School Based Behavioral Health Services Summary – February 2017

Good mental health and a substance free lifestyle is essential to children's success in school and in life. When students, throughout all grade levels, are provided with developmentally appropriate prevention activities and social-emotional supports including mental health counseling, they are more likely to achieve academically, develop a positive sense of self-esteem, maintain meaningful family and peer relationships, cope with adversity, and delay use of tobacco, alcohol, and other substances. Unfortunately, mental health and substance use disorders are common and often go untreated. The National Institute for Mental Health estimates than more than 20% of children and adolescents experience significant symptoms consistent with a diagnosable mental health and/or substance use disorder every year. Over half of all behavioral health conditions start before age 14.

School-based behavioral health services are an effective strategy in identifying youth at risk of or experiencing a mental health or substance use disorder and removing barriers to accessing services. Often times, stigma, lack of access to treatment providers, and transportation issues are barriers to accessing behavioral healthcare. With most children spending approximately 6 hours a day in the school setting, schools offer an ideal environment for the delivery of prevention, early intervention, and treatment services that naturally overcomes these barriers. Providing services through schools also supports coordination of care with regular communication between schools, families, and behavioral health providers.

The purpose of this document is to provide a sample of the existing school based behavioral health services and to support the knowledge transfer about best practices models in order to build and expand school-based behavioral health services through school and community provider partnerships.

This summary includes information from 36 behavioral health provider organizations that voluntarily responded to provide information about the school based behavioral health services they provide in their communities. These 36 provider organizations are currently delivering services in more than 200 school districts and over 1160 school buildings across Ohio. It demonstrates that Ohio has an existing, solid infrastructure in place that supports access to school-based behavioral health services including prevention, early intervention, and treatment services to meet the academic, social, and developmental needs of our children and their families.

Services offered include a wide variety of evidenced based prevention programing, early intervention activities, and clinical treatment services for students in all types of classroom settings. Examples of evidenced based services include Signs of Suicide (SOS), Second Step, Too Good for Drugs, Too Good for Violence, Coping Cat, Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Motivational Interviewing, just to name a few. The array of programs and evidence based services identified indicates that schools and providers are tailoring program and service design based on the individualized needs of students and communities, which is a best practice in and of itself.

The survey also addressed outcome measurement, organizational relationships between school districts and behavioral health provider organizations, and addresses the financing mechanisms that sustain school-based service delivery. Many school districts and provider organizations formalize their partnership through a memorandum of agreement or understanding while other rely on informal relationships. These formal documents are highly individualized and generally address roles and responsibilities of each party, financial arrangements, and any agreed upon outcome measurement.

A sustainable financial model was identified as a key issue to success and a barrier to school-based services. Medicaid reimbursement is the primary funder of school-based services although a number of provider organizations are also billing private, third party insurance when permitted or acceptable to the school or allowable under school policy. Other programs, particularly prevention services, rely on funding from the federal, state, and local resources provided by county Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards or other grant funders, such as the United Way. Some schools are also directly purchasing services and/or dedicated treatment staff from behavioral health provider organizations in order to make services more widely available to students regardless of their insurance coverage.

Clarity between schools and community providers about reimbursement practices, funding sources, purchase of services, and utilization of student's insurance coverage emerged as best practices. Understanding and using insurance coverage (Medicaid and third party coverage) is essential to support the sustainability of school based behavioral health services. Further strengthening federal insurance parity implementation will be important to increase the sustainability of behavioral health services, including prevention.

Behavioral health providers identified other key barriers and important lessons learned in their efforts to establish successful partnership with schools. Common barriers included finding adequate space to meet with students, working around academic teaching time, parent engagement, and gaining buy-in from principals, school counselors, and teachers in the benefit of school based services in both academic achievement and student growth and development. Emerging best practices included: providers learning and respecting school culture and their primary focus on academic achievement; open communication that builds trust and mutual respect; individualizing service delivery/interventions to the needs of each school building/community; cultivating relationships with school counselors and teachers; and working through the business and school/provider expectations prior to implementation of school based services.

Based on this sample, Ohio is well positioned to rapidly expand school based behavioral health services using existing school and community partnerships. Strengthening financial and reimbursement strategies and applying lessons learned will support further adoption an expansion of school based behavioral health services to support both the optimal healthy development and academic achievement of our students.

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The document includes "Partnership Profiles" completed by the behavioral health provider organization that describe individual provider organization and school district collaborations from the perspective of the behavioral health provider. These Partnership Profiles are organized by behavioral health provider agency as well as school districts. It also includes an index of evidence based practices that are being used.

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PARTNERSHIP PROFILES – ALPHABETICAL BY BH PROVIDER

BH Provider Organization	School Districts Served By Provider	Page
A Renewed Mind	Toledo Public; Springfield Township	19
Allwell Behavioral Health Services	Muskingum; Nobel; Morgan; Guernsey; Perry; and Coshocton Counties	21
Alta Care Group	Youngstown City	22
Ashland County Council on Alcoholism and Drug Abuse, Inc. (A.C.C.A.D.A)	Loudonville, Mapleton, Ashland City, Crestview and Hillsdale	28
The Buckeye Ranch, Inc., The Bonner Academy at Cross Creek	ESCCO: All Franklin County and outlying districts	30
The Buckeye Ranch, Inc., Community Programs	Southwestern City, Reynoldsburg	31
The Buckeye Ranch, Inc., Day Treatment Programs	Columbus City Schools, Dublin City Schools, Westerville City Schools, Reynoldsburg, Jonathan Alder, Southwest Licking, London, Groveport Madison, Worthington	33
Catalyst Life Services	Mansfield City (K-12), Lexington High (7-12)	35
Child and Adolescent Behavioral Health	Canton City, Massillon City; Alliance City, Plain Local, Marlington Local, Sandy Valley Local, Fairless Local, Tuslaw Local	37
Child Guidance & Family Solutions	Barberton City, Copley-Fairlawn City, Cuyahoga Falls City, Green Local, Hudson City, Life Skills, Nordonia Hills City, Stow-Munroe Falls City, Woodridge Local	39
The Children's Home of Cincinnati	Cincinnati Public (18), Loveland City (6), Mt. Healthy City (3), Northwest Local (12), Readingy City (4), Three Rivers Local (3), Wyoming City (6)	42
Concord Counseling Services	Groveport Madison Local, Gahanna-Jefferson Public, New Albany-Plain Local, Westerville City	45
Consolidated Care, Inc.	Bellefontaine City, Benjamin Logan, Indian Lake, Riverside Local, West Liberty-Salem, Urbana City, Graham Local, Mechanicsburg, Triad	48
The Counseling Center of Wayne & Holmes Counties	Green (Smithville) Local	50
Crossroads	Madison, Willoughby-Eastlake, Painesville City, Fairport Harbor, Mentor, Perry, Wickliffe, Kirtland,	52

	Lake County Educational Service Center	
Firelands Counseling & Recovery Services of Lorain County	Vermilion, Amherst, Midview, Sheffield, N. Ridgeville, St. Peter's, St. Joseph's, Firelands	56
FRS Counseling (Hillsboro and West Union)	Hillsboro City, Fairfield Local, Greenfield-McClain, Bright Local, Lynchburg-Clay Local, Hillsboro Christian, Ohio Valley Local (Peebles, Seaman and West Union campuses) and the Manchester Local	58
Harbor Behavioral Health	Toledo Public, Maumee City, Oregon City, Perrysburg, Holy Rosary, Queen of Apostles, Bennet Venture Academy	61
Hopewell Health Centers, Inc.	Hocking (Logan-Hocking; Logan Elm), Belpre (Marietta City, Warren Local, Belpre), Vinton County, Meigs (Meigs, Eastern Local, Southern Local), Jackson (Jackson City, Welson, Oak Hill), Athens (Trimble, Nelsonville, Athens, Federal Hocking, Alexander), Pickaway (Teays Valley)	65
Lake Geauga Recovery Center	Chardon and West Geauga	68
Marion Area Counseling Center	Marion City and County	70
Maumee Valley Guidance Center	Defiance City, Central Local, Northeastern Local	72
Mental Health Services for Clark and Madison Counties, Inc.	Springfield City, Tecumseh Local, Clark-Shawnee	74
Muskingum Behavioral Health (MBH)	Zanesville City, Foxfire	76
Nationwide Children's Hospital	Bexley, Canal Winchester, Columbus City	78
New Horizons Mental Health Services	Lancaster City, Pickerington, Liberty Union, Amanda-Clearcreek, Walnut Township, Fairfield Union, Bloom-Carroll	81
OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	*Cuyahoga County:* Berea City, Brooklyn City, Cleveland Metropolitan, East Cleveland City, Euclid City, Garfield Heights City, Fairview Park City, Lakewood City, Parma City, South Euclid-Lyndhurst City, Charter/Private/Parochial. *Medina County:* Brunswick City *Lucas County:* Springfield Local, Charter Schools	83

OhioGuidestone (Lorain County)	Avon Lake, Elyria City, Lorain City, Sheffield Lake and Charter Schools: Constellations	86
OhioGuidestone (Central Ohio)	Big Walnut Local	87
Personal and Family Counseling Services, an OhioGuidestone Organization (Tuscarawas and Carroll Counties)	Garaway, Strasburg, Indian Valley, Newcomerstown, Conotton Valley, and STAR Alternative	89
Pastoral Counseling Service (PCS)	Akron Public, Woodridge Local, Norton City, Tallmadge City, Barberton City, Wadsworth City, I CAN-Akron School, University Charter School and Main Street Charter School, Imagine Charter School	92
Recovery & Prevention Resources (Delaware and Morrow Counties)	Charter School	94
The Recovery Center	Pickerington, Fairfield Union, Berne Union, Liberty Union, Amanda Clearcreek, Bloom Carroll, Walnut Township (Millersport), and the Catholic Schools	96
Samaritan Behavioral Health, Inc.	Dayton Public, Career Technology Center, Miamisburg, Vandalia Butler, Piqua City, Milton Union	98
South Community	Montgomery County Educational Services Center, Kettering City, Northmont City, Northridge City, New Lebanon City, Centerville City, Oakwood City, Valleyview City, Summit Charter Schools, Huber Heights City, Eaton City and Dayton Public	100
St. Joseph Orphanage	Cincinnati Public (Dater High, Carson Elementary, Ethel M. Taylor Elementary), North College Hill, Ross Local, Hamilton City (Riverview Elementary), St. Joseph Catholic	103
Syntero, Inc.	Dublin, Grandview Heights, Hilliard City, Upper Arlington, Tolles	105
Talbert House	Cincinnati Public, Norwood City, Southwest Local, Princeton, Winton Woods, Deer Park City, Lakota, Fairfield, Western Brown, Southern Hills Career and Technical Center	108
Wingspan Care Group (Applewood/Bellefaire)	South Euclid Lyndhurst, Mayfield Heights, Euclid, Shaker, Lakewood, East Cleveland, Cleveland Metropolitan, Constellation Schools,	111

	Break Through Schools, Lorain City, Elyria City, Wellington Schools	
Youth to Youth	Columbus City, Dublin City, Westerville City	113
Zepf Center	Charter Schools: Discover Academy and Star Academy, some lower-level partnership with Perrysburg School District	115

PARTNERSHIP PROFILES – ALPHABETICAL BY SCHOOL DISTRICT

School District	BH Provider(s) Serving School District	Page
Akron Public	Pastoral Counseling Service (PCS)	92
Alliance City	Child and Adolescent Behavioral Health	37
Alexander	Hopewell Health Centers, Inc.	65
Amanda-Clearcreek	New Horizons Mental Health Services The Recovery Center	81 96
Amherst	Firelands Counseling & Recovery Services of Lorain County	56
Ashland City	Ashland County Council on Alcoholism and Drug Abuse, Inc. (A.C.C.A.D.A)	28
Athens	Hopewell Health Centers, Inc.	65
Avon Lake	OhioGuidestone (Lorain County)	86
Barberton City	Child Guidance & Family Solutions Pastoral Counseling Service (PCS)	39 92
Bellefontaine City	Consolidated Care, Inc.	48
Belpre City	Hopewell Health Centers, Inc.	65
Benjamin Logan	Consolidated Care, Inc.	48
Bennet Venture Academy	FRS Counseling (Hillsboro and West Union)	58
Berea City	OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	83
Berne Union Local	The Recovery Center	96
Bexley City	Nationwide Children's Hospital	78
Big Walnut Local	OhioGuidestone (Central Ohio)	87
Bloom-Carroll Local	New Horizons Mental Health Services The Recovery Center	81 96
Break Through Schools	Wingspan Care Group (Applewood/Bellefaire)	111
Bright Local	FRS Counseling (Hillsboro and West Union)	58
Brooklyn City	OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	83
Brunswick City	OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	83
Canal Winchester Local	Nationwide Children's Hospital	78
Canton City	Child and Adolescent Behavioral Health	37
Career Technology Center	Samaritan Behavioral Health, Inc.	98
Catholic Schools	The Recovery Center	96
Centerville City	South Community	100
Central Local	Maumee Valley Guidance Center	72
Chardon Local	Lake Geauga Recovery Center	68
Charter School	Recovery & Prevention Resources (Delaware and Morrow Counties)	94
Cincinnati Public	The Children's Home of Cincinnati St. Joseph Orphanage Talbert House	42 103 108

School District	BH Provider(s) Serving School District	Page
Clark-Shawnee Local	Mental Health Services for Clark and Madison Counties, Inc.	74
Cleveland Metropolitan	OhioGuidestone (Cuyahoga, Medina and Lucas Counties) Wingspan Care Group (Applewood/Bellefaire)	83 111
Columbus City	The Buckeye Ranch, Inc., Day Treatment Programs Nationwide Children's Hospital Youth to Youth	33 78 113
Conotton Valley-Union Local	Personal and Family Counseling Services, an OhioGuidestone Organization (Tuscarawas and Carroll Counties)	89
Constellations Charter School	OhioGuidestone (Lorain county) Wingspan Care Group (Applewood/Bellefaire)	86 111
Copley-Fairlawn City	Child Guidance & Family Solutions	39
Coshocton City	Allwell Behavioral Health Services	21
Crestview Local	Ashland County Council on Alcoholism and Drug Abuse, Inc. (A.C.C.A.D.A)	28
Cuyahoga Falls City	Child Guidance & Family Solutions	39
Dayton Public	Samaritan Behavioral Health, Inc. South Community	98 100
Deer Park City	Talbert House	108
Defiance City	Maumee Valley Guidance Center	72
Discover Academy	Zepf Center	115
Dublin City	The Buckeye Ranch, Inc., Day Treatment Programs Syntero, Inc. Youth to Youth	33 105 113
East Cleveland City	OhioGuidestone (Cuyahoga, Medina & Lucas Counties) Wingspan Care Group (Applewood/Bellefaire)	83 111
Eastern Local	Hopewell Health Centers, Inc.	65
Eaton City	South Community	100
Elyria City	OhioGuidestone (Lorain County) Wingspan Care Group (Applewood/Bellefaire)	86 111
Euclid City	OhioGuidestone (Cuyahoga, Medina and Lucas Counties) Wingspan Care Group (Applewood/Bellefaire)	83 111
Fairfield Local	FRS Counseling (Hillsboro and West Union) Talbert House	58 108
Fairfield Union	New Horizons Mental Health Services The Recovery Center	81 96
Fairless Local	Child and Adolescent Behavioral Health	37
Fairport Harbor	Crossroads	52

School District	BH Provider(s) Serving School District	Page
Fairview Park City	OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	83
Federal Hocking Local	Hopewell Health Centers, Inc.	65
Firelands	Firelands Counseling & Recovery Services of Lorain County	56
Foxfire	Muskingum Behavioral Health (MBH)	76
Gahanna-Jefferson City	Concord Counseling Services	45
Garaway Local	Personal and Family Counseling Services, an OhioGuidestone Organization (Tuscarawas and Carroll Counties)	89
Garfield Heights City	OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	83
Graham Local	Consolidated Care, Inc.	48
Grandview Heights City	Syntero, Inc.	105
Green Local	Child Guidance & Family Solutions The Counseling Center of Wayne & Holmes Counties	39 50
Greenfield-McClain (Greenfield Exempted Villiage)	FRS Counseling (Hillsboro and West Union)	58
Groveport Madison	The Buckeye Ranch, Inc., Day Treatment Programs Concord Counseling Services	33 45
Guernsey	Allwell Behavioral Health Services	21
Hamilton City	St. Joseph Orphanage	103
Hilliard City	Syntero, Inc.	105
Hillsboro Christian	FRS Counseling (Hillsboro and West Union)	58
Hillsboro City	FRS Counseling (Hillsboro and West Union)	58
Hillsdale Local	Ashland County Council on Alcoholism and Drug Abuse, Inc. (A.C.C.A.D.A)	28
Holy Rosary	Harbor Behavioral Health	61
Huber Heights City	South Community	100
Hudson City	Child Guidance & Family Solutions	39
I CAN-Akron School	Pastoral Counseling Service (PCS)	92
Imagine Charter School	Pastoral Counseling Service (PCS)	92
Indian Lake Local	Consolidated Care, Inc.	48
Indian Valley Local	Personal and Family Counseling Services, an OhioGuidestone Organization (Tuscarawas and Carroll Counties)	89
Jackson City	Hopewell Health Centers, Inc.	65
Jonathan Alder	The Buckeye Ranch, Inc., Day Treatment Programs	33
Kettering City	South Community	100

School District	BH Provider(s) Serving School District	Page
Kirtland Local (Kirtland Educational Service Center)	Crossroads	52
Lake County Educational Service Center	Crossroads	52
Lakewood City	OhioGuidestone (Cuyahoga, Medina and Lucas Counties) Wingspan Care Group (Applewood/Bellefaire)	83 111
Lakota Local	Talbert House	108
Lancaster City	New Horizons Mental Health Services	81
Lexington Local (Lexington High)	Catalyst Life Services	35
Liberty Union	New Horizons Mental Health Services The Recovery Center	81 96
Life Skills	Child Guidance & Family Solutions	39
Logan Elm Local	Hopewell Health Centers, Inc.	65
Logan-Hocking Local	Hopewell Health Centers, Inc.	65
London City	The Buckeye Ranch, Inc., Day Treatment Programs	33
Lorain City	OhioGuidestone (Lorain County) Wingspan Care Group (Applewood/Bellefaire)	86 111
Loundonville-Perrysville	Ashland County Council on Alcoholism and Drug Abuse, Inc. (A.C.C.A.D.A)	28
Loveland City	The Children's Home of Cincinnati	42
Lucas County Charter Schools	OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	83
Lynchburg-Clay Local	FRS Counseling (Hillsboro and West Union)	58
Madison	Crossroads	52
Main Street Charter School	Pastoral Counseling Service (PCS)	92
Manchester Local	FRS Counseling (Hillsboro and West Union)	58
Mansfield City (K-12)	Catalyst Life Services	35
Mapleton Local	Ashland County Council on Alcoholism and Drug Abuse, Inc. (A.C.C.A.D.A)	28
Marietta City	Hopewell Health Centers, Inc.	65
Marion City	Marion Area Counseling Center	70
Marlington Local	Child and Adolescent Behavioral Health	37
Massillon City	Child and Adolescent Behavioral Health	37
Maumee City	Harbor Behavioral Health	61
Mayfield City (Mayfield Heights)	Wingspan Care Group (Applewood/Bellefaire)	111
Mechanicsburg	Consolidated Care, Inc.	48
Meigs Eastern Local	Hopewell Health Centers, Inc.	65
Mentor	Crossroads	52
Miamisburg	Samaritan Behavioral Health, Inc.	98

School District	BH Provider(s) Serving School District	Page
Midview Local	Firelands Counseling & Recovery Services of Lorain County	56
Milton-Union	Samaritan Behavioral Health, Inc.	98
Montgomery County Education Service Center	South Community	100
Morgan Local	Allwell Behavioral Health Services	21
Mt Healthy City	The Children's Home of Cincinnati	42
Muskingum	Allwell Behavioral Health Services	21
Nelsonville	Hopewell Health Centers, Inc.	65
New Albany-Plain Local	Concord Counseling Services	45
New Lebanon Local	South Community	100
Newcomerstown	Personal and Family Counseling Services, an OhioGuidestone Organization (Tuscarawas and Carroll Counties)	89
Nobel	Allwell Behavioral Health Services	21
Nordonia Hills City	Child Guidance & Family Solutions	39
North College Hill	St. Joseph Orphanage	103
North Ridgeville	Firelands Counseling & Recovery Services of Lorain County	56
Northeastern Local	Maumee Valley Guidance Center	72
Northmont City	South Community	100
Northridge City	South Community	100
Northwest Local	The Children's Home of Cincinnati	42
Norton City	Pastoral Counseling Service (PCS)	92
Norwood City	Talbert House	108
Oak Hill Union Local	Hopewell Health Centers, Inc.	65
Oakwood City	South Community	100
Ohio Valley Local	FRS Counseling (Hillsboro and West Union)	58
Oregon City	Harbor Behavioral Health	61
Painesville City	Crossroads	52
Parma City	OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	83
Perry Local	Allwell Behavioral Health Services Crossroads	21 52
Perrysburg	Harbor Behavioral Health Zepf Center	61 115
Pickerington	New Horizons Mental Health Services The Recovery Center	81 96
Piqua City	Samaritan Behavioral Health, Inc.	98
Plain Local	Child and Adolescent Behavioral Health	37
Princeton	Talbert House	108
Reading City	The Children's Home of Cincinnati	42
Reynoldsburg	The Buckeye Ranch, Inc., Community Programs	31

School District	BH Provider(s) Serving School District	Page
	The Buckeye Ranch, Inc., Day Treatment Programs	33
Riverside Local	Consolidated Care, Inc.	48
Ross Local	St. Joseph Orphanage	103
Sand Valley Local	Child and Adolescent Behavioral Health	37
Shaker	Wingspan Care Group (Applewood/Bellefaire)	111
Sheffield Lake	Firelands Counseling & Recovery Services of Lorain County OhioGuidestone (Lorain County)	56 86
South Euclid-Lyndhurst	OhioGuidestone (Cuyahoga, Medina and Lucas Counties) Wingspan Care Group (Applewood/Bellefaire)	83 111
South-Western City	The Buckeye Ranch, Inc., Community Programs	31
Southern Hills Career & Technical Center	Talbert House	108
Southern Local	Hopewell Health Centers, Inc.	65
Southwest Licking	The Buckeye Ranch, Inc., Day Treatment Programs	33
Southwest Local	Talbert House	108
Springfield City	Mental Health Services for Clark and Madison Counties, Inc.	74
Springfield Local	OhioGuidestone (Cuyahoga, Medina and Lucas Counties)	83
Springfield Township	A Renewed Mind	4
St. Joseph Catholic	St. Joseph Orphanage	103
St. Joseph's	Firelands Counseling & Recovery Services of Lorain County	56
St. Peter's	Firelands Counseling & Recovery Services of Lorain County	56
STAR Alternative	Personal and Family Counseling Services, an OhioGuidestone Organization (Tuscarawas and Carroll Counties) Zepf Center	89 115
Stow-Munroe Falls City	Child Guidance & Family Solutions	39
Strasburg	Personal and Family Counseling Services, an OhioGuidestone Organization (Tuscarawas and Carroll Counties)	89
Summit Charter Schools	South Community	100
Tallmadge City	Pastoral Counseling Service (PCS)	92
Teays Valley	Hopewell Health Centers, Inc.	65
Tecumseh Local	Mental Health Services for Clark and Madison Counties, Inc.	74
Three Rivers Local	The Children's Home of Cincinnati	42
Toledo Public	A Renewed Mind	4

School District	BH Provider(s) Serving School District	Page
	Harbor Behavioral Health	61
Tolles	Syntero, Inc.	105
Triad Local	Consolidated Care, Inc.	48
Trimble Local	Hopewell Health Centers, Inc.	65
Tuslaw Local	Child and Adolescent Behavioral Health	37
University Charter School	Pastoral Counseling Service (PCS)	92
Upper Arlington City	Syntero, Inc.	105
Urbana City	Consolidated Care, Inc.	48
Valleyview City	South Community	100
Vandalia Butler City	Samaritan Behavioral Health, Inc.	98
Vermilion Local	Firelands Counseling & Recovery Services of Lorain County	56
Vinton County Local	Hopewell Health Centers, Inc.	65
Wadsworth City	Pastoral Counseling Service (PCS)	92
Walnut Township	New Horizons Mental Health Services The Recovery Center	81 96
Warren Local	Hopewell Health Centers, Inc.	65
Wellington	Wingspan Care Group (Applewood/Bellefaire)	111
Welson	Hopewell Health Centers, Inc.	65
West Geauga Local	Lake Geauga Recovery Center	68
West Liberty-Salem Local	Consolidated Care, Inc.	48
Western Brown	Talbert House	108
Westerville City	The Buckeye Ranch, Inc., Day Treatment Programs Concord Counseling Services Youth to Youth	33 45 113
Wickliffe City	Crossroads	52
Willoughby-Eastlake	Crossroads	52
Winton Woods	Talbert House Youth to Youth	108 113
Woodridge Local	Child Guidance & Family Solutions Pastoral Counseling Service (PCS)	39 92
Worthington	The Buckeye Ranch, Inc., Day Treatment Programs	33
Wyoming City	The Children's Home of Cincinnati	42
Youngstown City	Alta Care Group	22
Zanesville City	Muskingum Behavioral Health (MBH)	76

INDEX OF SERVICES & EVIDENCED BASED PRACTICES

Service or Evidence Based Practice	# of Times Reported
7 Challenges	
Acceptance Commitment Therapy	
Active Substance Abuse Prevention (ASAP)	
AIT	
Angry Bird Anger Management	
Art Therapy	2
Balancing Act: Promoting Mental Well-Being of your MS & HS Students	
Behavioral Health Diagnostic Assessment	5
Behavioral Intervention Plans	
Behavioral Therapy	
Botvin's Life Skills	
Boys' Council	
Building Resiliency	
Bully Prevention (Olweus; Beane)	5
Busy Bees ADHD	
CARE	
Choice Therapy	
Circles Curriculum	
Club Save (Evidence influence by LifeSkills)	
Cognitive Behavior Therapy (CBT)	16
Community Collaborative (previously Care Teams	
Community Psychiatric Supportive Services (CPST)	13
Conscious Discipline	
Consultation: Classroom & Individual Student	14
COPE	2
Coping 10.1	2
Coping Cat	4
Crisis Intervention and Debriefing	7
Cybersmart (not evidence based yet)	
Developmental Assets Profile	
Devereux Student Strengths Assessment (DESSA)	
Dialectical Behavior Therapy (DBT) Groups	5
DINA	
Don't Worry, I'm FINE	

Service or Evidence Based Practice	# of Times Reported
Early Child Mental Health Consultation	
Environmental Strategies to Improving the Community	
Family Counseling	5
Family Wellness Survival Skills for Health Families	
Functional Behavioral Assessments	
Generation Rx (after school in home or group setting)	
Girl Circle/ Council on Men (Georgetown Model)	3
Girls in Real Life Situations	
Group Therapy (Grief Groups, Social Skills, Anger Management, etc.)	15
Helping Your Child Develop Coping Strategies to Manage Stress & Anxiety	
Healthy Bodies, Healthy Futures	
Hurting to Health: Understanding Self-Injurious Behavior in Youth	
I Can Do	
I Can Problem Solve	
IFAST	2
Incredible Flexible You	
Incredible Years	3
Individual Counseling and Therapy	18
Individual Screening (PHQ-9 and GAD07)	
Inside Out Emotional Regulation	
Junior Teen Institute (JTI)	
Life Coaching and Life Coping Skills	
Mental Health First Aid - Youth	2
Mix it Up	
Motivational Interviewing	5
NMT	
Overscheduling	
Owning UP	
Partial Hospitalization/Day Treatment	5
PATHS	3
PAX Good Behavior Game	2
PBIS	2
Pharmacological Management Service	2
Play Therapy	
PREP-Sexual Health for Teens/Communication	

Service or Evidence Based Practice	# of Times Reported
Project Alert Curriculum	2
Project SUCCESS	
Reconnecting Youth	
Recovery 360 Care (integrated AoD & MH)	
Red Flag	4
Relationship Plus	
RTI/AT/MTSS Teams	
Safe Dates	
Say Something	
SBIRT (using CRAFFT)	
Second Step	5
Self-Awareness, Affect Management, Self-Esteem & Self-Respect "SASS"	
Seven Challenges (AoD)	3
Seeing Red	
Signs of Suicide Prevention Program (SOS),	13
Skills Streaming Groups	6
Social Skills Intervention	3
Solution focused Therapy	3
Sources of Strength	
Strong Kids/Teens	
Stop and Think	2
Suicide Prevention Teacher Training	2
Teen Dating Violence	
Theraplay	
The Response Ability Pathways Model	
Thinking for a Change	
Thinking, Feeling, Behaving	
Too Good for Drugs (TGFD)	4
Too Good for Violence	3
Trauma Competent Care	2
Trauma Informed Cognitive Behavioral Therapy (TF-CBT)	9
Trauma Systems Therapy (TST)	
Youth Engaged in Leadership and Learning	
Youth Led Prevention Activities	3
Zones of Regulation Curriculum	2

PARTNERSHIP PROFILES

Self-reported sample from community behavioral health provider organizations and members of The Ohio Council of Behavioral Health & Family Services Providers

BH Provider Organization: A Renewed Mind

Primary Contact and e-mail: 419-720-0304 email: Josh Mielcarek at jmielcarek@arenewedmindservices.org or aboreman@arenewedmindservices.org

Partnering School District(s): Toledo Public, Springfield Township

Number of school buildings in which school based behavioral health services are provided:

5 Elementary 6 Middle School 3 High School ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular education and special education.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We provide pharm management which includes one-on-one and small groups for education. We also provide individual assessments and counseling as much as necessary per each client. A Renewed Mind provides partial hosp and case management in the school as well.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We are measuring the client's ability and progress in accepting and managing their mental health diagnosis and presenting symptoms. This includes education and assessment of each. School services benefit academic performance through minimizing mental health symptoms for each individual client. If mental health is addressed at school, a client will be better suited to learn with less difficulty in a group setting.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:
We are a resource to each school. There are contracts in place that state A Renewed Mind is allowed in each school setting to provide mental health services and assistance. There are no financial agreements included. We serve the Toledo Public schools and multiple charter schools in the area.

What is the reimbursement or financing mechanism for your school based behavioral health services?

We are financed through each individual client's insurance that we serve in the school. This includes private insurance and Medicaid.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The biggest challenges are educating teachers and principals regarding the mental health fields' role in the school. Many teachers are unsure and not open minded about a child's mental health even after we provide a professional assessment. We navigate this dynamic through ongoing education through the school administration.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

The key is to communicate with school staff that each person is there to serve the children in a different capacity. We allow the teachers to teach, and most teachers allow mental health professionals to address mental health needs. When both parties can understand that everyone has the common good of the child in mind, there are no issues of this working relationship and the children's needs are met on every level.

BH Provider Organization: Allwell Behavioral Health Services

Primary Contact and e-mail: Jim Still-Pepper jstillpepper@allwell.org

Partnering School District(s): multiple school districts across a 6 county region (Muskingum, Nobel, Morgan, Guernsey, Perry, Coshocton).

Number of school buildings in which school based behavioral health services are provided:

We provide services to 98% of all the school buildings in our coverage area, including two ESCs

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?
Regular and special education

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

- We provide Life Coaching and Life Coping skills
- We provide individual, group and family counseling. We provide CPST services.
- We do a peer led program called Teen To Teen that uses trained high school students to give creative public speaking presentations to middle school students.
- Emergency services and Crisis Debriefing services

Evidenced Informed:

- Family Wellness Survival Skills for Healthy Families
- IFAST
- AIT
- Incredible Years
- Conscious Discipline
- Thinking for a Change
- PREP—Sexual Health for Teens/Communication
- Play Therapy

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.
We measure the impact of Grades, truancy/attendance and behavior incidents in a before and after focus

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We do a lot of contracts with many different school districts. We have MOUs with several districts.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Contracts, grants and traditional reimbursement

BH Provider Organization: Alta Care Group

Primary Contact and e-mail: **Joe Shorokey,** joes@altacaregroup.org

Partnering School District(s): Youngstown City

Number of school buildings in which school based behavioral health services are provided:

10 Elementary **6** Middle School **5** High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Primarily regular education and alternative school classrooms, as well as SED settings.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Individual and group counseling, CBT, Crisis Intervention, Classroom and Student Specific Consultation, Classroom/Student Observations, Functional Behavioral Assessments, Behavioral Intervention Plans, Positive Student Supports and elements of best practices (Motivational interviewing, CBT, PBIS). Also, mental health education (Youth Mental Health First Aid, SOS – Signs of Suicide), Suicide Prevention Teacher Training, Early Child Mental Health Consultation.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We do behavioral based pre-post measures from teachers and administrator surveys. Areas of focus include suspensions, out-of-classroom removals, disciplinary referrals, problem severity ratings.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We have a contract with the Youngstown City Schools in which they support our staff time for the non-reimbursable, indirect services that we provide. Approximately 60% of our services are to non-clients or are not billable services. Additionally, the local Mental Health and Recovery Board provides funding for expanded services beyond the Youngstown City contract, as well as non-reimbursable services in other county public and private schools.

What is the reimbursement or financing mechanism for your school based behavioral health services?

1. Contract from the Youngstown City School District
2. Medicaid
3. Mahoning County Mental Health and Recovery Board
4. Mahoning County Educational Services Center
5. Individual School contracts

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Parent engagement, buy-in and trust from teachers, staying focused on what we are there to do and being helpful when we can, without allowing various requests to interfere with primary job. Motivational Interviewing skills have been very helpful, helping teachers actually implement behavioral intervention plans and providing supportive classroom consultation.

On the financial side, helping districts and schools understand that the majority of the services they want and we are asked to provide are not Medicaid reimbursable.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Staying in our lane, or deferring to the school guidance counselor and keeping them (including principal) informed. Relationships, trust, and good work are the keys.

ADDENDUM
Alta Care Group Behavioral Healthcare's Classroom Connections Program
Youngstown City Schools

It is important to make a distinction between the two types of services that Alta's Classroom Connections Program and staff provide:

- Direct Behavioral Health Services to Students
- Indirect Behavioral Health and Consultation Services to Students, Teachers and other school staff.

Direct Behavioral Health Services: These are direct behavioral health counseling services provided on-site to students who are also active cases of the Alta. These services are **primarily funded by Medicaid** and represent approximately 40% of time allocated by Alta assigned in schools. Students receiving these services are those that are identified and referred by school staff (usually through PSST process) due to significant behavioral health issues.

Indirect Behavioral Health and Consultation Services: These are services provided which support students not actively involved with Alta through consultation, observation/assessment, and other activities as described below. These services are **primarily funded by the contract that the School/District** has with the Alta and represent approximately 60% of time allocated by ALTA staff to the school. The Indirect services provided by Alta's Classroom Connections Program include:

- **Positive Student Support Team (PSST)** – Teams developed by the school to address the needs of the individual student, specifically for those students who are not experienceing success in the general educational classroom. ALTA Staff training, experience, and expertise assist in being a valued team member that can provide numerous recommendations, as well as follow up services that are a key component to the process. Alta staff input is often essential when discussing those referrals in which behavioral or mental health components are thought to be signficant, representing the majority of referrals.
- **Classroom Observations** – ALTA staff members play an integral role in conducting classrooom observations. Such observations include our expertise in identifying how a particular behavior is interfering with classroom learning, or when a mental health issue appears so prevalent in requires additional formalized assessment. Alta staff also make recommendations as to how disruptive the student is in relation the other students in the classroom. Our staff have experience and training in completing such formalized observations, utilizing the forms provided by the district. ALTA staff also offer the teacher recommendations to curb such behaviors, or provide information that will assist in the development of the Functional Behavioral Assessment.
- **Functional Behavioral Assessments (FBA'S)** – These formalized assessments identify specific target behaviors, and most importantly, describe what factors are occurring that are maintaining such behaviors, and how they are interfering with the student's educational progress. ALTA staff are trained to provide such assessments,

which are vital in developing the appropriate Behavioral Intervention Plan. ALTA staff members have years of experience in developing such assessments, and play a significant role in articulating why the student in engaging in such behaviors within the classroom.

- **Behavioral Intervention Plan (BIP)** – A behavioral intervention plan is based on the results of an FBA and, at a minimum, includes a description of the problem behavior, global and specific hypothesis as to why the behavior occurs, and intervention strategies that include positive behavioral supports. ALTA staff have developed numerous formalized Behavioral Intervention Plans that are mandated, and often the key component to inducing change**.** ALTA school based staff members have years of experience in developing such plans, with a host of recommendations. School administrators have often articulated the value our staff serves in the development and modification of the Behavioral Intervention Plan.
- **Individualized Educational Program Meetings (IEP's)** – Alta staff members sit in on IEP meetings to serve as a consultant regarding how the child's specific disability is to be addressed in the IEP. In our initial meetings and reviews, our role is to assist in writing a behavioral goal as an addendum to the already existing IEP. These addendums and recommendations are often key components or adjustments required based on our experiences in dealing with mental health related behavioral challenges that are interfering with the students learning and ongoing education.
- **Evaluation Team Report (ETR)** – The intent of the ETR is to provide guidance on the written requirements of the evaluation report, as well as the timeline in which the parents are provided both a copy of the evaluation report and documentation of the determination of either eligibility, or continued eligibility for special education services. Our role is to help explain to the parent what the potential changes or options in placements may look like specific to their child. These meetings and discussions with the parent are essential in helping to articulate the key aspects of the results of the reports, and help establish parent trust if such results convey the need for a change in class or building placement.
- **Manifestation Hearings** – ALTA staff members serve as a consultant on manifestation hearings held with the intent to determine if the child's behavior that resulted in disciplinary action was caused by (or has a direct and substantial relationship) to the child's disability. Intimate knowledge about the child is obtained by the ALTA staff person as a result of extensive communication with the family, or classroom observation and intervention that will be important in determining outcomes of the manifestation hearing.
- **Teacher Consultation (Classroom)** – ALTA Staff provide teacher classroom consultation under the direction of the Principal to assist in developing behavioral modifications within the classroom that may improve behavior. We develop classroom management strategies and classroom specific incentives to encourage appropriate behaviors and reduce disruptive behaviors. Goals and strategies may vary based on classroom needs. Staff members have experience and access to supervisory

strategies to assist in making recommendations**.** Staff have the experience of implementing such recommendations with very difficult to manage children through training, as well as at our Camp Challenge Program during the summer. There, such recommendations are implemented with a high degree of success, with children that have a history of severe behavioral disruptiveness in the classroom.

- **Teacher Consultation (student specific)–** ALTA Staff provide teacher consultation specific to a particular student's behavior, mental health needs, and interventions that are appropriate. Staff coordinate with the teacher(s) to make recommendations specific to their level of knowledge regarding the student's mental health issues, as well as to what the teacher may implement to improve the student's classroom behavior (i.e. prompts that may elicit the student to implement coping mechanisms that will improve behavior).
- **Student referral and linkage to treatment**– ALTA Staff may assist in identifying mental health issues, and in addition, assist the family in obtaining formal assessment and treatment at a facility of their choice. May also facilitate referral to additional services within the organization such as trauma based counseling, case management, or psychiatric services.
- **Crisis Management and de-escalation** – ALTA Staff assist the school in navigating crises within the building, and intervene to deescalate students that are presenting with immediate needs. Such efforts are of value to the school since this service allows for teachers to continue to educate and focus on the other students in the classroom. Such students can be seen, de-escalated and returned to the classroom as soon as possible without causing ongoing disruption to the other students. ALTA staff also coordinate with the school nurse, our own agency, or another agency in regards to medication compliance.

The value of the **Direct** Behavioral Health Services is measured in several ways and reported in an annual outcomes report to the school/district. These measures are both objective and subjective reports by parents and teachers that are primarily assessing behavioral health treatment progress. These measures typically include:

- student progress toward individualized treatment goals
- teacher report of reduction in disciplinary referrals
- teacher report of overall behavior change and impact on learning

The value of the **Indirect** Behavioral Health and Consultation Services must be seen by the administration and staff of the school/district in a different light. It is not possible to draw a straight line between the impact of indirect school-based behavioral health services and student achievement. There are far too many influences on student achievement and overall academic performance (family issues, poverty, exposure to traumatic experiences, familial substance abuse or mental health issues, environmental stressors, learning problems, etc.) to either credit or blame behavioral health services for academic progress or lack thereof. Rather, it is more appropriate to gauge the value of indirect behavioral health and consultation services in both economic and subjective terms.

- Economic Value: Are the Indirect Behavioral Health and Consultation Services valued by the beneficiaries of these services (students, teachers, administrative staff) and can they be provided at the same volume/level if provided by staff employed by the school/district?
- Subjective Value:
    - Services have been measured and evaluated by Ohio Mental Health Network for School Success at Miami University as an effective practice.
    - Bring clinical behavioral health expertise and offer individualized intervention strategies based on sound and evidence-based practices.
    - Provide prompt on-site assessment and intervention services. ALTA staff assist in identifying mental health issues, and provide the family with a formal assessment and engage them in treatment. Intakes conducted by ALTA staff members occur within the school to improve parental involvement and follow through. Further, such access facilitates referral to additional services within the organization such as trauma based counseling, case management, or psychiatric services.
    - Able to seamlessly coordinate with and provide access to additional behavioral health services and supports such as case management, medical/pharmacological, group, and family interventions.
    - Provide access to behavioral health services that students often would not have access to otherwise due to transportation, financial, or parental barriers.
    - Other recognized professionals have provided research and support for school based mental health services such as: The President's New Freedom Commission on Mental Health; The American Academy of Pediatrics; the National Institute of Mental Health's Blueprint for Change; and The National Alliance of Pupil Services Organization.

BH Provider Organization: Ashland County Council on Alcoholism and Drug Abuse, Inc. (A.C.C.A.D.A)

Primary Contact and e-mail: Dennis Dyer, Director – accada1@zoominternet.net

Partnering School District(s): Loudonville, Mapleton, Ashland City, Crestview and Hillsdale – All in Ashland County.

Number of school buildings in which school based behavioral health services are provided:

5 Elementary 5 - Middle School 2 - High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

The program is presented in regular classrooms.

We do the program Too Good or Drugs in the elementary level. In some schools we do all grades and in other the grades we are allowed in to do TGFDs.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We provide Too Good for Drugs (TGFD) that is evidenced-based.

We provide Too Good for Drugs to each of 5 school system in that are primary Ashland County schools. In one school we are in every grade but in some do every other year. We have also provided LifeSkills but have moved to using TGFDs.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We use pre and post tests related to the learning objectives.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We do not have contracts. We are funded by the Mental Health and Recovery Board. We offer the programming to the teachers and principals. We do the program when permitted. In one district the Superintendent assisted in setting up the programs in several elementary grade levels.

What is the reimbursement or financing mechanism for your school based behavioral health services?

For prevention it is funded by the MHRB. They pay A.C.C.A.D.A. to do the programs. They also have liaison workers to assist students.

There are some contracts for mental health services with the schools that are arranged by the community mental health agency

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The biggest challenge is getting access to the classrooms. The teachers seemed pressed by the testing and the push for higher scores and sometimes are reluctant to allow us access to the classroom. We do our programs when allowed and keep offering the services. One of our prevention persons is very persuasive and talks her way into schools. In some cases the MHRB liaison workers help us get access.

I would add that prevention works best when it is comprehensive. Maintaining current programming and building the program in other schools is challenging with 2 part time employees.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

We must have the support of certain school personnel to get into the schools and get scheduled. Once the service is going other teachers invite us to do the program. School leaders either do not support prevention or think it is already being done.

Most parents assume prevention is done in the schools even when it is not or at least not done in a comprehensive manner.

BH Provider Organization: The Buckeye Ranch, Inc., The Bonner Academy at Cross Creek

Primary Contact and e-mail: John Hiller. LISW-S; jhiller@buckeyeranch.org

Partnering School District(s): ESCCO: All Franklin County and outlying districts

Number of school buildings in which school based behavioral health services are provided:

_____Elementary 1 Middle School 1 High School 1 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

All students have an IEP from their home district

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Academics are provided by the ESCCO. 15 hours of behavioral health counseling each week (individual; group; PH)

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Grades, attendance, state testing. We also use Ohio Scales

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

School districts reserve "seats/slots" for the school year, summertime or a daily rate.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Medicaid/Franklin ADAMH non-Medicaid; private pay

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Having the school districts identify students who would benefit from this program. Educating the Special Ed. directors

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Constant communication between the program and the students' home school district

BH Provider Organization: The Buckeye Ranch, Inc., Community Programs

Primary Contact and e-mail: Sara Byers; sbyers@buckeyeranch.org

Partnering School District(s): Southwestern City; Reynoldsburg

Number of school buildings in which school based behavioral health services are provided:

_____Elementary 4 Middle School 2 High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular Education and Inclusion/Resource room, Behavioral Learning Center.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

The Buckeye Ranch (TBR) clinicians provide community based treatment which includes individual and family sessions as well as coordination and collaboration with the school and other systems involved. TBR clinicians utilize integrated family and systems techniques as well as CBT, NMT, Solutions Focused, and other evidenced based theories as applies to the client.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Clinicians utilize Ohio Scales, school performance reports, collaborative reports and observations from school personnel and family members. Our success in the school systems is evident by an increase in time spent in the regular classroom settings and a decreased time spent in disciplinary settings. Additionally, networking throughout the school systems regarding the success of the program has resulted in an increase in school partnerships.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Verbal requests from specific school/school districts have led to informal agreements to locate/assign clinicians to a specific school. There are no formal contracts; revenue is from Medicaid billing.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Clinicians utilize our standard Medicaid billing process to bill for services. Schools are not financially responsible for these services, as clinicians carry a specific caseload of clients that are Medicaid insured.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The most challenging aspect of developing these partnerships has been the inability to serve clients outside of the Medicaid eligibility.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

One of the key "lessons learned" over the past couple years is to provide services to customers that seek the benefits of having a home based clinician in their school rather than approaching schools that may not be interested. If the key players within the school are not fully invested in the opportunity, referrals will become scarce and justifying the position becomes difficult. We've also learned the specific benefits of having a clinician assigned to a school/school district. With this partnership, there is an increase in the collaboration with school staff and others working with the client and family. The clinician becomes more readily available during crisis situations involving clients within the school. This also allows the clinician to become well versed in the school culture, enabling them to bridge potential gaps between the school system and the families.

BH Provider Organization: The Buckeye Ranch, Inc. Day Treatment Programs

Primary Contact and e-mail: Amy Gamber, agamber@buckeyeranch.org

Partnering School District(s): Columbus City Schools, Dublin City Schools, Westerville City Schools, Reynoldsburg, Jonathan Alder, Southwest Licking, London, Groveport Madison, Worthington

Number of school buildings in which school based behavioral health services are provided:

X Elementary X Middle School X High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

We deliver behavioral healthcare services in a Day Treatment classroom setting.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We provide 2 hours of partial hospitalization groups and 1 hour mental health group on a daily basis. We utilize Zones of Regulation Curriculum in addition to other trauma informed care practices, including those supported by Dr. Bruce Perry. We also provide weekly individual counseling and bi-weekly family counseling in our day treatment program.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We use the Ohio Scales to measure outcome, in addition to attendance percentage, grades, standardized test scores and whether students return to less restrictive levels of care upon discharge from the day treatment program.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

School districts outside of Columbus City Schools and Southwestern City Schools pay a fee and sign a contract for the children in their district to attend Day Treatment Programs at The Buckeye Ranch. The Day Treatment Program at Cross Creek, which serves middle and high school youth, is a public school and their teachers are provided by the ESCCO. The Day Treatment Program at Rosemont, which serves 3rd-6th grade is a non-public school and their teachers and staff are employed by The Buckeye Ranch.

What is the reimbursement or financing mechanism for your school based behavioral health services?

School district tuition and Medicaid.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

One of the most challenging aspects of developing school based services for Rosemont Day Treatment is exposure and getting school districts to pay for their students to attend this specialized program.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

One of the main lessons learned is becoming familiar with what each school district is looking for and meeting their needs.

BH Provider Organization: Catalyst Life Services

Primary Contact and e-mail: Denise Williams MA, LPCC-S – Children's Department Director – Catalyst Life Services – denisew@catalystlifeservices.org

Partnering School District(s): Mansfield City School District (K-12), Lexington High School (7-12)

Number of school buildings in which school based behavioral health services are provided:

5 Elementary 1 Middle School 2 High School 1 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular Education, Special Education

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

1. Skills Streaming groups are provided to Mansfield City at the three elementary schools and Malabar Intermediate School to enhance students' healthy social interactions and coping skills.
2. Trauma Systems Therapy (TST) training has been provided for teachers and school staff at Mansfield City and select school staff actively participate to assist team based therapeutic interventions.
3. Signs of Suicide (SOS) presentations are provided to middle and high school students at Mansfield City and Lexington High School to increase student knowledge of the signs and symptoms of depression and suicidal thinking.
4. Crisis intervention needs assessment, linkage to community service providers are included in the duties of the School Mental Health Liaison working predominately with middle and high school students of Mansfield City.
5. Staff provides psychoeducation to students and staff of Mansfield City to assist with identified problematic behavior in classroom settings.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Catalyst monitors crisis intervention statistics, student report of stress reduction per intervention, and teacher report of classroom incidents.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Catalyst has a contract with the Mansfield City School District and Mental Health & Recovery Services board to provide 60 hours Skills Streaming groups weekly to the elementary and intermediate Mansfield City schools.

Catalyst has been awarded a grant from the Richland County Mental Health & Recovery Services board to fund the School Mental Health Liaison Position at Mansfield Middle & High School for FY17.

Crisis Support funding is provided through the Mental Health & Recovery Services board to provide Signs of Suicide (SOS) presentations to the Mansfield City and Lexington health and life skills classrooms.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Catalyst is funded through the Mental Health & Recovery Services board for 100% of the School Mental Health Liaison position and for 50% of the skills groups provided. The Mansfield City School District is financially responsible for the remaining 50% of the time allotted for skills groups.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The main barrier to development of services is the lack of a unified goal between school staff and behavioral health service providers. Although we are all in agreement that academic success is a primary concern, some school staff do not embrace the behavioral skills or intervention models that our service providers attempt to teach in the classrooms. Without the assistance of teachers and school staff following through techniques and modeling appropriate skills, the lessons we provide the youth have shown limited impact. Coordinating with teachers and administrators to allow time to work with students has also been challenging due to concerns of a reduction of academic instruction time.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Providing education about mental health services, basic therapeutic concepts, human behavior as it relates to traumatic events, and behavioral intervention techniques has proven extremely useful both for behavioral health providers and the teachers themselves. The school staff that have been willing to attend training and consistently work with our service providers have expressed gratitude and described improved outcomes in their classrooms.

BH Provider Organization: Child and Adolescent Behavioral Health

Primary Contact and e-mail: Georgene Voros gvoros@childandadolescent.org

Partnering School District(s): Canton City Schools; Massillon City Schools; Alliance City Schools; Plain Local Schools; Marlington Local Schools; Sandy Valley Local Schools; Fairless Local Schools; Tuslaw Local Schools

Number of school buildings in which school based behavioral health services are provided:

27 Elementary 8 Middle School 8 High School 1 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)? All of the above

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We provide consultation, individual therapy, group therapy, CPST, and family sessions in school based settings. Our therapists utilize numerous EBPs, such as CBT, Behavioral Therapy, for some TF-CBT, and a large number of group therapy curriculums ranging from grief groups to social skills groups, anger management groups, and many more. We also perform comprehensive diagnostic assessments in schools.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We measure discipline referrals, school connectedness, and resiliency factors for our consultation outcomes. For therapy clients, we have various measures depending on the therapeutic program to which the client is assigned. Measures include Ohio Scales, Trauma Symptoms Checklist for Children, DECA-C, TIP outcomes for adolescents.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We have contracts with each of the schools that provide us with consultation funding from the school district. We also have a contract with our local board (Stark Mental Health and Addiction Recovery Board, aka StarkMHAR) to provide services to schools that run their financial contributions through the board. Some contracts are very specific (number of consultation and contact hours at each school, services requested in each school [group, CPST, therapy], CareTeam participation, etc.). Other contracts are more general and

services are provided as requested and coordinated with the building school counselor. Contracts can vary widely.

What is the reimbursement or financing mechanism for your school based behavioral health services?

We receive consultation funding from both the school districts and from our local board (StarkMHAR)

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

There have been numerous challenges! Convincing schools to invest in consultation funds to have a BH provider in their school, convincing school counselors that we were not taking their jobs or their work, and helping schools understand how our staff are paid vs how their staff are paid (productivity vs salary). Parental involvement is always a challenge, particularly in school based services. Our StarkMHAR Board provides us with gas cards to encourage parent involvement.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

- All school districts are different; different needs, different populations, different expectations, different levels of comfort with BH providers, different funding allocations. We need to keep our services both consistent and flexible to meet individual needs.
- Stark County has a local CARE Team collaborative that, in partnership with our local Board, coordinates services, contracts, and billing; this is a very supportive and valuable partnership.
- The schools are another "layer" of consumer for our services. Building strong relationships is key; staffing school positions with the right provider and regular communication are both crucial.
- Youth that need BH services often don't stop needing interventions over the summer, we offer services year around and will meet families and youth in homes, our offices, or in the community as needed. This is important to communicate to families and schools.

BH Provider Organization: Child Guidance & Family Solutions

Primary Contact and e-mail: Elena Aslanides-Kandis, Clinical Manager- School Based Services - aslae@cgfs.org

Partnering School District(s):

- **Barberton City Schools**
- **Copley-Fairlawn City Schools**
- **Cuyahoga Falls City Schools**
- **Green Local Schools**
- **Hudson City Schools**
- **Life Skills**
- **Nordonia Hills City Schools**
- **Stow-Munroe Falls City Schools**
- **Woodridge Local Schools**

Number of school buildings in which school based behavioral health services are provided:

19 Elementary 10 Middle School 7 High School 2 ESC/Other/Alternative- but accept referrals from any ESC

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Most school based interventions occur outside the classroom (in a confidential space within the school building), however some staff do provide interventions in special education/affective education classrooms.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Services provided by school based therapists/CPST workers vary based on the type of relationship with the school. We offer two different models of services. One is a "contract model" where the school pays for the service. In this capacity, any student can be seen by the mental health worker, depending on how the position is funded. The other model is a billable services model which means our staff only work with students that have become active clients of the agency, which means they have a participated in a formal diagnostic interview with treatment plans and objectives. In contract positions, our staff are more integrated into the school culture. They are often utilized in crisis situations, to de-escalate students and then return them to the classroom. They assist with linking families to needed services. They participate in school wide initiatives and prevention frameworks such as implementing PBIS, Start with Hello, Say Something, AOD Prevention week, suicide prevention and education. They assist with building the school culture as they have created their own groups to focus on building school culture with clubs such as Chain Reaction. The club focuses on building a caring school environment by working on school wide activities to promote kindness and acceptance of all.

ROX (Ruling Our eXperiences) is another group that is run at two of the schools we provide services in. The mission of ROX is to equip girls with the knowledge and skills necessary to live healthy, independent, productive, and violence-free lives. It was created at the Ohio State University and research has shown the curriculum is validated and effective. There are pre and posttests completed.

In a billable model, we provide individual and group therapy services. We are able to provide consultation regarding behaviors that are exhibited as a result of mental health issues. Groups vary based on the need of the school, however we off groups such as Cognitive Behavioral Intervention for Trauma in Schools, which is an evidenced based curriculum. Other groups offered focus on social emotional skills, anger management, managing emotions (Dialectical Behavior Therapy Skills), etc.

We also are available to provide professional development to schools and their staff regarding education of mental health issues and how it impacts behaviors in the classroom. We provide an evidence based school mental health education program for school staff and parents created by the American Psychiatric Foundation titled Typical or Troubled. There is also a pre and posttest associated with the training as well.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Schools in the contract model have chosen not to pursue outcomes, despite efforts to create an outcomes report. The request information regarding the number and types of services provided.

Outcomes for clients include academic performance, attendance/tardiness, suspensions/expulsions, in addition to physical health and mental health outcomes.

Schools specifically identify success with having the service provided within their building so the students are not missing more academic time than necessary. It also provides immediate access for collaboration and consultation amongst teachers and administrative staff. This is beneficial in helping schools understand the cause of the behavior and how to best work with that student.

School based therapists are often contacted to assist with de-escalating or stabilizing a student, which allows them to return to the classroom rather than being sent home and missing more school. This type of work must occur as the incident is occurring rather than processing after the feelings have passed.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Contracts are written for schools that are paying for the service. It outlines the responsibility and liability of each entity. Schools use IDEA B funds to pay for these services.

No other MOU's or agreements have been requested for services where the family is paying for the service.

What is the reimbursement or financing mechanism for your school based behavioral health services?

As stated above, schools utilize their IDEA B funds to pay for school based mental health consultants who work with at risk/special education youth.

Otherwise, private insurance is utilized for those that are clients of the agency. Our county's Alcohol, Drug, and Mental Health Services Boards is also utilized to supplement services including a sliding fee scale for families that cannot afford services as well as reimbursement for mental health education and consultation.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The most challenging aspect continues to be access to buildings and integrating into the school. School counselors are often threatened to have mental health clinicians in the building as they are protective of their positions. They especially do not want our clinicians providing group services as they feel that is their role. Space is another concern. Even the buildings that are receptive to services lack space and our clinicians are often bounced between a staff lounge or under the stairs. These are not safe, therapeutic, nor confidential spaces that allow for therapeutic work to occur. Schools struggle with understanding the need for a confidential space. We work to be as flexible as possible with schools.

We have yet to find a way to overcome the barriers for school counselors that are not accepting to have mental health in their building. They typically are the gatekeepers for the referrals so they opt not to refer, which means students can not have access to services.

We have found that for services to be successful, a therapist must be integrated into the building full time. Due to productivity requirements of mental health therapists, this isn't always an option which only prolongs the relationship building that needs to occur.

Another challenge has been for schools to understand the ethics behind mental health and what information is appropriate to be shared with the school and what information is not appropriate to be shared. Continued education on ethics is required.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Schools need to feel that we are there to partner and help, and therapist's need to understand the laws of FERPA. Being able to provide cross-training is instrumental in a successful relationship.

Having one person to coordinate and take the lead has also been helpful in creating a more welcoming environment for mental health workers in the schools. Typically this can be the pupil service director, however having one person from each school building to act as a liaison is important. The greatest impact on access to services has been schools that have a contract position, in addition to a billable therapist. The contract therapist is integrated into the building, and understands the dynamics of both entities and works as a liaison and assists with coordinating referrals and linking families to these services.

BH Provider Organization: The Children's Home of Cincinnati

Primary Contact and e-mail: Debbie Gingrich, dgingrich@thechildrenshomecinti.org

- **Partnering School District(s):**
- **Cincinnati Public Schools (18)**
- **Loveland City Schools (6)**
- **Mt Healthy City Schools (3)**
- **Northwest Local School District (12)**
- **Reading City Schools (4)**
- **Three Rivers Local School District (3)**
- **Wyoming City Schools (6)**

Number of school buildings in which school based behavioral health services are provided:

35 Elementary 7 Middle School 14 High School 3 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

- Regular education
- Special education—self-contained and inclusion
- Disability specific—typically SED

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

- Assessment
- Behavioral Health Counseling: TFCBT, Theraplay, 7 Challenges, CARE,
- Community Psychiatric Supportive Treatment: Teaching Family Model
- Pharmacological Management Service
- Prevention (minimal and dependent on grant funding)—social skills groups, Second Step

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We use OH Scales (Parent and Youth version) and the Strength and Difficulties Questionnaire (Parent and Teacher). Pharmacologic Management uses the Vanderbilt scale. We have attempted to pair assessment tool data with school data such as grades, discipline referral, attendance, but only one school district has provided this data. The goal is to minimize social, emotional and behavioral disruptions to the school day so children are able to focus on academics.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Our agency has an MOU with each of the schools/districts where we are the lead mental health partner. Generally, these MOUs are business agreements, without specific financial agreements. The agency agrees to provide behavioral health care and the school agrees to provide confidential space, equipment, etc.

What is the reimbursement or financing mechanism for your school based behavioral health services?

School based services are generally financed through third party reimbursement, i.e. insurance. In a few instances, schools have contracted with us to provide an additional service that is not a reimbursable health care service. School reimbursement has been very minimal. Grant dollars are also used minimally to provide services for uninsured or underinsured children or to provide prevention groups.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

While school based services provide great access to care for children, there are some significant barriers. One of the greatest challenges is parent and family involvement. Our clinicians try to address his by providing evening appointments or even home visits, but it remains a significant challenge. On average 70-75% of children who are referred are ultimately enrolled in services. Parent contact remains the largest barrier.
Another challenge is the nature of the school based partnership. In essence, the school community itself becomes another customer. While our providers focus on the children who are in their care (consented for service), the school frequently asks for therapist assistance with non-enrolled students. Our staff are frequently called into behavior management issues. We have tried to address this by offering a consult to school staff and then attempting to convert to a referral if needed. Additionally grant or prevention dollars are needed to fully provide the level of service needed by the schools.

Another challenge is overcoming the stigma of mental health care and especially the concern about mental health information being shared in the school. One of the therapist's main responsibilities is to build trust with children and families. They must also educate school staff on the limits of sharing information.

Finally, there are challenges arranging a therapy schedule in a way that does not interfere with academics. Teachers, students and parents do not want children to miss academic instruction which limits the amount of time children can be seen for therapy. Additionally, school wide testing interferes greatly with the therapist schedule and makes it challenging to keep productivity consistent.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

One of the largest lessons learned is that to be a good partner and still maintain a viable financial model, we need to partner with additional organizations who can provide service to the school (such as bullying prevention programs, dating violence prevention programs, etc.) It is essential to meet the needs of the school population, but every service does not

need to be provided by the lead mental health partner. Additionally, we can offer "a la carte" services that may meet the school's needs, but are not part of insurance reimbursed health care. Our agency has provided school-based service for over 12 years and I would be willing to speak with others across Ohio regarding this work.

BH Provider Organization: Concord Counseling Services

Primary Contact and e-mail: Anne Karapontso, LISW-S (Manager of Prevention Services) annekarapontso@concordcounseling.org

Partnering School District(s): Groveport Madison Local Schools, Gahanna-Jefferson Public Schools, New Albany-Plain Local Schools, Westerville City Schools

Number of school buildings in which school based behavioral health services are provided:

9 Elementary 9 Middle School 3 High School 0 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

In the majority of our schools, we mainly work with students in regular education. In Westerville, we additionally provide support services to students who are in special education with an ED designation and have mental health services on their IEPs, as well as identified students in the middle school Autism Unit.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Concord's school-based prevention program consists of short-term individual and skill-building group services that strengthen healthy coping skills and build resiliency. Services also include crisis intervention (individual and school-wide), referral to/linkage with community resources, school-wide universal programs that address issues such as bullying, suicide and academic performance, re-entry support from hospitalization, classroom observation, behavior modification, consultation, professional development to school staff and parent education. We are also a part of the RTI/IAT/MTSS teams. We use a variety of interventions, curriculums and evidence-based practices in our program. These have included: Mix it Up, Signs of Suicide (SOS), Youth Engaged in Leadership and Learning (YELL), Dialectical Behavioral Techniques, Cognitive Behavioral Techniques, Mindfulness, Motivational Interviewing, Coping 10.1, I Can Do, Strong Kids/Teens, Skill Streaming, Owning Up, Girls in Real Life Situations, Incredible Flexible You, Second Step, Coping Cat. COPE, Sources of Strength, Say Something and Seeing Red. Summer programming is planned to start in Groveport Madison Local Schools in June 2017. It will likely consist of similar services including groups, individual, consultation, community linkage, and parent education.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We measure improvement in attendance, academics, discipline and social/emotional challenges. We collect baseline and final data from grade cards, attendance records and discipline reports on all students enrolled in individual and/or group services. In addition, students enrolled in individual services complete a pre/post behavioral health screening form (such as the BYI or BASC2/BESS). Students enrolled in group services complete a pre/post test that reflects the objectives of the group curriculum. We also collect data on

how many students we sent for an emergency psychiatric evaluation, how many students were hospitalized, how many children's services reports we had to make, and how many students got involved with the juvenile justice system. At the end of the school year, we generate comprehensive reports that include cumulative data for the whole school year per district and per school building. The results are shared with the school districts. Concord's school-based prevention program is designed to offer short-term, strength based, skill-building interventions to students who are struggling in school. Their struggle could be related to poor academics, attendance, discipline, and/or for social or emotional reasons. Prevention staff help students identify barriers to their school success and help them set realistic goals to get them back on track. Some prevention staff conduct needs assessments early in the school year to determine building needs and identify students for services.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We have 13 staff on the Prevention Team (4 WCS, 2 GJPS, 5 GMLS, 2 NAPLS). Staff are assigned to no more than 3 buildings (most only have 1-2 buildings). Prevention staff are integrated into their assigned school buildings and work closely with school staff and administrators. A school-based mental health prevention grant through Franklin County ADAMH funds the majority of the staff positons and services. Three of our 4 districts also provide additional funding to expand services. Concord has financial agreements with these 3 districts.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Concord manually invoices the school district monthly for payment. For services funded by the ADAMH grant, Concord submits claims through their electronic system.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Meshing behavioral health and education is a challenge in itself as the two disciplines do not think or communicate alike. Much care needs to be taken by behavioral health staff to show school staff how we can be of help without stepping on others toes. Patience is important until school staff see behavioral health staff as an asset instead of an outsider or threat. Time, gentle encouragement and consistency will usually break down the barriers. Each of our school districts assigned a district liaison who works closely with our program. They are the go-to for any issues within the school buildings that arise. The liaison and the Concord program manager meet at least quarterly throughout the school year to discuss what's working and to problem solve any challenges. We send program performance surveys to school administrators and other staff on a quarterly basis to gather data on the performance of the program and staffing to ensure services are meeting their needs.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Being aware of the communication breakdown, resistance to services and not being accepted by some school staff prior to starting services. If you have a game plan going in it makes it easier. Principals are the leaders of their school buildings, they are the ones determining how services are utilized even if we don't always agree from a behavioral

health perspective. Learning the rules of the school district as far as what you can or cannot say or do with students is important. Also, learn how the school wants you to communicate with parents as it can be different from your instincts as a behavioral health provider. Find out what the chain of commands is, who needs to know about crisis situations, what the crisis plan is for the school building and if there are any district forms you need to fill out. Always be professional, courteous and respectful because we are their guest.

BH Provider Organization: Consolidated Care, Inc.

Primary Contact and e-mail: **Doug Steiner, dsteiner@ccibhp.com**

Partnering School District(s): Bellefontaine City Schools, Benjamin Logan Schools, Indian Lake Schools, Riverside Local Schools, West Liberty-Salem Schools, Urbana City Schools, Graham Local Schools, Mechanicsburg Schools, Triad Schools

Number of school buildings in which school based behavioral health services are provided:

_____Elementary __5__Middle School ___9___High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Health classes, regular and special educ.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

1) Signs of Suicide(SOS)/ TeenScreen for all high school students who are taking Health classes (education on depression & signs of suicide and screening for same), 2) Crisis intervention for any students who present with suicidal ideation/behaviors, and 3) Consultation to schools for students with any MH concerns.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

For the SOS program, we measure use a Pre-/Post-test to measure education the students receive in the health classes. We also measure the number of students who screen "positive" for signs of depression or suicide and the number who follow-thru for recommended services. No specific outcomes are measured for the Consultation services.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

No contracts or MOU's with the school districts.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Services are covered through local MHDAS Board funds. Part of the SOS program is funded by the Logan Co United Way.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

School districts vary in their need for services and openness to having MH providers. We have found this is very much based on relationships with individual school districts and their staff. Another barrier is that the SOS program requires passive consent from parents, so some student's parent choose to not have their children screened.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Maintain good relationships with school districts and staff, and help them with funding issues since most districts report difficulty funding these programs.

BH Provider Organization: The Counseling Center of Wayne & Holmes Counties

Primary Contact and e-mail: Karen Berry, CEO, kberry@ccwhc.org; Jim Foley, Director of Community Education and Prevention Services, jfoley@ccwhc.org

Partnering School District(s): Green (Smithville) Local Schools

Number of school buildings in which school based behavioral health services are provided:

__X__Elementary __X__Middle School __X__High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Services are provided to students from all classrooms, although services are rarely provided in the room, nearly always pulling students out to an individual session.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Services include individual and family counseling, crisis intervention, consultation with school staff and other service providers, and participation in meetings related to the students. There is no curriculum other than the educational component of any CBT or related evidence-based psychotherapy practices used.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Outcomes include the Ohio Youth Scales, pre and post, and the BASC, as well as teacher and parent satisfaction surveys. School success is related to some of the items on these measures.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

There is a memo of agreement between the school district and our agency, signed by our CEO and the Superintendent, outlining the expectations of the job description. The main relationship is between the agency staff person and the teachers and principals.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Services are reimbursed quarterly for staff service by the school district per the memo of agreement.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The most challenging issues are highlighted in the section below.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

It would be good to have a clear expectation at the beginning about some issues: what are the best type of cases to refer, who gets to determine when the caseload is full, how much staff consultation time and note-writing time is allowed along with student face to face time, what are the types of information are shared vs. kept confidential, and what are the billing procedures, including what kind of documentation that needs to be provided along with billing. Over time, it is important to build relationships that demonstrate respect for the expertise and the role of the staff and parents, resulting in mutual respect. This, along with generally making the counselor's presence and role known throughout the district, leads the staff and parents to seek and value the counselor's input and involvement. Staff continuity is of course important in the building of those relationships and reputation.

BH Provider Organization: Crossroads

Primary Contact and e-mail: Lauren Wright, LWright@crossroads-lake.org

Partnering School District(s):

Madison
Willoughby – Eastlake
Painesville City
Fairport Harbor
Mentor
Perry
Wickliffe
Kirtland
Lake County Educational Service Center

Number of school buildings in which school based behavioral health services are provided:

11	Elementary	12	Middle School	9	High School	2	ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

We deliver services to all classroom settings requested by our districts, which include regular education classrooms, cross categorical classrooms, emotionally disturbed classrooms (ED units), special education classrooms, and gifted/ honors classrooms.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We deliver case management and counseling services to our clients in the school districts to assist them in improving their overall social-emotional, behavioral and academic functioning. This includes individual sessions, one on one, and group sessions that range from small group to whole classroom. We also offer trainings to the educators in the school districts pertaining to any mental health information they feel a need for. Some trainings that we have been requested to do in the past are classroom interventions for specific mental health diagnoses such as, ADHD, Trauma, Depression, Anxiety, and Oppositional Defiance. We have trained districts on requirements for mandated reporting regarding reports made to Child and Family Services. We also do very broad trainings that introduce Mental Illness, prevalence, signs, and symptoms. We have also conducted parent intervention services, trainings, and family nights.

We utilize a strengths based approach in all interventions and eclectically include practices from a broad range of counseling interventions including, Cognitive Behavioral Therapy, Trauma Informed Cognitive Behavioral Therapy and DBT, to name a few. Some of our prevention programming has included Drug and Alcohol intervention utilizing Insight programming and Social Skills intervention utilizing the Circles Curriculum.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We measure outcomes from clients individually, parents, and school staff. In our prevention programming we administer outcomes surveys, at the end of six to eight sessions, to the clients and they offer individual opinion of helpfulness, what they have learned and what they liked or disliked about the sessions. We also collect outcomes from any trainings we provide through surveys that are administered.

As an organization there is a client satisfaction survey that is given to all clients including, school based clients. This includes three questionnaires, one for parents, one for clients 8 years of age and older, and one for clients younger than 8 years old. This measures the clients and parents overall satisfaction with services provided to them across the agency.

We gather outcomes from the school staff including principals, educators, guidance counselors, school psychologist, secretaries, school nurses, and classroom aids, as well. We send out surveys to the aforementioned individuals twice a year. The initial survey is sent out in January and the final survey is sent out in May, at the end of the school year. The results are compared and reviewed to address strengths of programming and areas of improvement. The areas of these outcome surveys that are measured include accessibility of our staff, communication between our staff and school, improvements in the students overall functioning, types of presenting issues made in referrals, overall satisfaction and areas of improvement.

In the past we have utilized Ohio Outcomes Scales and DESSA reports and we continue to research to identify the most effective outcome measures that will give a valid overview of the impact of our services.

Overall, our school based mental health services have impacted our districts, clients and their families positively. This is evidenced not only through the feedback received in our outcomes but by all the districts we serve increasing contracts year to year or maintaining the contract amount. Our districts let us know often how our services are valued in their schools and needed.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Crossroads has a strong and long standing relationship with 8 of the 9 school districts in our county in addition to the ESC. Because Crossroads is an organization that offers a broad range of services it allows our school districts to find comfort in follow through and wrap around for all of their student's needs. They are able to have easy access to any of our services that a school based provider alone cannot provide. Crossroads offers outpatient counseling and case management services, psychiatry, intensive home based services, transitional youth services, early childhood services, partial hospitalization programming, consultation and training for school wide prevention services and community projects, alcohol and drug programming.

Annually we meet with our districts to discuss maintaining or increasing our yearly contracts. Our districts that have more student bodies on free and reduce lunches get a discounted rate per hour that is off set through our local Alcohol Drug and Mental Health

Services board or (ADAMHS). We bill Medicaid for clients that are Medicaid eligible and have this insurance, otherwise we are paid through our yearly contracts.

As far as staffing, each district has different needs and therefore staffing is based on student body, volume of referrals, and need in the district. Some of our districts have one or two staff deployed for the whole district other districts have one staff deployed for each school in their district.

What is the reimbursement or financing mechanism for your school based behavioral health services?

All prevention services and services delivered to clients with private insurance or no insurance are reimbursed through the school contracts at $80.00 an hour, any school districts under our reduced rate contract, which is either $50.00 or $65.00 dollars an hour, are off set through our Lake County Alcohol Drug and Mental Health Services Board. We are also reimbursed through Medicaid if a client that is given a diagnosis has Medicaid coverage,that is our first payer for any case management services billed throughout the school day.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

One of the most challenging aspects of developing school based services was building trust with the parents in our districts. Families often feel fear and associate a stigma to social workers or counselors "getting involved in their personal life". But once we were established in our districts and had consistent staff that became known to the school and families of those schools it seemed to be less challenging.

At times not being able to see a student without a release and consent form can be challenging. Our providers are often viewed by the school as school staff and in the midst of a crisis the school staff wants the mental health provider to get involved right away. Without consent or a release from the parent we unable to do this, however, we have overcome this barrier by consulting and guiding the school staff involved in the crisis and not the student directly. Also, we have in some of our districts where getting consent is a changllenge, collaborated with the district and sent out an "opt out" form. This has allowed us to intervene in crisis situations without having to get consent and then follow up with the parent or guardian once the situation has diffused.

Building the bridge between school and home while building therapeutic relationships can be a challenge, as well. Because we see students in the school during the school day it is often a struggle to have parents be as involved as we would like them to be. We try to overcome this by having our staff endlessly outreach and connect to parents and guardians even during prevention services and build a solid therapeutic relationship. We also offer home visit case management services as well as community sessions to take the sessions outside of the school setting and separate our providers from the school staff. Another challenge that we face is determining the best time of the school day to pull clients and meet with them. We often get resistance from teachers if students are pulled during academic times and from the students if we are pulling them from non - academic times. We manage this by closely and regularly communicating with teachers and guidance staff to make our scheduled sessions individual to each student or client.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

The most valuable lesson that we have learned is that communication is vital for change in students. Our providers have to communicate regularly with teachers, guidance counselors, principals and the parents all relevant information regarding topics such as skills that are being worked on, interventions that should be put in place in the classroom and reminders of what is most important for the school to be working on with the client. Really for our providers to build that bridge between school and home and be the person closing the loop among all involved with our clients. We also have learned that we need to stay on top of most recent research and techniques to keep up with the ever changing youth and issues they face. It is important to stay relevant and present with the times. School based services and mental health issues are ever changing and it is vital to remain flexible and creative to maintain relevance with our districts, clients and families.

BH Provider Organization: Firelands Counseling & Recovery Services of Lorain County

Primary Contact and e-mail: krohd@firelands.com

Partnering School District(s): Vermilion, Amherst, Midview, Sheffield, N. Ridgeville, St. Peter's, St. Joseph's, Firelands

Number of school buildings in which school based behavioral health services are provided:

13 Elementary 8 Middle School 5 High School _____ ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular and special education.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Prevention groups (Boys' Council, Coping Cat, Girls' Circle, SOS, Incredible Years), Consultation and individual counseling. Topic specific education.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Suicide rate in county for minors has decreased. Measure of resiliency.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

MOU between the district and the Mental Health Board.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Mental Health Board pays for consultation, education and prevention groups. Individual counseling is paid for through student insurance and sliding fee scale.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Schools do not understand the fee for service reimbursement which pays for BH. They frequently want a clinician on site without a clear understanding of what they want from

that person or that there is not reimbursement when there is no activity. We developed a comprehensive presentation package that we review over each summer before the school year.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Schools do not understand the value and limitations of BH within the school setting. They default to referring extensively to individual therapy which will serve the least number of children. They also will refer students whose caregivers are non-responsive to the school and look for behavior change within that student with externalizing behaviors. Without involving the parental figures, very little change will occur.

BH Provider Organization: FRS Counseling (Hillsboro and West Union)

Primary Contact and e-mail: Erin Holsted: eholsted@frshighland.org

Partnering School District(s): Hillsboro City Schools, Fairfield Local Schools, Greenfield-McClain Schools, Bright Local Schools, Lynchburg-Clay Local Schools, Hillsboro Christian School, Ohio Valley Local Schools (Peebles, Seaman and West Union campuses) and the Manchester Local Schools

Number of school buildings in which school based behavioral health services are provided:

8: Elementary 10: Middle School 10: High School
3: ESC/Other (1 Vocational School and 2 Educational Day Treatment programs)

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

FRS Counseling provides behavioral health services (prevention and clinical services) as appropriate to students across all grade levels and ability levels in a variety of school settings with parent involvement and consent. All of our school-based clinical work (assessment, individual/family/group counseling, case management) is done in private offices or private classrooms. Meetings with teachers and other professional staff are also done in confidential locations. Psychiatric services are only offered at our outpatient office locations at this time. Prevention services are provided in offices for individual and small group prevention. Whole classroom and whole school prevention services are also provided in classrooms and school assemblies.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

FRS Counseling provides cognitive-behavioral and some trauma-focused behavioral health counseling services in schools. In addition, FRS Counseling has staff who are trained in motivational interviewing skills and in play therapy for younger students. We also provide prevention curriculums including Safe Dates, Skill-Streaming, I Can Problem Solve, Too Good for Violence, Too Good for Drugs, Project SUCCESS and Second Step.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

FRS Counseling has recently implemented the Strengths and Difficulties Questionnaire as an outcome measure for all students receiving individual or small group prevention services in schools. Additionally, students who receive clinical services note their session progress at each session and their overall progress as part of treatment plan review. In 2017, a full panel of outcome measures (including the PHQ-9, GAD-7, Vanderbuilt, etc) will be implemented and will be associated with client diagnosis/diagnoses.

When a student receives the behavioral health care that they need either through prevention services or clinical services, the student's school success should improve, including increased academic, behavioral and social success in school. Discipline and absenteeism should also decrease.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

FRS Counseling has contracts with the Hillsboro City Schools and the Ohio Valley Local Schools for educational day treatment programs for students identified with Emotional Disturbances who are clinically and behaviorally appropriate for day treatment programming. Other clinical services and prevention services are not formally recognized by MOU's but are mutually agreed upon verbally. Non-exclusive MOU's were extended by FRS Counseling to each of the districts but all declined, preferring to maintain the informal relationships.

What is the reimbursement or financing mechanism for your school based behavioral health services?

FRS Counseling bills client insurances to pay for clinical behavioral health care. Most of our clients have Medicaid because we serve a rural Appalachian population with a high rate of poverty. We also have a grant from one of our ADMHS Boards which supports prevention services in Highland County, Ohio. Finally, the Healthier Buckeye Grant has increased both clinical and prevention services in schools and in communities across Highland County.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The most challenging aspect of developing school based services includes getting real buy-in and investment in a para-school program from the school district (as evidenced by our difficulty in obtaining MOU's). The school districts served by FRS Counseling incur no direct costs and offer only in-kind supports such as office space, electric, heat/AC, etc. This barrier is an ongoing barrier but is addressed by collaboration with each school district. Also, mutual respect of the FERPA, HIPPA and 42CFR confidentiality standards is important. In addition, negotiating the schedule due to our attempts to avoid taking students out of their core curriculum classes can also be challenging, especially if teachers do not recognize or value the positive impact treatment can have on a child's ability to be successful at school. This barrier is addressed by garnering the support from school administrators and teachers via teacher staff meetings and in-service trainings as well as working with individual teachers regarding specific student needs. If our staff can help a teacher to be successful with a student or we can help the teacher to be more effective in classroom management, then we have a greater chance at being able to see the child with behavioral health needs at school. Finally, parent engagement in the treatment process can be a challenge since the parents do not have to bring their children to an outpatient office to be seen (except for psychiatry/medical services). Like in schools, family engagement in school success is one of the biggest challenges we face. FRS Counseling encourages and expects parents/guardians to be involved in their child's care. FRS staff contact families by telephone/mail, have face-to-face meetings and offer other family engagement opportunities, such as our day treatment programs' monthly Family Night activities.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

FRS Counseling has learned that partnering with a school and being responsive to school needs as well as individual student needs has helped our school-based programs to be more successful with regard to school collaboration, access to students and student outcomes. FRS Counseling has implemented the PRIDE survey of all students in Highland County to help schools identify the overall social and behavioral needs of their students and prevention programs are tailored to address those needs for each school.
Tracking and reporting student outcomes is also a helpful way of engaging and collaborating with schools. FRS Counseling has implemented school meetings with school administrators at least three times per school year to provide an overview of school based services and to discuss our program outcomes and to address any concerns. MOU's provide a strong support for para-school behavioral health programs but many school districts are reluctant to formalize these relationships despite the added benefits of such an agreement. FRS Counseling recognizes that a student's primary reason for attending school is to be educated and our school-based programs seek to respect and enhance that primary mission. Students served by our school-based behavioral health programs are supported and encouraged in their efforts to be successful at school, at home and in the community.

BH Provider Organization: Harbor Behavioral Health

Primary Contact and e-mail: Cara Douglas, cdouglas@harbor.org

Partnering School District(s): We partner with multiple public, private and charter schools in Lucas and Wood Counties including: **Toledo Public Schools, Maumee City Schools, Oregon City Schools, Perrysburg Schools, Holy Rosary, Queen of Apostles, Bennet Venture Academy.**

Number of school buildings in which school based behavioral health services are provided:

18 Elementary 12 Middle School 8 High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Partial Hospitalization/Day Treatment: We have had a partnership for 35 years with Toledo Public Schools in two buildings with multiple classrooms for grades 1-12. All students have an IEP and have been deemed not appropriate for a less restrictive setting. Day treatment staff are in the classroom at the same time as teachers.

Individual/Group Therapy: A collaboration with multiple public and private schools for K - 12. A private office/space is made available in the school to provide services to the students. The students may be in regular or special education. The parents must sign a consent for treatment and students must have a diagnostic assessment to get opened at the agency prior to providing any services. We also have to have the parent sign a release of information for the school.

Prevention:
Prevention Partners – Open to all middle and high school students in Perrysburg. Most of the participating students are regular education.

Prevention Programming – Provided in whole classrooms and in small group settings in the community.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Partial Hospitalization/Day Treatment and Individual/Group therapy: A variety therapy techniques are utilized including Cognitive Behavior Therapy, Solution Focused Therapy and Motivational interviewing to name a few.

Prevention:
Prevention Partners – The program provides peer-to-peer education, participation in alternative positive activities/behaviors, and surrounds teens with a support system of

other healthy and Alcohol, Tobacco, and Other Drug (ATOD) free teens as a way to increase prevention.
Second Step – The program works with grades K – 3 to help increase social and emotional skills.
Life Skills Training – The program is a tobacco based drug prevention program for grades 3-6.
Project alert – A substance use prevention program for junior high students.
Group Presentations – Prescription drug and heroin presentations for high school students.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Partial Hospitalization/Day Treatment: Multiple factors are evaluated including how many students are mainstreamed, attendance, and frequency of behavior incidents. With increased attendance and fewer behavior incidents students are more available to learn content being taught during the school day. If students are mainstreamed, they are able to have a greater variety of classes to be enrolled in.

Individual/Group Therapy**:** It is hard to directly measure the impact on school performance as we do not have access to school records. The hope is that it will help reduce behavior/disciplinary incidents, increase attendance, reduce tardiness and improve grades.

Prevention:
Prevention Partners – The program uses surveys throughout the year, evaluations, and the annual Wood County Youth Survey to measure increases in knowledge, leadership skills, attitudes toward prevention, number of positive/supportive relationships, etc.
Second Step - Teachers evaluate students on their coping skills.
LifeSkills - We evaluate for increased knowledge, resistance skills and perception of harm and risk.
Project Alert – The program is evaluated for increased knowledge, resistance skills, perception of harm and risk as well as delayed onset of use.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Partial Hospitalization/Day Treatment - There is a MOU with the school.

Individual/Group Therapy**:** There are some informal agreements where the schools open their doors and find space for our staff to work and collaborate freely. Other schools have a formal MOU, or signed contract for funding.

Prevention:
Prevention Partners: We rely solely on good working relationships with school counselors, students, principals, and the superintendent's office along with the effectiveness of our programs to maintain our presence within the school.

Prevention Programming: We have a great track record with the schools in Lucas county. We provide services on a 1st come first served basis and often have a waiting list. This school year we took part in a series of trainings with Toledo Public schools: Partners with

Purpose is their effort to ensure quality programs in their buildings and serves as a monitoring mechanism for the district.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Partial Hospitalization/Day Treatment: The program bills Partial Hospitalization services to Medicaid. If a child does not have Medicaid, then the Lucas County Mental Health and Recovery Services Board provides funding.

Individual/Group Therapy: The majority of services are provided by billing Medicaid. Most private insurance providers will not reimburse when the service is not provided in the office and the school location is considered "in the field." If a child does not have insurance or does not have insurance that will cover the service, if the family qualifies for non-Medicaid funding through the Lucas County Mental Health and Recovery Services Board, then the service can be billed through that funding source. We also have contracts with two schools that will pay for therapy services if the family exceeds the income limit for the LCMRSB, and one also covers some time for coordination of care.

Prevention:
Prevention Partners: We receive a grant from Ohio MHAS and we fundraise throughout the year in order to fund our program. There is also a fee to be a member but non-members are always welcome.

Prevention Programming: We are funded through the Mental Health and Recovery Services Board of Lucas County.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

- Not having adequate space. – Work with the school to try to be creative to find a quiet, confidential space.
- Helping schools realize that we don't want children to miss instructional time and having services in the school can help reduce that. Office based clinicians only so many before and after-school appointments available. Kids will often miss more class to leave the school to go to an office based appointment in the middle of the day. – Educate schools that if the service is provided at the school, the child may miss less class time.
- Some parents have barriers such as work schedules that prevent them to getting the child to the appointment or they can be unreliable and won't get their child to treatment appointments regularly. If the service is provided in the school, then a child can get more regular services in some cases. – Educating the school personnel helps.
- Community mental health centers can have a higher staff turnover rate than school systems are accustomed to. Therapist often are entry-level staff who are seeking supervision and move on once they are independently licensed. – It helps to try to find a

therapist that works well in that type of environment and if there are transitions mid-year, help to minimize any disruptions in care for the children.

- School staff want agency staff to help with children who are not receiving services/enrolled at the agency. – Set clear expectations in the beginning so there is a shared understanding of the roles.

- Providing services in the school may make it more difficult to engage with the parent because they don't physically have to transport the child. We may elicit the school personnel's help to try to engage the parents. – Having discussions about expectations prior to starting services in a school helps.

- Children may have significant trauma issues that are not appropriate to be addressed during the school day and may need to come to the office in addition to school based services. – Educating school staff about what issues can be addressed in therapy in a school setting helps with having realistic expectations.

- Build trusting and active relationships within our school system in order to fully capitalize on our program's potential. – It helps to have increasing interactions and communications has been instrumental to overcoming this barrier and building a relationship.

- A challenging aspect with school based is working around the testing. Most of the schools have had our programs for over 2 decades and it not as difficult to work us in but when we are engaging new contacts. - We have to "sell" the value of our programs and what we can do to aid in their testing process. Our selling points are: increased decision making skills, goal setting, stress reduction and our visits are a nice reprieve from the stresses of testing time.

- Reluctance to have agency staff in the building from the school counselors. – It helps to educate them on the differences in our roles.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

- We are a valuable asset to the educational system.

- Be respectful that each school has its own dynamics in terms of expectations, access allowed, who we connect with regularly about progress and what each set of students may be dealing with depending on the communities they are coming from.

- Making sure that the program is something that the teens want and have helped to design and create, your program can be an amazing program but if no one shows up it will not succeed. Having to get the teens to "buy" into the program has been a difficult lesson and trying to learn that balance between making a program that they have created so that they are truly vested in the program but yet also is educationally sound, has been a struggle.

- We are the "experts" around ATOD when it comes to supplementing the health classes. Our programs fit directly in the core curriculum for students.

BH Provider Organization: Hopewell Health Centers, Inc

Primary Contact and e-mail: kristi.pennington@hopewellhealth.org

Partnering School District(s): Hocking (Logan-Hocking; Logan Elm); Belpre (Marietta City, Warren Local, Belpre); Vinton County (Vinton County Schools); Meigs (Meigs, Eastern Local, Southern Local); Jackson (Jackson City, Welson, Oak Hill); Athens (Trimble, Nelsonville, Athens, Federal Hocking, Alexander); Pickaway (Teays Valley)

Number of school buildings in which school based behavioral health services are provided:

20 Elementary 9 Middle School 8 High School 5 k-12 sites

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

We have one program in Logan Hocking (STARS---we named it Successfully Teaching and Reaching Students = ED classrooms) where we work in conjunction with the ED rooms in the district. We place a Therapist and Case Manager to work as staff in the rooms providing those services as well as crisis services. The program is slightly different at each level or account for the developmental stages of the students. These sites provide us with office space in their building full time.

We have several sites who will complete groups in special education classrooms.

The majority of our school based services are provided to individual and small groups spaces that the school allows us to use.

In Jackson schools, there is an agreement where at least in the past, our services can be provided in a whole classroom (regular ed) environment.

There are a few buildings (mostly ES) that we included in the above data but do not having an ongoing staff in that building. However, we have clients with whom we see there during the school day as well as work with teachers to improve school functioning.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

All of our therapists our trained in TF-CBT. We have used PATHS curriculum in some social skills groups. CBT groups/ DBT groups for HS students/ Various Social Skills groups at all levels. These groups and individual practices vary on the medical needs of the students.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

All of our clients have individual service plans so no general outcomes. We often look at data based around grades, school attendance, and behavioral referrals for objectives on the Service Plans.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Most of our relationships are informal. We do have MOUs for the STARS program in the Logan Hocking Schools and a few other districts. Most of the informal relationships are based on the district providing us space to work with their students.

What is the reimbursement or financing mechanism for your school based behavioral health services?

We may have one financial deal with a district in Jackson. Most of our services are paid for by Medicaid/Insurance of the client. In the area of STARS- there have been occasions where the district has agreed to pay for assessment and counseling services for the student in the program who had no payer source.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Convincing teachers to allow the students time outside of class (not everyone can be seen during PE and some of our clients NEED to Move, so PE is essential for them)- Helping them see the value of the service once tried as well as explaining that if the service does not happen on site, the amount of the time outside of the classroom is greater. This often reduces over time as the school sees the benefit of the service with the client's improving functioning.

Being asked for assistance with behavior planning and then no follow through on the behavior plan- administrative intervention helps, if needed, also time and trust of the staff in the building.

School referring lots of students and little support from the parents or some school staff not understanding the difference between typical development and mental health disorders . Helping the school understand that we are not employed by the school, so we cannot see clients without parent permission.

Space….Real Estate in some buildings is a hot commodity. Needing the school to understand the need for confidentiality.

Helping teachers understand confidentiality and not needing or having the right not know all of the information about the case.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Good Relationships take time. We have to understand each others' vital interests in the services and work together to meet those needs.

Staff who are a good fit and understand the school system are essential. All districts are run differently and fit is essential.

Periodic meetings with both admin staff is good to address small issues and miscommunications. We have to learn how to speak the same language.

Helping everyone understand what is the definition of crisis and what is the appropriate protocol for a crisis in each building/district.

School Based services work because school is a child's work and is essential for meeting them where they are, but excellent services are also supplemented with those who tie the home to the school.

BH Provider Organization: Lake Geauga Recovery Center

Primary Contact and e-mail: Matthew Petersen; mpetersen@lgrc.us

Partnering School District(s): Chardon and West Geauga

Number of school buildings in which school based behavioral health services are provided:

_____Elementary ___2__Middle School___1__High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular Education Classrooms

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

In the Chardon school district efforts are being made to provide the Project Alert curriculum to the 8th grade classes. My role is to work with high school students so that they can present the information to the middle school students. We partner with Prevention workers that are in the schools to help enhance services.

Also within the school exists a Youth Led Prevention, group that at the high school is known as Active Substance Abuse Prevention (ASAP) and at the middle school is known as Junior Teen Institute (JTI). ASAP is the group responsible for leading the Project Alert classes for the 8th graders. When they can JTI will partner with ASAP to enhance the class sessions provided.

We are just starting talks with West Geauga Schools to develop a program that is similar in structure to what we do at Chardon. This is where I teach and monitor high school students on the curriculum and then they present to the 8th grade classes.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Because this was a trial run we no pre/post test was given. Our biggest concern was recruiting enough high school students to cover all the classes. I did observe that some youth were more willing to reach out for assistance during the trainings both high school teachers and middle school participants. These were youth facing their own difficulties around family member's drug use who reached out for professional help because of what they heard or experienced in these classes.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

My organization works with the Chardon school district through a Community Coalition grant. The grant has been in place for over 10 years now and provides for the betterment of the Chardon local district through the efforts of the Chardon Community Action Team.

This community coalition works within the community to provide prevention services and educational opportunities to its members.

What is the reimbursement or financing mechanism for your school based behavioral health services?

The coalition will reimburse me for any direct costs related to our prevention efforts in the Chardon schools. The agency is reimbursed through the Community Coalition Grant and the Geauga Prevention grant from the Geauga MHRS board.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

One of the biggest challenges I faced was developing a partnership with the key staff from the school. I was new to my position and had to determine what role I would like to take within their program. Once I clearly explained what my role was they were very open to me and willing to work with me and include me in their programing.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Flexibility is key when working within schools. Many times schools don't like outside faces in their building so you have to work with them and be willing to put in the extra effort to show them that you can be trusted. Also, in regards to teaching classes try to find commonality in regards to curriculum. If their health class has a lesson on drugs and alcohol, contact the health teacher and offer services at that point. Schools face many challenges of their own and the easier we can make their day the more likely they are to was to partner with us.

Provider Organization: Marion Area Counseling Center

Primary Contact and e-mail: Beverly Young, byoung@maccsite.com

Partnering School District(s): Marion City and County Schools

Number of school buildings in which school based behavioral health services are provided:

6 Elementary 5 Middle School 5 High School 2 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

We conduct Signs of Suicide in all the middle and high schools. Each school does it different. Some is a part of a classroom and some are done in groups, some are the initial homeroom.

We are doing counseling at a couple of the high schools and middle schools. We are trying to provide CPST services at the elementary schools with students and coordination with the teaching staff.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

SOS, Trauma group, individual treatment services, crisis intervention, and/or consultation services.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Signs of Suicide is measuring the youth suicide rates in Marion County of middle and high school students. Others not really measuring in a formal way. More case by case improvement, grades and staying in school.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

No written agreements or contracts.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Schools want services but do not want to help pay for any. Try to Medicaid for individual services rendered. ADAMH Board has agreed to support some services in the schools. SOS is paid for in a combination of United Way, Marion Community Foundation, and the ADAMH Board.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Most difficult part is the schools understanding that you can't just come in and provider services – there has to be parent involvement in completing a diagnostic assessment and parent authorizing the treatment services to be provided. Every time there is a staff change at the school, you have to go back through this again. Getting the parents to attend a session to do the diagnostic assessment and signed permission forms has a high no show rate. They also don't understand that if the school staff bring the child to see the psychiatrist without the parents, medication cannot e prescribed.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Trying to get guidance counselor/school social workers to take a more assertive role in getting the parents at the meeting/first session.

BH Provider Organization: Maumee Valley Guidance Center

Primary Contact and e-mail: mvgccp@defnet.com

Partnering School District(s): Defiance City Schools, Central Local Schools, Northeastern Local Schools

Number of school buildings in which school based behavioral health services are provided:

_____Elementary __1___Middle School __3__High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

We are delivering behavioral health services in regular classroom settings. For our high school classrooms, we are specifically delivering services in the health classrooms.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

The evidence-informed prevention that we provide to the high schools and middle school is the SOS Signs of Suicide Prevention Program. Although the material and the approach differs slightly from middle school to high school, the goals of this program in both settings are equivalent. The curriculum lessons and goals include decreasing suicide attempts by increasing knowledge and adaptive attitudes about depression, encourage help-seeking behaviors, link suicide to mental illness which requires treatment, engage parents and school staff as partners in prevention, reduce the stigma associated with mental health problems, increase self-efficacy and access to mental health services for at-risk youth, and encourage schools to develop community-based partnerships to address issues connected with student mental health. In this program, educational DVDs are shown with discussion guides to both the high school and middle school students. In these videos, students are encouraged to use the ACT technique (Acknowledge, Care, Tell). This technique teaches students to acknowledge a friend has a problem, tell the friend you care, and then tell a trusted adult. The ACT message is portrayed through various dramatizations that include depressed/suicidal teens in the movie. Following the video, a Brief Screen for Adolescent Depression screening is completed by the students; it is important to note that parental consent is needed to screen each student. The screenings are reviewed, depending on a student's score determines if parents are notified and if further services are needed.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

The outcomes that are measured in the SOS Signs of Suicide Prevention Program are suicidal thoughts/behaviors and knowledge, attitudes, and beliefs about mental health. Depression and thoughts of suicide can affect many areas of a student's life. Depression often causes feelings of sadness/hopelessness, inability to concentrate, low energy, and withdrawing from activities/people that once brought joy to their life. However, The SOS Signs of Suicide Program helps students understand that depression is a treatable illness by educating the students on the signs, risk factors, and various treatments that are

available for individuals experiencing depression. By doing this, students can seek help for themselves or for a friend, ultimately reducing the symptoms of depression and signs of suicide that negatively affects different areas of a student's life, specifically their academic performance and school success.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

The SOS Signs of Suicide Prevention Program is funded by the local United Way.

What is the reimbursement or financing mechanism for your school based behavioral health services?

The SOS Signs of Suicide Prevention Program is funded by the local United Way.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

One challenging aspect of developing school based services is getting into every possible school that our grant funds. We have noticed that one school in particular does not want to implement our SOS Signs of Suicide Prevention Program into their school because they believe this topic does not need addressed in their classrooms.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

We have noticed that schools and teachers tend to really focus on a strict curriculum throughout the year in preparation for students to pass state standardized tests. Therefore, we have found it beneficial to work with teachers who do not teach subjects that are state tested, as their schedules are more flexible and more open to having our program in their classroom.

BH Provider Organization: Mental Health Services for Clark and Madison Counties, INC

Primary Contact and e-mail: Sue Fralick at Sue.fralick@mhscc.com

Partnering School District(s): Springfield City, Tecumseh Local, Clark-Shawnee

Number of school buildings in which school based behavioral health services are provided:

_1____Elementary 1____Middle School _____High School
_1____ESC ED program where there is elem, middle and high in one building
_1____ ED alternative school where we serve elementary, middle and high

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Special education

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Partnering with the school for PBIS, provide assessments, individual and group CPST services, consultation, training.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Some schools want number served, we give outcome measures for trauma, some mental health symptom based outcomes, return to regular school numbers, behavior indicators such as suspensions,etc., successful completion of MH treatment,

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

MOU's/financial agreements

What is the reimbursement or financing mechanism for your school based behavioral health services?

Medicaid and a contractual amount with the schools for non-Medicaid students.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

- Getting parents to attend assessments so cases can be opened—still an issue
- Making a plan for serving non IEP students, identifying the need and servicing with funding from the school, interpreting federal Medicaid rule, parents also would not understand paying as it is during the school day.

- Funding crisis intervention services in the various school buildings—not solved yet
- Communication on what to put on IEP for MH treatment and then sharing data between two IT systems so schools have what they need when audited

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

- Have a person in charge from MH and from the schools that all issues go through to be solved
- Getting involved in school initiatives is important on the mental health end

BH Provider Organization: Muskingum Behavioral Health (MBH)

Primary Contact and e-mail: Steve Carrel, scarrel@gmail.com

Partnering School District(s):
Currently: Zanesville City Schools; Foxfire Schools

Prior to elimination of the Drug-Free Schools Grants: Zanesville City Schools; Foxfire Schools; Franklin Local Schools; West Muskingum Schools; Ease Muskingum Schools; Tri-Valley Local Schools; Maysville Local Schools

Number of school buildings in which school based behavioral health services are provided:

Currently
4 Elementary _____Middle School 1 High School _____ESC/Other

Previously
13 Elementary 2 Middle School 3 High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular, Special Education classrooms

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Club Save – Evidence influence by LifeSkills
Previously – Care Teams – Community Collaborative where local social service organizations, including courts and child welfare provided prevention, intervention and referral to treatment

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Increased knowledge

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:
Zanesville and Foxfire schools pay a small amount for services. Muskingum Behavioral Health used federal SAPT Block Grant funds to provide all of the services.

What is the reimbursement or financing mechanism for your school based behavioral health services?

X dollars per month, depending on what the school has available
Previous – Schools paid MBH most, if not all, of their Drug Free Schools grants, and MBH used Block grant to pay for services. Example – West Muskingum Schools paid $17,000 and received in excess of $90,000 in services.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Finances is always a barrier. Schools that want the programs will find ways to help fund the services.

One barrier that has yet to be overcome is the Battelle for Schools contracts with schools. Their contracts lock schools into using only their survey of school environment. It's not a great survey instrument. We used to use the Search Institute Developmental Assets survey, in conjunction with our Educational Services Center, in over 12 school districts at the Middle and High School levels. The last survey we did, we used the CAYSI (http://cayci.osu.edu/surveys), developed by The Ohio State University College of Social Work and Muskingum Valley Educational Services Center. It's an online tool which students can complete as school time allows.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Meet them on their terms. Each district has a different personality, as does each building. Each have their own needs. Evidence Based programs MUST be tailored to meet these needs. Fidelity does not work when you have diverse populations and needs.

BH Provider Organization: Nationwide Children's Hospital

Primary Contact and e-mail: Kamilah.Twymon@Nationwidechildrens.org

Partnering School District(s):

- **Bexley School District**
- **Canal Winchester Schools**
- **Columbus City Schools**

Number of school buildings in which school based behavioral health services are provided:

17 Elementary 13 Middle School 10 High School 5 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

We collaborate with school staff to implement PAX Good Behavior Game, a Tier 1 Universal Prevention Strategy in the classrooms setting. PAX is primarily being implemented in regular education classrooms and is also being implemented in a handful of ED classrooms. We also provide counseling Services to students that are placed in both regular classrooms and special education classrooms.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We utilize a multi-tiered delivery system. Tier 1 includes universal strategies that promote a positive school climate through the implementation of prevention programs that provide consistent and structured responses to behavioral and emotional concerns. Tier 1 strategies don't target a specific group; they are typically implemented school wide or grade wide. Our Tier 1 strategies include PAX Good Behavior Game for grades K-6 and Signs of Suicide for grades 6-12. Both are Evidenced-based Practices that are listed in SAMHSA's National Registry for Evidence-based Practices and Programs.

Tier 2 includes targeted strategies for students not yet experiencing impairment but risk factors are identified. Education and prevention groups along with brief individual prevention are utilized to address concerns and reduce risks. Our Tier 2 Evidenced-based prevention groups include:

- Skillstreaming
- Too Good for Drugs
- Too Good for Violence
- Coping Cat
- Relationship Plus

Tier 3 includes Individual, Family and Group Therapy. Students exhibiting significant issues around their mental health and behavior that prevents them from being successful in school can be referred for therapy by school staff or self-referred by their

parent/guardian. School staff will contact the parent/guardian to ask permission to refer the student to counseling services. Nationwide Children's staff will contact parents/guardians to complete the intake process and identify the appropriate service for the student.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Our program targets students that are experiencing non-academic barriers to academic success. We also work with school leadership and staff to create and maintain a positive and effective school climate. The multi-tiered delivery system provides opportunities to impact students prior to reaching full impairment. We utilize the Ohio Scales to track the problem and functioning scales. We also utilize individual treatment goals to assess individual progress. Additionally we track data related to inattentive behavior in classrooms that are participating in the PAX Good Behavior game.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We are co-located in each of the schools we partner with. Our therapist have access to an office where they can hold a confidential therapy session. We also require that there is a locked file cabinet, land line and access to Wi-Fi along with ability to plug into the network. Additionally we request that NCH staff assigned at the school sites have access cards and keys needed to access the building, office and bathrooms. School Staff and the NCH therapist regularly collaborate regarding potential referrals, continuity of care and caseload volume. NCH staff also provide consultation and training for school staff. We have Memorandum of Understandings with the districts to outline the logistics of the partnership and set the expectation of compliance with confidentiality laws. We don't have a financial agreement with any of our partners.

What is the reimbursement or financing mechanism for your school based behavioral health services?

The primary source for reimbursement of services is through Medicaid and insurance. The majority of the clients in our program qualify for coverage through Medicaid. ADAMH funds a small portion of prevention, consultation and education services that we provide in Columbus City Schools. ADAMH funds prevention, consultation and education along with other services that are not reimbursable by Medicaid or insurance in Bexley and Canal Winchester. Students that are receiving treatment services and don't have access to health care or have a financial obligation through their private insurance must meet ADAMHs income guidelines to receive financial assistance. In some cases it is possible that a family is identified as self-pay and will pay of pocket for treatment services.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Typically school staff can identify students that will benefit from counseling services. Unfortunately we sometimes face a variety of barriers to actually linking with the client. The referral process can sometimes be seen as a barrier. NCH staff works closely with school staff to help eliminate barriers and walk them through the referral process. We've

also experienced lack of family or caregiver engagement as a barrier. Caregiver consent is needed for treatment services and their participation is recommended. NCH therapists have flexible schedules and also provide sessions in the home and community to help decrease barriers and increase engagement.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Collaboration and assessment is needed to be effective. We complete assessments prior to partnering with a school to understand the needs and dynamics of the school. We've also requested monthly site meetings at a minimum to identify successes to anchor off of and identify emerging needs, concerns and barriers.

BH Provider Organization: New Horizons Mental Health Services

Primary Contact and e-mail: Nate Green, ngreen@newhorizonsmentalhealth.org

Partnering School District(s): Lancaster City, Pickerington, Liberty Union, Amanda-Clearcreek, Walnut Township, Fairfield Union, Bloom-Carroll

Number of school buildings in which school based behavioral health services are provided:

8 Elementary 7 Middle School 6 High School 4 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular education, special education – ED classes and county ED school. Also, private counseling sessions within the school buildings.
Preschool building and HeadStart locations.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Outpatient individual counseling; group counseling; SOS suicide prevention education and screening program; Early Intervention (broad service, much is 1:1 and similar to counseling services).
Consultation services regarding behavioral health to preschool and HeadStart.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Pre and post-surveys regarding depression suicide awareness regarding SOS presentation and screening.
Total number of students screened and presented to.
Individual functioning and quality of life outcomes for students in counseling.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Many of our counseling and case management services are Medicaid billable and do not involve specific contracts with a school district, but rather agreements regarding access / office space / referral process.
Our SOS program is directly funded by a grant from our local United Way and ADAMH Board and school district contracts
Some districts, HeadStart, and the County ESC pay us directly for intervention and/or consulting services.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Counseling and case management – Medicaid.
SOS – grant from ADAMH Board and United Way, and school district contracts.
Intervention and consulation services – contracts and quarterly payments from the school districts to us directly.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The barriers we have 'overcome' are just year-to-year communicating with the schools in the Spring time to solidify our plans for the following school year. We have mostly consistent relationships with a number of our local districts.

Some challenges have not really been 'overcome' to this point:

- The variations from year-to-year regarding schools and budget decisions is a challenge.
- Regarding counseling and case management, we have struggled to hit necessary targets regarding billable service hours due to a variety of issues – working around academic schedules, students' attendance issues, snow days, holiday and other 'off days' for school districts that are 'work days' for our staff.
- Providing work over the summer is a challenge – we have found ways to offer PT work for our staff, but would prefer to have year-round, FT jobs for these folks.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Of course, contract-based positions are a 'win-win' for the agency and the school districts, as these positions are much more flexible and do not require strict attainment of billable service targets. But – the funding for these positions is limited and not 100% consistent.

We are still working on maximizing billable service hours, but doing so in such a way that the job remains 'doable' and attractive to quality clinicians. This is a real challenge.

BH Provider Organization: OhioGuidestone (Cuyahoga, Medina, & Lucas Counties)

Primary Contact and e-mail: Jane Wood – jane.wood@ohioguidestone.org

Partnering School District(s):

Cuyahoga County **– Berea City Schools, Brooklyn City Schools, Cleveland Metropolitan Schools, East Cleveland City Schools, Euclid City Schools, Garfield Heights City Schools, Fairview Park City Schools, Lakewood City Schools, Parma City Schools, South Euclid-Lyndhurst City Schools, Charter/Private/Parochial Schools.**

Medina County **– Brunswick City Schools**

Lucas County **– Springfield Local Schools, Charter Schools**

Number of school buildings in which school based behavioral health services are provided:

35 and 23 (K-8) Elementary 12 traditional -Middle School____ 27___High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

OhioGuidestone School- Based Mental Health and Support Services offers behavioral health services in settings listed above: regular education, special education, schools with specific populations on autism spectrum and attention deficit disorders.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Our programs offer schools: mental health assessments, behavioral health counseling (individual, group, family), community psychiatric supportive services (CPST), Prevention services with the Georgetown Model for Consultation and Prevention (funded by Cuyahoga County ADAMHS Board).
As needed, our Agency offers Psychological and Pharmacological Services/Management.

Thus far we have offered Cognitive Behavior Therapy, Trauma Competent Care, Acceptance Commitment Therapy, Dialectical Behavior Therapy, Recovery 360 Care(integrated AOD & MH), and our trained Art Therapists integrate art therapy as indicated and appropriate, treatment for sexual behavior problems and treatment for victims of sexual violence is provided through our PROTECT program as appropriate. A few therapists are trained in Second Step and/or PATHS (promoting alternative thinking strategies) both evidence-based violence prevention social skills programs.
We are presently being trained in the Ross Greene Model of Collaborative Proactive Solutions (CPS) and will be piloting with a school this spring 2017. Additionally, OhioGuidestone is the Family Nurturing Center of Ohio and are able to offer various Nurturing Parenting Programs.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

OhioGuidestone utilizes the age appropriate Child Behavior Check List (Achenbach) for measuring Internalizing, Externalizing and Total Problems. This is administered and completed by parent at initial meeting and subsequent 6 months thereafter. On a quarterly basis Client Satisfaction Surveys are randomly distributed to be completed by Parent and at closing of case. Teacher and Non-Teacher Satisfaction Surveys are distributed and collected twice during the school year. More recently our School Services have begun to collect client's end of year report cards, attendance, and behavioral referrals to the office to measure impact of services.

Our behavioral health services assist students with addressing social emotional issues working closely with the educational staff, parents, and families as partners helping increase coping and social skills with the goal of increasing capacity for academic learning. Innovative programming is custom designed to meet the needs of each school and can include individual, group, parent and family services in addition to offering professional development to school staff as requested.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

OhioGuidestone utilizes MOU's specifying each parties responsibilities in addition to a Business Associates Agreement (specifying HIPPA compliance) with each school district or charter/private school. OhioGuidestone has a long standing contract with our local Cuyahoga County ADAMHS Board and the Board funds our Consultation and Prevention Services (non-Medicaid funding) for schools we serve in Cuyahoga County.

What is the reimbursement or financing mechanism for your school based behavioral health services?

The Insurance of choice that pays for our school-based mental health services is primarily Medicaid in the State of Ohio. In addition schools have the option of purchasing additional services as needed with individual contracts. And, as mentioned above, we receive some funding for the Georgetown Model of Consultation and Prevention through CC ADAMHS Board.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

OhioGuidestone (formally Berea Children's Home and Family Services) has provided School-Based Mental Health and Support Services in Cuyahoga County since the late 1990's. With the support and monthly provider meetings held at our ADAMHS Board since inception we have had very few barriers. Our program's reputation of offering competent services in schools have contributed to expansion of schools from 3-5 schools in 2003 to 97 schools serving the 2016-2017 academic year. An on-going challenge facing many schools is a lack of space and collectively we problem solve as those issues arise.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

The key "lessons learned" in partnering with schools include open and honest communication and building strong trusting Relationships. Frequent face to face meetings working together as a team benefits all and as required/necessary includes schools staff, parent/caregiver, student and mental health specialist. Team work ensuring everyone is on the same page and working together for the improvement of student academic performance is paramount.

BH Provider Organization: OhioGuidestone, Lorain County

Primary Contact and e-mail: Joanna.Gioia@ohioguidestone.org

Partnering School District(s): Avon Lake, Elyria City, Lorain City, Sheffield Lake and Charter Schools: Constellations

Number of school buildings in which school based behavioral health services are provided:

21 Elementary 2 Middle School 1 High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular education but some special ed youth are in the classrooms. Blended classrooms

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Incredible Years, DINA, PAX Good Behavior Game

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

DECA is used. Also other associated pro-social skills data collection

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

MOUs are in place. Funding is primarily through local grants or County Mental Health Board. Schools are not paying for any services.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Grants. Lorain County Mental Health Board. Medicaid for individual behavioral counseling or CPST services, or Group Therapy

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Space issues in the school for confidentiality, and flexibility of teachers/administration to allow students to participate in mental health services during the school day beyond lunch/recess time.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Establishment of administrative supports is critical! Need administration to buy-in to the importance of mh services and prevention programs.

BH Provider Organization: OhioGuidestone – Central Ohio

Primary Contact and e-mail: lisa.clark@ohioguidestone.org

Partnering School District(s): Big Walnut Local Schools,

Number of school buildings in which school based behavioral health services are provided:

3 Elementary _____Middle School _____High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Primarily regular ed settings, but since it can be client specific, therefore special ed and disability specific children are provided services as well.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We provide counseling on the school site. Groups are completed under CPST billing or behavioral health counseling. Groups provided include social skills training, anger management training, feelings identification and expression, problem specific groups such as children who come from divorced families. EBP primarily is Cognitive Behavioral Therapy. We also utilize Art Therapy (LPCC Art Therapist).

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

For client specific services we utilized the Child Behavioral Checklist (Achenbach). Additionally we keep data on school attendance and performance. We have not examined this data yet (school attendance and performance) as we are completing our first full year, this school year 2016-17. Achenbachs show behavioral health improvement overall.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We utilize an MOU. This MOU includes services we will provide, and besides counseling/CPST services, it includes classroom observations and consultation. These rates are comparable to Medicaid rates for time spent – i.e. $85 to $90 per hour.

What is the reimbursement or financing mechanism for your school based behavioral health services?

We bill Medicaid, and they also pay us utilizing Title I funds for non-Medicaid billable services.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The biggest challenge is educating the schools on how we can provide services under OHMAS, Medicaid and other requirements. Once this is completed however procedurally it works smoothly.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

- Make sure the school understands the need for a private space. Space is a challenge in schools, and it can be a challenge with space issues.
- Do ALL procedural requests and trouble shooting up front as much as possible.
- Once you prove that these services are valuable, other schools within the district will also want services.

BH Provider Organization: Personal and Family Counseling Services, an OhioGuidestone Organization (Tuscarawas and Carroll Counties)

Primary Contact and e-mail: Pam Trimmmer ptrimmer@pfcs1.org

Partnering School District(s): Garaway, Strasburg, Indian Valley, Newcomerstown, Conotton Valley, and STAR Alternative School.

Number of school buildings in which school based behavioral health services are provided:

10 Elementary 6 Middle School 6 High School _____ESC/Other

13 buildings for Elementary and Middle School AoD Prevention-Botvin's Life Skills

6 districts are engaged in Youth Led Prevention at the High School Level.

6 school districts, including an alternative school are engaged in school based services. Other schools in the Tuscarawas/Carroll counties also allow counselors to come into the school to work with youth who are clients of PFCS.

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Primarily with regular education classrooms, however we also are located in our Alternative School (STAR) in Tuscarawas County. Our counselors linked to the schools are to be present in the buildings, see youth as needed throughout the day based on teacher referral.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Prevention services are only focused on AOD using Botvin's Life Skills. We provide the service to 4-6th grades in 13 buildings.

Treatment services focus on CBT interventions, TFCBT, and trauma informed practices. We also follow Ross Greene's work of Collaborative Problem Solving. This work focuses on identifying lagging skills that are impacting a child's ability to manage behaviors.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We utilize the CBCL/Achenbach as outcomes for all students. We have not yet specifically looked at the change in academic success of students involved in BH Services. It is something we do want to begin measuring.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We have an MOU with all schools involved, schools provide a private space for meeting, WIFI access, and collaborative discussions with teachers as needed. PFCS provides a dedicated staff member, who is responsible for measuring outcomes and following best practice principles. Schools do not provide any financial assistance towards the project. Services are billed to Medicaid, private insurance, and/or placed on a sliding fee scale with reimbursement from our ADAMHS Board.

What is the reimbursement or financing mechanism for your school based behavioral health service?

See above

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

- Some schools had difficulty identifying a private space which has caused the counselors to be quite flexible in terms of where sessions take place. Sessions are limited in time which impacts the ability to use an EBP or to focus on more than crisis intervention and short term coping skill development.
- Parent involvement is also a barrier to services. Staff is still required to get parental consent and prefers to have parental involvement; however some parents refuse to sign for services so the children then are unable to receive counseling services.
- School partners also like to use the counselors as consultants throughout the day, particularly for students who are not yet clients of the agency. This impacts the counselor's productivity and creates down time. However, this is also a service that builds relationships and trust with an outside agency. We try to limit this or try to get the student in question to become a client.
- One of the biggest challenges has been getting the schools to recognize the impact that BH problems have on student's academic success, the value in the service, and prioritizing/addressing these needs despite the teachers needs to insure the school and students meet the academic success indicators per the state. Generally we hear a lot that pulling kids out of academic classrooms is not in their bests interest as they get too far behind and are then likely to be unable to pass the core curriculum testing. There is limited understanding that the students are already distracted, unable to focus on the work, and are doing poorly already and won't be ready for testing if their anxiety and depression continue to go unaddressed.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

- It is important to educate the school system on the value of the service, use data to support how the service can ultimately have an impact on student success, and provide some limited training on typical struggles students encounter.
- We expect very little from the school.
- It is also in the best interest of providers to continue to provide services to the students over the summer to maintain continuity and take that opportunity to address more of the trauma symptoms with more time invested, and involve the parents. Our staff are

required to do in home therapy throughout the year as the parents agree, but all of the work is done in the home in the summer.

- Other keys to success is to develop relationships with not only the superintendents and principle but more importantly with guidance counselors and teachers, this is where the referrals come from. This also gives an opportunity to educate teachers on BH interventions or small things they can do in the classroom to assist the student in their success.

BH Provider Organization: Pastoral Counseling Service (PCS)

Primary Contact and e-mail: Ann Robson, VP Clinical Services; arobson@pcssummit.org

Partnering School District(s): Akron Public Schools, Woodridge Local Schools, Norton City Schools, Tallmadge City Schools, Barberton City Schools, Wadsworth City Schools, I CAN- Akron School, University Charter School and Main Street Charter School and Imagine Charter School.

Number of school buildings in which school based behavioral health services are provided:

45 Elementary 15 Middle School 13 High School _____ ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

PCS delivers behavioral health services to all types of classrooms. Our focus when we began school based mental health services was special education, but we have expanded to all classrooms.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

PCS provides Individual and Group Therapy as well as CPST services within the school setting. Our therapists and CPSTs arrive in the morning and stay all day in their assigned school. We also provide after school services in the home or in a group setting within the community. We have recently started providing prevention through a program called Generation Rx. We have presented this program in 5 middle schools and will continue after the new year.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

This year PCS is taking a closer look at graduation rates with clients on our caseloads compared to the general school population. In the past, we have provided each school with a diagnostic picture of the students the school has referred. We wanted each school to know the different types of behavioral and mental health disorders that are making up their classrooms. We measure client, family and school satisfaction on an annual basis and make staff adjustments according to need.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

PCS has a written agreement with 4 of the schools we serve. The other schools are served with a verbal agreement. We have been invited into all the schools we serve.

What is the reimbursement or financing mechanism for your school based behavioral health services?

PCS does not receive any reimbursement from our schools that we serve. PCS bills our client's insurance companies or accepts self-pay. Our funds are primarily reimbursed by Medicaid.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

PCS developed our school based program in 1998. At that time, our biggest barrier was developing a positive relationship with each school's guidance counselor. The guidance staff felt threatened by our presence and this made the referral process very difficult. PCS was able to develop relationships with the school staff by consistently working with the students, showing a genuine interest in helping children and families engage in the school process, staying all day at one or two schools, and working cooperatively with all school personnel.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

We remind our staff that we have been invited into our school sites and we are guests. Our communication is cooperative and inclusive especially in emergent situations. We are experts in our subject matter, but we can always learn from other perspectives and how our work impacts school performance is key to our academic stakeholders, community partners and mostly parents.

BH Provider Organization: Recovery & Prevention Resources (Delaware and Morrow Counties)

Primary Contact and e-mail: Carol Kasha-Ciallella, Carol.Kasha-Ciallella@rprdm.org

Partnering School District(s): Charter school

Number of school buildings in which school based behavioral health services are provided:

_____Elementary _____Middle School _____High School 1___ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

In a charter school setting that meets the needs of students who have not been successful in more traditional school environments.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We provide Seven Challenges via groups and individual counseling for students with substance use disorders, and CBT groups for those with behavioral challenges.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We are not currently formally measuring outcomes, though our programs address the issues that tend to cause the students to drop out or be expelled. We have seen our clients return to school year after year and go on to graduate.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

The agency providing services in this county prior to us was instrumental in the development of the school and thereby an integral part of it. We have strived to continue their work- though the school has changed a great deal over time. Our clinicians go over to the school to provide the services then leave when finished.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Students who wish to engage in our services become clients of the agency. Medicaid is billed for those clients with that coverage. In-county residents without Medicaid are served via DMMHRSB funding,

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The most challenging aspects were not in the development of school based services when the alternative school was first started. However, as new regulations came into play for

charter schools and the school received funding to improve its outcomes, it became harder to provide the services. We had a lot more flexibility in the past to hold groups for an ample length of time and meet with clients individually as needed. We are now limited to a 37 minute period to do the groups and find it difficult to pull students from classes without putting their educational goals at risk. We overcome these barriers by working with the school guidance counselor and director to get the students the services they need with as little interference as possible.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

In the past we had funding to do what was termed "student assistance" services. This allowed us to serve the students without the paperwork process required for them to become clients. This was helpful in allowing us to get to working with the student more quickly, and made the services easy to access in the main stream schools as well as the charter school (though the funding only allowed us to serve in-county residents).

BH Provider Organization: The Recovery Center

Primary Contact and e-mail: Trisha Farrar, tfarrar@therecoverycenter.org

Partnering School District(s):
Pickerington,
Fairfield Union,
Berne Union,
Liberty Union,
Amanda-Clearcreek,
Bloom Carroll,
Walnut Township (Millersport),
And the Catholic Schools

Number of school buildings in which school based behavioral health services are provided:

6 Elementary 9 Middle School 9 High School 1 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)? Regular classrooms and selective groups for early intervention and children of people with substance use disorders.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We provide: Too Good For Drugs, Too Good For Violence, Project Alert, Cybersmart (not evidence based yet) and Reconnecting Youth in the school setting.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We use the pre and post-tests that are a part of the curriculum. We measure retention and increase in knowledge and skills. We also complete teacher satisfaction surveys.

Our county does a Youth Behavior Survey (now through our ADAMH Board, used to be Family, Adult and Children First Council). This survey is completed every two years with all students in the 10th and 12th grades throughout our county- 8 school districts. Even in spite of the opiate epidemic, our survey is showing a decline in youth substance abuse! We have lots of information to share and it can be accessed through the Fairfield County ADAMH Board's web site.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We used to have financial agreements with some schools to help pay a portion of our programming, however in the past 10 years, schools don't have funds to assist with this. Services have been paid through our ADAMH Board and United Way. These funds have been decreased and continue to decrease.

We work with the school staff and schedule services. Because our services are universal mostly, we don't do much with MOU's or financial agreements. Prevention Specialists work with teachers and guidance counselors to schedule programs.

Currently, we have three full time Prevention Specialists providing services. In the past, it was as high as 6.

What is the reimbursement or financing mechanism for your school based behavioral health services?

ADAMH and United Way – again these are decreasing because of the many priorities, even though our county youth behavior survey shows the progress.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

It was initially difficult to get into most schools because of all their requirements. However, once we get our foot into the classroom, teacher's embrace our services and want more!

Productivity is somewhat of an issue because of the holidays, snow days, testing days etc and our staff do a lot of driving throughout the county.

We also try to provide services at two grade levels at each school district however much more prevention is needed over the course of a child's development to truly be successful.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

It's so important for the staff to buy into the programming. In the past, there were schools who didn't think they had any problems, or were afraid of the perception in the community if we were doing prevention services. That is improving thank goodness.

The same goes with a teacher in the classroom- they must value what we are doing and typically they do but a program won't be successful if the school staff don't want it to be. We also need to have dynamic prevention staff who are professional and energetic.

Evidence based programs are SO important. Sometimes we are up against presenters who come into the school one time and do a presentation and use scare tactics or give wrong information- this is not prevention and it doesn't work!

We are seeing more and more students with family struggles. We see more students who are not living with their parents, who are homeless and who have a lot of basic needs that aren't being met often because of their parent's substance abuse. This group of students needs more support!

Overall, the school and agency partnership is working very well. School staff are very enthusiastic about the programming we provide and we are seeing positive results.
If you need more information, we have success stories, pre and post test results and the youth behavior survey which are all very informative!

BH Provider Organization: Samaritan Behavioral Health Incorporated

Primary Contact and e-mail: Beth Esposito, baesposito@premierhealth.com

Partnering School District(s): Dayton Public Schools/Career Technology Center/Miamisburg Schools/Vandalia Butler Schools/Piqua City Schools/Milton Union Schools

Number of school buildings in which school based behavioral health services are provided:

22 Elementary 5 Middle School 4 High School 2 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular classroom except for two special education classes at Vandalia Butler.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Individual and family therapy, some case management services and consultation work. Curriculums are not utilized however, TF CBT, MI.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Outcome measures are used such as Vanderbilts for ADHD, PHQ-9 for depression, and GAD 7 for anxiety and PCL for PTSD and we continue to utilize the C GAS score for kids and Ohio Outcome Measures.

School attendance is better and no suicides have occurred while we have provided services

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We have various relationships with the different schools. Dayton Public Schools, Piqua Community Schools, and Milton Union Schools are an MOU relationship as we bill Medicaid for the clients we see. Vandalia Butler, Career Technology Centers, and Miamisburg have contracts where we provide services and they pay us directly. We utilize a varied staffing patterns that includes sending staff to multiple sites depending on the need.

What is the reimbursement or financing mechanism for your school based behavioral health services?

For MOU schools, we bill Medicaid and the schools are not involved with payment. For the contract schools, they pay an hourly rate for the time our staff is there providing services. We bill them monthly for those fees. For some of the contract schools it is a flat monthly rate.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The positions can be difficult to fill as they are not year round positions. We also struggle at times aligning a referral process when first entering a school system as each school understandably has its own way of doing this.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

We have learned to be very up front about space needed for staff to protect the confidentiality of our students. We have also learned to say up front that we need at least 15 referrals to start providing one day of service at the school site and growing it from there. We have also learned to keep a consistent line of communication with our staff as the staff spend more time at the school sites and begin to view the school sites as their employer vs us.

BH Provider Organization: South Community

Primary Contact and e-mail: Stephanie Stratton, Program Director for School Programs, 937-643-7088, sstratton@southcommunity.com

Partnering School District(s): Montgomery County Educational Services Center, Kettering City Schools, Northmont City Schools, Northridge City Schools, New Lebanon City Schools, Centerville City Schools, Oakwood City Schools, Valleyview City Schools, Summit Charter Schools, Huber Heights City Schools, Eaton City Schools and Dayton Public Schools

Number of school buildings in which school based behavioral health services are provided:

27 Elementary 13 Middle School 11 High School 2 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

We provide a continuum of services depending on the needs of the district and our contracted services. At the ESC we provide therapy services for the dual diagnosis program for SED and DD classrooms as well as SED, we have six contracts with Districts to provide therapists in SED classrooms across the district and 8 additional MOUs to provide school based services to the Medicaid population in their districts.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

South Community trains all middle school and high school therapists in the evidence based practice model of Seven Challenges for AOD treatment. In addition, staff work in each district to develop curriculums for the specific district utilizing best practice interventions in trauma informed care, positive behavioral supports and several resiliency based models of care including the 40 development assets and The Response Ability Pathways model which is based on a Native American evidence based practice, other evidence based practices utilized frequently are motivational interviewing and trauma focused CBT.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

South Community completes client and teacher satisfaction surveys on an annual basis and consistently demonstrates extremely high satisfaction across districts and consumers. In addition, South Community school programs completes the emerging measure from the APA called the DSM-5 Cross-Cutting Symptom Measure. This tool measures a student's level of symptoms across several diagnosis categories at intake, discharge and at the end of the school year to measure the success of interventions for client progress throughout treatment and the school year. Consistently students with mental health needs in their

school environment demonstrate progress academically, and behaviorally when they are engaged in mental health services in their school environment.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Originally most of the agreements South Community had in districts were contracts with specific schools where the school agrees to a certain amount of money for each FTE purchased. While some districts provide a continuum of services paid by the district across the district, most districts purchase for their SED classrooms typically a therapist per building. In an SED classroom typically about a caseload of 20-25. In addition several districts purchase psychiatric time for their SED students to have access to our child prescribers. In an effort to maintain contracts in districts for the services several districts have in recent years added a Medicaid reconciliation clause in their agreements. In those districts South Community agrees to bill Medicaid to the extent clients are eligible for those services and in the last quarter of the year those Medicaid dollars are returned to the district.

In the last six years as the understanding in districts has grown regarding the need for mental health treatment in schools for the general population. South Community has entered into Memorandums of Understanding with different districts to provide outpatient mental health services. Essentially the district agrees to provide confidential space and access to their school WIFI and South Community agrees to provide services to students in their building. In some districts that is almost exclusively Medicaid and in others the district pays a minimal amount to allow access for all of their students to services and for crisis management and support.

What is the reimbursement or financing mechanism for your school based behavioral health services?

South Community bills community Medicaid in most instances or direct invoicing to the district. There are two remaining districts that have our SED therapists bill school Medicaid through HPC for the services they provide to the district.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

For the most part school districts who have invited us into the conversation and into these agreements embrace the need for mental health services. We have with any service faced some challenges specific to the nature of the work. Schools are sometimes truly stretched for space and our staff have worked and are grateful for converted closets. Sometimes issues like ID badges electronic issues like school vs agency email, or printing in each school building have been challenging. But for the most part schools work to understand our need for HIPPA secure communications and documentation. And staff are flexible in adapting to support staff that are in a different location.

There have been some times when the challenge is continuing to have parent engagement once the student is open for services. Having CPS staff available and hiring therapists who value community based services and will do home visits with parents to continue to engage them in services has been a core value in our service delivery and all of our school based service providers are equipped to provide services with a mobile, secure electronic record.

In some districts our work has included staff presentations and training to grow the knowledge base for educators who are diverse in their understanding and appreciation of mental health services in schools. And recently our work in districts has been challenging in continuing to collaborate to provide services in a very competitive environment with other agencies both in hiring and recruiting staff and in ensuring client choice if districts have more than one provider in the district. How to engage staff for 10 month positions and provide comparable compensation and to work through issues related to hourly employee status have been recent challenges to overcome.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

School based services are the at times the best possible service provision for outpatient based services. Service providers in the buildings work in close collaboration to provide outpatient therapy but also community based interventions to reduces and manage mental health symptoms for students. Crisis are managed in the moment and students go back to class to complete their education requirements. Teachers are supported in having a mental health professional manage the mental health and can focus on educating rather than in managing crisis. Parents have ready access to treatment and supports and the barriers of transportation are virtually eliminated. And students who receive mental health intervention are more likely to complete their education and graduate from high school.

Districts and community providers who collaborate well together provide the optimum environment for positive outcomes. And South Community continues to value the relationships of the partnerships we have developed with districts.

BH Provider Organization: St. Joseph Orphanage

Primary Contact and e-mail: Mykish Summers; mykish.summers@sjokids.org
Diane Young; diane.young@sjokids.org

Partnering School District(s): Cincinnati Public Schools (Dater High School; Carson Elementary; Ethel M. Taylor Elementary); North College Hill School District; Ross Local School District; Hamilton City School District (Riverview Elementary); St. Joseph Catholic School.

Number of school buildings in which school based behavioral health services are provided:

7_____Elementary **2**_____Middle School **2**_____High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

We are in regular education classes, in Dater High School we provide services in the Cognitive Disabilities Classroom, Special Education Classroom

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We provided embedded daily Case Management Services as well as Individual and if needed family Therapy. We provided specialized groups to address Anger, bullying, Self-Esteem and Coping Skills. We also provided daily Partial Hospitalization services in two of our schools, that follow curriculums such as Stop and Think.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We measure how our program effects number of referrals, suspensions and expulsions with the clients that we have. Our services directly affect academic performance because we are able to help the clients manage more in the classroom and spend more time in the academic setting. We are also able to help school staff recognize deficits in clients that may have been overlooked. We send out two surveys a year to school administration and staff asking about the effectiveness of our services. We also go over our clients DLA-20 reports to see what progress is being made in what area.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We have MOU's with all of our school districts that outline the schools particular need and what we as the organization is able to provide as a whole and what we will specifically provide in that school, i.e. therapist, case management, PH programming etc…

What is the reimbursement or financing mechanism for your school based behavioral health services?

We are Medicaid based services and we have some fee for services.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

One of the most challenging aspects was developing and building a case load to sustain staff for embedded services five days a week. We were able to work openly with the schools on appropriate referrals and increasing compliance with guardians to complete referrals in order to build the caseloads. We also work with MindPeace as a liaison in three of our schools that help with barriers.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Key Lessons learned is that when education and mental health in specific work collaboratively we can get greater results. We also have schools where the physical health is also addressed and they are part of the team and it makes for a more holistic approach for the clients. School Based services are a much-needed service and it helps to be embedded it the daily happenings and get true measurements on the clients as well as provide hands-on interventions on the spot. It is vital that we work together for our clients.

BH Provider Organization: Syntero, Inc.

Primary Contact and e-mail: Sara Harrison-Mills (sharrisonmills@syntero.org)

Partnering School District(s): Dublin, Grandview Heights, Hilliard, Upper Arlington, Tolles

Number of school buildings in which school based behavioral health services are provided:

33 Elementary 12 Middle School 8 High School 5 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Primarily regular education classrooms. However, we do provide supports to many students on IEP's and have done some classroom work with special education students.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

The school based services we provide are primarily prevention services. We provide services based on a 3-tier model:

Universal:

- Presentations: Professional Development (for school staff), Parent Workshops (open to community members), and classroom presentations. Topics include, but are not limited to: Hurting to Heal: Understanding Self-Injurious Behavior in Youth; Red Flags: Depression Awareness; Signs of Suicide; Balancing Act: Promoting Mental Well-being of your MS & HS Students; Don't worry, I'm FINE (Parenting MS Students); Overscheduling; Helping Your Child Develop Coping Strategies to Manage Stress & Anxiety; Bullying & Suicide; Building Resiliency; Trauma and Impact on Learning; Classroom Strategies for Managing Anxiety, Classroom Strategies for Managing ADHD; and Alcohol/Other Drug Prevention Strategies for Youth.
- Screenings: Devereux Student Strengths Assessment (DESSA), Signs of Suicide, SBIRT (using CRAFFT)
- Classroom presentations: 12 sessions of Coping 10.1 (CBT program), Teen Dating Violence (1-2 sessions), Healthy Bodies, Healthy Futures (separate from school prevention program-provides 3 educational presentations on sexual health, following 17 CDC recommendations for comprehensive sexual health education).

Selected:

- Brief Individual prevention (guideline of up to 5 sessions; assist with linkage to outpatient if more services are needed), Individual screenings using PHQ-9 and GAD07
- Educational/skills building groups for students who had been identified as "at-risk"

- Groups offered using evidenced-based curriculums including: COPE (Creating Opportunities for Personal Empowerment), Skillsstreaming (Social Skills), Coping Cat, Zones of Regulation, CBT based groups (Angry Birds Anger Management, Inside Out Emotional Regulation, Busy Bees ADHD, Star Wars Mindfulness), DBT based groups (Self-Awareness, Affect Management, Self-Esteem, & Self-Respect "SASS")

Indicated:

- Services for students who have been identified as needing more intensive services, we have provided case management and "risk reduction" services to link students/families with outpatient mental health counseling.
- We are able to provide this service at the school or at either of our locations.
  - When there are barriers for accessing outpatient services at one of our offices, we work to get students linked to provide this service at school, if possible.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

Performance targets include: 1) Increase number of students who demonstrate school bonding and educational commitment; 2) Increase number of students who perceive substance use as harmful and non-use as the norm; 3) Increase number of students who improve their quality of life and live in a safe environment; 4) Increase students' knowledge and utilization of healthy coping strategies; and 5) Minimize negative impact of critical events.

These outcomes are evaluated using pre/post questionnaires, verbal report from student and referring school staff, review of student records, and/or use of pre/post screening tools (PHQ-9, CRAFFT, GAD-7).

We also monitor attendance, disciplinary concerns, and grades. We have found that students who participate in our prevention services develop increased ability to identify and apply healthy coping strategies. We have also seen increased attendance, improved grades, increased school bonding, and decrease in disciplinary concerns.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We have been providing school prevention services for Dublin, Hilliard, Grandview Heights and Upper Arlington through funding received by the ADAMH Board of Franklin County for the past four school years (starting with the 2013-14 school year). We have contracts in place with all 4 school districts to provide these services. We also have a private contract for 1 FTE with both Dublin and Hilliard to expand the prevention services already in place. In addition, we have a private contract with Tolles to have a school clinician provide services 1 day/week.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Please see above

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Scheduling prevention services has posed challenges. Many schools have very limited time they will allow school clinicians to provide groups and/or meet with individual students. Participating in monthly meetings with key contacts within each district has been very helpful in planning and improving services. School based clinicians have experienced some resistance from the elementary level in providing prevention services, likely due to the overlap of school prevention services and the role of the elementary guidance counselors. We have discussed this with administrators from the school district and they are working with us to determine strategies for strengthening this partnership. We have seen significant improvements in this area since starting services in the 2013-14 school year. Syntero recognizes the importance of building relationships and that integration with a school system can take time. Administrators from Central Office within each district have been instrumental in building and supporting relationships in each of the buildings throughout the districts we serve. We have had some challenges communicating with parents and following-up regarding satisfaction with program. We have continued to prioritize the communication between school clinicians and parents through use of phone calls, scheduling meetings, and email. We identified increased need at some schools and adjusted staffing levels to accommodate these needs. We engaged district staff through mid-year surveys to facilitate communications regarding strengths and areas of desired growth within our partnership. We also administer end of year satisfaction surveys to better assess the challenges/barriers experienced by our schools in order to plan improvements for the next school year.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

- Building strong relationships with each school is extremely important and can take time.
    - Having a consistent School Clinician year to year helps with building this relationship.
    - Clear, open, and consistent communication between School Clinicians and School Staff is essential.
- It is important to understand the unique culture that each district and each school within the district has in order to fully understand the school's needs and to develop programming to meet the specific needs of each school.
- Programming needs to be flexible to accommodate the emerging needs of each building.
- Having a point person for each district that works to promote services throughout the district helps with "buy in" and in improving school's receptivity to services.
- Participating in regular meetings with key district staff to discuss services, identify unmet needs within the district, develop programming, and evaluate services is critical.

BH Provider Organization: Talbert House

Primary Contact and e-mail: Kelly.hibner-kalb@talberthouse.org

Partnering School District(s):

- **Cincinnati Public**
- **Norwood City**
- **Southwest Local**
- **Princeton**
- **Winton Woods**
- **Deer Park City**
- **Lakota**
- **Fairfield**
- **Western Brown**
- **Southern Hills Career and Technical Center**

Number of school buildings in which school based behavioral health services are provided:

30 Elementary 12 Middle School 9 High School 2 ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Students from all types of classrooms are being served in most of our districts including tradition classroom, special education and alternative school settings. Prevention/education services are provided to all types of classrooms in some of our districts.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Services provided include behavioral health assessment, counseling, CPST, crisis intervention and mental health and substance use prevention. All services have a foundation based in one the following evidenced based practices- CBT, DBT, Motivational Interviewing, Solution focused Therapy and Choice Theory. Many are trained in trauma-informed cognitive-behavioral treatment (TF CBT). Prevention services utilizes the Developmental Assets Profile and Second Step as the framework for prevention and education services.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

SBS uses the Ohio Scales, PH-Q-9, GAD-7, DESSA, DAP and academic performance as outcome measurements. Brown County utilizes the strengths and difficulties questionnaire, Rosenberg Self-Esteem and modified aggression. The services we provide benefit academic performance by providing and oulet for emotional dysregulation. The clients are able to develop coping skills which allow for improved focus and ability to communicate needs to

educational staff. We are also able to assist teaching staff in understanding students needs and challenges and helping them come up with effective strategies in the classroom to assist each child in being successful.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Every school district and many individual schools have MOUs with the program. Two districts have financial agreements for prevention services. The associate director has ongoing contact with school administration to update service provision needs. Clinical supervisors have frequent meetings with school principals (or other pertinent school staff) to address individual needs of specific schools. Providers have weekly (or more frequent) meetings with primary referral sources in the school and frequently consult directly with other school staff to coordinate services.

What is the reimbursement or financing mechanism for your school based behavioral health services?

The majority of the behavioral health services provided are covered under Medicaid. Non Medicaid youth may have access to the mental health board funds based on income and county of residence. A small percentage of youth are private pay/insurance. A couple school districts provide small amounts of funding for limited prevention services. Prevention funding also comes from the United Way, DOE, and the local mental health board.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

The key to success is the "buy in" of school administrators and staff regarding the importance behavioral health services can play in meeting the goal of improving overall functioning in the school setting. Ongoing communication with key school stakeholders is critical. The referral process, at least in the beginning, can be challenging, as staff need time to become aware of the who, what, and how of our services. For a school which has never had services, we and the school staff must educate guardians regarding the benefits of our services, as well as the logistics of the assessment/treatment phases. With the latter, education, often on a one-to-one basis is essential. Often letters of introduction of our program services are mailed to guardians by the school. Smaller, but often critical barriers, include adequate/ appropriate space to conduct services, availability of students (not taking out of core academic classes) and access/quality of technology (access to telephone, printer, fax, internet). These are addressed on an individual basis, but many providers are given portable Wi-Fi devices to access internet.

Getting schools to understand the financial model can be a challenge when they are dealing with so many behavioral challenges and youth in crisis on a daily basis. At times the schools perception of need doesn't always match up with the level of referrals that convert to open cases. Schools sometimes will request a certain number of behavioral health staff, but that doesn't match up with the utilization of the services. Ongoing communication with the school is needed to assist them in understanding the model and how they can assist. The model of having one agency be the lead mental health agency for a school is the most beneficial model from a treatment and financial perspective.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Collaboration is key for success in partnering in schools. In order to have a collaborative relationship, there must be consistent, clear communication. Assumptions often lead to difficult interactions. Utilizing email, phone calls, and frequent meetings between all stakeholders is vital to having a successful relationship. Honest communication regarding barriers and a common focus on improving the lives of students is essential for this collaboration.

BH Provider Organization: Wingspan Care Group (Applewood/Bellefaire)

Primary Contact and e-mail: Jeffrey Lox, COO – loxj@bellefairejcb.org

Partnering School District(s): South Euclid Lyndhurst, Mayfield Heights, Euclid, Shaker, Lakewood, East Cleveland, Cleveland Metropolitan, Constellation Schools, Break Through Schools, Lorain City Schools, Elyria City Schools, Wellington Schools

Number of school buildings in which school based behavioral health services are provided:

57 Elementary 41 Middle School 12 High School _____ ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular, Special Education including self-contained and Multi-Handicap classrooms.

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

We use Girl Circle/ Council on Men, Georgetown Model for consultation, TF-CBT, CBT, Solution Focused, I-Fast. Psychoeducation groups using Thinking, Feeling, Behaving, and Social Decision-Making/Social Problem Solving, Red Flags, and Signs of Suicide (SOS).

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

We use Ohio Scales and DESSA mini to evaluate social emotional learning and competency. We also conduct teacher and administration surveys to evaluate the outcome of services. In our Lorain County services specifically, we use a 14-item resiliency scale for pre/post test measure in Psychoeducation groups, the Lorain County Mental Health Board has developed a individual consultation evaluation so that the schools are able to evaluate the effectiveness of that particular service, and Ohio Scales are used to measure the progress of individual counseling services.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

We use MOU's to outline our services which includes staffing.

Each year, the Lorain County Mental Health Board has each district's superintendent sign a contract for Consultation, Education, and Prevention Groups. Those particular services can only start once the contract is signed. The school-based supervisor and the school-based therapists meet with school principals and guidance counselors prior to the start of

the school year to discuss the services that can be provided throughout the school year and then attend teacher staff meetings in order to provide them with service information.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Medicaid and ADAMHS Board and Department of Juvenile Justice; Lorain County Board of Mental Health

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Getting the right children referred for services, confidential space in buildings, understanding of our roles in the school. Overcoming took patience and education on the agency and therapist's part.

Supervisors meeting with building level principals and advocating for what we needed to be successful in a building.

Receiving additional funds to services children who did not meet the need for therapy but still needed and intervention.

Staff retention, which is an ongoing concern, we utilize bonus structure and incentives to encourage productivity and longevity

Helping districts understand confidentiality, what we can and cannot share, needing private space for provision of services. Addressed these barriers by meeting with superintendents, principals and other administrators as well as with teachers directly to explain the rationale.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Understanding the demographics of the school or district and if what we are capable of providing is achievable (enough children who have a mental health diagnosis and have Medicaid). Being up front with the district or school about other services that could be provided at an additional cost of the school. Providing the district or the school clear understanding on how we will provide the service and the frequency of the clinician is based on the need of the school. Too often schools did and do not understand that our therapists cannot be in their building 5 days a week if the referrals are not there to support our staff.

It's important for the supervisors and therapists to regularly meet with school staff in order to evaluate the effectiveness of the services provided.

Because there is so much pressure on teachers in regards to testing, teachers need more frequent reminders about the mental health services available in their buildings, which can help to alleviate some of the pressure on them by addressing mental health concerns that impact learning in the classroom.

BH Provider Organization: Youth to Youth

Primary Contact and e-mail: Cheryl Sells, csells@youthtoyouth.net

Partnering School District(s): Columbus City Schools, Dublin City Schools, Westerville City Schools

Number of school buildings in which school based behavioral health services are provided:

_____Elementary __2___Middle School __5___High School _____ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

Regular education and after school services

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Prevention education and leadership development on Alcohol, Tobacco, other drug use as well as bully prevention and mental health awareness. Youth Led Prevention activities, environmental strategies to improving the community they live in.

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

For one program we have seen a decrease in relational aggression among female students, for another program we have seen a decrease in perception of (alcohol, tobacco and drug) use among the students as well as community awareness and in the 3rd program being able to provide drug free alternatives and decreasing the perception of use among youth.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

With all 3 of the programs we are providing to the schools, we are providing a service that the school counselors and or teachers would have otherwise had to provide. Our relationship with many of the schools is a working relationship with administration and or school counselors. Some grant funding is provided but not from the schools. The schools are benefiting from the organization that is providing the service.

What is the reimbursement or financing mechanism for your school based behavioral health services?

Most of the funding for these programs is provided from outside grants or agency in kind donation. The schools are providing little to no financial support. One school does pay for lunch for the students involved as they meet during lunch time. They also provide space for the programming to take place.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Forming a trusting relationship with the school. As an outside organization we have to prove our value and worth to the school to show they can trust us to come in and provide services for their students. Ensuring the school, we are asking little commitment and work on their behalf helps a lot.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

The less we ask of the schools, the more we can do. We have had many issues working with schools previously where they are not willing for us to come into their school to provide services but once we inform and show the school we are asking very little of them and they are getting a wonderful service for their students, they are much more willing to cooperate!

BH Provider Organization: Zepf Center

Primary Contact and e-mail: Kristin Bruce, kbruce@zepfcenter.org

Partnering School District(s): Charter Schools: Discover Academy and Star Academy, some lower-level partnership with Perrysburg School District

Number of school buildings in which school based behavioral health services are provided:

2 Elementary 2 Middle School _____ High School _____ ESC/Other

In what type of classroom setting(s) are you delivering behavioral health services (e.g. regular education, special education, disability specific, etc.)?

- regular education
- largely, removing youth from instruction to provide individual therapy intervention services
- some youth seen during their lunch breaks

Describe the services, curriculums, and/or evidence-informed prevention or behavioral health practices you are providing in school based settings.

Individual and group bullying prevention, education, and intervention services for staff and students, based in Olweus and Beane bullying programs

What outcomes are you measuring? Describe how school based behavioral health services benefit academic performance and school success in your program.

- Using pre/post surveys based on CDC outcomes, measuring student perception and parent perception surveys
- We are also being used in place of suspensions for bullying behaviors—our intervention specialist provides services to help amend behavior in lieu of the discipline
- Our program helps to resolve conflicts, link to mental health services, and reduce out-of-school suspensions.

Describe the relationship between your organization and the school district(s), including use of contracts, MOUs, financial agreements, staffing, etc.:

Using MOU's currently to set up basic financial and other arrangements

What is the reimbursement or financing mechanism for your school based behavioral health services?

One school is receiving free services, one school is paying $500/month. These are introductory rates and the program is also offered to internal Zepf clients, so it is primarily supported through insurance billing for the short-term individual and group sessions. We will be increasing cost for services next school year.

What were the most challenging aspects of developing school based services and how did you overcome these barriers?

Having schools that will amend schedules/develop alternate routines to accommodate, and to free up a school official to help manage the time/services.

What have been the key "lessons learned" in partnering with schools to provide behavioral health services?

Administration being supportive with student time, administrator time for coordinating, and communicating the benefit to the school are the most important takeaways—the schools need to have an explicit idea to grasp as to why it will improve their bottom line. The program participation in lieu of suspension has been attractive to the schools we are servicing.

*****Our Integrated Care/case management (IC) department partners with schools to advocate for student needs, observe behaviors, provide interventions as needed, etc. This is on an individualized basis and is part of our IC program rather than a specific school-based service.