Quarterly Report

To: Dr. Charneta Scott, Project Manager, DC Department of Behavioral Health

From: Child Trends Research Team

Re: Child Trends Quarterly Report for Quarter 3 (**September – December 2020)** Reporting Period

Date: January 14, 2020

Executive Summary

The DC Department of Behavioral Health (DBH) is partnering with Child Trends, a nonprofit research organization, to evaluate the expansion of comprehensive school behavioral health supports in DC and promote continuous quality improvement (CQI). This memo summarizes the activities conducted by the Child Trends research team over the last quarter.

Key activities conducted in Quarter 3

- Developed draft school resource map.
- Launched crisis response and services survey.
- Conducted crisis response and services focus groups and interviews.
- Established data use agreement with Catholic Charities.
- Developed and piloted monthly clinician survey.
- Facilitated logic model discussions with members of Coordinating Council.

Deliverables submitted in Quarter 3

- Memo outlining recommendations for assessing unmet behavioral health need in schools and for matching community-based organizations (CBOs) and schools.
- Draft and final evaluation design memo.
- Draft CQI plan memo.
- Summary of data from monthly clinician survey pilot.

Key findings in Quarter 3

Data collection is ongoing. Key findings listed below are preliminary and may change as more data are collected.

Crisis response and services (102 schools reporting)

- Most respondents agreed that their school crisis plan is written clearly (82%) and adequately addresses how to respond to a behavioral health crisis (80%).
- In the previous school year, 37 percent of respondents agreed that efforts to make families aware of their school crisis plan were adequate.
- Approximately half of respondents did not think their school crisis plan had been adequately revised to address needs during the pandemic.

- In the previous school year, very few respondents (13%) were dissatisfied with the way that Child and Adolescent Mobile Psychiatric Service (ChAMPS) interacted with staff, students, and family members/caregivers when responding to a behavioral health crisis.
- In the previous school year, 45 percent of the respondents agreed that they were satisfied with the time it took ChAMPS to arrive to school once they were called.

Monthly clinician survey pilot (40 clinicians reporting activities in November)

- Almost all clinicians reported conducting Tier 1 and Tier 3 activities; 60 percent reported conducting Tier 2 activities.
- Nearly half of clinicians reported conducting activities across all three tiers.
- Nearly one in five clinicians reported caseloads of 16 or more students; the median caseload was nine.
- A little less than half of clinicians reported having at least one session with all of the students on their caseload.
- About half of clinicians who conducted Tier 1 activities did so with families.
- Approximately 20 percent of clinicians reported that they did not feel well-equipped to conduct Tier 1 activities.
- Approximately two thirds of clinicians who provided Tier 3 services felt supported by their supervisors.
- Approximately two thirds of clinicians felt integrated into their school behavioral health team.

Base Year approach

Phase 1: Gather information (Quarter 1)

In this phase, the evaluation team will engage in efforts to orient themselves to the expansion.

Phase 2: Set priorities (Quarters 1 & 2)

In this phase, the evaluation team will engage with individuals representing a variety of perspectives—including DC agencies, students, families, school staff, and CBOs/providers—to identify priorities for the evaluation.

Phase 3: Draft evaluation plan (Quarter 3)

In this phase, the evaluation team will work with DBH, the Office of the State Superintendent of Education (OSSE), and other stakeholders to draft an evaluation plan that addresses the priority research questions and is perceived as feasible by key stakeholders.

Phase 4: Pilot evaluation plan (Quarter 4)

In this phase, the evaluation team will conduct a pilot of the evaluation plan to ensure that data collection activities are feasible and result in information that will be useful for answering the research questions.

Progress toward achievement of the identified goals and objectives

In this section we summarize progress on each of the key tasks that were executed during Quarter 3.

Project management and reporting

Key activities

- Updated Dr. Scott on project status during biweekly check-in meetings.
- Attended Coordinating Council meetings.
- Established "core team" monthly meeting with DBH, OSSE, DC Public Schools (DCPS), and DC Public Charter School Board (DC PCSB) staff to streamline data collection efforts across partners and reduce burden on schools.
- Established data use agreement with Catholic Charities and identified data source and began developing scopes of work for the data use agreements with DBH, OSSE, and DCPS.
- Prepared and submitted Quarter 2 report on September 11.

Child Trends submitted a quarterly report and summary slides to DBH for the Quarter 2 (July–August 2020) reporting period on September 11; the slides were used to provide a summary of project progress to the Coordinating Council. In Quarter 3, Child Trends continued meeting biweekly with Dr. Charneta Scott to plan and share project updates and progress. Over the course of these discussions, Child Trends provided DBH with drafts of the logic model and other project materials that will drive and support the planning and evaluation of the comprehensive expansion of school-based behavioral health services.

During the last quarter, Child Trends collaborated with Dr. Scott to convene a meeting of staff from DBH, OSSE, DCPS, and DC PCSB to form a "core team" that would meet monthly to discuss the proposed timeline for Child Trends' evaluation activities and troubleshoot ways to increase evaluation participation. Child Trends uses core team meetings to ensure that the timing of Child Trends' data collection efforts complement partners' activities and leverage partners' existing communications and relationships with the target audience for each data collection activity. Child Trends held two core team meetings in November and December; agendas and notes from the meetings were provided to all core team members, regardless of meeting attendance.

The Child Trends evaluation team also continued working with Child Trends' Contracting and Compliance team to establish data sharing agreements with Expansion partners. Child Trends and DBH routinely checked in on progress with data use agreements during Quarter 3. Child Trends and Dr. Scott also held calls with the Data and Evaluation Committee co-chairs, Philippa Stuart, and other technical and support staff at DBH to identify data for inclusion in a data use agreement. Child Trends shared early drafts of the data use agreement with Dr. Scott for feedback and submitted the formal data use agreement for DBH General Counsel review on November 23. DBH General Counsel responded with edits to Child Trends' data use agreement on January 4, 2021. Because Child Trends and the GWU Center for Health and Health Care in Schools (CHHCS) team are working on the same project for DBH, DBH General Counsel determined that a data use agreement did not have to be established between the two organizations when the data to be shared are deidentified and all contract terms are followed. Child Trends' Contracting and Compliance team also shared a data use agreement with Catholic Charities to obtain ChAMPS satisfaction survey data for the period from August 1, 2019, through June 30, 2020. Catholic Charities' data use agreement was executed on January 5, 2021, and Child Trends anticipates receiving the ChAMPS satisfaction data by the end of January. Lastly, in the December core team meeting, it was determined that Child Trends would need to

establish data sharing agreements with DCPS and OSSE in order to receive Panorama, trauma-informed school response reports, Youth Risk Behavior Survey (YRBS), and Health and Physical Education Assessment (HPEA) data. Child Trends will continue to work with Dr. Deitra Bryant-Mallory at DCPS and Tia Brumsted at OSSE to establish these agreements in Quarter 4.

Crisis intervention services and response evaluation

Key activities

- Shared crisis survey with all DC Public Charter Schools (DC PCS) and some DCPS schools (remaining DCPS schools will receive survey access in January 2021).
- Received 196 responses to the survey from a total of 102 schools (60 DC PCS; 42 DCPS).
- Completed two focus groups with ChAMPS, one focus group with the DBH crisis team, and one focus group with the DCPS crisis team.
- Scheduled 10 interviews with school staff to be conducted in January 2021.

At the end of Quarter 2, Child Trends submitted to DBH for review the crisis services and response evaluation plan as well as protocol drafts for a school survey, school interview, student focus group, parent/caregiver focus group, school focus group, ChAMPS crisis team focus group, and DBH and DCPS crisis teams focus group that would be used to evaluate the crisis intervention services and response. During Quarter 3, Child Trends finalized the protocols and began collecting data through the crisis response survey; focus groups with the ChAMPS, DBH, and DCPS crisis teams; and interviews with school staff. Child Trends leveraged the November and December core team meetings with DBH, DC PCSB, DCPS, and OSSE staff to finalize a data collection timeline that complemented and aligned with each agency's own timeline.

For the crisis survey, Child Trends received a total of 196 responses by December 21, 2020. Of these responses, 147 are from DC PCS staff, 44 are from DCPS staff, and 5 are from school staff that did not share their school name. These responses represent a total of 60 different charter schools and 42 DCPS schools. Information about the survey and the link to complete it was shared with all DC PCS schools through their Wednesday Newsletter on November 18, 2020. Child Trends' project members followed up via email with schools in the expansion who had not completed the survey a week after the Wednesday Newsletter had been released; schools that had still not responded after Thanksgiving break received a phone call follow-up to encourage completion before the survey closed on December 4, 2020. Responses from DCPS schools were received thanks to Carla Hall sharing the link with school behavioral health coordinators (SBHCs) during their last meeting in November. Child Trends had adjusted the timeline for DCPS data collection for the crisis evaluation based on feedback from DCPS in early November; the majority of data collection efforts will be conducted in January 2021 for DCPS schools. Preliminary results largely reflect DC PCS experiences, with many respondents reporting that their schools have good crisis plans that cover how to respond to crises. There was less satisfaction among respondents for the awareness of the plan; respondents do not think that staff or families are as aware of their school's crisis plan as they should be. There are also mixed feelings about ChAMPS' response time, but surveys reflect positive experiences around the services ChAMPS is providing in schools.

In November and December, Child Trends also conducted two focus groups with Catholic Charities' ChAMPS crisis teams—one with the ChAMPS crisis specialists (8 participants) and one with the ChAMPS managers (3 participants). Focus groups were also held with the DBH crisis team (4 participants) and the DCPS crisis team (3 participants) in December. Recruitment efforts for the DBH crisis team focus group were supported by Erica Barnes who recommended clinicians who may be knowledgeable about the topic and interested in participating; Carla Hall at DCPS supported recruitment efforts for the DCPS crisis team

focus group. Preliminary results are similar to the survey results, with participants sharing that while schools see ChAMPS as a resource to support them in their response to behavioral health crises, there are mixed feelings about their response time and perceived role. Additionally, participants noted that ChAMPS does a great job of following up with students after the crisis and connecting them to services.

In addition to the survey and focus groups, Child Trends began to schedule interviews with school staff to better understand the way schools respond to behavioral health crises. Ten DC PCS schools were identified based on their survey response, which included a mix of schools who reported implementing their crisis plan 2-5 times or more than 10 times in the previous school year, as well as different grade levels and wards. Given that the crisis survey has not been shared with all DCPS schools, our partners at DCPS identified 10 schools to interview who would be able to speak to the way they respond to behavioral health crises and their engagement with their school crisis plan. At the end of the quarter, 10 schools were scheduled for interviews to be conducted in January 2021.

Evaluation plan

Key activities

- Drafted and finalized the evaluation plan.
- Began drafting evaluation protocols and tools that will be piloted in up to five schools in Quarter 4.

In addition to the crisis intervention services and response evaluation, Child Trends invested heavily in developing the evaluation design for the process and outcomes evaluation that will be largely conducted in the option years of this project to evaluate the expansion of comprehensive school behavioral health supports in DCPS and DC PCS. A draft of this plan was submitted on September 18, with a revised memo submitted to Dr. Scott on September 24 for review. Throughout Quarter 3, Child Trends sought input on the plans from Dr. Scott, DBH staff, and other key stakeholders on the evaluation design, and incorporated feedback on the logic model and key research questions gathered through focus groups, trainings (further described later in this memo), Coordinating Council and subcommittee meetings, regular check-ins with Dr. Scott, emails, and other meetings. Child Trends submitted a final evaluation plan and evaluation design executive summary to Dr. Scott on December 22.

The expansion's proposed evaluation design is guided by the logic model, which visually describes a theory of change for how the initiative works and focuses on the inputs, activities, outputs, and outcomes that comprise the expansion. The logic model for the expansion includes both coordination at the systems level (i.e., city-wide components of the expansion led by DBH and the Coordinating Council on School Behavioral Health) and implementation at the school level (led by SBHCs and other school leaders). The logic model is an iterative tool for the program planning and evaluation and may evolve and/or be refined throughout the project; likewise, the evaluation plan may be updated accordingly.

As communicated in the evaluation design memo, the Base (current) Year is largely a planning and piloting year and data collection will occur during Years 1 through 3, with annual reports each year. A summative report—with findings from the longitudinal analyses across all three years of data collection plus pre-expansion baseline data—will be submitted in Year 4. The evaluation will include complementary process and outcomes evaluations to help understand the extent to which expansion activities are being implemented as intended and the associated outcomes for schools, youth, families, and staff. The evaluation will be conducted in collaboration with key stakeholders to provide insight into implementation quality and progress toward desired outcomes, as well as timely and actionable recommendations for program improvement. The memo presented the research questions that the process evaluation and outcome

evaluation seek to answer and indicated whether questions would be answered at the system and/or school level, as illustrated in the logic model. Further, the evaluation plan presents administrative and other existing data, as well as new, primary data that could be collected during Years 1–3, to answer the evaluation questions. Child Trends aims to reduce duplication of efforts across DC agencies and the burden on individual schools in evaluation activities wherever possible, which explains the heavy emphasis on existing administrative data. Much of this data will require data use agreements with OSSE and DCPS (see *Project Management).* Child Trends is working with Ms. Brumstead and Dr. Bryant-Mallory on these agreements. One additional existing data source, the DBH and CBO clinician monthly survey, was developed by Child Trends and is currently being piloted; additional information about this survey is described below. The new data collection activities include citywide stakeholder interviews, a citywide survey of families and youth, a survey of all school behavioral health coordinators, and surveys and focus groups with key stakeholders in target schools including staff, clinicians, family members, and youth.

To ensure that evaluation results and recommendations are relevant and timely, Child Trends will analyze data each year in collaboration with key stakeholder groups, including family members and youth as well as members of the Coordinating Council. Data from interviews and focus groups will be transcribed and uploaded to a qualitative data analysis software; codes will be developed based on both protocol themes (a priori) and analysis of themes from the data (emergent). For quantitative data (e.g., surveys and other administrative data sources), Child Trends will use three primary analytic models: (1) interrupted time series to compare trends before and after the expansion; (2) multi-group structural equation models to examine the strength of relationships between implementation and outcomes; and (3) marginal effects to model the predicted change in school-level outcomes based on a specific change in implementation. Insights provided by key stakeholders will help ensure the analyses reflect critical contextual factors including changes to the policy landscape as well as the health, economic, and educational effects of the coronavirus pandemic.

Continuous quality improvement

Key activities

- Administered monthly clinician satisfaction surveys with select DBH and CBO clinicians at DC Public Schools and DC PCS reporting on October and November activities. The final clinician satisfaction survey was administered on January 7, 2021 to all DBH and CBO clinicians.
- Provided data and data visualizations on the October and November clinician satisfaction survey. Used each month's data to inform improvements to the following month's survey and refine the presentation of the results (e.g., iterating charts that most clearly answer the questions at hand).
- Developed a draft version of the school behavioral health resource map tool in Tableau. This included designing the tool, cleaning and updating the data, and conducting a demonstration of the tool for key staff.
- Submitted recommendations for fostering effective partnerships between CBOs and schools and for calculating unmet need among schools.

Child Trends also made progress on several CQI activities during the last quarter, including the clinician monthly reports, recommendations for fostering effective partnerships between CBOs and schools and for calculating unmet need among schools ("matching and unmet need"), the resource mapping tool, and training. These activities are further described in the section below.

Clinician monthly reports

During Quarter 2, DBH expressed a desire to streamline the monthly reports that CBO clinicians and DBH clinicians are required to submit and asked Child Trends for their support and guidance on how to improve

the monthly reporting. Child Trends suggested that the report requirements include both monitoring and performance elements, which would provide insight into clinicians' satisfaction with how things are going and monitor the multi-tiered clinical services provided.

Child Trends piloted a clinician experience and satisfaction survey in early November, December, and January. The survey asked clinicians about the Tier 1, 2, and 3 activities conducted with youth, families, and staff in the prior month. Questions were aimed at understanding clinicians' perception of engagement and outcomes as well as partnership and coordination within schools. After reviewing data from the October survey, DBH requested that Child Trends add questions about clinicians' activities at all three tiers (e.g., the number of activities conducted and caseload numbers) for the November and December surveys. With each iteration of the clinician satisfaction survey, Child Trends looked for ways to improve the survey response rate and the quality of the data. Some changes that were identified included making the survey shorter, introducing skip logic, and including better descriptions, in addition to adding questions about clinician activities as requested by DBH.

The October clinician experience and satisfaction survey was sent to 38 CBO and DBH clinicians. Of the 38 clinicians, 17 were CBO clinicians and 21 were DBH clinicians. Child Trends received 7 responses from CBO clinicians and 8 responses from DBH clinicians. We estimate that the CBO and DBH clinician response rates were 41 and 38 percent, respectively.

For the November survey, we analyzed a combined 40 responses from CBO and DBH clinicians. Although 40 clinicians responded to the survey, not all clinicians answered every question. One major difference in the response total is that, while we initially sent the survey to the same group of CBO and DBH clinicians as October, we later opened up the November survey to all CBO clinicians due to a low response rate; the November survey was then sent out by all CBO supervisors to their supervisees. We do not know how many CBO clinicians ended up getting the survey. However, disregarding emails failed to deliver, we estimate that the survey was sent to 121 clinicians in total (17 DBH and an estimated 104 CBO clinicians). CBO clinicians made up 75 percent of the response (30 clinicians) while DBH clinicians made up 25 percent of the response (10 clinicians). The CBO and DBH clinician response rate was 29 and 59 percent, respectively.

The December iteration of the clinician experience and satisfaction survey is the last survey in the pilot phase of the CQI. As a result, this survey included additional questions that provided feedback on the survey design. Based on the information received from the November survey, it was recommended that the December survey be sent to all CBO and DBH clinicians. The survey was sent on January 7, 2021 and will be open for a week.

Some notable findings from the November survey include:

- Two thirds of respondents were in their first or second year working as a clinician in a school setting.
- 60 percent of respondents had a graduate licensure.
- 55 percent of clinicians reported being involved in activities for all Tiers.
    - 80 percent reported conducting prevention or promotion (Tier 1) activities.
    - 57 percent reported conducting early intervention (Tier 2) activities.
    - 80 percent reported conducting treatment (Tier 3) activities.
- Among the clinicians (32) who reported engaging in Tier 3 activities in November:
    - 66 percent agreed or strongly agreed that they received adequate support from their supervisors to help meet the need of students on their caseloads.
    - 70 percent agreed or strongly agreed that their students made progress towards their treatment goals.
    - Clinician caseloads ranged from 1–25 students, with a median of 9 students on a caseload.
    - 44 percent saw all the students on their caseload at least once.

        - Almost all clinicians with caseload exceeding 15 students saw all of their students at least once.
- 22 percent of respondents participated in DC Community of Practice (CoP) activities and felt it helped with effective collaboration.
- 68 percent of respondents agreed or strongly agreed that they feel well-integrated into their respective school's behavioral health team.

Matching and unmet need

To recommend a process for supporting schools and CBOs in establishing effective partnerships, Child Trends reviewed documents related to the current matching process and best practices for teaming and partnering to address behavioral health needs of students. Child Trends also used information from conversations with staff involved with the matching process at the DBH and DCPS—in addition to our DC School Behavioral Health Expansion Logic Model and feedback gathered from the various survey and focus group data Child Trends has collected since the summer of 2020—to develop a set of recommended steps for matching schools and CBOs. Child Trends developed a process diagram that was reviewed by Dr. Scott prior to submitting the recommendations for matching and unmet need on December 18, 2020. Child Trends recommended that the process for establishing effective partnerships and matching schools and CBOs be viewed in five phases: (1) assess needs and resources, (2) explore and prioritize potential matches, (3) identify a match, (4) formalize the partnership, and (5) provide ongoing support. Each phase works toward a goal that is supported by key strategies; these phases align the existing matching process with best practices and expand activities DBH and partners could do to strengthen future matches. Similarly, Child Trends reviewed potential sources of data as well as literature related to measuring behavioral health needs and resources within schools to make recommendations regarding calculating unmet need. Child Trends recommended a calculation of unmet need include indicators of both needs and resources and suggested indicators (i.e., Needs: suspensions, attendance, OSSE at risk determination, mental health literacy, special education; Resources: mental health staff, health staff, parent mental health education, mental health curriculum, mental health and school climate initiatives, community partnerships, clinician caseload) that could be used to rank schools with respect to unmet need. This form of calculation can be particularly useful for setting priorities when limited resources must be allocated across multiple schools. Akin to other aspects of this project, Child Trends highlighted the potential to leverage existing and new data sources to inform the matching process and calculate unmet need.

Resource mapping tool

In September, Child Trends met with staff at OSSE, DBH, the Office of the Deputy Mayor for Education (DME), and the co-chairs of the Coordinating Council committee on Data and Evaluation to identify the potential users of the school behavioral health resource map, the potential questions that users would want the map to answer, and the most critical functionality.

Following that conversation, Child Trends developed a rough mock-up of the map in Tableau using the final data provided by OSSE. Screenshots of the rough mock-up were reviewed by Dr. Scott and Ms. Brumsted, and Child Trends incorporated their feedback to develop a fully interactive mock-up. During this time, Dr. Scott provided an updated DBH and CBO clinician list to Child Trends, to update the partnership data for the resource map. Child Trends conducted additional data validation and cleaning and held several calls with Ms. Brumsted and/or Dr. Scott to resolve conflicts in the data, address questions about the final format of the data, and ensure data quality.

Child Trends demonstrated the interactive mock-up for OSSE, DBH, and DME staff in early December. Feedback was incorporated into a full draft of the tool, which Child Trends will demonstrate for additional OSSE, DBH, and DME staff in January or February 2021.

Training

During Quarter 2, Child Trends recognized the need to provide members of the Coordinating Council a capacity building training related to program evaluation. This training would be used to establish common language for discussing evaluation design and encourage high quality feedback on evaluation documents that are shared with the Coordinating Council. In Quarter 3, Child Trends conducted an initial training on logic models and selecting outcomes to the co-chairs of the Coordinating Council committees on October 31. During this training, the co-chairs were asked to provide feedback on the logic model components. Following the training, Child Trends sent a link to a shared document to gather suggestions for how to identify, prioritize, and measure evaluation outcomes. Three people responded and provided input.

Using the learnings from the co-chair training, such as the need for more explanation of key terminology, Child Trends updated the training and delivered it to the full Coordinating Council on December 8. During the training, the council members provided feedback on the logic model. Following this training, a partner organization asked for Child Trends' training slides so they could provide a training on logic models to their staff.

Other activities

Community of Practice

Child Trends continued to meet monthly with the GWU CHHCS team to discuss DC CoP evaluation activities. During Quarter 3, Child Trends launched the monthly DC CoP evaluation survey that was developed in Quarter 2 in September 2020, and the GWU CHHCS team disseminated the evaluation survey to DC CoP members over email. This initial survey had approximately 50 respondents out of a potential 300+ DC CoP members, and the following two surveys that were sent in October and November had less than 20 respondents each. Child Trends, GWU CHHCS, and DBH had numerous conversations about what data was necessary for the evaluation related to DC CoP and strategized potential ways to increase participation. These approaches included adding questions to the registration forms for the monthly DC CoP meetings and reserving time at the end of each DC CoP meeting to complete an evaluation survey. GWU CHHCS also began offering continuing education credits for DC CoP activities; to receive credit, attendees must complete an evaluation survey. Child Trends and GWU CHHCS worked to identify questions that could be added to both the continuing education evaluation survey and DC CoP registration forms and incorporated evaluation questions into these forms instead of preserving a separate evaluation survey. This incorporated approach has yielded greater response rates than the separate Child Trends' evaluation survey and still provides Child Trends and GWU CHHCS with the useful information needed for their respective DBH contracts. Similar to the monthly clinician survey, the survey questions ask respondents to reflect on the prior month's activities. Based on results from the December 2020 survey, most respondents (68–80 percent) applied things they learned in the DC CoP to improve implementation of Tier 1, 2, and 3 school behavioral health programs and practices during the month of November. Child Trends will continue to work with GWU CHHCS to refine the survey and add additional questions to the DC CoP continuing education evaluation surveys as needs or requests arise from GWU CHHCS or DBH.

Stakeholder engagement

During the Quarter 3, Child Trends also worked to identify key community stakeholders who could review and inform evaluation and CQI activities, protocols, and data interpretation. Child Trends met with the executive director of The Young Women's Project (YWP) in November to learn more about what YWP has learned about school-based behavioral health and to discuss ways youth could be engaged to share input on the evaluation activities. Child Trends plans to meet with a group of youth from YWP every three weeks from January through March to gather feedback on overarching evaluation questions and the evaluation and CQI plans. Child Trends has also worked with members of the core team to identify additional community stakeholders who Child Trends should seek out for feedback and input on the evaluation.

Challenges

Similar to previous quarters, the circumstances related to COVID-19 have impacted some of the activities that have taken place during Quarter 3. Child Trends had to alter and extend the data collection timeline for the crisis response services evaluation based on DCPS and DC PCS initial plans to return to hybrid or in-person classes in November, which were postponed, and requests from DCPS central office staff that Child Trends hold off on collecting survey data until January 2021 due to planned DCPS trainings in December. The evaluation activities (surveys, focus groups, interviews) that were conducted as scheduled have continued to take place online.

In addition to timeline adjustments, Child Trends experienced lower and slower response rates to evaluation activities and review requests. Child Trends had proactive and reactive conversations with DBH and other stakeholders to strategize ways to combat survey fatigue. Child Trends established the monthly core team call with staff from DBH, OSSE, DCPS, and DC PCSB to share updates and data collection activities. These meetings have been crucial in adjusting Child Trends' data collection timeline to complement other agencies' internal timelines and leveraging partners' existing communication with target populations to disseminate links to surveys. We have also extended the data collection periods and opened surveys up to a larger population as a way to increase response rates. For the DC CoP, Child Trends and GWU CHHCS also meet monthly to discuss data collection and evaluation activities.

Finally, we have experienced challenges in receiving approval to provide incentives to youth and family members for their participation in evaluation activities. We have shared information with the Contracting Officer (CO) regarding rationale for such incentives and directed them to the proposal budget that clearly outlines the proposed use of incentives. We are awaiting resolution of this matter and are hopeful that we will receive approval to provide incentives to youth and family members as a way to respectfully compensate them for their time and to increase response rates to evaluation activities.

Next steps

In Quarter 4, Child Trends will complete the crisis intervention services and response evaluation, finalize the CQI plan, and pilot test and revise the process and outcomes evaluation protocols and tools. Child Trends will engage key stakeholders from DBH, OSSE, DCPS, DC PCS, YWP, and the community to establish data use agreements, gather existing administrative data, pilot data collection within a sample of schools, determine the feasibility of piloted tools and protocols, and finalize the evaluation and CQI plans. Child Trends will submit a final report documenting Base Year activities at the end of the quarter in addition to a final report on the crisis intervention and response evaluation, finalized protocols for the process and outcomes evaluation, and a final CQI plan. Additional activities, which are outlined within the workplan, are listed below.

- **Project management and reporting**
    - Biweekly meetings with DBH in January, February, and March.
    - Monthly meetings with DBH, OSSE, DCPS, and DCPCSB "core team" in January, February, and March.
    - Submit final report on March 26.
- **Crisis intervention services and response evaluation**
    - Share survey with all DCPS schools by the end of January.
    - Complete all interviews with school staff by the end of January.
    - Complete data analysis.
    - Complete draft report by February 19.
    - Consult stakeholders to get feedback on draft report by February 26.
    - Submit final report on March 26.
- **Process and outcomes evaluation**
    - Work with stakeholders to build data collection and storage system and inform the buildout of a secure data transfer and integration system.
    - Complete pilot data collection in up to five schools.
    - Revise and finalize protocols based on pilot data collection and initial analysis of data, including any needed changes to data collection and storage system, by March 26.
- **CQI**
    - Integrate feedback on CQI plan from DBH, OSSE, GWU CHHCS, and the Coordinating Council by January 29.
    - Engage with YWP and other community stakeholders to review and advise project deliverables.
    - Submit final CQI plan by March 26.