MEMO

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

From: Child Trends Research Team

Re: Recommendations for fostering effective partnerships between CBOs and schools and for calculating unmet need among schools

Date: March 26, 2021

Executive Summary

This memo summarizes Child Trends' recommendations for: (1) matching schools and Community-Based Organizations (CBOs) as part of the School Behavioral Health Expansion and (2) calculating unmet need in schools. In order 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 partnership to address behavioral health needs of students. Child Trends also used information from conversations with staff involved with the matching process at the Department of Behavioral Health (DBH) and DC Public Schools (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. Similarly, Child Trends reviewed literature related to measuring behavioral health needs and resources within schools as well as reviewing potential sources of data to make recommendations regarding calculating unmet need.

Child Trends received feedback from stakeholders after submitting the deliverable to DBH on December 18, 2020. Feedback has been compiled into an appendix at the end of this memo.

Recommendations for establishing effective partnerships

We recommend that the process of forming a relationship between schools and CBOs be viewed as consisting of the following phases.

Phase 1: Assess needs and resources

Goal: Support schools and CBOs in assessing their gaps and strengths in order to address unmet behavioral health needs.
Key strategy: Administer a survey/rubric that helps to identify unmet needs

Phase 2: Explore and prioritize potential matches

Goal: Identify a few CBOs with potential for filling a school's gaps or with expertise in meeting the needs of special populations at the school.
Key strategies: (1) Provide schools and CBOs with information on potential matches that is easy to review and compare and (2) Facilitate discussions between schools and CBOs to clearly communicate expectations.

Phase 3: Identify a match

Goal: Ensure that schools get their preferred match when possible while also balancing the need to consider the capacity of CBOs.
Key strategies: (1) Set deadlines to receive preferences from schools and CBOs and (2) Ensure administrative team has necessary information to prioritize school preferences whenever feasible.

Phase 4: Formalize the partnership

Goal: Ensure that schools and CBOs engage in a visioning and goal-setting process to position the new clinician to integrate quickly within the school and to ensure there is a mutual understanding of how to establish and maintain effective communication.
Key strategies: (1) Provide clear guidance about best practices for establishing MOAs or other formal agreements and (2) Provide timelines and guidance for developing a joint vision and plan for behavioral health that includes families—and students when feasible—as decision makers.

Phase 5: Provide ongoing support

Goal: Ensure that schools and CBOs are able to effectively identify and resolve challenges and celebrate and share successes.
Key strategies: (1) Establish mechanisms to monitor the quality of the partnership over time and (2) Share best practices across schools to address common challenges and celebrate successes.

Recommendations for calculating unmet need

We recommend that a calculation of unmet need include indicators of needs as well as resources. We suggest the following core indicators, which can be used to rank schools with respect to unmet need:

Needs

- Suspensions
- Attendance
- Office of the State Superintendent of Education (OSSE) At Risk determination
- Mental health literacy (Health and Physical Education Assessment)
- Special education (IEPs and 504s)

Resources

- Mental health staff
- Health staff
- Parent mental health education
- Mental health curriculum
- Mental health and school climate initiatives
- Community partnerships
- Clinician caseload

Conclusion

We recommend that the matching of schools with CBOs be viewed as a multi-phase process, with the final phase consisting of ongoing support to establish and sustain an effective partnership. We also recommend that the calculation of unmet need incorporate indicators of needs as well as resources. Such a metric can be particularly useful in setting priorities when limited resources must be allocated across multiple schools. We highlight the potential to leverage data collected for the establishment of effective partnerships to calculate unmet need.

Matching Process

Phase 1: Assess needs and resources

Goal: Support schools and CBOs in assessing their gaps and strengths in order to address unmet behavioral health needs.

Key strategy: Administer a survey/rubric that helps to identify unmet needs.

The first phase should consist of an initial needs and resources assessment to identify key gaps and strengths; a more extensive needs and resources assessment is suggested once schools and CBOs are matched in Phase 4. Prior to implementing new or additional behavioral health supports in a school, it is important to assess the needs and resources of each partner (school and CBO) to support behavioral health within a school. Such a process can be useful for each organization as an opportunity to reflect on their strengths as well as their gaps when it comes to all three tiers of a multi-tiered system of support (MTSS), including prevention, early intervention, and treatment. For example, some schools may have multiple community partners that deliver effective prevention programming but lack clinical staff to deliver treatment services. Alternately, a school may already have a clinician with a strong track record of delivering treatment services to students but lack the capacity to deliver prevention and early intervention programs. Similarly, one CBO may have extensive experience delivering behavioral health promotion and prevention programming in addition to treatment services, whereas other CBOs may primarily have expertise in treatment services which may include experience with specific populations (e.g., Spanish-speaking populations) or modalities (e.g., trauma-informed care). Not only is this a useful exercise for self-assessment, but it also provides the sort of information that can foster complementary partnerships. When there is a need to match multiple schools across multiple CBOs, it is helpful to have a standardized form. Rubrics can be particularly useful because they list out important categories to consider but also provide a description of when the varying degrees might look like for each category. For example, a category about Tier 1 Prevention activities might look like the one shown in Figure 1.

Figure 1. Sample rubric indicator

Category	Just starting	Making progress	Well-established
Tier 1 Prevention activities. These are activities that are relevant for all students, families, or staff. They are often delivered universally. For example, schoolwide bullying prevention or SEL programs.	Our school does not currently have any schoolwide prevention programs. Some staff may deliver their own programming or even use a structured curriculum, but these efforts are not coordinated.	Our school has a plan to coordinate prevention programs. We have begun to ensure that staff receive the training they need but we do not yet have data to demonstrate that the programs are achieving the intended outcomes.	Our school has a plan to coordinate prevention programs that is based on an assessment of needs and strengths that engaged students and family members in decision-making. Our staff are well-equipped, and we have evidence that our programs are achieving the intended outcomes.

In addition to helping schools and CBOs to identify needs and resources prior to exploring potential matches, the data collected through the survey/rubric can also be used to help DBH develop a metric of unmet need to inform the allocation of clinicians. Such a measure could be used to determine timing of when schools receive a clinician but could also be used to determine whether the level of unmet need in some schools warrants more than one clinician while the level of unmet need in other schools may suggest they do not have sufficient unmet need to warrant an additional clinician at the time. The "Measuring Unmet Need" section of this memo details further recommendations around developing and using a metric of unmet need.

Phase 2: Explore & prioritize potential matches

Goal: Identify a few CBOs with potential for filling a school's gaps or with expertise in meeting the needs of special populations at the school

Key strategies: (1) Provide schools and CBOs with information on potential matches that is easy to review and compare and (2) Facilitate discussions between schools and CBOs to clearly communicate expectations.

The second phase builds on the results of the first phase by leveraging needs and resources assessments to identify which CBOs might have the potential to fill identified gaps for specific schools. This sort of preliminary review can be done by schools themselves if they have access to information about community-based providers, such as in a centralized database maintained by DBH. This initial review can also be done by an administrative team. For example, the administrative team may examine a school's self-assessment data and identify a small number of CBOs that seem to have potential for filling identified gaps or that have experience working with specific populations that are relevant for a school, which can be shared with the school.

Schools and their potential CBO matches should have an opportunity to engage in a discussion at this point to help them prioritize potential matches. At this stage, it is also important that schools and CBOs are clear on the expectations for a potential partnership so that they can assess potential matches within the context of the parameters of the Expansion. It can be particularly helpful to provide a standard set of questions to guide these discussions that help to ensure potential partners have a common understanding of the likely goals for the partnership. For example, some current survey questions are repeated on the interview guide and could be removed or rephrased. Other interview questions could be supplementary or could be asked within first 45-90 days of a match as a part of the Phase 4. Reducing the number of questions in the interview guide allows more time to be spent on the most critical questions. The interview guide could also be updated to include questions that will help increase communication around expectations and roles from the start.

For example, it is important for schools to understand what are allowable activities when it comes to a clinician that will work in their building or the level of participation that a CBO expects when it comes to determining the scope of work for the clinician. Similarly, it is important for CBOs to understand what schools are looking for, especially when it comes to Tier 1 and 2 activities as priorities and existing capacity can vary dramatically across schools. It may be useful to have a member of the administrative team join initial discussions to help ensure common misunderstandings are addressed explicitly early on to better position partnerships for success. However, it can be helpful to provide schools a significant level of autonomy at this stage as well.

Phase 3: Identify a match

Goal: Ensure that schools get their preferred match when possible while also balancing the need to consider the capacity of CBOs.

Key strategies: (1) Set deadlines to receive preferences from schools and CBOs and (2) Ensure administrative team has necessary information to prioritize school preferences whenever feasible.

In cases when multiple schools are being matched with a CBO, it is important to balance schools' preferences with the capacity of provider organizations. There are a number of ways that matching can be done. One strategy is to request that all schools and CBOs submit their preferences on the same date. This can help with administrative efficiency because decisions can be made and announced at once. However, one drawback is that a single submission date could result in several schools not getting their preferred match. Another approach is to make matches on a first-come, first-served basis. This approach gives priority to schools that are able to quickly identify their preferences, which could disadvantage some schools that struggle to complete the exploration phase in a timely manner. However, it is also likely to reduce the number of schools that do not get their preferred match because CBOs that reach their capacity could be removed from the pool of potential matches. A hybrid approach could be to set two or three deadlines such that schools can submit their preferences up to a certain date, at which point matches will be made based on preferences and availability. Schools that do not submit until the later deadlines would likely have fewer providers to choose from as some CBOs may have reached their capacity in the previous wave, but the hybrid approach also reduces some of the administrative burden associated with an on-going matching process.

Phase 4: Formalize the partnership

Goal: Ensure that schools and CBOs engage in a visioning and goal-setting process to position the new clinician to integrate quickly within the school and to ensure there is a mutual understanding of how to establish and maintain effective communication.

Key strategies: (1) Provide clear guidance about best practices for establishing MOAs or other formal agreements and (2) Provide timelines and guidance for developing a joint vision and plan for behavioral health that includes families—and students when feasible—as decision makers.

Once matches have been confirmed, it is important for schools and CBOs to formalize their partnership through the establishment of an agreement such as a Memorandum of Agreement or MOA. Schools and CBOs should be provided with guidance about what to address in a formal agreement. In cases where the CBO may need to hire a clinician or select one from among several clinicians, it is helpful for schools to have an opportunity to share particular preferences or, when appropriate, be involved in the staffing decisions.

Schools and CBOs should be provided guidance with respect to identifying a goal for behavioral health at the school and establishing a realistic plan for achieving that goal and a preferred timeline for doing so. This process should involve family members at a minimum and should also include students and other key stakeholders when feasible. During this phase, schools and CBOs should also revisit their initial needs and resources assessment. For the current Expansion, the School Strengthening Tool is a more comprehensive needs and resources assessment that should lay the foundation for this joint school/CBO plan. In addition to identifying needs and resources, the School Strengthening Tool can likely to serve as guidance for identifying roles and setting goals. It is helpful to offer proactive support for matched schools and CBOs given the critical role that these plans can play in effective partnerships. One approach is to request that clinical supervisors working at the CBO meet with clinicians to review and discuss the school plan to ensure that it is reasonable given the parameters of the formal agreement. Technical assistance providers may also want to review plans with the school behavioral health coordinators to help share lessons learned from other schools in an effort to proactively address common challenges. Other resources, including the DC School Behavioral Health Community of Practice, can serve a key role in promoting peer-support to share best practices across schools and CBOs.

Phase 5: Provide ongoing support

Goal: Ensure that schools and CBOs are able to effectively identify and resolve challenges and celebrate and share successes.

Key strategies: (1) Establish mechanisms to monitor the quality of the partnership over time and (2) Share best practices across schools to address common challenges and celebrate successes.

Partnership does not end with the establishment of a formal agreement and development of a plan. Rather, partnership is an ongoing relationship that requires attention and investments. While the plans that are developed in the prior stage should outline processes for resolving conflicts, it is also useful to establish regular check-ins to identify when a partnership might benefit from some additional support. For example, tracking how CBO clinicians view their relationship with their school on a regular basis can help supervisors to identify when additional supports might be beneficial. Similarly, regular feedback from school behavioral health coordinators or other school leaders through group check ins or surveys can flag potential challenges early on so that additional supports can be provided. In many cases, it is likely that these regular check-ins can help to ensure that partnerships are able to navigate the challenges that are a natural part of partnerships. It is important to note that these check-ins should not be viewed solely as a strategy for addressing challenges. Rather, they also present opportunities to identify and celebrate successes and can serve to highlight promising strategies that other partnerships might also find useful. Other resources, such as the DC School Behavioral Health Community of Practice or technical assistance providers, can serve a role by offering continuing education or trainings around teaming, sharing best practices and other resources across schools, and providing additional supports to school and CBO partnerships who experience challenges.

Potential roles for key stakeholder groups during each phase

The table below applies the phases described above to key stakeholder groups in the Expansion, including:

- DC Department of Behavioral Health
- District of Columbia Public Schools (this includes DCPS schools and central office)
- District of Columbia Public Charter Schools (this focuses on charter schools)
- Community-Based Organizations (CBOs)
- Other community partners, including the Coordinating Council on School Behavioral Health, DC School Behavioral Health Community of Practice (CoP), OSSE, and DC Public Charter School Board

For each stakeholder group, we outline proposed activities to accomplish the goals of each phase. When possible, we tried to maintain the types of activities that these stakeholder groups typically engage in currently to minimize changes. However, in some instances, these activities reflect a slight change to what we understand to be current practice. We view these potential activities as a good starting point for thinking about how to apply this phased approach, but we recommend that discussions be held with each stakeholder group to ensure the feasibility and utility of the proposed activities.

Table 1. Overview of matching phases and stakeholder roles

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Phase	Assess needs and resources	Explore and prioritize potential matches	Identify a match	Formalize the partnership	Provide ongoing support
Goal	Support schools and community-based providers in assessing their gaps and strengths in order to address unmet behavioral health needs.	Identify a few community-based providers with potential for filling a school's gaps or with expertise in meeting the needs of special populations at the school	Ensure that schools get their preferred match when possible while also balancing the need to consider the capacity of community-based providers	Ensure that schools and community-based providers engage in a visioning and goal-setting process to position the new clinician to integrate quickly within the school and to ensure there is a mutual understanding of how to establish and maintain effective communication	Ensure that schools and community-based providers are able to effectively identify and resolve challenges and celebrate and share successes

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Key activities	Administer survey/rubric to identify unmet needs	Provide schools and CBOs with information on potential matches that is easy to review and compare Facilitate discussions between schools and CBOs to clearly communicate expectations.	Set deadlines to receive preferences from schools and CBOs Ensure administrative team has necessary information to prioritize school preferences whenever feasible	Provide clear guidance about best practices for establishing MOAs or other formal agreements Provide timelines and guidance for developing a joint vision and plan for behavioral health that includes families—and students when feasible—as decision makers	Establish mechanisms to monitor the quality of the partnership over time Share best practices across schools to address common challenges and celebrate successes
Materials needed	Needs/resource assessment survey Overview of the matching timeline	Database of CBO survey responses Standard set of questions to guide CBO and school discussions that can help to ensure potential partners have a common understanding of the likely goals for the partnership	Deadlines for when schools and CBOs should all submit preferences	Guidance around establishing MOAs or other formal agreements Timelines and guidance for schools and CBOs to develop joint vision and plan for behavioral health School Strengthening Tool	System to monitor the quality of the partnership over time
DBH role	Hold information session to explain the survey and matching process and timeline Coordinate completion of surveys/rubrics	Establish administrative team that can support matching process and join initial conversations between CBOs and DC PCS schools Provide DCPS administrative team and	Set and communicate deadlines with schools, CBOs, and administrative teams Communicate information about CBO capacity with	Create guidance around establishing MOAs or other formal agreements Create timelines and guidance for schools and CBOs to develop joint vision	Develop system to monitor the quality of the partnership over time (e.g., surveys, group check-ins, listening sessions) Gather and share best practices across

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
		DC PCS principals the CBO survey response database DC PCS administrative team is available to support conversations between schools and CBOs	administrative teams and schools	and plan for behavioral health Communicate guidance and timelines with schools and CBOs Technical assistance providers may want to review plans with the school behavioral health coordinators to help share lessons learned from other schools in an effort to proactively address common challenges	schools to address common challenges and celebrate successes
DCPS role	Schools complete survey	Administrative team identifies a number of CBOs from database that have potential to address identified gap or have experience working with specific populations that are relevant for a school and shares the CBO information with the school Schools reach out to CBOs to schedule and conduct interviews	Submit CBO preferences	Schools develop joint vision and plan for behavioral health that includes families—and students when feasible—as decision makers with CBOs	Regularly check-in with CBO, school behavioral health coordinators or other school leaders, and technical assistance providers to identify when a partnership might benefit from some additional support

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
		Administrative teams is available to support conversations between schools and CBOs			
DC PCS school role	Schools complete survey	Schools review CBO survey response database Schools reach out to CBOs to schedule and conduct interviews	Submit CBO preferences	Schools develop joint vision and plan for behavioral health that includes families—and students when feasible—as decision makers with CBOs	Regularly check-in with CBO, school behavioral health coordinators or other school leaders, and technical assistance providers to identify when a partnership might benefit from some additional support
CBO role	Complete survey	Conduct interviews with DCPS and DC PCS schools	Submit school preferences	Develop joint vision and plan for behavioral health that includes families—and students when feasible—as decision makers with schools CBO supervisors can meet with clinicians to review and discuss the school plan to ensure that it is reasonable given the parameters of the formal agreement	Regularly check-in with school, supervisors, and technical assistance providers to identify when a partnership might benefit from some additional support
Additional partner roles	Coordinating Council on School Behavioral Health provides feedback on	Coordinating Council on School Behavioral Health provides feedback on		LEAs, DC CoP, and OSSE provide technical assistance and resources on best	LEAs, DC CoP, OSSE, and/or other technical assistance providers

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
	needs/resource assessment survey Local education agencies (LEAs), DC CoP, OSSE, and DC Public Charter School Board communicate information about matching process and timeline across their networks to reiterate DBH message	standard set of questions to guide matching process		practices and key elements of school behavioral health plans OSSE or other technical assistant providers review plans with school behavioral health coordinators and share lessons learned from other schools DC CoP shares best practices and lessons learned across schools and across provider organizations	offer additional supports to partnerships in need (supports could include trainings, resources, listening sessions)

Measuring Unmet Need

Overview

In this section, we present recommendations for measuring unmet need. DBH could use school-specific indicators of unmet behavioral health needs in several ways. First, these indicators can help DBH and the Coordinating Council on School Behavioral Health determine which schools should be prioritized to receive new clinicians. Second, they could allow DBH and the Coordinating Council to eventually establish cut-offs such that DBH and the Coordinating Council could allocate available resources proportionally. For example, some schools may reach a level of unmet need that suggests the school could benefit from two clinicians; whereas other schools may have a relatively lower level of unmet need, suggesting that they may have a less urgent need for a new clinician. Or, in the case of schools that decline to participate in the Expansion because they do not think they need an additional clinician, the metric of unmet need could be part of the discussion as to whether the school might benefit from another clinician or to support the decision not to add a clinician (if their unmet need is relatively low).

An indicator of unmet behavioral health need should have two components—metrics quantifying the needs in a school and metrics quantifying the resources available in the school to meet those needs. The gap between those two metrics is essentially the unmet need. We recommend several indicators of both need—many of which were used to determine the initial ranking of schools for the Expansion—as well as new indicators of resources to meet those needs. We also suggested methodology for combining and comparing those indicators. The indicators align with many of the components of the Whole School, Whole Child, Whole Community (WSCC) framework, with a priority on those that are most closely related to behavioral health and for which there are known, accessible data.

Indicators and data sources

The primary challenge with quantifying behavioral health *needs* is that there is no existing data for all students at all schools in DC on behavioral health needs, such as data that would come from universal behavioral health screening of students. Developing a process for universal screening would be a significant undertaking that should include a careful planning and piloting process that involves students and families; also, universal screening is not without drawbacks.[1] Although this is something that might be considered for longer-term planning around unmet need, to inform DBH resource allocation decisions in the short-term, there are other indicators of need that could give DBH and the Coordinating Council a picture of behavioral health need at the school level. While these are not direct measures of identified behavioral health needs, they are measures of well-being (or distress) and social determinants of health, which could be considered proxies for behavioral health need.[2] A list of potential indicators is in Table 2 and includes behaviors (or school responses to behaviors) that are associated with behavioral health problems and demographic and

[1] Two examples of guidance documents related to planning and implementing behavioral health screening are: https://www.samhsa.gov/sites/default/files/ready_set_go_review_mh_screening_in_schools_508.pdf & http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Screening-1.27.20.pdf

[2] Behavioral health interventions have been found to reduce violence, bullying, problem behaviors, and improve emotional health, among other outcomes; see for example: http://healthinschools.org/wp-content/uploads/2016/10/CHHCS_2014-Annotated-Bibliography-FINAL1.pdf

other factors that are associated with a higher risk of behavioral health problems.[3] Several of these indicators were used to determine the initial ranking of schools for Expansion cohorts. For some schools, there are also available data on social emotional skills or competencies that, when summarized at the school level, could be an indicator of the overall behavioral health of the student body.

The other piece of information that determines unmet need is what *resources* are available at a school to support the behavioral health of students and the school community. A high-need school may have multiple resources to address their students' needs and, therefore, have more manageable unmet need than a similarly situated school with fewer resources available. Resources should be available to support all three tiers of supports, including offering prevention and early intervention services and activities as well as individualized supports and treatment. To be most effective, services and resources also need to be coordinated by a wellness or behavioral health team that oversees and implements these services and activities, guided by a common vision, defined workplan, and clear referral pathway. Table 2 describes several potential indicators of school resources to meet behavioral health needs.

The data for need and resource indicators could come from a variety of sources—some publicly available and some likely only available to DBH, OSSE, DCPS, or other coordinating agencies. A potential additional new source of data could be the needs and resource assessment survey/rubric proposed earlier in this memo as part of the Expansion matching process. Table 2 below lays out the possible sources of data for each potential indicator of need and resources and indicates for which schools at which grade levels the data is likely to be available as well as the most recent school year for which we understand there is data.

[3] For more information about indicators of students' mental health and selecting measures, see for example: http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Screening-1.27.20.pdf and http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Needs-Assessment-&-Resource-Mapping-2.3.20.pdf

Table 2. Indicators of behavioral health needs and resources at the school level

Category	Priority indicators	Potential metrics	Potential data source(s)	Data availability					
				DCPS	DCPCS	ES	MS	HS	Most recent SY available
Needs									
Behavior	Suspensions	% of students with 1 or more out of school suspensions	Office of Civil Rights	X	X	X	X	X	2017
Behavior	Attendance	In-seat attendance rate	OSSE	X	X	X	X	X	SY 2019-2020
Risk	Special education	% of students with an IEP	OSSE	X	X	X	X	X	SY 2019-2020
Risk	OSSE At Risk determination	% of students with At Risk status	OSSE	X	X	X	X	X	SY 2019-2020
Mental health knowledge	Mental and emotional health scores	Average % correct	Health and Physical Education Assessment (HPEA)	X	X	X (5th)	X (8th)	X (students in health classes)	SY 2018-2019
Resources									
Staffing	Clinicians	Ratio of clinicians to students meets recommended levels (e.g., 1:250 for social workers)	SHP and OSSE census data	X	X	X	X	X	SY 2019-2020
Staffing	School nurse	Has a school nurse	SHP	X	X	X	X	X	SY 2019-2020
Tier 1 services	Parent education	Offers mental health education for parents	SHP	X	X	X	X	X	SY 2019-2020
Tier 1 services	Mental and emotional health education	Has mental and emotional health curriculum	SHP	X	X	X	X	X	SY 2019-2020
Tier 1 services	Mental and emotional health initiatives	Participates in 1 or more initiatives, such as restorative justice program	SHP	X	X	X	X	X	SY 2019-2020
Tier 1-3 services	Community partnerships	Has 1 or more partnerships with CBOs	SHP	X	X	X	X	X	SY 2019-2020
Tier 3 services	Clinician caseloads	No clinicians have reached full capacity on caseload	Expansion needs/resources survey	X	X	X	X	X	

Method for calculating unmet need

Composite measures that combine several component measures into a single metric can be calculated using a variety of methods. One approach is to standardize each individual component measure, then calculate a weighted average of those measures, which was the approach used to calculate the behavioral health need indicator used to initially rank schools for the Expansion cohorts.

For the calculation, not all individual metrics should be weighted equally. As in the initial rank score for the Expansion, we recommend giving more weight to the OSSE At Risk determination indicator as well as more weight to referrals indicators, which are more closely related to behavioral health needs than measures of behavior (suspension, chronic absenteeism). For the resources, we recommend giving greater weight to the staffing and caseload indicators and the partnerships indicator, which are resources most closely related to directly serving students.

To streamline the creation of the unmet need metric and to minimize the amount of missing data, we recommend prioritizing the indicators listed in Table 2. One of these priority indicators—clinician caseloads—may not be available in the existing data and could instead be asked on the survey in Phase 1 of the matching process. However, if this survey is only administered to a sub-set of schools being considered for Cohort 4, this indicator could be removed from the priority list. Including other indicators would give a more complete picture of behavioral health needs (for example, by including a metric of students' social and emotional health) and resources (for example, coordination of services); however, the data for these metrics are unlikely to be available for all schools from existing sources. For example, some data is only collected from certain schools, or data is only reported by some clinicians and not others. Potential indicators to consider prioritizing for measurement and data collection in the future, in order to inform a more complete unmet need metric, could include:

- Crisis referrals
    - Ratio of referrals to enrolled students
- Behavioral health services referrals
    - Ratio of referrals to enrolled students
- Office referrals
    - Percent of students with 1 or more office referrals
    - Percent of students with 1 or more office referrals for fighting, threats, or other serious incidents
- Social emotional competencies
    - Percent of students not "favorable" on Perseverance, Self-Efficacy, Self-Management, and Social Awareness on the Panorama survey
- Social emotional supports/environments
    - Percent of students not "favorable" on Rigorous Expectations, Sense of Belonging, and Student Satisfaction on the Panorama survey
- SBH Coordinator
    - Has an identified SBHC
- Workplan
    - Has completed SST and Workplan
- Referral plan
    - Has a written referral plan

Once the data have been compiled for each school, the steps for generating a metric of unmet need are as follows:

1. **Calculate the average z-score for needs.**

a. This process would be similar to the process used to generate the z-score for the initial ranking of schools for the Expansion, with an expanded set of indicators of need that includes HPEA mental and emotional health knowledge scores. Positive measures such as HPEA scores can be reverse-scored. The average should be weighted so that OSSE At Risk determination counts more heavily toward the mean.

2. **Calculate average z-score for resources.**
   a. Because the resource indicators are all "yes/no" indicators, they are not well suited to calculation of z-scores for each individual indicator. Therefore, this should first be turned into an index score by adding up all the "yes" responses for each school. Each school will then have a value of 0 to 6 resources.
   b. The index score would then be converted into a z-score.
3. **Combine or compare the two scores. The need and resource z-scores could be compared or combined in two different ways.**
   a. *Option 1*: The individual z-scores for need and resources can be categorized as High, Medium, or Low, based on the distribution of the individual z-scores across schools. For example, schools with z-scores for need in the highest third of the distribution would be categorized as "High need," schools with z-scores for need in the middle third would be categorized as "Medium need," and the bottom third would be "Low need" (see Table 3 for an example). Schools could then be selected for prioritization based on being high need and low resource, or other combinations of need and resource rankings. The advantage of this approach is that schools with similar "need" z-scores would be grouped together, which is likely a more accurate assessment of need than assuming that there is a meaningful difference between the needs of a school with the highest need z-score and the second highest need z-score; both schools are "high need". The disadvantage of this approach is that many schools may fall into the "High need/Low resource" category, although individual z-scores could help further prioritize within this group.

Table 3. Example ranking of schools based on High, Medium, Low categories

School	Need z-score	Need rank based on z-score	Resources z-score	Resources rank based on z-score	Need category	Resources category
I	0.6	2	-1.0	3	1. High	3. Low
F	0.5	3	1.2	7	1. High	2. Med
A	0.8	1	2.2	9	1. High	1. High
C	-1.7	6	-3.2	1	2. Med	3. Low
H	-1.9	7	0.6	5	2. Med	2. Med
D	0.2	5	1.6	8	2. Med	1. High
E	0.2	4	2.7	10	2. Med	1. High
G	-2.1	9	-3.0	2	3. Low	3. Low
B	-2.6	10	0.3	4	3. Low	2. Med
J	-2.0	8	0.8	6	3. Low	2. Med

   b. *Option 2:* Alternatively, schools could be assigned a total rank based on the combined rank of needs and resources. First, schools would be ranked by the z-score for need, where 1 is the highest need z-score. Next, schools would be ranked by the z-score for resources, where 1 is the lowest resource z-score. Then, the two ranks would be added to create a total rank (see Table 4 for an example). The advantage of this approach is that there will be more differentiation between schools, making it easier to prioritize, although some schools will still have the same total rank.

Table 4. Example ranking of schools based on total rank

School	Need z-score	Need rank based on z-score	Resources z-score	Resources rank based on z-score	Total Rank
I	0.6	2	-1.0	3	5
C	-1.7	6	-3.2	1	7
A	0.8	1	2.2	9	10
F	0.5	3	1.2	7	10
G	-2.1	9	-3.0	2	11
H	-1.9	7	0.6	5	12
D	0.2	5	1.6	8	13
E	0.2	4	2.7	10	14
J	-2.0	8	0.8	6	14
B	-2.6	10	0.3	4	14

Both approaches should be tested with real data from a representative sample of schools. Although these recommendations draw on best practices and experience with administrative data sources generally, as well as some initial tests of ranking approaches with made-up data, they still need to be tested and validated with actual data from DC schools.

Conclusion

We recommend that the process of matching schools and CBOs be thought of as starting with each partner assessing their own needs and resources and ending only when concrete steps to develop the partnership have been undertaken and an effective relationship between school and CBO is developing. Supporting schools and CBOs through this period of formalizing and growing their partnership will set them up for success from the very beginning. We also recommend that a metric of unmet need incorporate an expanded list of need indicators as well as indicators of resources schools have to meet those needs. One potential source of data to inform this metric is the survey administered to schools and CBOs in the first phase of the matching process. This metric of unmet need can be used to guide decisions about the allocation of clinician resources across schools. Over time, additional data can be collected to refine and enhance this metric of unmet need, to give a more complete picture of both needs and resources at all schools.

Additional resources:

- DC School Behavioral Health Community of Practice. (2020). School Behavioral Health Teaming: Best Practices for Schools and CBOs Participating in DC's School Behavioral Health Expansion
- National Center for School Mental Health (NCSMH, 2020). *School Mental Health Quality Guide: Needs Assessment & Resource Mapping*. NCSMH, University of Maryland School of Medicine. http://www.schoolmentalhealth.org/Resources/Needs-Assessment--Resource-Mapping/
- National Center for School Mental Health (NCSMH, 2020). *School Mental Health Quality Guide: Teaming*. NCSMH, University of Maryland School of Medicine. http://www.schoolmentalhealth.org/Resources/Teaming/

Appendix A. Stakeholder feedback on recommendations

Laura Heaven, one of the co-chairs of the Data and Evaluation subcommittee of the Coordinating Council on School Behavioral Health, shared the memo with committee members for feedback on January 6, 2021 with the following instructions:

Please review the information prepared by Child Trends with recommendations for the matching process as well as assessing unmet need. You will find that some of what is described mirrors components of what was used for the earlier Cohorts. As you review the document, I welcome your individual reactions and thoughts. And, I welcome feedback on the following:

1) *Given the unusual circumstances of the pandemic and the challenges of distance learning, what are your thoughts about re-ranking using SY19-20 OSSE data or using the current rankings that were used for determining Cohort 3?*
2) *What are your thoughts about the description for assessing unmet need? Is this process best used for the partnership matching process? Is the assessment of unmet need best used for a school self-assessing the school's own sustainability and infrastructure for meeting the prevention, early intervention, and treatment needs of the students in that school?*

Please share your feedback by 1/14/21. Thanks a lot.

In total, three committee members provided feedback on the memo. Ms. Heaven shared all feedback with Dr. Scott who then forwarded the feedback along to Child Trends.

One committee member shared the following feedback:

- For consistency, maintain current logic for the rankings. I believe it was changed once before (to add English Language Learners). Perhaps, some of the proposed items (e.g., staffing) could be considered elsewhere – for example, the matching process.

- For unmet need, a hybrid approach may be suitable. For example, in the beginning, partners could take the lead in supporting schools in this assessment – while also preparing the school to take the lead in self-assessing as the process moves along. Also, there's little mention of 'sustainability' in the PDF document – perhaps, this aspect of the process (sustainability practices) could be highlighted.

Another committee member shared:

> 1) I recommend leaving the ranking unchanged at this time in order to minimize confusion and/or loss of faith in the process being fair and transparent.
>
> 2) For longer-term unmet need metrics, I suggest a set of school- and CBO-reported quantitative metrics of both access and quality that are comparable across different underlying risk levels. For example, average wait time from referral to receipt of services, % of students with office referrals assessed for and offered tier 2 and tier 3 services, turnover of counseling and psychology staff at school and CBO, etc. I suggest engaging CBO and school partners on the selection of these metrics.
>
> For the initial ranking, we were more estimating underlying risk than unmet behavioral health service need, knowing that resources were and are not sufficient. Once the level of total resources stabilizes, I think we will want to move towards metrics that address performance of school-level and CBO systems as a way to both drive continuous improvement and demonstrate value to

stakeholders. These same metrics would also show when a system is overwhelmed by demand or needs more resources or training/systems support.

A third committee member provided the most feedback, sharing additional feedback within a commented PDF version of the circulated memo that Dr. Scott shared with Child Trends on January 15, 2021:

> Thank you for the opportunity to provide feedback on the Child Trends' recommendations for the matching process and assessing unmet need. On review of the documents, I wanted to note that it will be helpful to have additional context for this report, including its focus on refinement of matching process. Additionally, with the presentation of these new recommended processes, it will be beneficial to have more information on the previous process for matching and assessing need (as well as the identified gaps in those previous processes that these recommendations seek to address).
>
> Please see below my responses to your specific questions, as well as some feedback about the document.
>
> 1. Given the unusual circumstances of the pandemic and the challenges of distance learning, what are your thoughts about re-ranking using SY19-20 OSSE data or using the current rankings that were used for determining Cohort 3?
>
>> We recommend using the same rankings. This will help the process (and by extension, the program) be viewed as more reliable and consistent, especially by schools awaiting services. Also, with the transition to distance-learning towards the end of SY19-20, there could be potential issues with data from that year. DCPS students began distance-learning around March 2020 and SY19-20 ended in May 2020. Therefore, depending on OSSE's data collection methods, the SY19-20 data may (or may not) reflect changes due to the pandemic. Further, even if the SY19-20 data does reflect changes due to the pandemic, given the concerning decrease in enrollment during remote learning[4], the data could potentially be missing critical populations and underrepresent students at risk. If the SY19-20 OSSE data is to be used, averaging data over the most recent three SYs is a better approach.
>
> 2. What are your thoughts about the description for assessing unmet need? Is this process best used for the partnership matching process? Is the assessment of unmet need best used for a school self-assessing the school's own sustainability and infrastructure for meeting the prevention, early intervention, and treatment needs of the students in that school?
>
>> The inclusion of measures of mental health knowledge and existing relevant resources are useful for updating the assessment of unmet need process to be used for future ranking of schools in the expansion. If the measurement of existing resources is to be included, it should be ensured that resources are defined in alignment with SMHP standards. For example, the proposed metric of "Has mental and emotional health curriculum" should be defined more clearly to ensure that the school has an adequate curriculum.

[4] Stein, Perry. "D.C. Says 20,000 Students Started the Enrollment Process, but Did Not Complete It." *Washington Post*. Accessed January 11, 2021. https://www.washingtonpost.com/local/education/dc-says-20000-students-started-the-enrollment-process-but-did-not-complete-it/2020/09/11/2aca8a66-f448-11ea-999c-67ff7bf6a9d2_story.html.

The proposed indicators are not comprehensive/detailed enough to be used in the partnership matching process or for a school self-assessment. While the ranking of school requires data that is universally available for all schools, school self-assessment and partnership matching require the most recent school-specific data (which should be provided by the school and any of its behavioral health clinicians). This information should be more detailed to provide a complete picture of the behavioral health of students (including social determinants of behavioral health) and the existing services. The panorama survey (https://dcps.dc.gov/surveys) and youth risk behavior survey (https://osse.dc.gov/service/dc-youth-risk-behavior-survey-yrbs) are also sources of some indicators that can be used as proxies for behavioral health need in the assessment process.

Additional comments (also directly included in the Child Trends Memo PDF under the yellow highlighted text):

- With reference to Phase 4 and 5 of the matching process, we recommend changing the 1-year grants awarded to the CBOs to 5-year contracts. This will allow for continuity of consistent services within schools, which is necessary to drive long-term changes in behavioral health outcomes.
- With reference to Table 1, under Phase 1, consider separating the "Needs/resource assessment survey" into: (1) Needs/Resource Assessment for Schools and (2) Capacity Assessment for CBOs. These are distinct materials to be developed that will be used in different manners.
- With reference to Table 1, under Phase 2, the database of CBO survey responses is likely to be a useful tool for schools in the matching process. In this database, it may be helpful to include information on the schools already served by the CBO and remaining available capacity. Additionally, Table 1 does not address the dynamic nature of CBO information. Consider adding the regular maintenance of the CBO database as a role and assigning it to the appropriate body.

- With reference to Table 1, under Phase 4, we suggest removing "when feasible" from the repeated phrase "includes families—and students when feasible". As the primary recipients of the services, students should be involved in the creation of the plan and vision for these services.
- With reference to Table 2, specifying the type of clinicians who are qualified to provide services within the MTSS will elicit more meaningful data.