary schools ( $n = 199$ ) constitute the most frequently reported type of school served (see Table 1). Additionally, Apex providers continue to prioritize implementing services in areas more challenged by access to mental health services with 78% of schools ( $n = 231$ ) located in rural settings. The implementation of summer programming as indicated on the YES has fostered year-round engagement with schools through the summer months, which have traditionally been the months with the fewest number of schools served. Summer programming is available in 75% of schools ( $n = 416$ ), a 7% increase from Year 3. The most frequently reported partners in implementing summer programming include the schools (53%), local mental health resiliency clubhouses (26%), “other partners” (23%), Boys and Girls Club of America (12%), and the YMCA (3%).

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*319,003 students had access to SBMH services during the 2018–2019 academic year.*

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**Table 1. Type of Engaged Schools Served by Apex in Year 4 (n = 436 schools)**

School Type (n = 436)	Number of Schools	Percentage of Schools	Overall Enrollment	Percent Overall Enrollment
Elementary school	199	46%	130,763	41%
Middle school	107	25%	82,186	26%
High school	109	25%	106,054	33%
Alternative	21	4%	N/A	N/A
Total	436	100%	*319,003	*100%
<i>Note.</i> *Total excludes alternative schools				

### *Students Served*

An average of 12,948 students were served each quarter, and an average of 22 students were served per school per month. The total student enrollment in the Apex program increased after the start of the academic year and remained consistent throughout the term. The academic calendar continues to impact overall student enrollment, as there are declines in students served in months with school breaks (December, June, and July), but there was not a decrease in enrollment during months of testing (April and May) as previously observed in Year 3. This leveling-out in students served may be attributed to providers making more efforts to reach students, in addition to providing year-round programming.

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*The Apex program provided first-time access to 5,419 students in Year 4, a 124% increase from Year 1.*

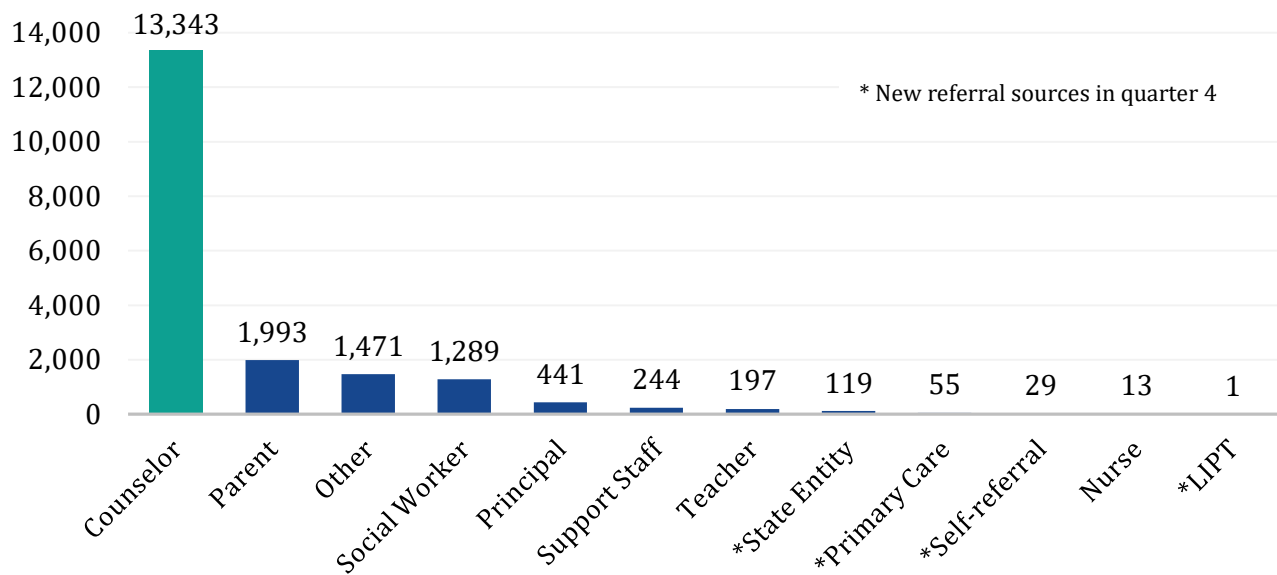
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### *Referral Sources*

A diverse referral network is one indicator of greater buy-in from school administrators and staff for SBMH services. During Year 4, a total of 22,815 referrals were made for SBMH services, with school counselors and parents accounting for the majority of referrals. Figure 3 identifies the referral network for Year 4.



**Figure 3. Total Referral Sources (n = 19,195)**



#### Top Diagnoses

**38% Disruptive, impulse control, and conduct disorders**

**30% Depressive disorders**

**9% Trauma and stress-related disorders**

Knowing the referral reason for services is critical to ensuring the appropriate services and supports are offered to students. Apex providers reported on the YES the top three referral

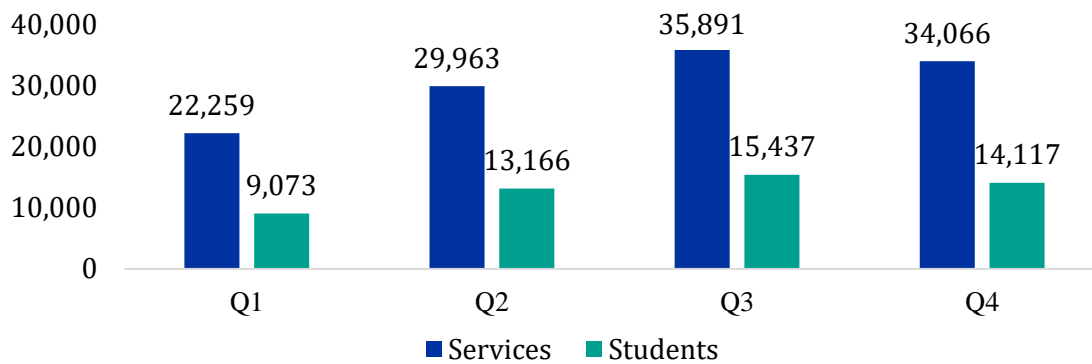
reasons and the number of students served for each referral reason during Year 4. Seventy-four (74%) of providers cited “behavior outside [the] classroom” most frequently, followed by “classroom conduct (65%)” and demonstration of symptoms of “depression (52%).” Diagnosis is also important to capture, as it directs the course of treatment and resource needs. Apex providers were asked to identify the top three diagnoses and the number of unique youth presenting with each diagnosis in Year 4 on the YES. Thirty-eight percent (38%) of presenting students were diagnosed with a disruptive, impulse control, and/or conduct disorder.

#### *Services Delivered*

An average of 7,470 services were provided in schools monthly across all Apex providers. As indicated in Figure 4, delivery of services steadily increased during the academic year, peaking in the third quarter, specifically in the month of March. This trend remained well above the average through the end of the academic year. Based on the number of services provided in comparison to the number of students served, the data suggest that Apex providers are providing multiple services to students served. Lastly, the location of where services are provided is primarily schools. However, the student’s home, private settings, and the recent addition of telemedicine options have also been utilized.

**A total of 89,642 services were delivered in schools through Apex Year 4.**

**Figure 4. Total Services and Students Served per Quarter During Year 4**

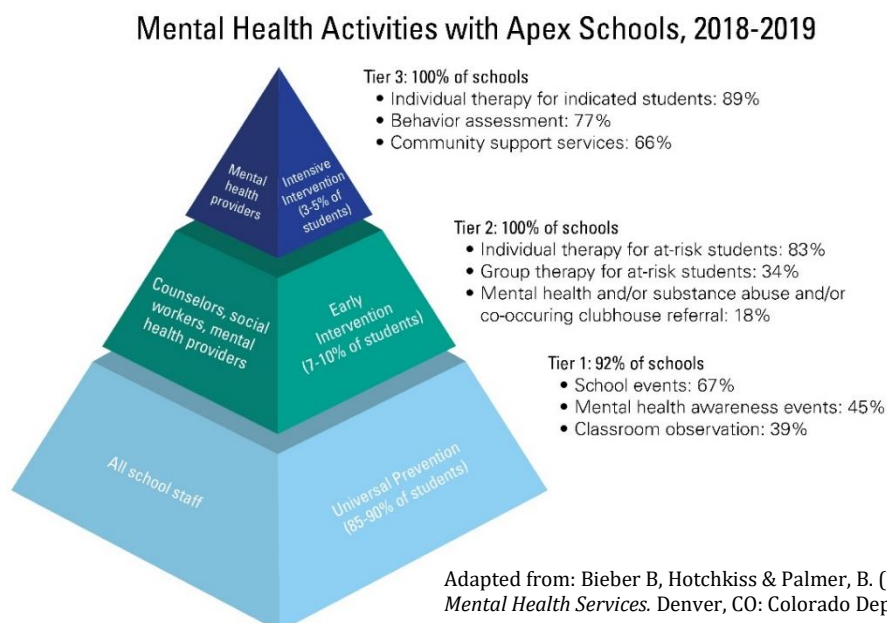


**5,419 students received mental health services for the first time in Year 4, representing a 124% increase in students served from Year 1.**

### *Critical Components of Program Design and Implementation for School-Based Mental Health*

While the Apex program prioritizes access to core behavioral health services for students with a diagnosed mental illness or behavioral concern (Tier 3 services), the providers have succeeded in providing access to care across tiers 1 and 2. In the YES, providers reported participation in any Tier 1 activity for 92% of schools and participation in any Tier 2 activity for 100% of schools (see Figure 5). Apex provider involvement in the tiered activities demonstrates that providers are not only focused on providing access to services for students with a diagnosable condition, but are also maximizing their partnerships with the schools to advance mental health awareness and prevention efforts in the school environment.

**Figure 5. Tiered Services Provided in Schools in Year 4 ( $n = 416$  Schools)**



### *Evidence-Based Practices*

As reported in the YES, providers are actively implementing a variety of EBPs to meet the needs of the students they serve with a diagnosable mental illness or behavioral health concern. EBPs are therapeutic methods whose effectiveness in treating mental illness in children is supported by a large body of clinical research and evidence. Cognitive-Behavioral Therapy (CBT) was the most frequently reported utilized EBP (94% of providers), followed by play therapy (73%), trauma-focused CBT (70%), and mindfulness (70%).

### *Barriers and Facilitators to Implementing SBMH*

According to the YES, providers are also integrated into the school setting in a variety of ways:

- 49% of the providers have a private office within the school;
- 45% have a shared space in which they operate;
- 37% attend staff/committee meetings, as well as serve on the disciplinary team/protocol (23%); and
- 18% hold a school ID or email (16%).

Positive practices associated with successful SBMH programs, including integration into the school culture, incorporating mental health prevention and promotion activities, and utilizing EBPs, have also been demonstrated in the Apex program. Strong partnerships between the providers and the schools are also critically important components of successful SBMH implementation.

Information derived from the qualitative analysis, informed by the peer learning site visits and focus group coding, helps to validate the importance of relationship-building between school partners and providers. There were some key themes from the qualitative analysis that illuminate the lessons learned from providers and school partners that warrants further exploration:

### *Assessing Readiness for Apex Implementation*

- Develop formal and informal application processes to help inform school selection.
- Ensure clear understanding of the expectations of both partners; many have developed memoranda of understanding and data-sharing agreements to outline responsibilities and to support the exchange of information.
- Confirm availability of space, sufficient scheduling options, referral processes, and other appropriate resources to ensure constant and consistent presence of a provider.

### *Workforce Development*

- Draft appropriate job descriptions to ensure applicants are aware of the unique requirements of the position such as traveling, supporting integration into school culture, establishing and maintaining student referral processes and sources, and going beyond merely providing individual therapy to students.
- Offer adequate administrative and clinical supervision to school-based staff.
- Align the provider clinical staffing model for school-based therapists with the educational staffing model.

### *Best Practices*

- Foster relationships with schools and school districts to ensure buy-in for programming.
- Engage in nonbillable activities early and frequently.
- Educate school staff on mental well-being to ensure appropriate referrals.

## **Program Outcomes**

Over the last four years of implementation, the Apex program has demonstrated growth in each of the programmatic goals set forth. The advancement of these goals has transferred into positive program outcomes, as demonstrated on the MHPET, the Parent Survey, the CANS tool, the Governor's Office of Student Achievement (GOSA) discipline data analyses, and annual GaDOE school climate scores.

### *Mental Health Planning and Evaluation Template (MHPET) Analysis*

The MHPET assesses school mental health programs across eight dimensions based on item-level responses: operations; service delivery; stakeholder involvement; school coordination and cooperation; staff and training; community coordination and cooperation; identification, assessment, and referral; and quality assessment and improvement. An abbreviated version of the MHPET incorporating 11 questions, selected by DBHDD, was added to the September 2018 and May 2019 MPRs. The MHPET scale ranges from 1 to 6, with 1 representing "item was not at all in place," and 6 representing "item was fully in place." Matched results were analyzed for 341 school partnerships. Mean differences scores between the two administration points were analyzed using nonparametric paired-samples *t*-tests (i.e., Wilcoxon signed rank test). On average, there were significant positive changes in the perception of policies and procedures shared ( $p < .01$ ), training and ongoing support and supervision ( $p < .01$ ), receipt of culturally competent trainings ( $p < .05$ ), and service delivery for youth and training competencies ( $p < .05$ ). Overall, there were positive mean differences from September 2018 to May 2019 across 7 of the 11 items examined, showing a general trend in improvements despite the lack of

statistical nonsignificance.

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***There were significant increases in the September 2018 to May 2019 MHPET scores in the following areas: policies/operations adherence, evidence-based/strength-based training, service delivery, and training on competency***

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#### *Child and Adolescent Needs and Strengths (CANS) Analysis*

The CANS was developed to be administered upon initial intake and at the end of every 90-day service period, according to the DBHDD provider manual. The results from the CANS administration provide information about the level of functioning for students receiving services through the Apex program. Of those reassessed ( $n = 2,102$ ), 56% improved in functioning during the 90-day service period.

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***Per the YES, the average number of students requiring a higher level of care per school (one student) remained steady from Year 3 to Year 4, indicating that very few students receiving Apex services were hospitalized due to crisis or required more intensive external services during the program year.***

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#### *Parent Survey and Student Outcomes*

The Parent Survey is administered to parents in the Apex provider agency when children are assessed with the CANS tool. The Parent Survey includes questions related to the parent's perception of their child's mental health progress, self-efficacy, and satisfaction. A total of 314 parents completed the Parent Survey in Year 4. Overall, 94% of parents reported they were satisfied with the services their child received. Also, 83% of parents reported knowing how to access appropriate resources for their child.

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***80% of parents reported being able to spend more time at work since their child received services at school; 72% are satisfied with their family life right now as indicated on the Parent Survey.***

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#### *School Climate, Discipline, and Attendance Outcomes*

The quantitative findings via the GOSA discipline dashboard and GaDOE data analysis support the notion that the presence of Apex contributes to positive outcomes in overall school climate, attendance, and discipline. A series of paired-samples  $t$ -tests were conducted to examine mean differences across time for public schools statewide ( $n = 1980$ ), schools only implementing

Apex ( $n = 52$ ), and Apex plus PBIS (Apex + PBIS;  $n = 60$ ). The simultaneous implementation of PBIS provides a framework for improving the school environment that may also further support school-related outcomes associated with positive school climate. Direct statistical comparisons between the three groups were not made due to the large differences in sample size, which would have impacted the validity of the comparison. A summary of the analysis is presented in Table 2. Overall, significant mean differences across all school types were observed for many of the indicators examined, except expulsion.

Qualitative data collected from school partners further supports observations in the classroom related to student discipline. Apex and Apex + PBIS schools showed larger significant mean differences than the remainder of public schools statewide on the following school climate indicators: star rating; initial and final score; student discipline; bullying and harassment; personnel, student, and parent perception; violent incidents; and out-of-school suspension.

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***“We had a lot of discipline go down because now teachers and administrators know there may be other things going on. People are looking for the root instead of defaulting to discipline.”***  
**—School partner**

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**Table 2. School Climate, Attendance, and Discipline Mean Difference Analysis 2015-2018**

	Statewide ( $n = 1980$ )	Apex Schools ( $n = 52$ )	Apex + PBIS ( $n = 60$ )
Mean Differences in Averages per School from 2015 to 2018:			
Student Discipline Incidents	-0.85**	-1.40	-2.50
Bullying/Harassment Incidents	-24.29**	-27.66**	-25.72**
In-School Suspension Rate	+1.94**	+1.90	+.78
Out-of-School Suspensions Rate	+.92**	+.92	+1.65
Violent Incidents	+11.05**	+10.89**	+14.42**
Drugs/Alcohol Score	-1.80**	-1.47*	-.50
School-wide Attendance	-2.16**	-2.27**	-1.50**
Student Attendance	-9.80**	-13.67**	-8.86**
Climate Star Rating	-.35**	-.44**	-.68**
Final Climate Score	-3.71**	-3.34**	-5.47**
Student Perception Score	-2.24**	-4.39**	-1.32*
Parent Perception Score	-2.54**	-2.35**	-3.30**
Personnel Perception Score	-3.56**	-3.99**	-4.44*
Safe and Substance-Free Environment Score	-.98**	-2.09**	-.63
Note: * $p \leq .05$ ; ** $p \leq .01$			

## Conclusions

Findings from the Year 4 evaluation continue to provide evidence of advancing the programmatic goals: increased access, early detection, and increased and sustained coordination between community-based mental health providers and schools/school districts. Providers are collaborating with schools to advance mental health promotion and prevention strategies by delivering services across all three tiers identified in the SBMH framework. Additionally, positive school-related outcomes are beginning to be observed across a variety of indicators of interest for the program. As related to school climate, Year 4 Apex schools report significant changes in program outcomes. Finally, after four years of Apex implementation, both providers and school partners reported many lessons learned related to assessing readiness for implementation and workforce development, as well as identifying best practices, that were captured through the evaluations' various qualitative data outlets.

## Considerations for Apex Y5 Evaluation

Programs such as the Georgia Apex Program have made it easier for students to have access to much-needed mental health services. In the fourth year of implementation, 33 agencies, funded by the Georgia DBHDD, maintained engaged partnerships with 436 schools out of 562 schools touched throughout the year, served 5,419 students who had not previously received services, and delivered 89,642 services in schools. As the program enters into its fifth year, monitoring and evaluation efforts will:

- Focus on collecting data to support the achievement of programmatic and evaluation goals;
- Continue to collate best practices for support program improvements;
- Identify opportunities to track student-level outcome data;
- Understand the unique experiences to implementing in rural areas; and
- Investigate opportunities and barriers for improved provider-school partnerships.

In Georgia, policymakers, state agencies, educators, mental health providers, and the public are lending their support to promote the healthy development of children by supporting school-based initiatives. The information garnered from the program evaluation and technical assistance provided by the Center of Excellence for Children's Behavioral Health will continue to provide evidence and information to inform the development, expansion, funding, and sustainability of Apex programming.

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