Criteria, rationale for ranking schools in Cohort 2 of
City-Wide School Behavioral Health Expansion
May 17, 2019

To support the identification of tiered cohorts of schools for roll-out of the expanded school behavioral health model, the Coordinating Council on School Mental Health has identified a set of administrative data measures to be used as proxies for behavioral health need.

For cohort 2 (roll-out in SY2019-20), the Coordinating Council has unanimously voted in support of the following data elements: % of students defined as at-risk, % of students with disabilities, attendance rates, out-of-school suspension rates, and % of students identified as English Learners. All data analyzed are from SY2017-18.

Using these data and the corresponding methodology outlined in the appendix, the top 67 schools identified will be included in the year 2 expansion. The discussion below outlines the rationale and methodology utilized for the ranking.

Rationale for data elements utilized

The model for the District's school behavioral health expansion focuses on providing all three tiers of behavioral health supports, ranging from universal and preventive supports (Tier 1) to early intervention (Tier 2) to intensive individual-level interventions and treatment (tier 3). In the absence of population-level behavioral health screening data, the spirit of the analysis leveraged by the Coordinating Council is to identify populations that may be at higher risk for stress or trauma (who are in turn at higher risk for developing behavioral health disorders), as we believe those communities should be prioritized with corresponding multi-tiered supports.

Administrative data utilized

Five data elements were leveraged to approximate schools' behavioral health need, and thus to inform the prioritization of schools within cohort 2. The data utilized are outlined below.[1]

1. **At-Risk**: Percent of students enrolled in School Year 2017-18 meeting one or more of the following OSSE "at-risk" criteria:
   - ✓ Experiencing homelessness;
   - ✓ Under the care of DC's Child and Family Services Agency (CFSA), i.e., children living in foster care);

[1] Technical definitions for all elements are outlined in the 2018 OSSE DC School Report Card and STAR Framework Technical Guide: https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2018%20DC%20School%20Report%20Card%20and%20STAR%20Framework%20Technical%20Guide.pdf

- ✓ Eligible for Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program (SNAP); or
- ✓ A high school student that is one year older, or more, than the expected age for the grade in which the student is enrolled.

2. **Students with Disabilities:** Percent of students with disabilities (defined as students evaluated and found eligible to receive specialized instruction and related services in school and provided an Individual Education Plan [IEP]) in School Year 2017-18.
3. **In-Seat Attendance rate**: Percent of the cumulative sum of instructional days in School Year 2017-18 on which enrolled students were present at school.
4. **Out-of-School Suspension rate:** Percent of students in a school enrolled during School Year 2017-18 that received an out-of-school suspension.
5. **English Learner:** Percent of students in School Year 2017-18 identified as an English Learner. Students are identified as EL if all of the following apply[2]:
   - ✓ The parent answers on the Home Language Survey that the student speaks a language other than English or a language other than English is spoken in the home.
   - ✓ The student is screened on an OSSE-approved screener and is not proficient in English.
   - ✓ The student is entered as an English learner and remains classified as such until scoring proficient on the ACCESS assessment.

The first four criteria were also used to identify schools in cohort 1 (using data from SY2016-17); the fifth element was newly introduced for cohort 2.

Ranking methodology

1. **Determine the school's "z-score" for each indicator above.**
   - ✓ A school's "z-score" is a ranking method similar to a percentile that also has the benefit of distinguishing between schools otherwise very similarly situated.
2. **Calculate a composite score for each school by taking the average of all 5 z-scores, weighting the OSSE at-risk indicator equal to the other 4 indicators combined.**
   - ✓ This balances the weight of external environmental factors and internal student/school dynamics.
3. **Remove schools included in Cohort 1, schools that are closing in School Year 2018-19, and schools in the following categories: secure facilities, adult only, and online-only programs. Sort all remaining schools by this new composite score.**
4. **Select the top 67 schools to create cohort for year 2 implementation.**

Specific considerations for Cohort 2

Existing partnerships or clinical staff

As in the first year of the city-wide expansion, the group decided to not include in its determination of behavioral health need an indicator regarding existing resources in the school building, including DBH, school-based, or partnering clinicians. The rationale for this decision was multi-fold.

[2] "Delivering Education Services to English Learners; Policies and Procedures for Administrators, Instructional Leaders, and Teachers in the District of Columbia." District of Columbia Office of the State Superintendent of Education, Version 4.0, April 2019.
https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/EL_Policy_Update%202019.pdf

First, service delivery models in a school setting take many forms and come from many sources, both within and outside of the school system. The number and types of behavioral health related programs and associated personnel within a school may vary year to year, and even within a school year, which presents a challenge to ensuring the reliability and accuracy of any data collected on school-level resources.

Second, a behavioral health clinician in a school building may play a number of other roles, or may be limited in the population that he or she can serve. Therefore, one FTE doesn't necessarily mean that all of that individual's responsibilities relate to behavioral health programming.

Third, the intent of the model is to offer schools the opportunity to identify the elements of its behavioral health model that are not currently met – regardless of their current staffing and partnership model – and to leverage the comprehensive expansion to fill those gaps.

Pre-school only

This year, we opted to include pre-school only programs in the ranking, although none were sufficiently highly ranked to be included in cohort 2. We believe that pre-school only populations have behavioral health need that could be meaningfully addressed through the expansion. Additionally, pre-school classrooms are supported in public and public charter elementary schools previously included in the rankings. Supporting our youngest learners with multi-tiered interventions is important to putting them on track for success in school and in life.

English Learner status

The addition of English Learner status was proposed by Coordinating Council members as a proxy measure for immigration status. Research demonstrates that children from immigrant families may be at high risk for stress and trauma.[3,4,5,6,7] In parallel, those children are less likely to access routine health care and public benefits.[8,9]

We do not ask about immigration status at the time of school enrollment and do not have a standardized source of data to define this target community of immigrants or children in immigrant

[3] Huang, K. Y., Calzada, E., Cheng, S., & Brotman, L. M. (2012). Physical and mental health disparities among young children of Asian immigrants. *The Journal of Pediatrics*, 160(2), 331-336.
Potochnick, S. R., & Perreira, K. M. (2010). Depression and anxiety among first-generation immigrant Latino youth: key correlates and implications for future research. *The Journal of Nervous and Mental Disease*, 198(7), 470

[5] Kupersmidt JB, Martin SL. (1997) "Mental health problems of children of migrant and seasonal farm workers: a pilot study." *J Am Acad Child Adolesc Psychiatry*. 36(2):1–9pmid:9000769

[6] [6]Providing Care for Immigrant, Migrant, and Border Children. (2013) COUNCIL ON COMMUNITY PEDIATRICS. *Pediatrics*. 131 (6) e2028-e2034; DOI: 10.1542/peds.2013-1099

[7] Cervantes, R. C., Padilla, A. M., Napper, L. E., & Goldbach, J. T. (2013). Acculturation-related stress and mental health outcomes among three generations of Hispanic adolescents. *Hispanic Journal of Behavioral Sciences*, 35(4), 451-468

[8] Foundation for Child Development. Children in immigrant families: essential to America's future. Available at: http://fcd-us.org/node/1232.

[9] Bridges, A. J., de Arellano, M. A., Rheingold, A. A., Danielson, C. K., & Silcott, L. (2010). Trauma exposure, mental health, and service utilization rates among immigrant and United States-born Hispanic youth: Results from the Hispanic family study. *Psychological Trauma: Theory, research, practice, and policy*, 2(1), 40.

families.[10] However, as of 2017-18, **97% of immigrant students in District schools are identified as English Learners, the closest proxy measure.** (Full list of criteria for identification as an English Learner is above)

In the absence of the EL indicator, immigrant populations with significant behavioral health need may be inadvertently overlooked; 50% of the overall weight in the original algorithm for defining need is made up of the OSSE 'at risk' score, which includes TANF and SNAP participation. However, as above, immigrant communities may be less likely to be eligible for and to access these benefits and thus risk being undercounted using those indicators.

Analysis by the DBH epidemiology team with data including EL status gives us further confidence that the EL status is indeed identifying immigrant communities. We found 8 schools elevated with the addition of EL status; the overall rankings for other schools were minimally impacted, indicating validity of the measure in identifying a defined population. **Those 8 schools identified with the EL indicator are known to have large immigrant populations.** Given concerns from school leaders regarding unmet behavioral health needs of these specific immigrant communities, all 8 of these schools are currently connected with (or have reached out to) community-based behavioral health organization(s) with expertise in immigrant health to request targeted interventions and supports for this community.

[10] We do not systematically capture immigrant status on large local collections of data regarding stress, trauma, or mental health need. Therefore, we are not able to compare immigration status against other subcategorical data. However, the DC Youth Risk Behavior Survey demonstrates striking rates of depression, suicidality, and lack of safety among youth who identify as Hispanic/Latino, which represents the largest subpopulation of immigrants in DC. https://osse.dc.gov/node/1308786