A Study of Medicaid-Funded School-Based Behavioral Health Services

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This research study focused on identifying exemplary school-based behavioral health services that implement empirically supported programs to produce significantly better outcomes for children. In order to promote and optimize the healthy mental health development of children, national models for effectively integrating behavioral health services into school settings were explored that subsequently may be adapted for implementation in Florida sites. Using a case study approach, three school-based mental health programs were reviewed that have demonstrated efficacy in other states. Medicaid has provided a significant source of funding for the implementation of these programs, and all three models require strong partnerships between education and mental health systems in the delivery of services. An analysis was completed that investigates key components of these programs that have successfully integrated services between local mental health providers and schools on behalf of students with behavioral health needs.

Selected Programs:

**Building Bridges of Support: One Community at a Time (Bridges)**
The Kentucky Bridges project is an “expansion of the efforts to establish a system of care for children and adolescents with serious emotional disturbances” (Crotty, 2003). The program is funded by the Center of Mental Health Services (CMHS) and serves 22 counties across three regions of eastern Appalachian Kentucky. These include Kentucky River, Cumberland River, and the Mountain areas.

**Reaching Educators, Children, and Parents (RECAP)**
The Tennessee RECAP program is a manualized, school-based skills training program that includes child, teacher, and parent components. RECAP was designed to address the needs of children with multiple mental health problems. It is Medicaid-funded, and children are usually from lower income backgrounds.

**Positive Attitudes for Learning in Schools (PALS)**
The PALS program is based in three public schools located in urban communities of Chicago. It is designed to provide services to children and their families by integrating mental health services with daily school routines and established resources. Focusing on kindergarten to fourth grades, this Medicaid-funded program offers clinic-based, school-based, and family-directed services.

**Framework of Critical Components**
The following challenges to implementation of the programs were identified, as well as the critical components that were infused to meet the behavioral health care needs of children in the schools:

**Challenge 1: Organizational structure of the school and mental health agencies contributed to negative attitudes of administrators, clinicians, and teachers.**

Critical Component 1A: Getting individuals with authority to buy-in prior to entering the schools and fostering a readiness to change

Critical Component 1B: Agreeing on a service delivery model by establishing linkages between the mission of the school and mental health agencies

Critical Component 1C: Emphasizing goal attainment and overall measurable progress in school
Challenge 2: Developing and sustaining funding sources

Critical Component 2A: Optimizing the flexibility of service delivery by integrating nontraditional services and blending funding to meet needs

Critical Component 2B: Negotiating flexibility in the use of Medicaid resources

Challenge 3: Engaging families and facilitating access to mental health services in remote areas

Critical Component 3: The program staff has found that often the key to enrolling children is having access to parents, and they have based their models on an engagement framework that includes maintenance of an ongoing working relationship to establish and to connect family priorities and treatment goals.

Challenge 4: Coordination of services

Critical Component 4A: Programs found that having a liaison increased communication between the school and the agency, which is important to each program’s success.

Critical Component 4B: Provider sensitivity and flexibility is needed to gain access to classrooms and teachers and facilitate the partnership between the education and mental health service systems.

Challenge 5: Teacher resistance

Critical Component 5: For the program’s success, the leadership of the school administrators is essential.

Challenge 6: Expanding implementation of the service model by other providers as well as recruiting and retaining quality staff

Critical Component 6A: The programs have designed and provided consultation, live and web-based trainings, and periodic, on-site meetings.

Critical Component 6B: Manualizing interventions
All three programs have “manualized” their programs, using templates for the treatment plans, establishing guidebooks for implementing the billing and tracking process, and/or creating manuals that detail the program activities.

Policy Recommendations

New evidence-based models exist that produce significantly better outcomes, and these models call for much greater integration of education and mental health systems in the delivery of services. However, these models are difficult to support in the context of the current funding streams and require blending of multiple resources. Medicaid can be a significant source of funding to implement these models, but states are trying to reduce Medicaid expenditures. Since the state is looking at major Medicaid reform, Florida is uniquely positioned to explore new approaches that improve outcomes and offer financing advantages.
Specifically, the following policy changes are suggested:

**Behavioral Health Programs must be implemented in collaboration with relevant community stakeholders:** The development of effective school-based mental health services requires the careful collaboration, partnership, and shared vision of a broad range of community stakeholders.

**Behavioral Health Programs must be uniquely designed to fit local community needs:** Evidence-based mental health service programs must be adapted to meet the specific needs of the local community and populations.

**Behavioral Health Programs must be locally controlled:** Because the program requires the continuing support and cooperation of teachers, school staff, service providers, and parents, the program must provide for local control and operating authority.

**Behavioral Health Programs must be integrated as part of the larger educational mission of the school:** The traditional mental health model needs to be transformed to support life skill development for children with an emphasis on academic functioning.

**Behavioral Health Programs must develop adequate procedures to identify, assess, and enroll students in need of services:** Effective programs require outreach to introduce services and to identify and enroll under-served, high-risk populations; culturally and locally sensitive procedures to screen and assess students’ needs; and clear, inclusive definitions of eligibility determinations.

**Behavioral Health Programs in the school environment must develop adequate procedures for outreach, engagement, training, and supporting the efforts of parents and family members:** Effective mental health services require enlisting the parent as an active participant in the delivery of services and should provide support and education for parents.

**An empirically sound evaluation must be conducted to assess and document program implementation, fidelity, operation, outcomes, cost/benefit analysis of the effort, and sustainability:** The implementation of a program of services should be undertaken with the understanding that programs are seldom implemented without significant modifications based on their performance.

**The provision of services must be undertaken with careful attention to ethical considerations for informed consent, confidentiality of participation, and security of records:** The confluence of two distinct service entities, the schools and mental health service agencies, represents two historically different interpretations of consumer rights.

Presently, Florida is in a propitious position to address some of the challenges facing the state in providing effective services for children. This is an excellent time for AHCA to lead by making proposals about more effective service delivery for this group of youth that will capitalize on the advantages of basing services in school, will be guided by the best available data concerning effectiveness, and will be consistent with the broad goals of the education system to improve outcomes for all children.
A STUDY OF MEDICAID-FUNDED SCHOOL-BASED BEHAVIORAL HEALTH SERVICES

INTRODUCTION

The existing literature on mental health systems of care indicates a need for fundamental change in the way services are conceptualized and delivered (President's New Freedom Commission on Mental Health, 2003). However, fragmented bureaucratic structures and the lack of coordinated federal policy present serious obstacles to systems change (Lourie & Hernandez, 2003; President's New Freedom Commission on Mental Health, 2003). Specifically, the last several years have seen increased attention to integrating the mental health service delivery system and the public school system. This attention is driven and supported by the notion that this integration would:

- increase access to evidence-based mental health services by children and their families, and
- increase prosocial behaviors associated with school-related outcomes (e.g., academic skills and attending school without being suspended).

Improving access and school success are two areas that have challenged the mental health delivery system. It is estimated that less than one-third of the nation’s children who are emotionally impaired to the point of needing mental health intervention receive any services (Friedman, Kutash, & Duchnowski, 1996). Further, approximately 70% of children who receive any mental health services at all receive it in their school (Burns et al., 1995). Adding to this pressure is the growing number of children who are identified as needing mental health service each year. For example, Wagner and colleagues (Wagner, Kutash, Duchnowski, & Epstein, 2005) found that the number of children identified by the school system as having an emotional disturbance has grown each year by 16%. While precise, epidemiological data are not available, there is a consensus in the field that approximately 20% of all children have a diagnosable emotional disorder at any point in time and that 5% of all children experience emotional disturbance at a severe and persistent level (Friedman et al., 1996). At present, approximately 5 million students (1%) are identified as having emotional disturbance and are served in special education programs (U.S. Department of Education, 2004), and about 1.3 million children are served in the U.S. mental health system (Warner & Pottick, 2004). Approximately, 10% of children receiving Medicaid services are receiving some type of mental health services (Dougherty Management Associates, 2004).

A significant literature base documents the poor school-related outcomes of children identified as emotionally disturbed (Atkins et al., 2002; Atkins et al., 2003; Franca, Kerr, Reitz, & Lambert, 1990; Rones & Hoagwood, 2000; Wagner et al. 2005). They have the lowest graduation rates, the lowest grades, and the highest incidence of contact with the justice system compared to peers who have either other types of disabilities or no disability (e.g., Wagner et al., 2005). As they transition into adulthood, they are at continued risk for poor psycho-social outcomes (Greenbaum et al., 1996). These conditions present a formidable challenge for the public school system.

Furthermore, the provision of mental health services is legislatively mandated in U.S. public schools by the Individuals with Disabilities Act (IDEA). The 1997 IDEA amendments emphasize proactive and effective means to interfere with behavioral problems and identify mental health services as important interventions to remove barriers to education, learning, and teaching. Despite this legislated requirement, few schools have enough resources to respond to large numbers of students who are experiencing a wide range of psychosocial barriers that interfere with learning and performance. Consequently, school administrators are eager to find effective interventions that are evidence-based to improve the outcomes for these children and the quality of their lives.
Rationale for the Current Study

While the public school system historically has been educating and serving youth with mental health needs within their own system, development of effective models that would facilitate the integration of the mental health service delivery system into the school system has been slow to evolve. Nonetheless, promoting evidence-based practices in both the mental health service delivery system and education settings has dominated discussion in both contexts (Weist, 2003). While recent reviews find multiple mental health programs with substantial empirical support, little systematic implementation of these programs has taken place nationally (Chorpita & Nakamura, 2004; Schoenwald & Henggeler, 2004; Stirman, Crits-Christoph, & DeRubeis, 2004; Walker, 2004). Particularly lacking are models that deal with a range of problems in children, are school-based, and are directed at Medicaid eligible populations (Atkins et al., 2003).

Research has suggested that schools may function as the de facto mental health system for many children and adolescents (Burns, Costello, Angold, Tweed, et al., 1995; Rones & Hoagwood, 2000), with 70% of mental health interventions provided in school settings. Not only can schools serve as critical settings in which children’s behavioral health needs are first identified, but schools also can facilitate access to and delivery of mental health services and behavioral interventions.

During 2003-2004 the Florida Mental Health Institute initiated a study of school-based, Medicaid funded behavioral health services (Berson et al., 2004). The research indicated that school districts in Florida are participating at a low rate in the provision of direct interventions funded through the Medicaid-Certified School Match program. This program funds services provided or arranged by a school district for Medicaid enrolled students with identified disabilities. The proportion of the total enrolled Medicaid population that had a school-based service claim remained relatively small, ranging from 1.7% to 2.5% of the Exceptional Student and Education (ESE) enrolled population. However, this proportion represented a 47% rate of increase in the use of school-based behavioral health services, suggesting substantial growth of the program across the state. Among service users of the Medicaid school-based behavioral health services, the majority of recipients were male (nearly 70%), approximately 40% of the students were Black, and service usage peaked at eight to ten years of age.

Despite the low number of behavioral health service claims under the school-based plan, many school districts reported that they contract or arrange with a community-based organization to provide mental health or social services to students. Additionally, school staff may provide direct services but do not bill Medicaid for these interventions. In FY 2001-2002, schools were the sole behavioral health service site for the majority of ESE students (over 60%). However, nearly 38% of the recipients of the school-based behavioral health services also received Medicaid-funded mental health services from a separate, community-based agency (Berson et al., 2004).

The number of children served by the Medicaid Certified School Match Program varied depending on the type of exceptionality with the greatest expenditures for children with developmental delays. In addition, for those children accessing additional Medicaid-funded mental health services, there was little duplication in the focus of the interventions with Attention Deficit Disorder, affective disorders, and disruptive disorders receiving greater emphasis in the claims submitted by community-based providers (Berson et al., 2004).

Schools have been encouraged to collaborate with local mental health systems to develop services for students in special education and for students with mental health problems not severe enough to qualify them for special education. The President’s Commission on Excellence in Special Education (2002) promotes and encourages flexible funding (combining IDEA funds with other agencies’ funds).
Although school-community collaborations can be successful and cost-effective over the long run, early findings indicate how difficult it is to establish collaborations. It necessitates a move from fragmented services to full integration of interventions that can reduce redundancy, waste, and ineffectiveness (Koyanagi, Boudreaux, & Lind, 2003; Weist et al., 2003). This integration can be enhanced by the use of “blended funding,” which weaves together school and community resources; however, careful coordination is necessary to avoid duplication.

The Florida Department of Education has sought to foster coordination between schools and mental health providers for children receiving intensive mental health services through ESE and other programs. This service integration is often detailed in contracts or agreements between the mental health provider and school district. Both the Multi-Agency Network for Students with Severe Emotional Disturbances (SEDNET) and the Shared Services Network have promoted mechanisms to enhance interagency contacts and communication. OPPAGA (2004) has found that overall these service coordination mechanisms are successful in avoiding unnecessary duplication; however, there is variability statewide in effectively implementing these strategies.

In summary, new evidence-based models exist that produce significantly better outcomes, and these models call for much greater integration of education and mental health systems in the delivery of services. However, these models are difficult to fund in the context of the current funding streams and require blending of multiple streams. Medicaid can be a significant source of funding for the implementation of these models, but states are trying to reduce Medicaid expenditures. Since the State of Florida is currently embarking on a major Medicaid reform which is designed to reduce the growth in the state’s general revenue responsibilities in the Medicaid program, Florida is uniquely positioned to explore new approaches that improve outcomes and offer financing advantages.

In order to understand viable approaches for enhancing the system of care for children, the purpose of this study was to explore exemplary national models that have creatively adapted Medicaid plans for mental health providers to work in collaboration with school districts. The research findings offer information that can be translated into policy issues specific to the Medicaid-funded behavioral health services provided in schools.

**Research Design**

Across the United States, policymakers, researchers, and advocates have identified and initiated strategies to enhance behavioral health interventions for children. In an effort to build quality and accountability into mental health service delivery for children, advocates in the field have been touting the diffusion of evidence-based treatments and alternative service delivery models. Many reports have highlighted and recognized specific programs that have demonstrated success (Atkins et al., in press; Crotty, 2003; Kentucky River Area Bridges Program, 2001; Robinson, Barrett, Tunkelrott, & Kim, 2000; Rones & Hoagwood, 2000; Weiss, Harris, & Catron, 2003); yet, despite existing evidence implementation has often been limited to isolated states or regions (Olson, Perkins, & Pate, 1998; Pianta, 2003; Ringeisen, Henderson, & Hoagwood, 2003).

This research study focused on identifying exemplary, school-based behavioral health services and describing key components related to program implementation, status, and access to care for children. In order to promote and optimize the healthy mental health development of children, national models for effectively integrating behavioral health services into school settings were explored that may subsequently be adapted for implementation in Florida sites. Using a case study approach, the research team reviewed three model, school-based mental health programs that have demonstrated efficacy in other states. All three of the programs described in the current investigation occur in community school settings, have empirical support for their effectiveness,
and integrate mental health services into the school system. They meet the highest standards for mental health services that are evidence-based and infused across service systems. An analysis was completed that investigates key components of these programs that have successfully integrated services between local mental health providers and schools on behalf of students with behavioral health needs.

**Methodology**
The FMHI Project team, in collaboration with AHCA staff, designed the project to foster consensus regarding specific strategies that promote high-quality behavioral health services in schools. The research sought to define the criteria necessary for implementation of a school-based services model that promotes healthy outcomes for children and their families.

The project was structured in three phases:

**Phase I: Literature Review.** The search for relevant literature drew upon recent studies from the fields of health, mental health, education, and health care financing. State Medicaid policy manuals also were reviewed. This information was then used to refine the research focus and shape site visit protocols.

**Phase II: Expert interviews: Practice description and model validation.** A group of accomplished, national experts in the area of school-based behavioral health services was interviewed to identify promising programs as well as essential components to achieve effective services in schools. Using a brief, expert interview protocol (See Appendix A) that was developed by the research team, seven experts were contacted and completed interviews. These resulted in numerous criteria and site recommendations. Although there was not consensus among the experts regarding exemplary sites, the team reviewed the feedback to determine which programs relied on Medicaid funding and had demonstrated success. Using these criteria, the project team narrowed the list to four potential sites in Tennessee, Kentucky, New Mexico, and Illinois.

Following the interviews, staff conducted a review of background information and literature on the recommended programs and established parameters to guide the selection of three national sites for in-depth case studies. Based on this feedback as well information gathered through a review of the literature and a discussion of the potential relevance of each model to Florida, the team selected the following three national sites:

**Building Bridges of Support: One Community at a Time (Bridges)**
The Kentucky Bridges project is an “expansion of the efforts to establish a system of care for children and adolescents with serious emotional disturbances” (Crotty, 2003). The program is funded by the Center of Mental Health Services (CMHS) and serves 22 counties across three regions of eastern Appalachian Kentucky. These include Kentucky River, Cumberland River, and the Mountain areas.

**Reaching Educators, Children, and Parents (RECAP)**
The Tennessee RECAP program is a manualized, school-based skills training program that provides child, teacher, and parent components. This was designed to address the needs of children with multiple mental health problems. It is Medicaid-funded, and children are usually from lower income backgrounds (Weiss, Catron, & Han, 2003).

**Positive Attitudes For Learning in Schools (PALS)**
The PALS program is based in three public schools located in urban communities of Chicago. It is designed to provide services to children and their families by “integrating mental health services into ongoing school routines and resources” (Atkins, et al., 2003). Focusing on kindergarten to fourth
grades, this Medicaid-funded program offers clinic-based, school-based, and family-directed services (Atkins et al., 2005).

**Phase III: Site Visits.** Semi-structured interview protocols were developed focusing on the salient features of Medicaid-funded behavioral health services in the schools (See Appendix B). The protocols were designed to gather descriptive data about the structure of school-based services, as well as the fiscal and regulatory arrangements necessary to support the programs. Questions included the following domains: (a) work roles and activities associated with implementation of the program; (b) access to direct behavioral health services reimbursed by Medicaid; (c) mechanisms to avoid duplication of services; (d) benefits of the program; and (e) barriers to effective implementation. In addition, respondents were offered three options for answering protocol questions: (1) responding via email; (2) participating in a phone interview; or (3) engaging in a face-to-face interview. In all scenarios a verbal consent process was completed prior to receiving stakeholder responses. Each protocol was developed in conjunction with representatives from AHCA and the Florida Department of Education (FDOE) to encourage a participatory approach and utility of the qualitative data.

The AHCA school-based services project team conducted interviews of key stakeholders at three national sites that have model programs for school-based mental health services. The programs were located in Tennessee, Kentucky, and Illinois. The interviews were structured as on-site data collection, telephone interviews, and face-to-face meetings based on the availability and convenience of the stakeholders. Although the original methodology had indicated all interviews would be completed on-site of the national programs, the divergence in data collection procedures allowed the team to host two national speakers for local community forums to facilitate a dialogue with providers and agency representatives from Florida. After completing site visits, the team identified the regulatory, legal, and fiscal structures that are necessary to facilitate these service systems.

**Subjects**
Interviews were conducted with key informants at the three selected national sites to obtain respondents’ views of exemplary models for integrating behavioral health service delivery in the school setting. Stakeholders included school administrators, coordinators and providers, representatives from managed care plans, staff or providers from participating community behavioral health agencies, school staff, students, and parents as available.

**Data Analysis**
The results include a descriptive analysis of the behavioral health services provided by the national model sites. The findings integrate a comparative summary of descriptive data and an analysis of qualitative information gathered via interviews.

Content analysis of the documents, the open-ended survey questions, and the in-depth interview responses were used to analyze the qualitative data collected for this study. Content analysis involves reviewing interview transcripts to select common themes and trends in the data. One may also note similarities and differences in the implementation process between stakeholders or service provider sites. The primary goal of content analysis is to condense the amount of qualitative data into a list of variables that can be examined for correlations. The research team began with text (qualitative data), made formal hypotheses as to the nature of the text’s content, performed systematic coding and analysis, and finally interpreted the results in conjunction with the quantitative data, thus allowing for the triangulation of data sources.

Based on qualitative analysis of interview data and a review of existing standards for school-based behavioral health services, a framework of critical components that are needed to meet the behavioral health needs of children in schools is outlined in this report. The study includes a policy
analysis to translate the findings into practical implications for school-based behavioral health services. The focus of the policy analysis includes:

- collecting information on the interrelationship between community-based mental health services and school-based mental health services to determine if changes in the organization and in the delivery of mental health services are affecting the demand for these services in schools.
- observing how school-based mental health services fit within the overall behavioral health care system.
- examining how variation in on-site support facilitates ease of implementation in school districts.
- identifying methods and options designed to integrate or coordinate school-based mental health programs and special education.

**RESULTS**

This overview presents a descriptive analysis of the design and implementation of three programs with empirically supported interventions that provide Medicaid-funded, school-based behavioral health services to children (Bridges, RECAP, and PALS). The project team explored trends in the data and organized the findings based on themes, including program design and implementation, access to services, outcomes, funding, intersystem collaboration between community providers and schools, and considerations for dissemination of intervention innovations. The results include a comparative summary of all relevant descriptive data and an analysis of the qualitative information gathered through interviews.

**Program Design**

In order to promote understanding of the applied interventions that were the focus of this research, a systematic study of the implementation process and the range of variables that affect the quality of services was undertaken. The following descriptions offer a succinct clarification of the salient components of each service model.

**Reaching Educators, Children, and Parents (RECAP)**

The Vanderbilt University intervention program Reaching Educators, Children, and Parents (RECAP) was created from research developed by Bahr Weiss, Ph.D., associate professor of Psychology and Human Development, and Tom Catron, Ph.D., associate professor of Psychiatry. The program was designed for students in pre-K to fifth grade and has been proven an effective, school-based, manualized intervention for students with emotional and behavioral problems (Catron, 2005; Weiss, Harris, Catron, & Han, 2003).

Catron and Weiss investigated options for evidence-based psychotherapies for children, but they discovered that most of these treatments were designed for single disorders only, such as depression or anxiety. Conversely, most children in the schools were presenting with co-occurring mental health disorders. After researching the most effective treatments for different types of disorders, they integrated them together into a single intervention program that is referred to as RECAP (Weiss, Harris, Catron, & Han, 2003).

The program was pilot tested and input was sought from teachers, parents, and students to improve the presentation, language, and materials of the intervention. The researchers then obtained a five-year, National Institutes of Mental Health grant to conduct a randomized, clinical trial, allowing them to carry out a study in Metro schools which proved to be very successful. This study demonstrated
that children who received the RECAP intervention improved their functioning and sustained these gains for a longer period of time compared to children who had received no treatment.

The original RECAP was administered by master's level mental health clinicians; however, the program has evolved into training teachers to administer the intervention. Recognizing the paucity of mental health resources in schools, the integration of teachers as change agents was designed to optimize the impact of the intervention as well as enhance the cost-effectiveness of the services.

RECAP focuses on individualization of treatment. Initial choices regarding treatment were guided by relevant literatures on what interventions generally have the best impact on improving functioning in a specific domain. Staff recognize that some children will need extra attention, thus consultants spend time with individual children with high needs and attempt to integrate RECAP lessons and issues into a child’s mental health treatment and behavioral contract, as well as into the teacher training component. In addition, the RECAP program teaches teachers to do specialized interventions and build skills.

The program has been implemented in 15 school-based mental health clinics throughout Tennessee, and recently the program was transported for implementation into the Charlotte-Mecklenburg (CMS) school system with a focus on Pre-K students. RECAP includes a training model that prepare psychologists and social workers to serve as consultants who train and supervise teachers. The intervention program focuses on teaching social skills, helping students understand their feelings, and improving problem solving skills. There are about three intervention sessions per week, totaling approximately 60 a year, and each takes about 15 minutes. The researchers are continuing to collect additional data regarding implementation and effectiveness; however, earlier research has found that the program offers the combined benefit of improving children's behavior and increasing classroom instruction time.

**Target Population**

RECAP was designed for children experiencing concurrent externalizing and internalizing problems. Externalizing problems were often associated with aggression, delinquency, and hyperactivity, whereas internalizing problems included anxiety, depression, and somatization in the clinical range. The program focuses on children in prekindergarten through fourth grade, and staff are hopeful that the model can be adapted to fit the needs of fifth graders as well. Different methods are employed with younger children, such as stop and think activities. These activities help students think about and practice strategies to become more reflective before acting. They are based on cognitive-behavioral theory and techniques and are presented in a playful context to help engage children while they practice self-control strategies.

Many of the children involved in the RECAP program have or are at risk for Severe Emotional Disturbance (SED), in addition to having problems coping with violence and trauma they witness at home or in their local community. Specifically, one study found that 48% of the RECAP population scored in the clinical range for internalizing problems on the teacher report component of the Achenbach, and 54% scored in the clinical range for externalizing problems (Weiss, Harris, & Catron, 2003). Staff regularly help children cope with anxiety and depression, although no one specific element of the program deals with these issues. Typically children are identified by their teachers and then referred to the RECAP program.
Staff Roles and Responsibilities

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<tr>
<th>POSITIONS</th>
<th>RESPONSIBILITY</th>
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<tr>
<td>Mental Health Providers</td>
<td>Provide consultative services to the teachers and offer direct interventions to the children through weekly, small group sessions to practice use of RECAP skills in a controlled environment as well as weekly classroom groups to increase the likelihood of generalization of skills. Interventions are school-based and developmentally appropriate. They involve working with the children, classmates, teachers, and caregivers.</td>
</tr>
<tr>
<td>Teachers</td>
<td>The teachers are the intervention agents. They are trained to integrate RECAP principles into routine classroom activities.</td>
</tr>
</tbody>
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**Positive Attitudes for Learning in Schools (PALS)**

PALS, Positive Attitudes for Learning in Schools, which was launched by Marc Atkins in 1994, aims to provide better child mental health services to inner-city children by reaching them through public schools in Chicago’s Near West and South Side neighborhoods. Schools are one of the few existing resources for children and families consistently available within urban, low income communities and therefore offer a unique opportunity to promote positive mental health for children and families. PALS takes an ecological view of circumstances affecting individual children – home, school and relationships -- and promotes communication and collaboration among teachers and parents. The ecological perspective emphasizes the need for least-restrictive, group-administered services that are flexible and individualized across the multiple contexts for children’s behavior and that integrate into ongoing school routines and resources.

The goal of the program was to capitalize on schools’ unique opportunities to provide mental health promoting activities for children in their communities. The program has been funded through Medicaid. In this program, schools are proposed as hubs for mental health and social service programs by working directly with teachers to improve children's academic performance and social relations and by linking families to schools through home-based and group administered services. The PALS team consists of the classroom teacher, a parent hired by the project, and a mental health provider who work collaboratively, guided by a manualized treatment that proceeds in four phases: (1) engagement of key constituents in urban schools, (2) development of collaborative partnerships among PALS team members, (3) systematic assessment of ecological classroom contexts, and (4) delivery of empirically-based services. Participants are children in kindergarten through fifth grades from three Chicago public schools selected for participation if identified by their teacher and parent as exhibiting disruptive behavior at school and home and their parent or guardian provides permission to participate in the project.

The program’s premise is that schools should take the lead in providing mental health services to needy students by encouraging greater involvement of families in children’s mental health services, by creating teacher key opinion leaders as on-site experts on topics related to children’s mental health, and by implementing the PALS program to foster and maintain parents and children in treatment. A three-year NIMH-funded study evaluated the effectiveness of PALS and yielded positive results.

**Target Population**

PALS participants include low income, inner-city children in grades kindergarten through sixth who have been identified by their teacher as showing signs of behavior disruptive to the classroom (Atkins et al., 2003). Program administrators would like to focus on the entire span of children, kindergarten through eighth grade, as well as special education groups, but their current funding sources are concerned about the developmental issues that might be unique to children of relatively
different ages and abilities. In addition, children from special education are currently excluded because there are not enough special education classrooms to include this population as a research group in a clinical evaluation.

The initial research component of PALS involved a school-wide screening; however, this inclusion met with criticism from teachers who were concerned that children who did not have any problems were being removed from class. In addition, gaining consent from the entire school was a tedious process. Thus, the screening process evolved to a multiple gating procedure involving a screening form that was completed by a child’s teacher. Teachers were asked to complete the form on any child who was exhibiting specific tendencies or academic difficulties. The forms were then submitted to each school’s mental health team that then reviewed it and determined whether it was appropriate to refer each child to mental health services.

PALS has implemented additional approaches to family outreach, such as coordinating a charitable campaign to assemble a book bag for each child in school. Also, screening is provided where the family is most comfortable, whether it be at the school, a community mental health agency, or the family’s home.

Staff Roles and Responsibilities

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<tr>
<th>ROLES</th>
<th>RESPONSIBILITIES</th>
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| Clinical Staff (University Mental Health Clinic) | • offer clinical services at the Mental Health Clinic  
• follow up with families through letters, phone calls, and reminders to ensure that they kept their appointments |
| Parent Advocates              | • assist in locating families, facilitate staff interactions with families, and assist in the design and delivery of parent-directed services |
| Project Staff                | Responsibilities include:  
• intake services (initial contact with parents, scheduling appointments with families)  
• classroom support to teachers |

Building Bridges of Support: One Community at a Time (Bridges)

Bridges has been working on a school-based mental health outreach project. The focus of this outreach project has been developing collaborative relationships with the schools and working with them at three levels of intervention: universal, targeted (for at-risk students), and intensive (for seriously emotionally disturbed children).

Three regions of Kentucky participate in the project. The goal of the project is for child-serving systems in the region to better integrate system of care principles in meeting children’s mental health needs. The region served is an area of Appalachia consisting of the five eastern-most counties in Kentucky. The project was originally designed as a demonstration project to develop collaborative models by co-locating mental health and parent-support staff in the schools. A five-year, federal grant from the Center for Mental Health Services supported the expansion of the existing system of care in the region.

The Bridges project prides itself on a three-tiered approach to reaching children. The universal level is preventative in nature and includes the entire school. The main goal for this level is increasing the overall level of health within the school environment. The targeted level addresses the needs of children who may be at risk for developing SED, and the intensive level focuses on providing more long-term clinical services to children who have been identified with an SED (Macro International, 2000).
Services are provided to school-age children, ranging from Head Start through twelfth grade. Schools are staffed with Student Service Teams (SST), consisting of a family liaison, a service coordinator, and an intervention specialist. In addition, a behavior consultant is assigned to each region. In collaboration with school staff, the SST and behavior consultant facilitate the implementation of a continuum of positive behavior supports.

**Target Population**

The Bridges project spans three primarily rural regions of Kentucky, including 22 counties. These three regions were targeted because they had higher risk factors such as income below poverty level, families with three or more children, and higher incidences of child maltreatment and domestic violence. Specifically, the Bridges program seeks to enroll children with SED who live in the rural Appalachian areas of Eastern Kentucky. Beneficiaries must meet specific geographic, age, and clinical requirements, as well as have a need for multiple services and/or some involvement with the social services department.

Nearly 90% of referrals to Bridges are from the school system, and 10% to 20% are from child welfare, juvenile justice, mental health, or self-referral. After a referral is made to the Bridges program, an intervention specialist meets with the family and completes several assessment measures (e.g., psychosocial assessment and bio-psychosocial assessment) and intake forms. A service coordinator is then assigned, and the first service contact is made within one work week of intake (Macro, 2003).

After one year of program implementation, the Bridges model had reached 75 children and their families (Macro, 2000). Eighty to ninety percent of the children in the schools served by the program are receiving free or reduced price lunch. A majority of the families are Medicaid-funded.

When the Bridges project was initially implemented in 1999, there was a significant outreach effort to inform the communities about services as well as help families to utilize Medicaid insurance. In 2000-2001 there was a statewide effort to do a huge outreach campaign for Kentucky Children’s Health Insurance Program (CHIP). This became the biggest outreach effort to ensure families and their children had health coverage. Enrollment exceeded the state’s expectations subsequent to this outreach effort and has since stopped further statewide outreach efforts have been stopped. It is left up to the local community mental health center and social service agencies to help educate families about Medicaid and CHIP. However, these staff are strongly encouraged to get children enrolled in Medicaid and, if possible will ensure a family's basic needs, such as clothing and electricity, are met.
**Staff Roles and Responsibilities**

In each region, Student Service Teams (SST) in collaboration with existing Family Resource and Youth Service Centers located within the elementary, middle, and high schools are developing, implementing, and coordinating a spectrum of services.

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<tr>
<th>POSITION</th>
<th>RESPONSIBILITIES</th>
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<tr>
<td>Student Service Teams (SST). This includes service coordinator, family liaison, and intervention specialist.</td>
<td>Provide direct services and function as the central link for service provision. The SST works in a collaborative partnership to develop behavior management plans as well as assist children in optimizing strengths and developing new skills to succeed in school, home, and community.</td>
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<tr>
<td>Student Service Coordinator</td>
<td>Responsible for the coordination of services received by children and families. Foster a strength-based, problem-solving approach using a wraparound philosophy, integrate natural supports and nontraditional resources into the system of care.</td>
</tr>
<tr>
<td>Intervention Specialist</td>
<td>Provides behavioral intervention and counseling in the schools and classrooms. This is a mental health clinician with specialized training in behavioral consultation and behavioral assessment.</td>
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<tr>
<td>Family Liaison</td>
<td>Provides advocacy and support services for families. The primary qualification of the Family Liaison is that each one is a parent of a child with serious emotional disturbance (SED). They help to educate schools about and expand schools’ work with families. The Family Liaisons also breakdown barriers to service by facilitating parent and family-support activities, conducting outreach with families, and making home visits.</td>
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<tr>
<td>Behavioral Consultant</td>
<td>Focuses on school-wide and classroom changes with universal interventions.</td>
</tr>
<tr>
<td>Transition Specialist</td>
<td>Assists children and families in transitioning between treatment levels and settings and in the transition from one developmental level to the next.</td>
</tr>
<tr>
<td>SIAC: State Interagency Councils</td>
<td>Responsible for the governance of the Bridges project. Reports to the Governor and the Legislative Research Commission.</td>
</tr>
<tr>
<td>RIAC: Regional Interagency Councils</td>
<td>Also responsible for the governance of the Bridges project. Serve as a local consultative and advisory group and include multi-agency and family representation.</td>
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# Overview of Programs and Services

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<th>PROGRAM</th>
<th>SERVICES</th>
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| **PALS** offers a flexible service delivery model that includes family services and classroom services. | **Classroom services** incorporate multiple levels of intervention and evidence-based practices. They include opportunities for contingency-based, class-wide behavior management strategies, such as the Good Behavior Game; academically-oriented interventions, such as peer tutoring; individualized programming, such as school-home notes; small groups for reading and social skills building; and teacher support.  

**Family directed services.** All PALS families receive family services by home visit or by attendance at twice-monthly parent groups held alternatively at the school and clinic offices, co-facilitated by a clinician and parent advocate. The range of topics includes helping with homework, communicating with teachers, establishing routines (e.g., morning homework, chores, bedtime), encouraging positive behaviors at home, implementing reward systems, using techniques for relaxation, and linking with other social service agencies to obtain services beyond the scope of the PALS program (e.g., assistance with food and shelter, medical problems, need for after school programs, summer camps, remedial academic programs). |

**RECAP** is a manualized, semi-structured skills training program. It is school-based and involves a child component and a parent and teacher component. The services include individual, group, classroom, teacher, and parent training in the RECAP skills-development curriculum, which was derived from empirically supported treatment programs for nonconcurrent internalizing and externalizing problems. | **Child components:** Focus on (a) social skills (e.g., making friends, avoiding involvement with negative peer behavior), (b) reattribution training for hostile attributions of others’ intentions as well as unrealistic self-appraisals, (c) affect recognition and expression, and (d) relaxation.  

**Parent and teacher component:** focus on (a) using appropriate praise and punishment, (b) improving adult-child communication, (c) strengthening the adult-child relationship, and (d) supporting the children in their use of RECAP skills (e.g. appropriate expression of affect). |

**BRIDGES** builds on the existing Kentucky IMPACT System. Acknowledging the importance of a relationship between the education and mental health systems, Bridges was designed as a school-based program. | The program provides an array of mental health and related support services in all three targeted regions. With the exception of formal respite care, respondents reported that all grant-required services are currently available in the Kentucky River service array.  

There are three levels of intervention:  

- **Universal level** – activities are focused on school-wide efforts such as training (e.g., safe school environment, universal discipline plan development) and having mental health staff on hand to support students and teachers when crises arise in the community.  

- **Targeted level** – Bridges staff consults with teachers and administrators on how to deal with emerging emotional or behavioral problems and provide short-term intervention to individual children.  

- **Intensive level** – The SST provides direct services and functions as the central link for service provision. It is through the Student Service Teams that most services for families with children at the intensive level are arranged and monitored. |
A Framework of Critical Components in the Implementation of School-Based Mental Health Services

Each model has encountered obstacles that could have detracted from the success of the interventions. Some of the identified challenges are detailed below and are accompanied by the critical components that were implemented to meet the behavioral health care needs of children in the schools:

**Challenge 1: Organizational structure of the school and mental health agencies contributed to negative attitudes of administrators, clinicians, and teachers.**

Critical Component 1A: Getting individuals with authority to buy-in prior to entering the schools and fostering a readiness to change.

As stated by two participants in the interviews:

We went initially to the Central Office, the Director of People Personnel, in charge of all of our services… [He] was very interested in promoting agencies coming in and doing things. He would get us to the principal and find principals who had an interest and valued the service.

In the best possible world, when starting a school-based mental health program, the relationship between the school and mental health agency should already exist. Once those relationships are developed, then that’s when the resources can really start to be applied collaboratively and be effective for kids.

PALS staff listed the example of a meeting in which community agency and internal coaches gather to discuss evidence-based practice. PALS administrators foster collaboration with the people that are going to make this happen. According to one administrator, “they are the ones that are going to help us figure out how to bring this to scale.”

PALS is also quite pleased at the relative ease it has had at getting schools on board enthusiastically, as well as its success with teachers. The PALS approach with schools in explaining their model is to acknowledge the fact that there is a shortage of trained mental health workers, and aware that teachers are already familiar with the traditional counseling model. However, PALS attempts to create is a new way of training the next generation of psychologists, social workers, and psychiatrists to understand how to do effective consultation in schools.

RECAP staff found that the networking approach they took with schools was critical, as well as soliciting the support of the Master’s level school psychologist to whom teachers already relate. According to the RECAP administrator, the school psychologist made all the difference in that, “They get up there and they talk about I was in the classroom, I have seen these kids, I know exactly what you are talking about. In their presentation you can feel it, you see it in their face they want us.” In general, identifying who the leaders in the school were and selling the program to them first was tremendously helpful in subsequently attracting teachers. These programs found that relationships, getting connected in the community, and maintaining trust and mutual respect were critical.

Critical Component 1B: Agreeing on a service delivery model by establishing linkages between the mission of the school and mental health agencies. Buy in from school administrators and teachers has been accomplished by focusing on target behaviors that are most relevant within an educational context, such as decreases in major disruption behaviors, increases in on-task behavior, and progress on academic objectives. Conversely, linkages with the community mental health agencies have necessitated ongoing communication with supervisors and directors about the broader mission of the agency, including its prevention focus and the extent to which they are involved in providing psycho-
social support beyond mental health issues and counseling. The statements that follow exemplify strategies that the three national model programs used to foster a shared sense of purpose and focus among the various stakeholders:

Spend time to find out what their [community agency and other stakeholders] vision is, how they see their work, how do I link with that and think that [even] at the state level all that would make sense as well.

Guide services by a behavioral-ecological mode that proposed that positive classroom environments and family linkages to school would mitigate the negative effects of poverty on children’s adjustment to school.

I think if we can make a case to them why this relates to mental health, I think that is the point and I think we can do that but again, that is just one part of the message. It happens to be a very important part and if you take it out, other things may not go as well, but my strategy might be at the policy level not to let one thing get in the way of the whole package. Let's implement this in stages if that is needed and add things as we need to. But again, if people are getting the big picture then again the little picture is, if we have a student on a caseload, they are in a classroom and the teacher is really on top of it and things are going well, then we can focus on some of the other things. If they are not going well and a lot of behavior problems in the classroom, I don't want to lose a kid, I don't want him to drop a grade behind, and that is a mental health goal.

Critical Component 1C: Emphasize goal attainment and overall measurable progress in school

Decisions about the merits of the national models were derived from measurable outcome criteria that documented improvements in the academic, behavioral, and emotional functioning of the children served. Additionally, each program has attempted to assess systematically the integrity of the treatment provided. Data are collected from parents on the child's functioning, and measures are used to assess parental involvement. Teacher ratings of academic performance, on-task behavior, and disruptions also have been collected.

For example, in an NIMH randomized clinical trial that evaluated RECAP’s efficacy, standardized assessments of the child’s functioning were completed by parents using the Child Behavior Checklist (CBCL; Achenbach, 1991); by teachers using the TRF, a teacher's version of the CBCL; and by the participating children, using the Youth Self Report Form, a child-report version of the CBCL. The participants in RECAP demonstrated significant improvements in parent, teacher, self, and peer reports of internalizing and externalizing problems compared to the control group that received services as usual (Catron, 2005). Consumer satisfaction with the program was also high based on results from a parent questionnaire. Weiss et al. (2003) reported that the positive effects were sustained throughout the nearly two-year, post-follow-up period with persistent improvements noted for externalizing problems such as oppositional and aggressive behavior, internalizing problems such as depression and anxiety, and peer relationships (i.e., children who received the RECAP treatment were disliked less at the end than children in the control group).

RECAP did not specifically target academic achievement; however, the developers have noted that there is evidence that psychopathology is related to children’s adaptive functioning in school settings. In fact, prior to the implementation of RECAP, Catron (2005) reported that the developers of RECAP conducted a SAMSHA funded evaluation of school-based services that compared customary mental health services with academic tutoring. After interventions were applied for two years with children from low socioeconomic backgrounds, the researchers found that school-based services resulted in increased treatment accessibility, increased treatment utilization, and customary treatment and academic tutoring offered similar benefits for the improvement of mental health functioning.
Although the initial versions of RECAP did not directly address academic skills, a variation of the program is now being developed that includes a reading skills component to address academic deficits. The developers have justified the inclusion of academic interventions as part of the mental health intervention based on their observation that “some academic problems may be related to behavioral and emotional problems that interfere with academics, but eventually as these kids fall behind in school these academic problems become self-sustaining because the kids are too far behind too catch up without extra help” (Weiss, 2005; personal communication).

PALS, on the other hand, has created a model that was designed to improve specifically children’s academic functioning as well as enhance their behavioral and social skills. Students in K-6th grade were identified by teachers as evidencing disruptive behavior in school and were randomly assigned by classroom to receive services through PALS or at a university-based mental health clinic (Atkins et al., in press; Atkins et al., 2003). PALS school-based services were positively associated with teacher ratings of academic competence, and more families enrolled and remained in the PALS program than the clinic-based program. The students also demonstrated reduced disruptive behavior as reported by parents. Improved outcomes in both behavior and academic performance were strongly correlated with the service focus that had shifted to emphasize tutoring and curriculum-based assessment.

**Challenge 2: Developing and sustaining funding sources**

Many communities have observed that the quantity and range of services that can be offered are limited by funding restrictions. All three national model programs were primarily supported through Medicaid billing; however, creative blending of funding from private insurance, self pay dollars, as well as other state resources have allowed for diversification of services. For example, some Medicaid-funded, school-based services may only be offered to students whose IEP explicitly identifies mental health interventions as part of their special education program. Also the Medicaid fee-for-service system can limit services to Medicaid enrolled children who meet diagnostic criteria. As a result, funds typically are not available to support multifaceted prevention and early intervention strategies, to provide consultation to school personnel and parents, or to restructure mental health services to reduce behavioral health problems in classrooms and enhance academic functioning.

**Critical Component 2A:** In order to optimize the flexibility of service delivery, some programs have integrated nontraditional services and blended funding to meet needs. The funding sources are linked to the documentation of shared goals that prioritize schools not only as a setting for the delivery of interventions but also as a setting that establishes academic competence as the desired goal. The following statements capture the efforts made by each of the national model programs to blend funding in a way that would facilitate expansion of services:

In the best of all worlds you have some combination of mental health and education dollars to make this happen, and if there were a way to marry the Medicaid reimbursement with DOE funds for teacher training, for the mandates they have, for programs to reduce violence, behavior management program, all things that we are mandated to do but don't spend much money on.

Medicaid supports clinician-driven intervention and blended funding supports teacher-driven interventions as well as parent engagement. For example, Bridges uses state-funded dollars to pay for any other needed service that is not covered under billable Medicaid services.

Medicaid doesn’t pay for kids to engage in non-traditional services, so we use state funds for these activities. Also principals choose to spend their Title I dollars on therapy.
Over the last five years parents also sought other funding opportunities to create new dimensions for supporting other parents as well as expanding current programs. They actually succeeded in receiving a couple of grants to cover the cost of renting space, furniture, supplies, and training materials. Some of that money goes towards stipends for families and funding community events and family outings. This group also continuously works on sustaining this project through fundraising and outreach projects.

Critical Component 2B: Negotiating flexibility in the use of Medicaid resources
Atkins et al. (in press) have noted that the integration of tutoring and curriculum based assessments into mental health service delivery not only enhanced academic performance but also reduced disruptive behaviors. As a result, peer tutoring that is facilitated by a mental health clinician is achieving empirical support as an effective mental health intervention in schools that has residual positive gains on academic performance.

One of the things about the Medicaid that I think is worth considering is that it is going to be cut, it is being cut now so we have to be smarter about how we use some of the resources. I think that from a public health perspective it can’t just be about enrolling school kids or else we will fail. We have to have a better strategy, so a public health perspective is a very logical one for Medicaid to consider, and if the state is willing to think about this and they spent some time thinking about it, we could see greater success in our interventions.

In PALS Medicaid waivers have been requested that will allow agencies to bill Medicaid for universal, prevention programs and provide a formal interface between school-based and community-based mental health providers. The focus is on positive, academic and behavioral development of children.

We have integrated some creative services for children, and the auditors liked very much what we were doing. They knew that we were tracking academic goals because that was part of the treatment plan. After three audits of our academically oriented school-based services that emphasize tutoring and teacher consultation, we have come through with flying colors.

Challenge 3: Engaging families and facilitating access to mental health services in remote areas
Critical Component 3: A lack of transportation can isolate families from services; however, school-based models employed a number of strategies to actively engage caregivers. The program staff has found that often the key to enrolling children is to have access to parents and have based their model on an engagement framework that includes maintenance of an ongoing working relationship to establish and connect family priorities and treatment goals. Overall, the three programs employed the following means of engagement:

- Program staff goes out with school people to talk to the families together.
- Community consultants bridge the gap between the University and the community.
- Consultants work with parent focus groups to identify and establish goals for the program.
- Utilization of family resource developers funded through social service agencies work with parents to identify how they can be more involved in their child's schooling, what the barriers are, and how they can be overcome.
- Ensuring parent liaison reflects the socio-economic status and demographics of the target population.
- Teaching parents home-based activities.
- Translating the goals of each program into understandable objectives.
• Establishing rapport and trust in situations where parents have been treated poorly in the past by other mental health providers.
• Caregivers are included in both state and regional components of program evaluation as member of quality assurance teams and as data collectors.
• Families are invited and encouraged to attend case review meetings.
• Family members are hired as staff to provide mentoring, advocacy, and support groups.
• Service planning meetings are scheduled after hours per request.
• Social marketing campaigns are under consideration.

Some programs anticipated that confidentiality could be a barrier to service provision. School meetings for PALS often focus on having better communication with the child's teacher or scheduling homework time at home. PALS staff has found that parents are more comfortable and more likely to attend a discussion of such topics, as opposed to ones that might place blame or intense focus on parent behavior and habits. Another issue program staff have faced is the potential stigma attached to one’s child receiving mental health or academic support services. PALS staff try to decrease stigma by focusing more on academic skills, such as learning and tutoring, rather than behavior problems.

Other specific examples include the home-based activities taught through PALS. Family-focused interventions address the development of parenting skills, such as showing parents how to put children to bed at night and ensuring they eat breakfast in the morning before going to school. Programs also found that in high poverty areas, there traditionally has been little parent advocacy, and efforts have been made to engage parents in active roles on behalf of their children.

The Bridges project provides several forms of parent engagement. Services are created based on family needs. Substantial family information is gathered during the initial meeting with families and then used towards service planning. There are eight domains that have been created to assess the family’s level of need by staff. Parents also have a personal connection with a component of the Bridges project called “COPE House” (Creating Opportunities for Parents Everywhere). This is a support and resource center that is located in an apartment within a local community housing area.

**Challenge 4: Coordination of services**

Critical Component 4A: Programs found that having a liaison increased communication between the school and the agency, which is important to the success of the program. PALS staff expressed the importance of ensuring that there is a continuous feedback loop between program staff and community mental health agencies. For example, one administrator explained, “I want them participating, I don’t want this to be bifurcated to where the community mental health people are doing the individual and the school people are doing the prevention because there is no communication, no linkage.”

Program staff acknowledges that keeping these communication channels open has been difficult. School principals and assistant principals were also mentioned as key figures to which communication should remain fluid. Memorandums of agreement are helpful in making sure that people are really clear about what is going on and that they know who program staff are. For example, at the beginning of the Bridges project the community mental health center drafted and implemented a detailed Memorandum of Agreement with each school and principal about the expectations of each party, policies/procedures, and benefits of collaboration.
Other ways to facilitate open communication include ongoing training, consultation, supervision, and informal updates that are distributed to all parties involved as well as being included in school newsletters.

Engagement is a constant process and it always needs work. Recognize that it is going to be tough. Everybody buys into the model but then struggles to put it in practice. Clearly, we certainly have the problem of being careful that we are not selling more than we can do.

Critical Component 4B: Provider sensitivity and flexibility
Areas where people have sensitivities normally have to do with the sharing of space or the encroachment of an unfamiliar person on one’s “professional territory” or classroom. Regarding the office space issue, PALS staff do not let lack of space be a barrier to serving children. According to one administrator, “We need to work within the setting, so if we are going to pull kids and do some tutoring, they will find room for us to do tutoring, trust me, or we will do it in the hallway, I don't care because we are not going to let something like that get in the way.”

Regarding gaining access to classrooms and teachers, PALS staff employ rapport building strategies and participant observation. Staff pay attention as to when to catch teachers at a good time during the day, which varies per teacher. Next, staff both ask a teacher how they can help, and they look for ways to provide immediate assistance to the teacher in each classroom, as opposed to sitting in the back of the classroom with a clipboard and observation protocol in hand. According to one administrator, “This is basic social work practice, after a while the teachers look forward to our staff showing up because they are there to help.” Over time, this leads to program buy-in from the schools.

Challenge 5: Teacher resistance

Critical Component 5: For the program’s success, the school administrators’ leadership is very important.

Where the principal is committed, there can be more success because the principal is in the best position to help make things happen.

We came up with what we called the Sunshine Rule, which is, let's get that door open, let's get lots of people going through there, let's talk to the assistant principal or to the principal. Let's get parents in there; let's just make sure that that teacher knows there is always somebody around to support them as much as possible.

Challenge 6: Expanding implementation of the service model by including other providers as well as recruiting and retaining quality staff

Part of the difficulty with the diffusion of the process is trying to discern what are the critical and essential elements because when you map onto a new place, not all variables are exactly the same.

The following barriers were experienced by the three school-based programs:

- Problems associated with transferring a successful program into rural areas where there are fewer children and resources
- Some services within a program with wait lists, such as after school activities and neurological assessments
- Service capacity cannot yet handle medication management
- Having adequate resources and professional skill level to be able to help children cope with community violence and drug abuse
- Psycho-social needs of children
- Immediate needs of families (e.g., housing)
- Children who need services but are not yet enrolled in Medicaid
- Cultural problem in immigrant communities regarding citizenship and Medicaid enrollment
- Consent for services when children are in the custody of the state or in informal placements with relative caregivers
- Being able to provide children with enough individual attention, particularly in cases where the child is not supported at home
- High teacher to student classroom ratios
- Avoidance of specific treatment language in IEPs

Critical Component 6A: Provide consultation and training
The following statements exemplify efforts to focus on training and capacity building of the staff.

Live and web-based trainings have been designed by the programs as well as by periodic on-site meetings. RECAP has two full-time dedicated staff who train the teachers with a strong focus on behavioral contracting. School social workers and psychologists are also trained to assist as consultants within the schools.

We would all have better outcomes if our folks had been better trained.

Without monitoring and training, things may drift back to old models of service delivery.

Critical Component 6B: Manualize interventions
All three program have manualized their programs, using templates for the treatment plans, establishing guidebooks for implementing the billing and tracking process, and/or creating manuals that detail the program activities. Additionally, the following components were identified by the program informants as critical to the success of the models:

- Intensive planning and preparation
- Using evidence-based processes
- Understand the community dynamics and site specific issues that require adaptation of the original approach
- Ongoing evaluation of effectiveness
- Linking academic success of students as a primary outcome to establish success of the program
- Support for staff
- Coordination and integration of services
- Careful maintenance and follow-up

CONCLUSIONS AND POLICY IMPLICATIONS

Accessing funding sources for the provision of school-based services for students with behavioral health issues can expand the role of education institutions in fostering quality care and ensuring that interventions are developmentally appropriate. However, in order to provide the type and scope of services covered through Medicaid, our research findings suggest that some existing policies need reconsideration.
An analysis of the qualitative key informant data derived a number of specific organizational and policy recommendations for the provision of mental health services in Florida schools. Recommendations for program development, implementation, and operation based on these analyses are provided below:

**Program Design, Organization, and Implementation:**
Behavioral Health Programs must be implemented in collaboration with relevant community stakeholders: The development of effective school-based mental health services require the careful collaboration and shared vision of a broad range of community stakeholders. The provision of services first necessitates the close cooperation of two distinct service entities, designated mental health providers and local educational agencies. These agencies, in turn, must be supported in their efforts by other critical community stakeholders, such as community service providers and parents. Critical stakeholders include school administrators and teachers, mental health authorities, community service providers, and parents. Additional local stakeholders may include law enforcement, social service agencies, faith-based organizations, juvenile justice, and the courts.

Behavioral Health Programs must be uniquely designed to fit local community needs: Remembering that communities have local needs and populations, evidence-based mental health service programs must be uniquely identified to meet the specific needs of the community. Programs of service must take into account ethnic and racial minorities, special need and high-risk populations, and the resources available in the area. The identification of local service needs should emerge from the findings of needs assessments, resource mapping efforts, or local community based planning efforts conducted using established standards of empirical quality. The shared vision of services based in local, empirical needs assessment provides the only foundation for the development and implementation of effective mental health services.

Behavioral Health Programs must be locally controlled: Because the program requires the continuing support and cooperation of teachers and school staff, service providers, and parents, the program must provide for local control and operating authority. An ongoing executive committee, board, or council responsible for oversight and control of program activities, should be developed to facilitate the organization and delivery of services. Local control provides the most effective mechanism for providing relevant management of services, oversight of community needs, and sensitivity to addressing emerging population needs.

Behavioral Health Programs must be integrated as part of the larger educational mission of the school. Teachers are critical stakeholders who not only serve as gatekeepers for access to the student population but also as allies in the provision of prevention and intervention services. Therefore, effective services in the school environment must provide a means of engaging, training, and supporting the efforts of teachers and educational administrators. Memoranda of agreement explicating policies, procedures, expectations, and roles must be developed for both educators and mental health providers.

**Accessibility, Outreach, Enrollment, and Referrals:**
Behavioral Health Programs must develop adequate procedures to identify, assess, and enroll students in need of services: Effective programs require (1) outreach to introduce services and to identify and enroll under-served, high-risk populations; (2) culturally and locally sensitive procedures to screen and assess students’ needs; and (3) clear and inclusive definitions of eligibility determinations. Behavioral health programs in Florida must be particularly sensitive to local populations of need including immigrant populations. Further, programs must develop procedures for both internal and external referrals for service. Programs must develop procedures to allow for
confidential referrals from within the school by teachers and other school staff, as well as a vehicle for the referral of students identified in the community who need services.

Behavioral Health Programs in the school environment must develop adequate procedures for outreach, engagement, training, and supporting the efforts of parents and family members: Effective mental health services require enlisting the parent as an active participant in the delivery of services and should provide support and education for parents.

Accountability:
An empirically sound evaluation must be conducted to assess and document program implementation, fidelity, operation, outcomes, cost/benefit analysis of the effort, and sustainability: The implementation of a program of services should be undertaken with the understanding that programs are seldom implemented without significant modifications based on their performance. Historically, even programs of proven effectiveness have been implemented without fidelity to the original model with the result that services are either ineffective, inefficient, or both. Therefore, programs must be implemented with an initial period of field testing to ensure appropriate implementation, fidelity to the model, and adequacy of resources. Further, the initial field test must be of sufficient duration to provide for a meaningful analysis of the organization, operation and outcomes of the program effort.

Ethics and Confidentiality:
The provision of services must be undertaken with careful attention to ethical considerations for informed consent, confidentiality of participation, and security of records: The confluence of two distinct service entities, the schools and mental health service agencies, brings with it two historically different interpretations of consumer rights. Program developers must identify specific enrollment procedures to ensure the informed consent of students and parents. In addition, procedures must be established to maintain the confidentiality of mental health services in the school with regard to the identification of a student as a recipient of mental health services, the confidentiality of records for non-professional personnel, and the accessibility of data and cross-agency sharing of student records.

Summary and Considerations for AHCA
This study has reviewed the literature describing exemplary programs that deliver school-based mental health services to children who have a need for intervention because of the serious impairment reflected in multiple domains of their lives. After an extensive review that included interviews with national experts in the field, three programs emerged as having potential to contribute information to AHCA for consideration in implementing Florida’s Medicaid Program for children. These programs were located in Chicago, Nashville, and Kentucky. A site visit was made to Kentucky, and the developers of each of the other two programs were brought to Tampa for an extensive interview and consultation with the entire study team.

The sites selected offered an opportunity to collect information from a program in the inner city of a very large metropolitan area, a mid-sized city, and a rural area. All three sites implemented programs in schools that served attendance areas in which the majority of families were experiencing economic distress and fell below the poverty level; consequently, there was a high degree of eligibility for the use of Medicaid to provide mental health services.

Interestingly, all three programs had important elements in common. They all had components that provided support for parents, they had strong teacher consultation and support activities, and they made use of evidence-based practices in providing interventions to the children. While some individual and group therapy was used in these programs, these services were clearly de-emphasized for more evidenced-based approaches. These programs all developed strategies in which Medicaid
supported services were integrated with other school-based activities to produce a comprehensive program that improved outcomes for very needy children.

Nationally, individual psychotherapy is the major mental health service for children that is reimbursed by Medicaid. There have been many reviews in the literature that indicate the lack of effectiveness of psychotherapy for children when it is delivered in community settings (as opposed to university-based clinics). In spite of the poor effectiveness of this intervention, it continues to be the staple of most school-based programs due, in large part, to the lack of information and knowledge about more effective alternatives. However, as this study has demonstrated, there are recently developed options that are emerging as exemplars of more effective use of Medicaid funding to improve the functioning of children who have emotional disturbances.

These programs have been guided by the growing, empirical base indicating that mental health programs that focus solely on the emotional component of the child through traditional psychotherapy are costly and not very effective. Alternatively, programs that incorporate support and education for parents about their child’s disability, support and consultation to the child’s teachers, and services to the child that address all the important domains of his/her life are both effective and cost-efficient. In particular, peer tutoring for students with behavioral disorders has been found to be associated with increased positive interactions, reduced classroom behavior problems, enhanced peer affiliation, improvements in student attitudes and self-concepts as well as increased academic benefits (Fantuzzo et al., 1992; Franca et al., 1990; Greenwood, Carta, & Hall, 1988). Consequently, the three programs identified in this study make use of mentoring and academic tutoring to address the serious gap in achievement in these children that serves as a major barrier to improved functioning. Atkins, the developer of PALS in Chicago, contends that if academic functioning is not addressed in children who have emotional disturbances, attempts to improve their behavioral functioning will be severely limited. Likewise, supporting parents and helping them to become partners in their child’s education and emotional development greatly enhances success. Finally, these programs reject the model in which therapists come into a school and see a child for a 50-minute therapy session and leave. Teachers may very well be the most critical, therapeutic agent in the lives of these children. With support and intensive consultation from mental health professionals, the teacher’s effectiveness with the child will also be enhanced.

**Implications for Florida**

Florida, like most states in the nation, has not developed strategic mechanisms that will lead to a reciprocal alignment of the major laws and policies that govern the delivery of mental health services to children who have emotional disturbances and who are eligible for support for these services through Medicaid. This is clearly a complex task, and many reports funded by the federal government have documented the frustration of policy makers and planners in their attempts to implement cohesive and effective programs for this group of children. Much of this complexity is due to the convergence of three complex federal laws that are implemented at the state and local levels and have significant bearing on poor children who have emotional disturbances and need mental health services. These three laws, the Individuals with Disabilities Education Act (IDEA), Medicaid, and the relatively recent No Child Left Behind Act (NCLB), all have components that are intended to help this group of children. Unfortunately, there are very few professionals across the country that have mastered the intricacies of these statutes to the point of being able to align them adequately to produce an effective and sufficiently funded program for this group of children who have disabilities. However, as this report has illustrated, there are programs across the country in which effective strategies have been developed and implemented. Furthermore, these innovative programs are in compliance with the requirements of the relevant laws and have been successfully audited.
Presently, Florida is in a propitious position to address some of the challenges facing the state in providing effective services for these children. The A+ Program, Florida’s version of NCLB, has received national attention for its efforts to improve academic functioning of all its children. The Medicaid program has undergone extensive study and will assuredly undergo some type of change in the near future. This is an excellent time for AHCA to take the lead and make proposals about more effective service delivery for this group of youth that will capitalize on the advantages of basing services in school, will be guided by the best available data concerning effectiveness, and will be consistent with the broad goals of the education system to improve outcomes for all children.

Regardless of whether the changes to Medicaid are large scale or incremental, AHCA is in a position to outline the current state-of-the-art and request that future contractors become familiar with these types of services and ultimately be able to provide them. This would hold for managed care options as well as other types of funding mechanisms. Previous reports conducted for AHCA by FMHI (Berson et al., 2004) indicate that traditional services such as assessment and psychotherapy compose the majority of services reimbursed by Medicaid and delivered in schools. Such a service array can easily lead to a situation in which upwards of $300,000 Medicaid funds are used for a mental health center to deliver psychotherapy to a group of 1500 children who are classified as seriously emotionally disturbed. This amount equates to an average of $200 per child with very little evidence in the way of improved functioning. A base of $300,000 could go a long way in developing a more comprehensive program for these children by blending funds from IDEA and Medicaid in order to produce improved outcomes.

Florida does have some mechanisms that are especially suited to implement pilot projects to foster the dissemination of sound innovations and subsequently develop important knowledge about going to scale with such initiatives. For example, SEDNET would be an ideal mechanism to develop pilot projects in various locations across the state.

In order to account for variations in program implementation across diverse states, stakeholders from Florida should convene to discuss practical applications of the findings and explore the transportability of processes and programs with demonstrated success in other states. An advisory panel comprised of representatives from AHCA, schools, and CMH providers should discuss which program(s) may be viable for implementation in Florida sites and explore the selection of one program that seems most feasible for a subsequent demonstration project, connecting managed care and school-based mental health services.

In this era of evidence-based practice and accountability, all state agencies will be searching for the best way to achieve their goals. AHCA is poised to take leadership in improving the cost-effectiveness and the client outcomes for programs that serve children who have intensive emotional disturbances. By taking bold action to face these challenges, Florida can break new ground, and over time other states will look to Florida as the innovator and early adopter of successful efforts to build quality and accountability in mental health service delivery for children in schools.
REFERENCES


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APPENDIX A: PROTOCOL FOR EXPERT INTERVIEW

The Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida is presently under contract with the Florida Agency for Healthcare Administration (AHCA) to identify model, school-based behavioral health programs across the country. In order to meet this goal, we are contacting you to enlist your assistance in fulfilling this task. Specifically, we are exploring promising approaches that may have components that are transportable for implementation in a subsequent demonstration project in Florida. We consider your expertise and experience invaluable and believe that the information you will share with us can be very useful for improving programs and helping school-aged children and their families. We hope you will agree to aid us by participating in this interview. Your participation in this study is voluntary, and the interview will involve approximately seven questions.

1. What are your criteria for a best practice or successful school-based behavioral health model?

2. Do you know of programs across the country that are successfully implementing these practices in school-based behavioral health?
   • Probes: Do you have first hand experience with any of these programs?

3. What diagnoses or behavioral health issues do these programs address?
   • Probes: Do you know of any sites that are utilizing promising practices for children with autism?

4. Where are the programs you’ve mentioned located? Who should we contact at that site to learn more about the program?

5. What factors do you think have led to the successful implementation of these practices at these sites?

6. Have you seen successful models not work well in other geographical areas? If so, what do you think accounts for this?

7. [If not mentioned] How are the successful programs funded?
   • Probes: [If not covered] To what extent is Medicaid used in these programs?
APPENDIX B: PROTOCOL FOR SITE SPECIFIC INTERVIEWS
MEDICAID-FUNDED SCHOOL-BASED SERVICES STUDY PROTOCOL

Key informant and observation themes relating to the organization, delivery, and oversight of children’s mental health services and Medicaid funding in the schools:

- **Identification of the necessary organizational contexts of schools to promote successful adoption of Medicaid-funded mental health programs**

  1. How do school administrators and those providing service coordinate services, collaborate on needs and goals, and power share? For example, is the program organized and operated from top down or does a local school administrator, such as a principal, negotiate and collaborate directly with a local service provider to address their uniquely perceived needs. Is the system as implemented a local solution to that school and community or something handed down from the state level? Along these lines, are contracts between community providers and local schools or at the state level? If the state level, then how does the school voice its needs both organizationally and with regard to service needs and population of concern? This also comes down to what’s in it for schools?

    a. What were the stages of policy development for this program? What were some obstacles? What were some key activities that promoted productivity?
    b. Is there a written policy or Memorandum of Agreement that relates to school-community partnerships?
    c. How are school-community partnerships enhanced and sustained? How are family partnerships facilitated?

  2. How do we know that sufficient and appropriate services are provided to the children in need? (Or what procedures are used to ensure that the right children are getting the right services?) This has to do with the kind and quality of services that are available to children. Is the set of services a one-size-fits-all approach provided under the guise of an ISP or ITP? Are services individualized with intensive need children receiving appropriate interventions? How is client creaming prevented? Do services address the needs of the average school population? Is there flexibility in the array of services available in each site?

    a. To date, how many children have been served through school-based mental health services?
    b. Who do you serve (target population)? What is the average age of children being served?
    c. What is an estimated cost per child?
    d. Describe how services are delivered to children & families within this program.
       i. Caseload size
       ii. Scheduling of services
       iii. Intensity/types of services
       iv. Access points
       v. Funding
       vi. Family/child, school, and Mental Health staff interact
       vii. Space in schools
    e. What strategies do you use to make your services convenient and accessible to families?
3. How does your program determine/measure progress and success with the children/families you serve?
   a. How do you collect individual outcome data for children? How do you collect overall program data?
   b. How are the mental health services structured to address children’s educational outcomes (e.g. IEP documentation)?
   c. Does participation in the school-based program improve the outcomes of children who receive services? Are school and family stakeholders seeing a difference?
   d. What do you see as the most effective aspect of your services?

4. To what degree is the system driven by service need, Medicaid policy, and school policy?

5. What is the level of involvement of teachers with clinical staff? What are the mechanics of cooperation between school staff, parents, and mental health staff? Do teachers know and understand the program? Do they understand how the program fits in their school day? Are clinical professionals aware of, and do they see the activities of the school? Do parents see this as a school program, or mental health program, or something else?
   a. What were the criteria used for staff selection for the school-based program?
   b. What are the designated roles and function of staff that provide services to children and families through this school-based program?
   c. What are your highest referral sources?

6. How are confidentiality and privacy rights ensured? How is the confidentiality of student participation maintained in the school setting? How many people, and who, knows that a child or family is receiving services? Are service recipients identified in school records? How are parent concerns for stigma addressed?

• Exploration of critical components to achieve effective diffusion of practice (i.e., what factors promote adoption of EBP in schools and successful uptake)

1. What was necessary to achieve full implementation and how long did it take?
   a. What type of training/supervision/consultation took place to promote and sustain this school-based mental health service structure? (training content, frequency, participation, program/practice manual)
   b. What type of community/statewide/school resources are available to staff?
   c. Who are the key leaders/stakeholders that are pertinent to the success of this program?

2. What have been the major obstacles to implementation and operation of your program?
   How did you cope? In retrospect, what are the most valuable “lessons learned”?

3. How many schools are currently involved in this school-based initiative for children’s mental health services? How many children are being served in your region/state?

4. Was this program initially implemented in a rural or urban area?

• How do you balance fidelity with reinvention of innovation to accommodate diverse settings?
   a. What fidelity measures are used for this program? How often are they reviewed and used?
• What strategies do you use to get Medicaid reimbursement for the various components of the program?

1. At what point in the organization and delivery of services does the source of funding become apparent to service recipients and those who deliver service? In other words, do families have to understand Medicaid issues of eligibility, application, and certification before they seek services? Do teachers and counselors in the school have to first consider eligibility before they can start thinking about the child's service needs? Is the form of payment and funding transparent to service recipients, to direct clinical staff, to clinical supervisors, to program managers? Is the funding process a matter for the medical billing department or line personnel?

a. What were some of the necessary Medicaid prerequisites that needed to be developed before implementation of this school-based initiative?

b. Did you start your program with Medicaid funding, or did you use grass roots funding to prove your program's viability then ask for Medicaid dollars? If policy changes were needed, who initiated this process?

c. What did it take to get your program started? If it was a non-Medicaid program, were there additional supports necessary to transition to a Medicaid-funded program?

d. Which staff currently bill Medicaid for services rendered?

e. How does your state's Medicaid Plan facilitate your ability to use Medicaid to fund innovative services?

2. What is the oversight and accountability process to ensure timely payment of funds, prevent fraud, and maintain program solvency and efficiency? This also relates to how costs are controlled/contained. Is eligibility limited, or are there procedures designed to limit accessibility to keep costs under control? Do local schools or MHC's control eligibility and access to services? Is there a statewide oversight that controls costs? Is there an audit process? How are new service recipients identified?

a. What percentage of the children you serve are on Medicaid?

b. Does your program do any outreach? (promote your program/services, educate parents/professionals concerning healthy social/emotional/behavioral development in young children) Please describe.

c. Please describe the types of school-based mental health services covered by Medicaid. (Child service team meetings?)

d. What are some specific examples of child/family services that were billed to Medicaid that you would consider “creative”?

e. Does Medicaid place any limitations on the frequency, intensity and duration of school-based mental health services for children? If so, what are they? What are some ways in which you overcome/cope with obstacles and limitations?

f. How does your program/agency MIS assist with using Medicaid? Does this technology make a difference in your ability to access these resources?

g. Describe the day-to-day process of capturing the data you need to bill. What are the procedures? Who fills out the forms? How many people does it take to fill out the forms? How much time does this take?

h. Approximately what percentage of your program’s total costs is covered by Medicaid during your fiscal year? Has this amount fluctuated over the last several years?

i. What do you need to have in place to “maximize” the usage of Medicaid?
j. How do you establish and maintain Medicaid eligibility for children? How aggressive is your site in getting children eligible for services?

k. What mechanisms are required to ensure sustainability of mental health school-based functions?

Is there anything else you would like to share with us that would help us to visualize the functions of this program?