School Behavioral Health Expansion Evaluation

Summary of Findings from Four Years of Data Evaluating the Expansion of School Behavioral Health in the District of Columbia

This evaluation is funded by the District of Columbia Department of Behavioral Health

Child Trends

DBH

Contents

Executive summary

The District of Columbia's Department of Behavioral Health (DBH), in partnership with community-based organizations and education agencies, implemented a phased expansion of school-based behavioral health supports beginning in school year (SY) 2018-19. The expansion fostered relationships between schools and community-based providers of behavioral health supports to increase access to school-based behavioral health services across a multi-tiered system of supports. This report summarizes findings from four years of evaluation data collected during SY 2020-21 through SY 2023-24.

Bright spots

Reduced Behavioral Health Stigma Both survey data and qualitative analysis revealed a decreased stigma around behavioral health. More than half of students consistently reported that having a mental or behavioral health challenge was "not at all embarrassing."

Positive Views of School Support Most students and caregivers expressed positive perceptions of how schools address behavioral health needs. Additionally, nearly three-quarters of students reported having a trusted adult at school they could approach with problems, suggesting many students have access to supportive relationships.

Improved Data Infrastructure DBH made substantial progress in developing a unified data tracking system, moving from disconnected tracking processes to a more comprehensive and centralized system. The collaborative development process engaged clinicians and supervisors to ensure usability, while ongoing training and data quality reviews have strengthened the system's foundation. The creation of benchmarks and data snapshot reports in later years allows for closer monitoring of implementation progress.

Areas for improvement

Persistent Demographic Disparities Female students are more than twice as likely as males to report behavioral health needs but less likely to have those needs met. Latino students report lower rates of trusted adult connections and more unmet behavioral health needs. LGBTQ+ students face alarmingly high rates of mental health concerns and low rates of having their needs met.

Gaps in High School While high school students report positive views of behavioral health and help-seeking, they also report weaker school belonging, fewer trusted adult relationships, and are less likely to have their behavioral health needs met compared to elementary students.

Limited Stakeholder Engagement Fewer than 10 percent of School Behavioral Health Coordinators reported involving students in decision-making during behavioral health planning, and fewer than 20 percent reported involving families.

Workforce Challenges Staffing vacancies have persisted, with levels generally hovering around 60 percent of allocated positions throughout the evaluation period. Simultaneously, school staff wellbeing has deteriorated alarmingly. This combination of behavioral health staffing shortages and increasing staff strain is worrisome given students' reliance on teachers as support figures.

Recommendations

System-Level Recommendations

Establish a Formalized Cross-Sector Strategic Plan The Coordinating Council should develop a comprehensive plan that articulates clear roles and coordination across education, health, and behavioral health sectors to ensure aligned implementation and consistent messaging.

Enhance Continuous Quality Improvement Infrastructure DBH should designate staff with dedicated CQI responsibilities, implement systematic data collection and review cycles, and establish regular reporting mechanisms to monitor progress against benchmarks for provider activities and student outcomes.

Implement Authentic Engagement Strategies for Students and Families DBH and the Coordinating Council should establish clear protocols for meaningful involvement of students and caregivers in planning processes, take steps to facilitate broader participation at the system level, and develop monitoring procedures to assess engagement progress.

Advocate for Dedicated School Behavioral Health Coordinator Positions Assess the benefits of establishing dedicated coordinator positions with sufficient time allocation to manage comprehensive behavioral health initiatives, recognizing that current coordination (1-2 hours weekly for most coordinators) is likely insufficient for effective implementation.

Develop Targeted Professional Development for Diverse Student Needs Establish a coordinated framework that equips school teams with competencies to address the needs of populations showing disparate outcomes (female, LGBQ, Latino, and secondary students), aligning investments across the district to prevent duplication.

School-Level Recommendations

Implement Authentic Engagement Strategies with Students and Families Establish formal mechanisms for including stakeholders in decision-making and create transparent feedback loops demonstrating responsiveness to community input.

Support Integration of Behavioral Health Providers within Schools Implement approaches to enhance provider integration, recognizing that relationships and trust are primary factors in help-seeking decisions.

Enhance Mental Health Literacy Among All School Stakeholders Implement comprehensive mental health literacy interventions addressing knowledge gaps, attitudinal barriers, and help-seeking competencies using culturally and linguistically appropriate materials.

Utilize Data-Driven Approaches to Tailor Behavioral Health Supports Develop data analysis competencies to identify populations experiencing disproportionate needs and create targeted intervention plans with measurable objectives.

Develop Comprehensive Staff Wellness Initiatives Implement structured approaches to employee wellness through representative committees that ensure initiatives respond to diverse staff needs and promote equitable well-being outcomes.

Introduction: Expanding School-Based Behavioral Health Services in the District of Columbia

A national youth mental health crisis

For more than a decade, students in the United States have increasingly reported experiencing mental health challenges—a trend that was exacerbated by the COVID-19 pandemic and ongoing social justice issues.[1,2] The most recent national data suggest that, while alarmingly high, reports of persistent feelings of sadness or hopelessness among high school students have remained unchanged for male, Black, Hispanic, and White students between 2021 and 2023; female and Hispanic students saw small improvements (see Table 1)[3]. The District of Columbia has seen similar trends, with the percentage remaining unchanged among male, Hispanic, and White students and improvements among female and Black students (see Table 1).[4]

Table 1. Two-year change in percentage of students who experienced persistent feelings of sadness or hopelessness (2021 vs 2023)

	National	District of Columbia
Female	↓ 57% vs. 53%	↓ 48% vs. 44%
Male	29% vs. 28%	23% vs. 23%
Black	39% vs. 40%	↓ 36% vs. 33%
Hispanic	↓ 46% vs. 42%	39% vs. 36%
White	41% vs. 39%	34% vs. 26%

Source: CDC YRBS[5] and OSSE YRBS[6]

The District of Columbia expands school-based supports

Schools are critical settings for the socioemotional development of children and youth, where interactions with peers and adults, school policies and practices, and school culture play vital roles

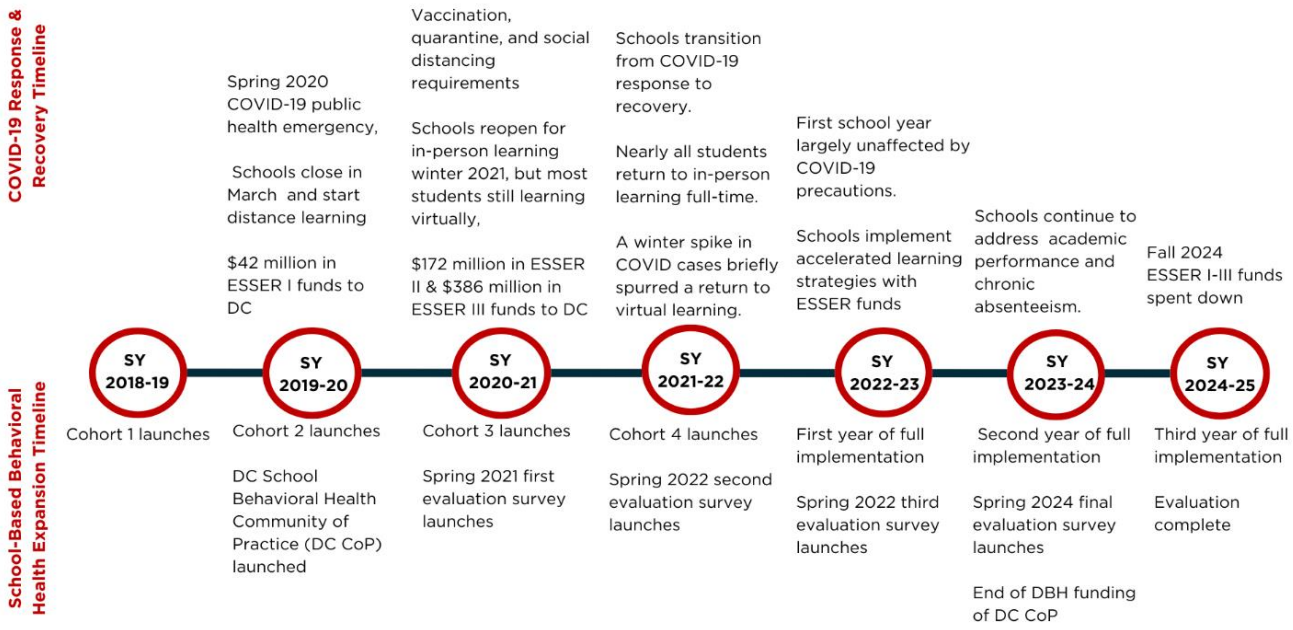
[1] Ethier, K. A., Mpofu, J., & Krause, K. (2025). The More We Know: Updates on the Mental Health Crisis Among Young People in the United States. *Journal of Adolescent Health*, *76*(1), 7-8.
[2] US Department of Health and Human Services. (2021). Protecting youth mental health: The US Surgeon General's advisory. *Washington (DC): US Department of Health and Human Services*.
[3] CDC. Youth Risk Behavior Survey Data Summar & Trends Report. https://www.cdc.gov/yrbs/dstr/pdf/YRBS-2023-Data-Summary-Trend-Report.pdf
[4] 2023 Youth Risk Behavior Survey Results: District of Columbia High School Survey Trend Analysis Report. https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2023DCBH%20Trend%20Report%20-%20Final.pdf
[5] CDC. Youth Risk Behavior Survey Data Summar & Trends Report. https://www.cdc.gov/yrbs/dstr/pdf/YRBS-2023-Data-Summary-Trend-Report.pdf
[6] 2023 Youth Risk Behavior Survey Results: District of Columbia High School Survey Trend Analysis Report. https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2023DCBH%20Trend%20Report%20-%20Final.pdf

in shaping their mental health.[7,8] Recognizing the critical role that schools can play in expanding students' access to services, the District of Columbia (DC) Department of Behavioral Health (DBH) – alongside community-based organizations (CBOs), the Office of the State Superintendent of Education (OSSE), The District of Columbia Public Schools (DCPS), and the District of Columbia Public Charter Schools (DCPCSB), and many other partners – implemented a phased expansion of behavioral health supports to successive cohorts of public and public charter schools across the city. The first cohort was launched in the 2018-19 school year (SY) with schools in the fourth and final cohort joining the expansion in the SY 2021-22.

The COVID-19 pandemic

The COVID-19 pandemic has cast a long shadow on the efforts to expand access to school-based behavioral health supports across public and public charter schools in DC, and on the evaluation of those efforts. The COVID-19 public health emergency was declared in March 2020—partway through the second year of the expansion—and resulted in the closing of school buildings and initiation of distance learning for DC students. In Spring 2021, the evaluation team launched the Strengthening School Behavioral Health (SSBH) surveys (which serve as a key source of data for this evaluation) mere weeks after all schools in DC reopened their doors for in-person learning.

Combined Timeline of School-Based Behavioral Health Expansion and COVID-19 Response & Recovery



[7] O'Reilly, M., Svirydzenka, N., Adams, S., & Dogra, N. (2018). Review of mental health promotion interventions in schools. *Social psychiatry and psychiatric epidemiology*, *53*, 647-662.
[8] Hoover, S., & Bostic, J. (2021). Schools as a vital component of the child and adolescent mental health system. *Psychiatric services*, *72*(1), 37-48.

About this report

This final report examines trends in student outcomes over time and in relationship to school-level and expansion factors. Focal outcomes aligned with the expansion's logic model include students' sense of belonging at school, connection with a trusted adult, use of positive coping strategies, behavioral health stigma, help seeking, and unmet behavioral health need. In addition to examining how these outcomes differed by age, race, ethnic groups, gender identities, and sexual orientation, we also examine relationships with school-level factors including school size, truancy, number of behavioral health staff, and number of behavioral health partnerships. Understanding how students fared over time, school-level characteristics, and expansion factors that contributed to student outcomes will offer insights that can be used to refine behavioral health services and supports for students through professional development for staff, implementation resources for school-behavioral health coordinators, and engagement with students and families.

Evaluation Design: A Mixed Methods Approach

KEY TAKEAWAYS

The evaluation employed a robust, mixed-methods approach to examine behavioral health outcomes comprehensively. The evaluation combines administrative data sources (including publicly reported truancy and enrollment data, school health profiles, and restricted-access Youth Risk Behavior Survey (YRBS) data) with primary data collection through a series of tailored surveys. The inclusion of both qualitative and quantitative analysis methods further strengthens the evaluation by capturing nuanced perspectives alongside measurable outcomes.

The evaluation design applies complex quantitative methods. Mixed-effects modeling was applied to account for the naturally nested structure of the survey data, where individual responses are grouped within schools. This approach effectively handles unbalanced data collection, inconsistent school participation, and missing data without requiring techniques like multiple imputation.

The qualitative methods apply a rigorous approach to centering the voices of students and families. Open-ended survey responses were analyzed using topic modeling. This method was used separately for each school year and findings were compared across years to track how student and caregiver perspectives on behavioral health supports evolved over time.

The demographic representation in the survey samples provides both strengths and limitations for interpretation. The student sample closely aligned with district enrollment data for Black students but included fewer Hispanic and White students and more Multiracial students than the overall district population. Family respondents were more likely to identify as White and have children in elementary grades compared to the student sample. These demographic patterns create opportunities to examine specific subgroup experiences while requiring careful consideration when generalizing about broader school populations.

Data sources

Administrative data sources

Publicly reported truancy and enrollment data, school health profiles data (which includes questions about behavioral health staff and partnerships) collected by OSSE, restricted-access YRBS data obtained through a data use agreement with OSSE, and DC School Behavioral Health Community of Practice (DC CoP) activity and participation data were used in this evaluation.

Primary data sources

The evaluation team administered a series of online surveys to supplement administrative data.

Surveys

The online Strengthening School Behavioral Health (SSBH)surveys were distributed by schools to students in grades 4 to 12, caregivers, school staff, and School Behavioral Health Coordinators (SBHCs). Students were asked questions about their school environment, perceptions of behavioral health and related supports, experiences seeking help, participation in different tiers of behavioral health services, and perceptions of helpfulness and support from school staff. In SY 2022-23 and SY 2023-24 surveys tailored to adult learners were administered—the surveys covered the same constructs as the student survey, but language was revised to reflect the different context

of adult learners. Caregivers were asked to complete an equivalent survey. No personally identifiable information (i.e., names, birth dates, or contact information) was collected. Students and caregivers had the option to complete surveys in English, Spanish, or Amharic. School staff were also asked to complete a survey regarding their perceptions of student behavioral health supports and staff wellness supports. SBHCs were asked to complete a survey about planning, delivery, and monitoring of behavioral health services and supports.

Survey revisions

Some survey items were revised over time to better capture actionable information based on feedback from stakeholders. Below we outline changes that were made to student and caregiver surveys. School staff and SBHC surveys remained unchanged.

Behavioral health need

In the first two years of survey administration, student and caregiver surveys focused on assessing the prevalence of unmet behavioral health need: "Was there any time you/your child had a mental/behavioral health challenge but didn't get the help you/your child needed?" In the third year, this question was revised to capture the prevalence of need and unmet need: 1) "Was there any time this school year when you/your child had a mental/behavioral health challenge or need? For example, if you/they were feeling worried, sad, or having trouble getting along with others." and 2) "If yes, did you get the help you/your child needed at school?"

Student behavioral health help seeking

In the first two years of survey administration, student surveys asked: "If you needed help with a mental/behavioral health challenge at school, do you know who to go to in order to get help?" After presenting data to stakeholders, it became apparent that it would be more useful to know who students would go to for help. In year three, the survey was refined to ask who they would actually go to for help: "If you needed help with a mental/behavioral health challenge at school, who would you go to for help? (you can select more than one answer for this question)." Students were able to choose from the following response options: teacher, principal, school resource officer, therapist, food service worker, custodian, coach, family member, friend, someone not listed, I don't know, I prefer not to answer.

Caregiver perceptions of school supports

Two questions were added to capture caregivers' perceptions of school-based supports. The first question focused on their experiences with treatment services: "During this current school year, which of the following best describes your child's experience with mental/behavioral health services at school (select all that apply): a) I haven't tried to access services for my child at their school, b) my child has seen a mental/behavioral health professional at school, c) My child is on a waitlist at school, d) I have tried, but my child has not been able to access services at school, e) I am seeking support for my child outside of school, f) my child is receiving support outside of school, g) Prefer not to answer." The second question focused on their overall perceptions: "Overall, my child's school does a good job meeting students' mental and behavioral health needs: a) strongly agree, b) agree, c) disagree, d) strongly disagree, e) prefer not to answer."

Data collection

Administrative data

The evaluation team accessed publicly available data on school-level enrollment and truancy from the OSSE website. Publicly available school-level responses to OSSE's School Health Profiles were also accessed from the OSSE website. Additionally, the evaluation team executed a data use agreement with OSSE to receive access to the YRBS. The evaluation team also obtained administrative data from the DC CoP. Meeting minutes and presentation slides from the Coordinating Council for School Behavioral Health were also collected.

Primary data

The evaluation team coordinated with DBH, school administrators, local education agencies (LEAs), the state education agency, and other community partners to distribute web-based surveys to students, caregivers, staff, and SBHCs annually in the spring beginning in SY 2020-21 and ending in SY 2023-24; a total of four years. While schools were encouraged to participate, participation was voluntary and not every school participated. Additionally, while schools were provided with materials to help them in planning how to administer the surveys, it was left up to each school how to administer the survey. Evaluation team members attended standing meetings for SBHCs—who were typically the primary point of contact at each school—to answer questions and provide support as needed. This flexible approach was agreed upon by the various DC agency partners in recognition of data collection fatigue resulting from the many requests schools received for data related to COVID-19 response and recovery. The evaluation team directly emailed survey links to SBHCs at each school based on a contact list provided by OSSE.

Data analysis

Both quantitative and qualitative data analysis methods were applied.

Qualitative analysis

Content analysis of the Coordinating Council for School Behavioral Health meeting presentations and meeting minutes was initially conducted using ChatGPT and then refined by the evaluation team.

To analyze open-ended survey responses from students and caregivers, the evaluation team employed a short text topic modeling approach to identify key themes within the data. Topic modeling is a data-driven process that detects patterns in textual responses without predefined topics; instead, meaning is assigned to emerging themes based on patterns identified in the data.

Prior to analysis, the evaluation team prepared the text by applying stemming (removing plurals, possessives, and verb endings) and filtering out stop words (e.g., "the," "and") to enhance model performance. The topic modeling process groups frequently co-occurring words into clusters of conceptually similar responses. Following this automated clustering, human review was conducted to assign meaningful labels to each topic.

Given the challenges that traditional topic modeling approaches face when analyzing short text responses, such as Latent Dirichlet Allocation (LDA), the evaluation team utilized a modified topic

modeling algorithm known as the Gibbs Sampling Algorithm for a Dirichlet Mixture Model.[9] This method is better suited for identifying meaningful themes in brief survey responses.

The evaluation team conducted topic modeling separately for each school year (SY 2020-21, SY 2021-22, SY 2022-23, and SY 2023-24) to examine perspectives at each point in time. The analysis focused on identifying what students and caregivers liked about their/their child's school's support for student mental and behavioral health, as well as areas for improvement. After generating topic models for each year, the evaluation team systematically reviewed and compared the findings across years to identify recurring themes, shifts in concerns, and areas of progress. This longitudinal approach allowed the team to capture both distinct and overlapping perspectives from students and caregivers, providing insights into evolving trends in perceptions of school-based mental and behavioral health support.

Quantitative analysis

Quantitative data analyses included both descriptive and hierarchical mixed-effects modelling.

Descriptive analysis

Descriptive analyses were used to summarize DC CoP data on participation in technical assistance activities. Descriptive analyses were also used to summarize the distribution of responses to questions in the School Behavioral Health Coordinator survey regarding the usefulness of DC CoP supports as well as other supports accessed by SBHCs.

Hierarchical mixed-effects model

Our analysis of student outcomes focused on data collected over the three most recent school years: SY 2021–22, SY 2022–23, and SY 2023–24. Although data were originally collected from SY 2020–21 through SY 2023–24, the first year was notably affected by the COVID-19 pandemic, leading us to exclude it from the primary analysis to ensure a more stable and comparable context across years. Descriptive data from all four years can be found in Appendix B.

The dataset possesses a naturally nested structure in which individual responses from students, families, and staff are grouped within schools. In addition, the data are unbalanced; not all schools provided complete responses from every surveyed group (i.e., students, caregivers, staff, SBHC) and not all subgroups (e.g., race/ethnicity, staff roles) within a school responded to the survey within or across years. Furthermore, inconsistent school participation across years resulted in missing data, contributing to unbalanced panels. While some individuals may have responded in multiple years, the absence of unique identifiers prevents us from tracking these repeated measures over time. As a result, we treat our data as repeated cross-sectional rather than as panel data, placing our emphasis on discerning population-level trends rather than following individual trajectories.

To address these challenges, we employed a two-level hierarchical mixed-effects model. In this framework, level 1 represents individual responses and level 2 accounts for the school-level clustering. Time (e.g., school year) is included as a fixed-effect covariate and treated as a

[9] Yin, J., & Wang, J. (2014, August). A dirichlet multinomial mixture model-based approach for short text clustering. In *Proceedings of the 20th ACM SIGKDD international conference on Knowledge discovery and data mining* (pp. 233-242).

categorical variable. The time variable in the model is used to control for time trends and allow trends across years to be examined – this is described below. This modeling approach allows incorporation of both fixed effects, which capture consistent influences across individuals and schools, and random effects, which account for variability within and between schools. Importantly, the use of maximum likelihood estimation (MLE) within the mixed-effects framework enables us to effectively handle the unbalanced and missing data without resorting to techniques such as multiple imputation or rank weighting. This approach ensures that our inferences about longitudinal trends remain robust despite the inherent data limitations

The models focus on eight key student outcomes as measured by the SSBH survey: school belonging, trusted adult, positive coping skills, views of mental/behavioral health challenges, perception of peer views of mental/behavioral health help-seeking, comfort talking to a therapist at school, mental/behavioral health needs, and whether mental/behavioral health needs were met. Aside from student-reported need, items were coded to ensure higher scores reflected more positive outcomes. For items that were on a scale of agreement (e.g., Strongly Agree to Strongly Disagree), responses were categorized into either Strongly Agree/Agree or Strongly Disagree/Disagree, where the analysis can more easily explain likelihood of a positive outcome. For coping, which was a count of positive coping skills used by students, responses were also categorized into two levels - using up to three versus four or more positive coping skills.

The model answered the question of which student characteristics (i.e., sex, race/ethnicity, sexual orientation, grade) and school characteristics are associated with outcomes, including overall trends across years. Student characteristics were gathered from student surveys. School characteristics were gathered from administrative enrollment, truancy, and School Health Profile (SHP) data. SHP data included information about the number of behavioral health support staff within the school (i.e., licensed clinical social workers, licensed graduate social workers, licensed professional counselors, licensed graduate professional counselors, psychologists) and number of community partners that help provide behavioral health services to students, although community partnerships may or may not be related to the expansion effort.

Parallel analyses were conducted using two different datasets. The first dataset consists of the SSBH surveys that were administered annually to students in grades 4 and up. The second dataset consisted of student responses to the YRBS which is administered every other year to all middle and high school students in DC; the YRBS is not administered to elementary school students. Some outcomes of interest in the YRBS are administered only to high school students. Complex sampling estimates available within the YRBS data were used in lieu of HLM analyses to be representative of all middle and high school students in DC. YRBS analyses focused on fewer but similar outcomes, including met need (i.e., “When you feel sad, empty, hopeless, angry, or anxious, how often do you get the kind of help you need?” (high school only), sadness/hopelessness (i.e., “During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?” (high school only), and trusted adult (i.e., “Is there at least one teacher or other adult in your school that you can talk to if you have a problem?”); responses were also reverse-coded and dichotomized as needed to examine likelihood of a positive outcome.

A note on datasets used to examine student outcomes

This report presents key findings from three different analyses of student behavioral health outcomes that account for different student and school characteristics (see Table 2). The first analysis uses the SSBH survey data plus administrative data on school characteristics, including behavioral health resources. The second uses the YRBS survey data, and the third uses YRBS survey data plus administrative data on school characteristics, including behavioral health resources. Each dataset presents unique strengths and gaps based on the nature of the data themselves. Table 2 outlines the features of the three different combinations of survey and administrative data that are used in the analyses presented later in this report to highlight the attributes of each dataset. Combined, these datasets provide useful insights into student behavioral health outcomes in DC.

Table 2. Strengths and gaps of survey and administrative data combinations for analysis

SSBH + school factors (see Table 10)	**YRBS** (see Table 14)	**YRBS + school factors** (see Table 14)
Strengths		
Outcomes are directly related to behavioral health experiences in schools. Data were collected from students across grade levels Surveys were administered annually for 3 years. School characteristics were included.	Data were collected from a robust sample. Surveys were administered at 3 timepoints spanning 7 school years. Data include a sufficient sample to examine gender identity.	Data were collected from a robust sample. Data include a sufficient sample to examine gender identity. School characteristics were included.
Gaps		
Survey questions asked specifically about experiences related to behavioral health in schools. Used a convenience sample with variable participation from schools year-to-year.	Survey questions were not specifically about experiences related to behavioral health in schools. Sample excluded elementary students.	Survey questions were not specifically about experiences related to behavioral health in schools The sample excluded elementary students. Surveys were administered at 2 timepoints spanning 3 school years.
What will you learn?		
Which school behavioral health outcomes changed over time? What differences are there in school behavioral health outcomes across groups of students?	Which behavioral health outcomes changed over time? What differences are there in behavioral health outcomes across groups of students, including transgender students?	Which behavioral health outcomes changed over time? What differences are there in behavioral health outcomes across groups of students, including transgender students?

Which school behavioral health outcomes are related to school behavioral health staffing and partnerships.	Which behavioral health outcomes are related to school behavioral health staffing and partnerships.

Sample characteristics

A total of 32,209 surveys across 243 schools were completed over four years, including 17,775 student surveys, 5,388 family surveys, 8,523 staff surveys and 523 SBHCs surveys (see Table 3). Tables 4 – 8 summarize the demographic distribution of survey respondents.

Table 3 Survey Respondents Counts

	School Year			
	2020-21	2021-22	2022-23	2023-24
Student Survey	4,122	4,899	4,547	4,207
Family Survey	1,346	1,656	1,375	1,011
Staff Survey	2,164	2,076	1,871	2,412
SBHC Survey	107	171	107	138

Table 4. Student Survey Respondent Characteristics (%)

	School Year			
	2020-21	2021-22	2022-23	2023-24
Race/ethnicity				
Black	65%	58%	67%	65%
Hispanic	12%	16%	12%	13%
White	6%	6%	4%	8%
Two or more races	10%	8%	9%	11%
Other	3%	12%	3%	3%
Gender				
Girl/Woman (cisgender)	52%	48%	51%	54%
Boy/Man (cisgender)	42%	49%	46%	43%
Transgender	2%	3%	2%	2%
Non-binary	2%	<1%	<1%	<1%
Sexual orientation				
Heterosexual	62%	64%	66%	68%
LGBQ	23%	16%	20%	21%
Do not understand question	7%	9%	15%	11%
Prefer not to answer	8%	11%	N/A	N/A
Grade				
Elementary	35%	49%	34%	21%
Middle	35%	23%	28%	35%
High	31%	28%	38%	44%

Table 4 summarizes characteristics among student survey respondents and Table 5 summarizes enrollment data by race/ethnicity and grade level for the same years. With respect to race and ethnicity, the evaluation sample includes a similar percentage of students who identify as Black when compared to the enrollment data. The evaluation survey sample has a smaller percentage of students who identify as White or Hispanic and a larger percentage who identify as more than one race compared to enrollment data. To some extent, we expect that these patterns are influenced by

the fact that the evaluation sample only includes students in grades four and up; enrollment in pre-K through third grade—students who would not have been eligible to complete the student survey—tends to include a larger percentage of White and Hispanic students compared to middle school and high school enrollment.

Table 5. District Level Student Race/Ethnicity and Grade (%)

	School Year			
	2020-2021	2021-2022	2022-2023	2023-2024
Race/ethnicity				
Black	64%	64%	63%	62%
Hispanic	20%	19%	20%	21%
White	12%	12%	13%	13%
Two or more races	3%	3%	3%	3%
Other	2%	2%	2%	1%
Grade				
Prekindergarten	21%	20%	20%	20%
Elementary	34%	35%	35%	34%
Middle	17%	18%	18%	18%
High	20%	21%	21%	20%
Other	--	5%	5%	8%

Note. District estimates are based on the SY 2020-21, 2021-22, 2022-23, and 2023-24 OSSE Enrollment Audit reports and reflect public and public charter school enrollment data. Relative to district estimates, the SSBH student survey was administered to students in grades four and above. Additionally, "Other" race/ethnicity includes American Indian or Alaska Native, Asian, Middle Eastern or North African, Native Hawaiian or Other Pacific Islander, or a different race/ethnicity not listed; survey sample sizes yielded concerns about representativeness and interpretation. Students preferring not to answer the race/ethnicity question are also included in the "Other" category.

There are no data on family/caregiver demographics with which the evaluation sample can be compared. However, it is notable that in the first and last years of survey administration the percentage of caregivers who identified as Black more closely aligns with the percentage of student survey respondents who identified as Black in those years (see Tables 4 and 6). In all four years, a larger percentage of caregiver survey respondents identified as White compared to student survey respondents. As noted in the discussion of student survey demographics, a larger percentage of students enrolled in early grades (pre-K through third grade) identify as White. Since caregiver respondents tended to report that their child was enrolled in an elementary grade, the difference in demographics of the student and caregiver samples is partially due to an overrepresentation of caregivers of children from younger grades compared to the student sample.

Table 6. Family Survey Respondent Characteristics (%)

	School Year			
	2020-21	2021-22	2022-23	2023-24
Race/ethnicity				
Black	62%	42%	40%	60%
Hispanic	11%	17%	11%	9%
White	16%	28%	33%	23%
Two or more races	4%	6%	6%	5%
Other	3%	7%	5%	3%
Gender				
Girl/Woman (cisgender)	87%	88%	86%	88%
Boy/Man (cisgender)	11%	12%	14%	12%
Transgender	<1%	1%	<1%	<1%
Non-binary	<1%	<1%	N/A	0%
Sexual orientation				
Heterosexual	85%	82%	85%	92%
LGBQ	6%	6%	6%	8%
Do not understand question	N/A	N/A	9%	0%
Prefer not to answer	9%	12%	N/A	N/A
Grade				
Prekindergarten	3%	16%	13%	15%
Elementary	51%	56%	52%	38%
Middle	12%	11%	14%	19%
High	35%	17%	21%	28%

Race and ethnicity data were not collected from school staff or School Behavioral Health Coordinators (see Tables 7 and 8). The survey did ask the amount of time the survey taker had worked at their current school. OSSE's Educator Workforce Report[10] from May 2022, which is based on data from the SY 2021-22, indicates 41 percent of DC teachers had five or fewer years of experience in that year and approximately one in ten teachers moved from a different school within DC (i.e., "movers"). While the survey question is not directly comparable to the OSSE data, this comparison suggests that the survey sample may overrepresent early career staff and "movers" within the system given that the staff survey sample has a higher percentage of respondents who are new to their school. Also notable, more than half of school staff responding to the survey identified as classroom teachers.

10 https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2022%20DC%20Educator%20Workforce%20Report_FINAL.pdf

Table 7. Staff Survey Respondent Characteristics (%)

	School Year			
	2020-21	2021-22	2022-23	2023-24
Time at school				
Less than 3 years	41%	28%	43%	31%
3 to 5 years	31%	42%	27%	30%
6 to 10 years	18%	19%	18%	24%
More than 10 years	10%	11%	11%	14%
Current role				
Classroom teacher	63%	56%	57%	58%
Behavioral health professional	N/A	8%	8%	4%
Administrator	9%	8%	9%	17%
Other	28%	25%	23%	20%

Table 8. SBHC Survey Respondent Characteristics (%)

	School Year			
	2020-21	2021-22	2022-23	2023-24
Time at school				
Less than 3 years	36%	20%	25%	25%
3 to 5 years	31%	39%	33%	33%
6 to 10 years	22%	23%	28%	28%
More than 10 years	11%	17%	14%	14%
Current role				
Behavioral Health Professional	63%	62%	68%	68%
Principal/Head of School	2%	3%	5%	5%
Other School Administrator	10%	10%	22%	22%
Other	25%	25%	7%	7%

Investments: Advancing School Behavioral Health Through Strategic Supports

KEY TAKEAWAYS

Coordinated multi-agency leadership structure guided comprehensive expansion. The Coordinating Council for School Behavioral Health brought together diverse stakeholders—including school leaders, educators, community providers, parents, youth, experts, government agencies, and advocates—to oversee the expansion of behavioral health supports across DC public and public charter schools.

Financial investments supported clinical staffing and supervision. DBH provided financial resources through multiple channels. These included stipends for CBO-hired providers, funds for clinical supervision, pandemic stabilization funding through the American Rescue Plan, and retention bonuses.

Comprehensive professional development ecosystem supported behavioral health providers. DBH investments in technical assistance have included dedicated Clinical Specialists providing implementation support and the DC School Behavioral Health Community of Practice.

Data collection systems have matured significantly but implementation monitoring remains limited. DBH made substantial progress in developing unified data tracking systems, moving from disconnected tracking processes to a comprehensive system capturing activities across the public health model. Data sharing with the Coordinating Council became more routine and benchmarks were established.

DBH provided many types of support to help address student behavioral health needs. These supports included bringing together different city departments to coordinate their work, providing money to hire behavioral health staff to work in schools, offering training and expert advice to school-based behavioral health providers and other school staff, and using data to track progress and make improvements. The Coordinating Council on School Behavioral Health (Coordinating Council) met regularly to guide these efforts. While this summary doesn't cover everything DBH did during this period, it highlights the main types of support based on Coordinating Council meeting records from SY 2020-21 through SY 2023-24 and reports from the DC CoP during the same period. The information about ongoing quality improvement efforts comes from the evaluation team's regular meetings with DBH throughout the five-year evaluation contract.

Cross-sector coordination

The Coordinating Council has supported the comprehensive expansion of behavioral health supports in DC schools, with a charge to "*to hold agencies and participating stakeholders accountable for timely implementation of the expanded School-based Behavioral Health System*." The Coordinating Council is comprised of school leaders, educators, community providers, parents, youth, school behavioral health experts, government agencies, city council chairmen, and advocates; and convened its first meeting on April 9, 2018. Over the years, the Coordinating Council has increasingly embraced a data-driven approach to school behavioral health implementation—moving from reactive crisis response during the pandemic to a greater focus on proactive system design and workforce development.

During SY 2018-19 and most of SY 2019-20, the focus of the Coordinating Council was on supporting the expansion of a public health approach to school behavioral health across more than

250 public and public charter schools in DC. This included determining the strategy for assigning schools to different cohorts, placing a strong emphasis on school and provider readiness, developing implementation supports for schools and provider organizations, and prioritizing effective engagement of youth and families. Toward the latter part of SY 2019–20, the Coordinating Council shifted to focus on ensuring students, families, school staff, and school behavioral health providers were adequately supported throughout the pandemic response and recovery. By SY 2021–22, when the fourth and final cohort of schools officially joined the expansion—and the public health emergency restrictions were easing—the Coordinating Council focused more intently on addressing persistent clinician vacancies, a focus that has remained at the center of Coordinating Council activities. During SY 2024-25, the Coordinating Council continues to address persistent challenges such as workforce shortages, slow uptake of alternative models, and uneven school-level implementation.

Support for recruitment and retention of behavioral health providers

Funds for staffing

Initially, DBH's primary supports included stipends to CBOs to partially fund clinician positions—with the expectation that CBOs would also seek reimbursement from health insurance for treatment services. Eventually, DBH also provided funds to support clinical supervision for those providers. Additionally, DBH provided supports for public charter schools to establish partnerships with CBOs; DCPS provided supports to DCPS schools. In SY 2021-22, DBH invested funds from the American Rescue Plan to stabilize clinical staffing amidst the disruption of the pandemic. In SY 2022-23, DBH also provided funds for retention bonuses. Later in the initiative, as it became apparent that staffing was a persistent implementation challenge, DBH also implemented several innovative strategies.

Efforts to expand the workforce

Staffing shortages and workforce retention challenges—which are nationwide issues—were a persistent implementation challenge, with staffing generally hovering around sixty percent. DBH, in consultation with the Coordinating Council, implemented a range of strategies to address gaps, but clinician vacancies were consistently cited as a barrier to full-service access. Notably, OSSE launched the Advancing the Recruitment and Retention of Our Workforce (ARROW) program in SY 2022-23. While not exclusively focused on CBO clinicians hired through the expansion, the program provided $1,000 retention bonuses for school-based clinicians; in February 2024 OSSE reported that 646 providers were verified to have returned for SY 2023-24. In SY 2023-24, retention bonuses were also offered to clinical supervisors of school-based clinicians.

Innovations to enhance recruitment and retention

In response to persistent challenges with staffing, DBH invested in small-scale implementation of three innovative strategies. Implementation of these innovations was initiated very recently and the number of schools that have participated is small as of the end of SY 2023-24. However, we briefly summarize the strategies below as context for understanding the challenges with recruitment and retention of clinicians.

Hybrid work model

This innovation involved allowing clinicians at high schools and adult learner schools to engage in a hybrid work schedule, which would allow the provider to conduct both in-person and telehealth sessions. During SY 2023-24 three schools applied to participate. However, due to staffing issues only one school was able to hire and retain a provider working a hybrid schedule. Notably, this option was only available to schools with a vacancy; currently placed clinicians were not able to choose to implement the hybrid model.

Student peer educator

DBH solicited applications from qualified organizations to implement a School-Based Behavioral Health Student Peer Educator Pilot Program, a program that was mandated by the District of Columbia Council. The purpose of this pilot program is to engage youth as leaders, peer educators, and advocates for behavioral health services within the district. The Young Women's Project was awarded funding and activities are planned for SY 2024-25. The project will train and support a cadre of 100 youth staff leaders (ages 14 to 19) from 10 DC schools who will use education, referrals, social media, and school-vetted student on-line support (SOS) virtual wellness centers to educate and engage 6,500 peers and connect them to mental health services.

Providing funding to schools rather than CBOs

This innovation allowed DC Public Charter Schools to apply directly to DBH for funding to hire a behavioral health clinician, rather than partnering with a CBO. When the request for applications (RFA) was initially posted, no schools applied for the funding. Schools were only eligible if they were not currently matched with a CBO partner or if they were matched but had a vacancy of at least 12 months. In March 2024, DBH selected five LEAs to receive funding, representing a total of seven schools.

Technical assistance and professional development

A number of technical assistance and professional development supports were available to school-based behavioral health professionals.

Department of Behavioral Health Clinical Specialists

DBH Clinical Specialists assist schools and SBHCs with the implementation and quality assurance of behavioral health programming. DBH Clinical Specialists support school teams in the School Strengthening Work Plan (SSWP) process. They offer technical assistance, office hours, and help SBHCs with goal setting and implementation of school behavioral health strategies. Clinical Specialists prioritize schools that are newly matched, have newly designated SBHCs, or failed to submit work plans in previous years. In addition to supporting the completion of SSWPs, Clinical Specialists helped schools navigate staffing disruptions, partnership transitions, and the use of assessment tools such as the Readiness Assessment to determine preparedness for behavioral health service implementation.

DC School Behavioral Health Community of Practice

DBH contracted with the Center for Health and Healthcare in Schools at The George Washington University to establish the DC CoP in SY 2019-20. Responses to the annual School Behavioral

Health Coordinator survey demonstrate that the percentage of survey respondents who had participated in the DC CoP and found it to be useful ranged from a high of 69 percent in SY 2019-20 to a low of 51 percent in SY 2020-21; in subsequent years the percentage hovered around 52 percent. It is important to note that schools transitioned to virtual learning in the Spring of SY 2019-20 in response to the COVID-19 pandemic. After SY 2019-20, the percentage of SBHC survey respondents who indicated they did not participate in the DC CoP hovered around 30 percent (12% in SY 2019-20). The percentage who reported that they participated in the DC CoP but did not find it helpful ranged from a low of 5 percent to a high of 12 percent. Below is a summary of DC CoP activities.

Monthly learning sessions[11] DC CoP activities included monthly learning sessions that covered a range of topics and were often co-designed and co-facilitated by members of the learning community, especially in the later years. Except for SY 2019-20, which experienced a disruption due to the COVID-19 pandemic, a total of nine sessions were held each year. The average attendance was approximately 75 participants.

Skill-Building Chats & Practice/Work Groups[12] DC CoP also hosted smaller, topic-specific groups that were designed for deeper engagement. Topics covered included: trauma-informed practices in schools, teacher wellness, family and youth engagement, and SEL implementation. Organizations with content expertise were often invited to participate in sessions. These sessions tended to be numerous—between 40 and 50 sessions each year—but with limited attendance (average of approximately 15 participants), which is aligned to the goal of providing opportunities to engage deeply on topics of shared interest.

Trainings DC CoP hosted a mix of foundational and advanced training sessions. Topics included Multi-Tiered Systems of Support (MTSS),[13] grief and loss,[14] and family engagement. Continuing Education Units (CEUs) were provided for social workers, psychologists, and counselors in later years. On average, the DC CoP hosted 11 training sessions per year, although the number of trainings each year varied widely with the most trainings occurring in the final year (25 trainings, average attendance of 32) and the fewest occurring in the first year (4 trainings, average of 9 participants).

Resources and toolkits[15] The DC CoP developed several practical tools including tip sheets, slide deck templates, introductory videos, and infographics.

Online platforms and digital resources[16] DC CoP used the Padlet platform to collect and organize digital resources on specific topics. The development of these Padlets[17] was often tied to monthly learning sessions or other training opportunities and served as a place to share resources. The DC CoP also hosted a website to disseminate information and resources.

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[11] https://dccop.publichealth.gwu.edu/meeting-archives
[12] https://dccop.publichealth.gwu.edu/overview
[13] https://dccop.publichealth.gwu.edu/mtss-training
[14] https://dccop.publichealth.gwu.edu/grief-loss-series
[15] https://dccop.publichealth.gwu.edu/resources
[16] https://dccop.publichealth.gwu.edu/
[17] https://dccop.publichealth.gwu.edu/padlets

Other supports

It is important to note that DBH is not the only source of professional development for school behavioral health clinicians. For example, OSSE's ARROW program initiated a cohort model in SY 2022-23 to support clinicians in their first year in a school-based position.[18] The ARROW program offered support for school-based clinicians to travel to national professional development opportunities. DCPS provided school-based clinicians with multiple opportunities to participate in professional development. Charter schools may also provide additional professional development opportunities as well. While it is beyond the scope of this evaluation to summarize these opportunities, it is important to recognize that supports provided by DBH are part of a larger system of supports for school-based clinicians working in schools in DC.

Continuous Quality Improvement

DBH has made substantial progress in collecting and summarizing data on provider activities. In March 2021, DBH and CBO clinicians tracked their activity separately – both tracking separate metrics and using different processes. In 2022, DBH developed a unified activity tracking system in Quickbase through a process that engaged and incorporated feedback from clinicians, supervisors, and other partners. DBH then rolled out the new system, trained all clinicians and supervisors, and provided ongoing support for data entry while actively reviewing data quality. With multiple years of data in the clinician activity tracking system, DBH has consistent data for both DBH and CBO providers on activity across the public health model that has enabled them to monitor and report on patterns and trends over time. Starting in SY 2024-25, DBH and Child Trends reviewed clinician activity data internally every month. Concurrently with these efforts, DBH refined mid- and end-of-year principal satisfaction surveys, and tested various strategies for reaching principals, leading to improved response rates.

DBH has shared provider activity data on a regular basis with the Coordinating Council on School Behavioral Health. In Spring 2024, DBH took over responsibility for preparing data presentations from the evaluation team (with continued support and advisement). These data presentations supported discussions about expectations for provider activity and data completeness across the system, the data were not generally used to identify schools in need of support or make other plans.

Benchmarks for provider activity data were established to measure progress in April 2023. During SY 2024-25, DBH developed a data snapshot report showing each clinician's progress on activities that have benchmarks associated with them. However, DBH has not looked at progress toward benchmarks (e.g., whether an individual clinician is meeting a benchmark and what percentage of clinicians are meeting benchmarks).

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18 https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2024.25%20First%20Year%20Cadre_One%20Pager.pdf

Experiences: Stakeholder Perspectives on School Behavioral Health Support Over Time

KEY TAKEAWAYS

Students and families rarely play decision-making roles in planning. While School Behavioral Health Coordinators express strong confidence in their plans (about 90% believe their plans adequately address school needs), student and family involvement in decision-making consistently remains low.

Students report positive views about behavioral health and a clear preference for going to teachers for support. Mental health stigma remains consistently low, with more than half of students reporting it is "not at all" embarrassing to have mental health challenges. Teachers consistently emerge as a primary resource for students, highlighting the critical role educators play in the behavioral health support system.

Concerning trends in staff wellbeing may threaten system sustainability. Staff wellbeing has deteriorated alarmingly over the four-year period, with positive work environment ratings dropping from nearly two-thirds to just over one-third. Rising exhaustion and stress levels among school staff—coupled with students' reliance on teachers as primary support figures—is worrisome.

Attitudinal barriers, rather than logistical challenges, predominantly prevent help-seeking. For both students and parents, the belief that problems would resolve themselves consistently emerged as the most common reason for not seeking help, followed by reluctance to disclose personal struggles. This suggests that addressing internal attitudes— including through mental health literacy interventions—should be a priority.

This analysis synthesizes findings from four consecutive years of survey data (SY 2020-21 through SY 2023-24), examining both strengths and challenges identified by students, parents/caregivers, school staff, and School Behavioral Health Coordinators. While many patterns remained consistent over all four years of data collection, the data summarized in this section are descriptive and caution should be used when applying the findings to the broader community. For example, because the survey data were not collected from the same people over time, the year-over-year changes may reflect a change in who took the survey from one year to the next rather than true changes in the outcome. Additionally, school staff, parent, and student responses are not linked so a change in staff outcomes may not be connected to a change in student outcomes because they may not be from the same schools. For complete survey response data, including response percentages for each year, please refer to Appendix A.

Student Perspectives

Positive Experiences

Student perceptions of behavioral health supports were moderately positive over the four-year period. Each year, approximately 60 percent of students reported a strong sense of belonging at their schools, with nearly 75 percent indicating they had a trusted adult at school they could approach with problems. Students largely viewed teacher support positively, with 68 percent to 75 percent agreeing that teachers effectively help students with emotional and social skills. Support from school leadership was also viewed favorably, though slightly less so, with 64 percent to 69

percent of students affirming that leadership effectively helps students with social-emotional challenges.

Mental health stigma remained consistently low among student respondents. Each year, slightly more than half (52-58%) reported it was "not at all" embarrassing to have mental health challenges, and slightly more (57-67%) believed their peers would not make fun of someone seeking therapy or counseling. When asked who they would turn to for help, students showed clear preferences: teachers consistently emerged as the primary resource, followed by friends and family members, with professional behavioral health staff ranking fourth. Notably, very few students reported having nobody to turn to for support, suggesting most students had at least some access to supportive resources.

Challenges and Concerns

Despite generally positive trends, a persistent minority of students reported concerning gaps in support. Approximately one in five (16-19%) reported not having a trusted adult at school—a pattern that remained stable across all survey years. Similarly, about 20 percent maintained negative perceptions of teacher and leadership support in helping students with emotional and social skills throughout the survey period, indicating a segment of the student population that felt consistently unsupported.

In the first two years students were asked about having unmet behavioral health needs; approximately 20 percent of students reported unmet behavioral health needs. In the last two years, the question was refined to ask if students had behavioral health needs that were not met at school, with approximately 16 percent reporting they had needs that were not met at school. Notably, in the last two years students were asked the reason they didn't get help in school and nearly one-third indicated the reason was that they got help outside of school. Assuming that pattern was similar during the first two years, the percentage of students with unmet behavioral health needs was likely consistent over time.

An examination of the other reasons for not getting the help they needed reveals that attitudinal barriers, rather than logistical challenges, were the main cause of not seeking help. The belief that problems would resolve themselves consistently emerged as the most common reason for not seeking help, followed closely by reluctance to disclose personal struggles. Skepticism about counseling effectiveness represented the third most significant barrier. In contrast, practical obstacles like transportation difficulties or appointment availability were rarely mentioned, suggesting that addressing internal attitudes might be more impactful than removing external barriers.

Parent and Caregiver Perspectives

Positive Experiences

Parents and caregivers consistently offered very positive assessments of their children's schools throughout the survey period. More than 90 percent reported feeling welcome at their child's school, and approximately 90 percent reported feeling comfortable speaking with school staff about their child's behavior. About three-quarters agreed that their child's school does a good job

meeting students' behavioral health needs— a consistently positive assessment across all four years.

Parents demonstrated extremely high willingness to seek help, both for themselves (87-89%) and even more so for their children (92-95%) when needed, reflecting positive attitudes toward help-seeking. Among those who attempted to access school-based behavioral health services, most reported success, with only about 5 percent reporting unsuccessful attempts. Approximately one-fifth of parents said their child successfully accessed school-based supports, while another tenth reported their child was receiving help outside of school.

Challenges and Concerns

Despite generally positive attitudes, parents reported persistent challenges in actually obtaining needed support for themselves. Between 20-30 percent indicated there were times they were unable to get the behavioral health help they needed, representing a significant access gap. When asked about specific barriers, parents identified three primary obstacles: difficulty securing appointments, lack of knowledge about available resources, and transportation challenges.

In the first two years, caregivers were asked about whether their child's behavioral health needs were met; approximately 12 percent reported their child had unmet behavioral health needs. In the last two years, the question was refined to ask if students had behavioral health needs that were not met at school, with approximately 15 percent of caregivers reporting their child had behavioral health needs that were not met at school. Notably, in the last two years, when caregivers who indicated their children did not get the help they needed at school were asked the reason, nearly half indicated the reason was that they got help outside of school.

School Staff Perspectives

Positive Experiences

Across all four years, approximately 85 percent of school staff reported strong knowledge of behavioral health referral processes. Between 62 percent and 72 percent of staff reported that they had made at least one behavioral health referral in the past year, with the percentage slightly increasing over the four-year period. Additionally, most staff who made referrals (50-60%) reported seeing improvements in student functioning following these referrals—a consistent pattern across years.

Despite some declines over time, most staff maintained positive views of behavioral health services across all tiers of the multi-tiered system of supports. Perceptions of Tier 1 (prevention) supports were most positive, followed by Tier 2 (early intervention) supports, with Tier 3 (intensive) supports receiving somewhat lower but still generally positive ratings. With respect to staff well-being, approximately 75 percent reported feeling engaged at school, a metric that remained stable even as other well-being indicators declined.

Challenges and Concerns

Staff wellbeing showed alarming deterioration over the four-year period. The percentage of staff who rated their working environment as "quite" or "extremely" positive dropped precipitously from

nearly two-thirds in SY 2020-21 to just over one-third by SY 2023-24. Similarly, feelings of hopefulness decreased from 63 percent to 46 percent, while slightly more than half reported high levels of exhaustion and stress by the final survey year. Only about 40 percent reported that they believed the staff wellness supports at their school were adequate— a concern that remained consistent across all survey years.

The percentage of staff who felt they received adequate behavioral health training also dropped from 78 percent in SY 2020-21 to approximately 65 percent in subsequent years. Additionally, across all four years between 25-30 percent of staff who made at least one behavioral health referral in the past year reported not knowing whether referred students experienced improvements, suggesting persistent gaps in communication and outcome monitoring.

School Behavioral Health Coordinator Perspectives

Positive Experiences

School Behavioral Health Coordinators consistently expressed strong confidence in their schools' behavioral health plans, with approximately 90 percent believing their plans adequately addressed school needs. They also perceived implementation fidelity to be strong, with about 85 percent reporting they were following their plans and just under 80 percent believing they had made significant progress on implementation goals across the four years. Coordinators were especially positive about service coordination, with 88-96 percent reporting effective coordination among behavioral health staff across all survey years. Most (about 75%) reported that school staff appropriately utilized the referral process.

Coordinators consistently reported that their school's referral process was clear and well-understood. Commitment to data use also appeared relatively strong, with approximately 75 percent reporting that their schools collected and reviewed implementation data, and 79-86 percentindicating they used data to monitor intervention effects. These patterns remained fairly consistent across the four-year survey period, suggesting stable perceptions of implementation practices.

Challenges and Concerns

Despite positive assessments of plans and processes, several concerning implementation patterns emerged. The most striking limitation involved stakeholder engagement, with student decision-making in planning remaining consistently below 10percent and family decision-making only marginally better at 4-17 percent across all survey years. Additionally, most coordinators (50-60%) reported spending one to two hours weekly on coordinator responsibilities, although 20 percent reported spending five or more hours per week. These patterns raise questions about Coordinators' capacity for comprehensive program management.

Positive assessments of CBO provider integration declined from 84 percent to 66percent over the survey period, though this corresponded with an increase in the percentage of schools reporting they did not have a CBO provider. Between 9-17 percent reported poor integration of their CBO provider— a persistent minority experiencing partnership challenges. Finally, fewer coordinators

(63-72%) reported using data to monitor whether services appropriately addressed school needs compared to those who simply collected data, suggesting gaps in data-driven decision making.

Alignment and Disconnects Across Stakeholder Groups

Analyzing the survey data across stakeholder groups reveals noteworthy patterns of both convergence and divergence in how students, parents/caregivers, school staff, and School Behavioral Health Coordinators perceive behavioral health supports in DC schools. It is important to keep in mind that the survey data were not collected from the same people over time, nor can parent and student responses be linked. However, these data offer insights that can help identify where the system functions cohesively and where gaps might affect implementation effectiveness.

Areas of Alignment

Stakeholder groups generally expressed positive views about the school environment and basic support infrastructure. Students, parents, staff, and coordinators consistently reported positive perceptions of school climate, although students reported a lower sense of belonging compared to parents' perceptions of feeling welcome at their child's school.

Another point of alignment emerged around the perceptions of the effectiveness of multi-tiered supports. Both staff and coordinators rated Tier 1 (universal) supports most positively, followed by Tier 2 (targeted) interventions, with Tier 3 (intensive) supports receiving the lowest ratings. This consistent pattern suggests system-wide challenges in implementing the most resource-intensive interventions. This may also reflect gaps in effective communication when it comes to treatment services, which require a stricter level of confidentiality than other tiers of support.

Key Disconnects and Perception Gaps

Despite these alignments, significant disconnects emerged across stakeholder groups. Most striking was the contrast between coordinator confidence in planning and implementation versus the actual engagement of key stakeholders. While approximately 90 percent of coordinators believed their plans adequately addressed school needs, student and family involvement in a decision-making role remained consistently below 17 percent— suggesting that coordinators may not view student and family engagement as fundamental to achieving a plan that aligns with the needs of the school.

Another key disconnect is the role of teachers as primary supports. The combination of students' preference for seeking help from teachers coupled with staff reporting increasing stress and exhaustion, suggests that the system may be relying heavily on a workforce experiencing significant strain.

Another notable contrast appeared in perceptions of access and utilization. School staff generally believed that students were aware of and could access behavioral health supports (approximately 70%), but only half believed students were satisfied with these supports. Meanwhile, about three-quarters of parents believed schools were doing a good job meeting mental health needs, yet most had never attempted to access treatment services. It is possible that parents whose children did require more intensive supports may have different perceptions than those whose children experienced minimal behavioral health challenges.

The assessment of service outcomes revealed another significant perception gap. While staff reported moderately increasing rates of referrals (from 62% to 72%), each year 25-30 percent of staff who made referrals did not know whether referred students improved. Additionally, relatively fewer coordinators reported using the data they collected to monitor service appropriateness (63% to 72%) compared to service implementation (71% to 75%). This suggests disconnects in feedback loops that could impede quality improvement efforts.

Shifting Dynamics Over Time

Comparing trends across stakeholder groups reveals both stable patterns and concerning shifts. Student perceptions remained remarkably stable over time, with consistent reports of school belonging, trusted adult relationships, and help-seeking preferences across all four survey years. Parent perceptions likewise showed little variation, maintaining high levels of comfort with school environments and strong help-seeking attitudes throughout the survey period.

In striking contrast, staff wellbeing metrics showed alarming deterioration, with positive work environment ratings dropping from 61 percent to 36 percent, and stress levels rising to 61 percent by SY 2023-24. This decline occurred alongside decreasing perceptions of support quality across all tiers. Meanwhile, the percentage of coordinators who reported that the CBO provider was well integrated in their school declined from 84 percent to 66 percent, suggesting potential challenges in maintaining community partnerships. These divergent trends raise important questions about sustainable implementation amid increasing staff strain, which may have also been influenced by staff recruitment and retention challenges.

Outcomes: Examining Student Behavioral Health Over Time

KEY TAKEAWAYS

Demographic disparities in behavioral health experiences are pronounced and consistent across datasets. Female students are nearly twice as likely as males to report behavioral health needs but less likely to have those needs met. Latino students are less likely to report trusted adult connections and more likely to report unmet behavioral health needs then Black students across both surveys. LGBTQ+ students—particularly transgender youth—are more than twice as likely as their heterosexual and cisgender peers to report behavioral health concerns while also being less likely to have their needs met.

Secondary school students face unique challenges in behavioral health support. While high school students demonstrate more positive views of behavioral health and help-seeking than elementary school students, they are less likely to feel a strong connection to school, to have a trusted adult at school, and dramatically less likely to have their behavioral health needs met.

School behavioral health staffing has some promising, if moderate, relationships with student outcomes. SSBH survey data revealed that students in schools with more behavioral health staff were more likely to feel comfortable reaching out to school behavioral health staff and marginally more likely to use positive coping skills or to have their behavioral health needs met at school. YRBS data revealed a marginal but negative relationship with having their behavioral health needs met; however, the YRBS question asked about getting help generally, while the SSBH asked specifically about getting help at school.

Patterns across SSBH and YRBS data are largely consistent. When examining comparable outcomes across the YRBS and SSBH surveys, patterns across several demographic characteristics are remarkably similar, with female, Latino, and LGBTQ+ students consistently reporting the poorest outcomes. Some promising, though inconsistent, findings also emerged between school behavioral health resources and student outcomes.

This section of the report presents key findings from three different analyses of student behavioral health outcomes that account for different student and school characteristics. One analysis uses the SSBH survey data and two use the YRBS survey data. The SSBH surveys cover a range of outcomes specific to behavioral health in schools and were administered to a convenience sample of DC students in grades 4 and up. The YRBS survey does not include outcomes that are specific to behavioral health in schools, but it does include a targeted set of relevant questions and is administered to all middle and high school students in DC every two years. When combined, these analyses provide a rich understanding of student behavioral health outcomes.

Strengthening School Behavioral Health Surveys

School effect

To account for the influence of shared environments—such as schools—on outcomes, the intraclass correlation coefficient (ICC) can be calculated to estimate the influence of that shared environment on a particular outcome. For example, one might expect that students attending the same school might have more similar outcomes with their peers than they would with students attending a different school because of their shared environment. The ICCs for the student

behavioral health outcomes from the SSBH surveys suggest that school environments account for 3 percent to 12percent of the variance in the student outcomes that were examined (see Table 9). The strongest clustering effects—effects of the shared school environment—were observed for having behavioral health needs met at school (12.2%) and peers' perceptions of mental health help-seeking (11.8%), indicating that school factors may have a larger impact on those outcomes.

Table 9. HLM Analysis of Student Outcomes with School Characteristics

	Belong	Trust. Adult	Positive Coping Skills	Mental Health Views	Peers' Mental Health Views	Comfort with School Therapist	Had Need	Need Met
ICC	5.9%	4.7%	8.2%	4.8%	11.8%	4.7%	3.3%	12.2%

Hierarchical Mixed-Effects Analysis of Student Outcomes

Below is a summary of the relationships between various student and school characteristics and student behavioral health outcomes (see Table 10).

Time

Year-over-year trends show some concerning patterns. During SY 2022-23, students were less likely to report positive outcomes like having a trusted adult at school (OR=0.84) or believing that peers held positive views of behavioral health help-seeking (OR=0.76) compared to SY 2021-22. Students were also less likely in SY 2023-24 to believe their peers had positive perceptions of behavioral health help-seeking (OR=0.82) and marginally less likely to report using positive coping skills (OR=0.88) compared to SY 2021-22. The lack of significant improvement in reports of behavioral health challenges mirrors national data which found an increase in behavioral health challenges followed by a plateau, with no significant change from 2021 to 2023.[19]

Gender

Gender differences are pronounced across several outcomes. Female students were less likely than males to report a strong sense of school belonging (OR=0.74) or to believe that their peers held positive views of behavioral health help-seeking (OR=0.83), but they were more likely to report having a trusted adult at school (OR=1.27) and to report using positive coping skills (OR=1.70). Female students were also substantially more likely than males to report having a behavioral health need (OR=2.64) but less likely to report their behavioral health need was met at school (OR=0.82). These patterns align with national trends over the past decade, which have found an increase in persistent feelings of sadness and hopelessness of 14 percentage points among girls compared to an increase of 7 percentage points among boys, a difference that has been linked to higher exposure to sexual violence among girls among other factors.[20]

[19] CDC. Youth Risk Behavior Survey Data Summary & Trends Report. https://www.cdc.gov/yrbs/dstr/pdf/YRBS-2023-Data-Summary-Trend-Report.pdf

[20] Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023*. U.S. Department of Health and Human Services; 2024.

Table 10. HLM Analysis of Student Outcomes with School Characteristics

	Belong at School	Trust. Adult	Positive Coping Skills	Positive Behavioral Health Views	Peers' Help-Seeking Views	Comfort with School Therapist	Had Behavioral Health Need	Behavioral Health Need Met at school
Sample size	9,548	9,272	9,491	8,704	9,122	8,992	5,507	2,460
School year								
SY21-22	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*n/a*	*n/a*
SY22-23	0.9	**0.84**	0.93	1.05	**0.76**	0.99	ref	ref
SY23-24	1.05	1.04	0.88*	0.96	**0.82**	1.03	0.91	1.06
Sex								
Male	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
Female	**0.73**	**1.27**	**1.61**	1.03	**0.82**	1.04	**2.56**	0.85*
Race/ethnicity								
Black	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
Latino	0.91	**0.69**	0.98	**0.82**	**1.22**	0.89	1.19*	**0.66**
White	**1.65**	0.97	1.12	**0.67**	**1.64**	**0.75**	**0.70**	**0.43**
Multiracial	0.89	**0.77**	**1.21**	**0.73**	0.93	0.92	1.19*	**0.64**
Other	0.77*	0.75*	0.91	**0.70**	0.90	**0.67**	1.16	0.75
Sexual orientation								
Heterosexual	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
LGBQ	**0.73**	1.02	1.01	**0.73**	**0.79**	0.94	**2.59**	**0.79**
Grade level								
Elementary	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
Middle	**0.82**	**0.65**	0.90	**1.18**	1.11	**0.64**	**0.74**	**0.52**
High	**0.48**	**0.68**	**0.76**	**1.86**	**2.01**	**0.54**	0.85	**0.32**
School size								
< 301	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
301-600	1.11	0.85*	0.92	1.11	1.16	1.10	**0.76**	0.95
> 601	1.14	**0.71**	0.87	1.03	1.20	0.98	**0.62**	**0.62**
Truancy	0.85	1.02	0.84	0.91	**0.33**	**1.43**	**0.67**	0.87
School behavioral health								
# Support Staff	1.02	1.07	1.06*	1.02	1.02	**1.08**	1.00	1.14*
# Comm Partner	1.00	0.96	0.98	1.03	0.99	0.99	1.00	1.01

Odds ratios are interpreted around 1, where odds ratios greater than 1 indicate higher odds and less than 1 indicate lower odds. "ref" indicates the reference group, which is the group that other groups are being compared to. For example, an OR of 1.5 means that members of a group have a 50percent higher odds of experiencing the outcome compared to the reference group. Bold indicates significant Odds Ratios (p<=.05). * Indicates marginally significant Odds Ratios (.05<p<=.10).

Race/Ethnicity

Racial and ethnic differences reveal complex patterns. Latino students were less likely than Black students to report having a trusted adult at school (OR=0.69) or—among those that reported having a mental health challenge—to report receiving the help they needed at school (OR=0.66). White students were more likely than Black students to report a strong sense of school belonging

(OR=1.65), but less likely to hold positive views of mental health (OR=0.67) and substantially less likely to report their behavioral health needs were met at school (OR=0.43). Multiracial students were more likely than Black students to report using positive coping skills (OR=1.21) but less likely to report having a trusted adult at school (OR=0.77) or holding positive views of behavioral health (OR=0.73).

The finding that White students are less likely to have their behavioral health needs met at school compared to Black students is surprising; however, because the question asked whether students had their needs met at school, it could be that White students are more likely to receive the behavioral health care they need outside of school. Notably, the analysis of YRBS data presented later in this report found that White students were more than twice as likely to get the help they need when they feel sad, empty, hopeless, angry, or anxious (see Table 14). For Latino students, cultural norms, language barriers, concerns related to immigration status, and experiences of discrimination and stigma may make it harder for them to get the help they need.[21]

Sexual orientation

LGBQ students were less likely than their heterosexual peers to report a strong sense of school belonging (OR=0.73), holding positive behavioral health views (OR=0.73), or believing their peers held positive help-seeking views (OR=0.79). They were also much more likely to report having a behavioral health need (OR=2.59) and less likely to report their behavioral health need was met at school (OR=0.79). LGBQ youth often experience identity-based discrimination and stigma that can increase their risk for experiencing a mental health challenge and create a barrier to accessing needed care.[22]

Grade level

Middle and high school students reported less-positive outcomes than elementary students across most measures, with high schoolers experiencing the most pronounced challenges. High school students were far less likely than elementary school students to report a strong sense of school belonging (OR=0.48), having a trusted adult at school (OR=0.68), or using positive coping skills (OR=0.76). However, high schoolers were more likely to report having positive behavioral health views (OR=1.86), to believe their peers held positive help-seeking views (OR=2.01). They were also less likely to report feeling comfortable seeking help from a therapist at school (OR=0.65) and, among those who reported a behavioral health challenge, they were dramatically less likely to report having their needs met at school (OR=0.32).

Middle school students showed similar but less extreme patterns, including being less likely to report a strong sense of school belonging (OR=0.82), having a trusted adult at school (OR=0.65), or feeling comfortable seeking help at school (OR=0.64). Middle school students were less likely than elementary school students to report having a behavioral health challenge (OR=0.74)—but among

[21] Lu, W., Todhunter-Reid, A., Mitsdarffer, M. L., Muñoz-Laboy, M., Yoon, A. S., & Xu, L. (2021). Barriers and facilitators for mental health service use among racial/ethnic minority adolescents: a systematic review of literature. *Frontiers in public health*, *9*, 641605.

[22] Kelleher, C. (2009). Minority stress and health: Implications for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people. *Counselling psychology quarterly*, *22*(4), 373-379.

those who did have a mental health challenge, they were less likely to report having their needs met at school (OR=0.52).

The finding that older youth are more likely to hold positive views about behavioral health and to believe their peers hold positive views about help-seeking may reflect adolescents' more nuanced understandings of behavioral health. While it may be surprising to see that elementary school students are more likely to report a mental health challenge than adolescents, this may also be related to the more nuanced understanding that older youth have of mental health. Emerging research finds that adolescents may view behavioral health challenges as something that is more normal than in previous generations.[23] Additionally, younger youth may interpret the question more broadly while adolescents may apply a stricter interpretation of what counts as a mental or behavioral health challenge.

School characteristics

There were a few significant relationships between school characteristics and student outcomes. For example, students attending larger schools were less likely than students attending small schools to report having a trusted adult (OR=0.71). They were also less likely to report having a behavioral health need (OR=0.62); however, among students who reported having a behavioral health need, they were less likely to report having their needs met at school (OR=0.62). Students attending schools with more behavioral health staff were marginally more likely to use positive coping skills (OR=1.06) and significantly more likely to report being comfortable seeking help from a therapist at school (OR=1.08). The number of community partnerships showed no significant associations with student outcomes, indicating that formal school-community organization connections may not translate directly to improved student behavioral health experiences without additional implementation supports.

The findings related to schools with high truancy rates are complex. Compared to students attending schools with low truancy rates, students in schools with high truancy rates were less likely to report having a behavioral health need (OR=0.67). Additionally, while they were less likely to believe their peers held positive views of mental health help-seeking (OR=0.33), they were more likely to report being comfortable seeking help from a therapist at school (OR=1.43). This seemingly contradictory pattern may reflect differences in how behavioral health services are structured or perceived in schools with attendance challenges. For example, in schools with high truancy rates, students may have more interactions with school mental health staff, leading them to feel more comfortable talking to them.

Youth Risk Behavior Survey & Strengthening School Behavioral Health Surveys: Comparing Datasets to Get a Fuller Picture

Given the limitations inherent in using a convenience sample of students to assess citywide patterns in students' experiences of school behavioral health, analyses were also conducted using YRBS data. Each survey presents different strengths and gaps for answering questions about students' experiences with school behavioral health (see Table 11). A comparison of the patterns

[23] Hermann, V., Durbeej, N., Karlsson, A. C., & Sarkadi, A. (2022). Feeling mentally unwell is the "new normal". A qualitative study on adolescents' views of mental health problems and related stigma. *Children and youth services review*, *143*, 106660.

and trends across these different data sources provides a more robust assessment of experiences across key student and school characteristics.

Two different YRBS datasets

Two key benefits of the YRBS are that (1) the surveys have been collected every two years over a long period of time and (2) the surveys are administered using a census approach (i.e., to all middle and high school students). However, the administrative data used to examine the effects of school resources—such as behavioral health staffing and community partnerships— were most complete during only the two most recent years of YRBS surveys. To benefit from the multiple years of YRBS data, one analysis used a database going back to the 2016-17 school year that included only student characteristics (see YRBS in Table 14). To examine relationships between school resources and student outcomes, a second database was created that combined the two most recent years of YRBS data with the same administrative data on school characteristics used in the SSBH analyses (see YRBS+ in Table 14).

Table 11. Characteristics of datasets

Analysis characteristics	SSBH + school factors	YRBS	YRBS + school factors
Outcomes are directly related to experiences of behavioral health in schools.	✓		
Data were collected from students across elementary, middle, and high schools.	✓		
Surveys were administered before and after the expansion/pandemic.		✓	
Sample was robust with all/most eligible students participating.		✓	✓
Allow for examination of the relationships between student outcomes and school resources.	✓		✓

Comparing key outcomes across surveys

While the SSBH surveys include questions on a broader range of experiences—and also focus more specifically on experiences in schools—both surveys include questions related to three key behavioral health outcomes: (1) having a trusted adult at school, (2) experiences of behavioral health challenges, and (3) getting behavioral health supports were selected for the comparison because questions about all three were included in each of the surveys. However, it is important to note some key differences (see Table 12). First, the surveys use different language when asking about behavioral health challenges, with the SSBH using terms that encompass a broader definition of behavioral health challenges. Second, when asking about getting help for behavioral health challenges, the SSBH asks specifically about getting help at school, while the YRBS question is more general.

Table 12. Comparison of SSBH and YRBS questions

Behavioral health construct	SSBH question	YRBS question
Relationship with a trusted adult at school	Is there a teacher or another adult at your school who you would feel comfortable talking to if you had a problem?	Is there at least one teacher or other adult in your school that you can talk to if you have a problem?
Experiences of behavioral health challenges	Was there any time this school year you had a mental/ behavioral health challenge or need? For example, if you were feeling worried, sad, or having trouble getting along with others.	During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?
Experiences getting help for behavioral health challenges	If yes, did you get the help you needed at school? [only asked of students who said yes to question above]	When you feel sad, empty, hopeless, angry, or anxious, how often do you get the kind of help you need? *[Note: not specific to help at school]*

High level comparison of outcomes

Several relationships between student demographic characteristics and behavioral health outcomes showed remarkable consistency across all three datasets (see Table 13). This pattern of consistent findings provides a robust foundation for understanding the behavioral health landscape in DC schools and reinforces the validity of conclusions drawn from analyzing the SSBH data regarding which student groups face the greatest challenges and where intervention efforts may be most needed.

Female, Latino, Multiracial, and LGBTQ students were more likely to report having behavioral health needs and less likely to report getting the help they need compared to male, Black, heterosexual, and cisgender students. White students were consistently less likely than Black students to report having a behavioral health need. LGBTQ+ students were consistently less likely than their heterosexual and cisgender peers to report having their behavioral health needs met, a relationship that was marginal for female students in two of the three analyses. Female, Latino, and Multiracial students were also consistently less likely to report having a trusted adult at school compared to male and Black students.

A notable difference in the findings is that White students were less likely to report having their behavioral health needs met in the SSBH survey compared to the YRBS. This important discrepancy may reflect differences in how the questions were framed or interpreted across surveys, with the SSBH specifically asking about behavioral health needs met "at school" while the YRBS question could have been interpreted more broadly to include supports outside of school. Research suggests that White students may be more likely to receive care outside of school, which could explain this difference.[24]

The findings regarding the impact of school behavioral health resources are promising but inconsistent. When controlling school characteristics, analysis of the YRBS data found that having

[24] Ali, M. M., West, K., Teich, J. L., Lynch, S., Mutter, R., & Dubenitz, J. (2019). Utilization of mental health services in educational setting by adolescents in the United States. *Journal of School Health*, *89*(5), 393-401.

more community partnerships was linked to lower odds of sadness/hopelessness, suggesting a protective effect. However, the SSBH analysis found no significant relationships between community partnerships and student outcomes. The relationship between behavioral health staffing and student outcomes also differed across datasets. Analysis of the YRBS showed a marginally negative relationship with getting help when experiencing emotional distress, while analysis of SSBH data showed a marginally positive relationship with having behavioral health needs met at school. As with the discrepancy described above in the odds of getting needs met among White students, it is important to recall that the SSBH question about getting needs met was specific to getting needs met at school whereas the YRBS question could be interpreted more broadly.

Table 13. Comparing race/ethnicity and time across datasets

	Trusted adult			Behavioral health need			Behavioral health need met		
Characteristic	**SSBH**	**YRBS**	**YRBS+**	**SSBH**	**YRBS**	**YRBS+**	**SSBH**	**YRBS**	**YRBS+**
Time (base year)	▼▲	▼▲	▲		▲			▼	
Race ethnicity (Black)									
Latino	▼	▼	▼	△	▲	▲	▼	▼	▼
White		▼		▼	▼	▼	▼	▲	▲
Multirac.	▼	▼	▼	△	▲	▲	▼		
Other	▽	▼							
AI/AN	-	▼		-			-		
Asian	-	▼	▼	-	▽	▽	-		
Nat Hawai/Othr. Pacific	-			-		△	-		
Sex (male)									
Female	▲	▲	▲	▲	▲	▲	▽		▽
Sexl. orientation (strght)									
LGBQ		▼		▲	▲	▲	▼	▼	▼
Gndr. identity (cisgnder)									
transgender	-	▼	▼	-	▲	▲	-	▼	▼
Grade level (Elementary)									
Middle	▼		▽	▼	-	-	▼	-	-
High	▼	▼			-	-	▼	-	-
Enroll. (< 301 students)									
301-600 students	▽	-	▽	▼	-			-	
> 601stdnts	▼	-	▼	▼	-		▼	-	
Truancy		-	▲	▼	-			-	▼
Behavioral health staff		-			-		△	-	▽
Community Partner		-			-	▼		-	

▲=OR >2.0 ▲=OR1.0-1.9 △= marginal positive
▼=OR<0.5 ▼=OR 0.5 – 0.99 ▽ = marginal negative

Full YRBS analysis

Table 14 provides a comprehensive summary of the relationships between student and school characteristics and student behavioral health outcomes, including odds ratios and the degree to which relationships were statistically significant.

Table 14. YRBS Student Outcomes: Relationships with Student and School Characteristics

	Met Need (high school)		Sad or Hopeless (high school)		Have Trusted Adult (middle and high)	
	YRBS	YRBS+	YRBS	YRBS+	YRBS	YRBS+
Sample size	21,517	12,133	35,712	18,815	60,423	34,736
School year						
SY16-17	*ref*	*n/a*	*ref*	*n/a*	*ref*	*n/a*
SY18-19	**0.89**	*n/a*	**1.37**	*n/a*	1.05	*n/a*
SY21-22	**0.77**	*ref*	**1.50**	*ref*	**0.77**	*ref*
SY23-24	**0.80**	0.95	**1.29**	0.94	*0.92**	**1.21**
Sex						
Male	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
Female	0.99	0.89*	**1.98**	**2.28**	**1.10**	**1.05**
Race/ethnicity						
Black	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
Latino	**0.85**	**0.75**	**1.22**	**1.18**	**0.64**	**0.67**
White	**2.24**	**2.06**	**0.75**	**0.73**	**0.90**	1.06
Amer. Indian/Alaska Nat.	1.44	0.49	1.09	1.08	**0.75**	0.91
Asian	1.02	0.89	*0.86**	0.81*	**0.65**	**0.68**
Nat. Hawai./Oth. Pac.Isl.	1.03	1.03	1.25	1.86*	0.91	1.18
Multiracial	1.08	0.98	**1.32**	**1.25**	**0.79**	**0.81**
Sexual orientation						
Heterosxl	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
LGBQ	**0.77**	**0.75**	**2.28**	**2.41**	**0.94**	0.96
Gender identity						
Cisgender	*ref*	*ref*	*ref*	*ref*	*ref*	*ref*
Transgender	**0.73**	**0.62**	**2.22**	**2.77**	**0.64**	**0.65**
Grade level						
High	n/a	n/a	n/a	n/a	*ref*	*ref*
Middle	n/a	n/a	n/a	n/a	**0.94**	0.94*
School size						
Enroll <301	n/a	*ref*	n/a	*ref*	n/a	*ref*
Enroll 301-600	n/a	1.11	n/a	1.04	n/a	0.91*
Enroll >600	n/a	1.14	n/a	1.03	n/a	**0.80**
% truancy[a]	n/a	**.58**	n/a	1.21	n/a	**1.17**
School bx health resources[b]						
# bx health staff	n/a	0.94*	n/a	1.01	n/a	0.98
# comm partners	n/a	1.01	n/a	**0.94**	n/a	1.03

Odds ratios are interpreted around 1, where odds ratios greater than 1 indicate higher odds and less than 1 indicate lower odds. "ref" indicates the reference group, which is the group that other groups are being compared to. **Bold** indicates significant Odds Ratios (p<=.05). * indicates marginally significant Odds Ratios (.05<p<=.10).

[a]Odds ratios for truancy should be interpreted as the predicted increase in the odds of experiencing the outcome per one percentage point increase in truancy rate.

[b]Odds ratios for school behavioral health items should be interpreted as the predicted increase in the odds of experiencing the outcome per additional support staff or community partner.

Beyond the Numbers: Student and Caregiver Voices on School Behavioral Health

KEY TAKEAWAYS

All school staff have a role to play in supporting behavioral health. Students consistently identified teachers as their primary support resource; yet they simultaneously expressed a desire for more trained behavioral health professionals to address deeper mental health concerns. This highlights the importance of equipping all school staff with mental health literacy skills while also focusing on behavioral health staffing.

Behavioral health awareness has improved, but access barriers persist. Schools have made substantial progress in promoting behavioral health awareness and reducing stigma. However, awareness alone doesn't solve access challenges. Students continue to express reluctance to use available services when they lack personal connections with providers, emphasizing that knowledge of resources must be coupled with relationship-building to be effective.

Reactive support systems need to evolve toward more proactive, preventive approaches. Schools have established reasonably effective systems for responding when students actively seek help. However, students and families consistently request more proactive approaches, such as regular behavioral health check-ins for all students— not just those visibly struggling.

The quantitative analyses presented throughout this report provide a data-driven understanding of how school behavioral health systems have functioned across DC schools over the past four years. These analyses reveal important patterns about student outcomes, help-seeking behaviors, and disparities among different demographic groups—showing that while some outcomes have remained stable, others suggest concerning trends. To complement these statistical findings and provide a more nuanced understanding of the lived experiences behind the numbers, we conducted an analysis of open-ended responses from students and caregivers across all four survey years.

This qualitative analysis illuminates the human context of our quantitative findings, offering rich insights into how behavioral health supports are perceived by those they are designed to serve. For example, while our statistical analyses revealed that students consistently report teachers as their primary source of support— ahead of behavioral health professionals— the qualitative data helps explain why, highlighting the critical importance of established relationships and trust in help-seeking behaviors. Similarly, where quantitative data showed improvements in mental health literacy and awareness over time, the qualitative insights clarify that awareness alone does not translate to access without accompanying structural supports and relationship-building.

The themes that emerged from student and caregiver responses align with and extend our statistical findings, revealing a developmental progression in how school communities understand behavioral health. This progression moves from basic awareness toward more sophisticated integration of behavioral health considerations throughout educational settings. The following thematic analysis explores six key patterns identified across four years of qualitative data, providing crucial context for understanding how behavioral health systems have evolved and identifying opportunities for future development to better serve the diverse needs of students in DC schools.

Dual Focus on Increasing Staff Capacity

The most striking contrast appears in how school staff are perceived. Throughout all four years, both students and caregivers referenced the availability of trusted adults and the quality of relationships with school staff, praising their caring, supportive attitudes and approachability. However, when it comes to more serious mental and behavioral health challenges, there was a persistent call for more trained behavioral health professionals. This suggests that while individual staff members may be perceived as supportive, there is a gap in adequate staffing when it comes to behavioral health professionals to meet the level of need.

For instance, a student noted how teachers "listen and hear the students out," while caregivers simultaneously reported that "there are not nearly enough counselors for the number of students and the amount of trauma that needs to be addressed." This contrast underscores that while general emotional support is accessible, schools may not have enough specialized professionals to address deeper, more complex behavioral health concerns.

Evolutionary Success: Awareness of Resources

Particularly interesting is how awareness of available resources appeared as both a challenge and a success over time. In earlier survey years, lack of resource awareness was frequently cited as a major improvement area. By SY 2023-24, this had shifted to become recognized as a strength, suggesting that schools had made meaningful progress in this specific domain. This evolution demonstrates that persistent focus on an identified weakness can transform it into a strength over time. It also provides an encouraging model for how other identified improvement areas might similarly evolve with dedicated attention.

Awareness Is Necessary but Not Sufficient

Another revealing pattern emerges when looking at mental health awareness efforts. Student and caregiver responses over time suggest that schools have made progress in promoting awareness about behavioral health issues, reducing stigma, and normalizing help-seeking behaviors. By SY 2023-24, students were specifically highlighting how "mental health is very advertised" with resources like QR codes on posters.

However, awareness alone wasn't sufficient. While students and families became more knowledgeable about mental health concepts, they continued to express frustration about the practical aspects of accessing services. Some students also shared that they were unlikely to seek support from a behavioral health professional at school—not because they were unaware of resources, but because they felt disconnected from the counselors themselves. As one student explained, “I don’t think I would feel comfortable talking to a mental health counselor at my school because I don’t know any of them. I know who they are, but they are also strangers.” This disconnect shows that raising awareness is only the first step; fostering familiarity and trust, and ensuring ease of access, represents a more challenging implementation hurdle.

Reactive Versus Proactive Approaches

Responses reveal that schools have been generally successful at responding when students actively seek help. However, a consistent theme in suggestions was the need for more proactive

approaches. Both students and caregivers repeatedly requested regular mental health check-ins for all students, not just those who were visibly struggling or who sought help themselves.

This contrast highlights a fundamental shift in thinking about mental health support—moving from a model where support is activated when problems become visible to one where regular check-ins might catch issues earlier or prevent them altogether. A student's suggestion to "check in with people even if they never or don't have problems" perfectly captures this desired shift toward prevention rather than intervention.

The Communication Continuum

Family communication represents another area with both successes and challenges. Caregivers appreciated when schools communicated effectively about available services and their children's needs. However, by SY 2023-24, some caregivers were discussing "a need for improved communication and follow-through on parental requests for support," citing instances where their concerns weren't adequately addressed.

This suggests that while basic communication frameworks exist, the quality and consistency of communication remains variable, particularly when it involves coordinating support for specific students rather than general information sharing.

New Dimensions of Understanding

By SY 2023-24, both the successes and opportunities for improvement had evolved to include more sophisticated and nuanced aspects of behavioral health support. For instance, students appreciated the confidentiality of services provided. They also raised concerns about how academic pressures contribute to behavioral health challenges. Caregivers requested more teacher training on behavioral health issues.

This reflects an evolution in how school communities understand and approach behavioral health—moving from basic awareness and support structures toward a more comprehensive integration of behavioral health considerations throughout the educational experience.

This developmental pattern provides valuable guidance for schools, suggesting that behavioral health support systems need to continuously evolve rather than reaching a static "solved" state. As foundational needs are met, new layers of understanding and support become necessary to address the full spectrum of student behavioral health needs.

Recommendations: A Blueprint for Strengthening School Behavioral Health Systems

KEY TAKEAWAYS

Effective cross-sector collaboration requires formalized structure. The recommendations call for a comprehensive, written strategic plan that coordinates efforts across education, health, and behavioral health sectors. A cohesive plan would establish a unified vision, align resources, ensure consistent messaging about available services, and prevent duplication of efforts across DC schools.

Data systems must evolve from collection to action-oriented improvement. While significant progress has been made in gathering data, the recommendations emphasize establishing formalized continuous quality improvement structures with dedicated staff time and regular review cycles to facilitate identification of implementation gaps and drive strategic adjustments to improve service delivery and outcomes at citywide and school levels.

Student and family engagement must include authentic partnership in decision-making. Citywide and school planning teams need clear protocols for meaningfully engaging students and families, with accessible meeting structures and formal feedback loops that demonstrate responsiveness to community input. Representation should reflect the demographic diversity of school communities and move beyond tokenistic inclusion to genuine shared decision-making.

Provider integration and staff wellness are critical to achieving student outcomes. Since students are likely to seek help from teachers before behavioral health specialists, intentional strategies to equip teachers with behavioral health literacy while also building trust and integrating providers into the school community are essential. Simultaneously, comprehensive staff wellness initiatives must address the high levels of stress and exhaustion reported by school personnel.

The following recommendations represent a comprehensive framework for enhancing behavioral health supports within DC's educational system, informed by extensive analysis of data collected from students, caregivers, school staff, and administrative sources. The system-level recommendations focus on establishing cross-sector coordination, enhancing data-driven decision-making processes, engaging students and families authentically in governance, creating dedicated behavioral health coordination positions, and developing targeted professional development opportunities. Complementary school-level recommendations emphasize strategies for meaningful student and family engagement, integration of behavioral health providers within the school community, enhancement of mental health literacy, utilization of data to customize interventions for diverse student populations, and implementation of comprehensive staff wellness initiatives. Together, these recommendations provide a blueprint for a more responsive, equitable, and effective behavioral health support system that acknowledges the interconnected nature of education, health, and behavioral health domains while prioritizing the diverse needs of the DC's student population.

System-level recommendations

1. Establish a Formalized Cross-Sector Strategic Plan

The Coordinating Council on School Behavioral Health should develop a comprehensive, written strategic plan that articulates cross-sector collaboration to promote behavioral health among students, caregivers, and school staff. This plan should delineate the specific contributions of government agencies and community partners across the education, health, and behavioral health sectors.

While DBH has assumed a leadership role in managing the expansion of school-based behavioral health, the implementation of multi-tiered systems of support requires coordination across multiple domains. For example, OSSE has established the ARROW program addressing workforce pipelines and professional development, along with the Youth Mental Health Ambassador initiative that now includes public charter schools. OSSE has also implemented new social and emotional learning standards and the DC SAYS school climate survey for the 2024-25 academic year. DCPS has launched Youth Mental Health Ambassadors in all high schools and maintains a comprehensive public-facing website with mental health resources. DC Health facilitates connections to health services for students in over 200 schools through the School Health Services Program, with seven school-based health centers operating in the DC.

A cohesive, cross-sector implementation and communication plan would strengthen the integration of behavioral health supports within educational settings and ensure consistent, city-wide messaging regarding available resources. Such collaborative planning is essential for establishing a unified vision, aligning policies and resources across sectors, and ensuring that professional development initiatives are complementary rather than duplicative.

2. Enhance Continuous Quality Improvement Infrastructure

DBH should build upon recent advancements in continuous quality improvement (CQI) processes by establishing formalized structures to support data-driven decision-making. Effective utilization of data requires a designated team that convenes regularly to analyze information and inform strategic decisions. DBH should establish a timeline by which at least one staff member has a clearly defined CQI role incorporated into their formal job description, with appropriate time allocation for these functions. Assigning CQI responsibilities to staff with already substantial workloads will inevitably result in these activities being superseded by more urgent matters.

Staff should continue to engage in a systematic CQI cycle that includes: data collection from multiple sources — such as provider activity tracker, Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), and principal satisfaction surveys; centralized data management; comprehensive analysis; stakeholder review to determine strategic responses; and implementation monitoring. Monthly review sessions would be optimal for identifying and implementing necessary adjustments, with quarterly presentations to the Coordinating Council for broader oversight.

The consistent collection and review of CAFAS/PECFAS data is particularly critical as these instruments provide essential information regarding student outcomes. Given that CAFAS

represents a relatively recent addition to many clinicians' assessment protocols, DBH should implement regular reporting mechanisms to identify providers who are not utilizing these instruments as expected and address any implementation barriers through targeted supervision and additional training.

3. Implement Authentic Engagement Strategies for Students and Families

DBH, in consultation with the Coordinating Council, should establish clear protocols and expectations regarding the involvement of students and caregivers in planning and evaluation processes. Current data indicates minimal engagement of these stakeholders in behavioral health programming. School teams should be required to document their methodologies for assessing student and caregiver needs, with particular emphasis on processes that authentically center student and caregiver perspectives. Documentation should also reflect the composition of planning teams and the specific roles of student and caregiver representatives— whether in advisory capacities or positions with decision-making authority.

Following the establishment of engagement expectations, DBH should implement systematic monitoring procedures to assess progress and provide targeted support. This might include collaborative reviews of school-specific data with community-based organization representatives, DBH supervisors, and school leadership to identify appropriate interventions for teams not meeting engagement standards. DBH should promote cross-sector collaboration within school teams to ensure coordinated efforts across education, health, and behavioral health domains. Recognition of schools demonstrating exemplary engagement practices could serve to highlight effective strategies and acknowledge successful implementation.

The Coordinating Council should restructure its operations to more effectively incorporate student and family perspectives in governance processes. Current representation is constrained by meeting schedules that conflict with school hours, creating barriers to participation for students and working parents without flexible schedules. Potential modifications include scheduling meetings during non-school hours, implementing hybrid attendance options, and selecting meeting locations accessible via public transportation. Rotating meeting locations throughout DC could enhance community participation and highlight local youth and family-serving programs. The Coordinating Council might also consider establishing formal relationships with existing youth advisory bodies, such as DC Health's Youth Advisory Council, to more effectively integrate youth perspectives in policy development.

4. Advocate for the Establishment of Dedicated School Behavioral Health Coordinator Positions

The Coordinating Council should conduct a comprehensive assessment of the potential benefits associated with establishing dedicated School Behavioral Health Coordinator (SBHC) positions in each educational setting. Research increasingly demonstrates the critical importance of coordination functions in establishing and sustaining effective multi-tiered behavioral health supports. Current data indicates approximately half of SBHCs allocate two hours or less per week to coordination functions, while one in five dedicate five or more hours to these responsibilities.

A dedicated coordinator would be responsible for articulating a shared vision for school behavioral health, establishing and communicating clear objectives, facilitating the development and implementation of a comprehensive, multi-tiered support plan, assessing and addressing staff mental health literacy, ensuring systematic data collection across all intervention tiers, managing community-based organization partnerships, coordinating additional community resources, maintaining communication with all stakeholders, establishing consistent referral protocols, and integrating related support services such as homeless liaison functions and special education services.

Given the variability in school configurations, student needs, and existing staffing structures across DC, differentiated staffing models may be appropriate, with some schools requiring multiple coordinators while others might function effectively with part-time positions. The implementation committee of the Coordinating Council could be tasked with examining the operational implications and resource requirements associated with establishing dedicated coordinator positions.

5. Develop Targeted Professional Development to Address Diverse Student Needs

DBH and the Coordinating Council should establish a coordinated professional development framework that equips school teams and behavioral health providers with the competencies required to address the needs of diverse student populations. Current outcome data reveals significant disparities among specific demographic groups. Female students and those identifying as LGBQ report behavioral health needs at nearly 2.5 times the rate of their male or heterosexual peers, respectively. Secondary school students demonstrate lower levels of school connectedness but more positive attitudes toward mental health compared to elementary school students.

These differential patterns necessitate tailored approaches that align with the specific characteristics of each school community. With the conclusion of DBH funding for the DCCoP, strategic coordination of professional development resources becomes increasingly important to ensure the comprehensive preparation of all behavioral health professionals. Given the diversity of providers, both in terms of professional preparation and institutional affiliation, DBH and the Coordinating Council are uniquely positioned to ensure that professional development investments across DC are aligned with the needs of diverse student populations.

School-Level Recommendations

1. Implement Authentic Engagement Strategies with Students and Families

School behavioral health teams should establish formalized mechanisms for including students, families, and community partners in decision-making processes. The National Center for Safe and Supportive Learning Environments[25] recommends multiple engagement strategies, including partnering with trusted community organizations, conducting student interviews and focus groups,

[25] https://safesupportivelearning.ed.gov/sites/default/files/13-ImpSchMnHlthSprtBtPrt-508_0.pdf

establishing caregiver advisory groups, and ensuring representation that reflects the demographic diversity of the school community.

School teams should develop comprehensive engagement plans that employ multiple complementary approaches. Critically, teams must establish feedback loops that demonstrate responsiveness to community input, including periodic updates to stakeholders regarding behavioral health initiatives and opportunities for ongoing dialogue. These updates should explicitly address how community feedback has been incorporated into programming decisions, creating transparency in the decision-making process.

The DBH and the Coordinating Council can support these efforts by providing high-quality professional development opportunities focused on authentic partnership strategies with students and caregivers, particularly for SBHCs and other team members responsible for engagement activities.

2. Advance Integration of Behavioral Health Providers within the School Community

School teams should implement strategic approaches to enhance the integration of behavioral health providers into the broader school community. Current survey data indicate students are more likely to discuss behavioral health concerns with teachers than with specialized behavioral health professionals. Analysis of open-ended student responses consistently highlight the primacy of relationships and trust in help-seeking decisions, suggesting that awareness of available services, while necessary, is insufficient to ensure utilization.

Given the diversity of school contexts, integration strategies must be tailored to specific community characteristics rather than implemented as universal protocols. DBH, in collaboration with the Coordinating Council, could facilitate the identification of exemplary integration practices through a formal recognition program. This initiative might include nominations from students, families, and school personnel, followed by structured interviews with identified providers to document effective practices. These interviews could be developed into multimedia resources or practice guides for dissemination across DC, with materials available in multiple languages to ensure accessibility.

It is essential to recognize that effective integration requires both capacity-building for individual providers and systematic efforts to address structural barriers. The DBH and the Coordinating Council should convene a working group comprising diverse stakeholders—including school administrators, providers, clinical supervisors, and community representatives—to identify and address systemic obstacles to integration. This analysis must include consideration of funding mechanisms that influence provider activities, acknowledging the differing expectations regarding billable services that exist between school-employed providers and those affiliated with community-based organizations.

3. Enhance Mental Health Literacy Among All School Stakeholders

School teams should implement comprehensive mental health literacy interventions for students, families, and school personnel to address knowledge gaps and attitudinal barriers that impede service utilization. Analysis of student survey responses reveals significant concerns regarding

confidentiality and provider trustworthiness, alongside recognition of mandatory reporting requirements for safety concerns, indicating an opportunity for educational intervention.

Mental health literacy encompasses multiple dimensions beyond service awareness, including the ability to recognize psychological distress, knowledge of risk factors and self-help strategies, understanding of available professional resources, attitudes that support help-seeking, and practical knowledge of how to access formal supports. School-based interventions should address all components of this framework, with particular emphasis on clarifying confidentiality parameters and developing help-seeking competencies.

Educational materials and programming should be culturally and linguistically appropriate, particularly for family-focused initiatives, to ensure relevance across diverse community contexts. By enhancing mental health literacy, schools can transition from simply raising awareness about available services to developing the knowledge, attitudes, and skills necessary for appropriate service utilization.

4. Utilize Data-Driven Approaches to Tailor Behavioral Health Supports

School behavioral health teams should develop competencies in data analysis and interpretation to ensure that programming addresses the specific needs of their unique school communities. Student outcome data demonstrates significant variation across demographic categories including gender, sexual orientation, age, and racial/ethnic identification, necessitating tailored intervention approaches rather than universal programming.

Teams should systematically review school-specific data while engaging with students, caregivers, and staff to identify populations experiencing disproportionate needs or access barriers. This analysis should include examination of referral patterns to detect potential under-representation or over-representation of specific demographic groups. Treatment outcome data, including CAFAS and PECFAS metrics, should be disaggregated to determine differential response patterns across student populations.

For groups experiencing elevated barriers or disparate outcomes, school teams should develop targeted intervention plans with specific, measurable objectives to assess progress. Additional data sources, including the newly implemented DC SAYS school climate surveys, chronic absenteeism statistics, and discipline referral patterns, can provide complementary insights when disaggregated by relevant demographic variables.

Professional development priorities for school behavioral health teams should align with identified population needs. Given that female and LGBTQ students report elevated behavioral health needs, teams should ensure adequate capacity in evidence-based approaches that have demonstrated effectiveness for these populations. Similarly, schools serving significant immigrant populations should prioritize training in culturally responsive practices for these communities and in hiring staff who can provide support in languages that are most spoken by students and their families. This principle extends to clinical needs, with professional development investments matched to prevalent presenting concerns as indicated by assessment data.

5. Develop Comprehensive Staff Wellness Initiatives

School leadership, in collaboration with behavioral health teams, should implement structured approaches to promote employee wellness as a foundational element of school climate. Staff survey data indicates high levels of stress and exhaustion, with nearly half of respondents expressing dissatisfaction with current wellness supports.

The U.S. Surgeon General's Framework for Mental and Emotional Well-Being at Work[26] emphasizes the multidimensional nature of workplace wellness. The Office of the State Superintendent of Education's Educator Wellness model[27] further delineates four critical domains: school environment and structure, job demands, work resources, and social-emotional learning competencies. While behavioral health providers can contribute significantly to enhancing staff social-emotional competencies and fostering positive school environments through Tier 1 interventions, addressing job demands and resource allocation requires administrative leadership.

School administrators should establish representative wellness committees that include diverse staff roles to ensure wellness initiatives respond to the specific needs of all employee groups and promote equitable well-being outcomes. Several systemic resources are available to support these efforts, including the Office of the State Superintendent of Education's Blueprint for a Whole School Approach to Educator Wellness[28] and resources compiled by the DC CoP through its teacher wellness practice group.[29]

[26] https://www.hhs.gov/surgeongeneral/reports-and-publications/workplace-well-being/index.html

[27] https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/WNS_ApproachToEdWell_graphics%20final%20%281%29.pdf

[28] https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/Blueprint%20Approach%20to%20Educator%20Wellness.pdf

[29] https://chhcs.padlet.org/chhcs1/teacher-wellness-working-group-cr8tpof69qm8grtc

Conclusion: Sustaining Momentum for an Equitable and Effective School Behavioral Health System

KEY TAKEAWAYS

COVID-19 pandemic effects are inseparable from program impacts. The pandemic fundamentally altered school operations, service delivery models, and likely student behavioral health needs in ways that cannot be cleanly separated from the effects of the expansion itself.

Persistent staffing shortages and implementation measurement gaps likely underestimate potential program benefits. With staffing levels consistently near 60 percent of allocated positions, many schools operated with incomplete behavioral health teams during the evaluation period. As a result of widespread vacancies, combined with the limitation of using proxy measures for implementation quality (rather than direct fidelity assessments), the evaluation may not capture the full potential impact of the expansion as designed.

SSBH and YRBS surveys bring unique strengths but also require nuanced interpretation. While SSBH surveys collected information on a range of school behavioral health experiences, administration relied on voluntary participation, creating an unbalanced dataset that may not represent all student experiences. The YRBS is restricted to middle and high schools and does not ask specifically about school-based behavioral health supports, but it includes multiple years of data with a robust sample size. In combination, these surveys provide a rich and nuanced understanding of school behavioral health experiences and outcomes.

Starting in the 2018-19 school year, DBH quickly scaled up an initiative to increase access to behavioral health supports in schools across the city. Keeping this complex program going during COVID-19 is a testament to the dedication of city leaders, teachers, school behavioral health staff, community partners, parents, and students.

However, some groups of students still face bigger challenges, especially girls and LGBTQ students. Addressing these persistent disparities will require efforts to ensure students and families have a real voice in decisions—both in DC government and in individual schools.

Finding and keeping qualified staff remains difficult. As DC tries new approaches to behavioral health staffing in schools, it is necessary to carefully track whether these changes help students and families, particularly those from communities that have historically been poorly served by education and behavioral health systems. To do this tracking well, better data systems are needed at both the city and school levels, which will require more resources and attention.

For lasting success, everyone—students, parents, and school leaders—needs to see behavioral health supports as an essential part of how schools work, not just an extra program. If DC wants to remain a national leader in school behavioral health, District leaders must strengthen their commitment to true partnerships with students and families so that every school has the behavioral health supports needed for all students to thrive.

Evaluation limitations

Several important limitations should be considered when interpreting the findings from this evaluation of the DC's school behavioral health expansion initiative.

First, the data collection approach relied on voluntary participation from schools and individuals within those schools, resulting in sample limitations. The uneven participation across schools and years created an unbalanced dataset that may not fully represent the diversity of experiences across DC. Additionally, the student survey sample showed some demographic differences compared to overall enrollment data, with fewer White and Hispanic students and more Multiracial students than in the overall student population.

Second, survey modifications over time created challenges for longitudinal analysis. Key measures such as those related to student behavioral health needs and help-seeking were revised in the third year, making direct year-to-year comparisons difficult for these important outcomes. While these changes improved measurement clarity and relevance, they limited our ability to assess change in these areas across all years.

Third, the COVID-19 pandemic significantly impacted both the implementation of school behavioral health services and our evaluation efforts. The pandemic disrupted school operations, shifted service delivery models, and likely affected student behavioral health needs and help-seeking behaviors in ways that are difficult to disentangle from the effects of the expansion itself. The first survey administration occurred shortly after schools reopened for in-person learning following pandemic closures, potentially affecting response patterns. Given the unique circumstances, data from the first evaluation year were excluded from analysis.

Fourth, persistent staffing challenges and vacancies in school-based behavioral health positions limited our ability to assess the full potential impact of the expansion. With staffing levels generally hovering around 60percent of allocated positions, many schools operated with incomplete behavioral health teams or experienced high turnover, making it difficult to attribute outcomes to the expansion as planned.

Finally, while we incorporated school characteristic data to examine contextual factors, our measures of expansion implementation were limited. School Health Profile data related to overall behavioral health staffing and community partnerships to provide behavioral health services, which may not be related to the expansion, were used in lieu of CBO clinician data given the challenge of tracking staffing over time. Additionally, the complexity of capturing implementation quality rather than just presence of services means that our analysis may not fully capture the relationship between implementation fidelity and student outcomes.

Despite these limitations, the consistency of findings across multiple data sources (e.g., SSBH and YRBS surveys) and the comprehensive inclusion of stakeholder perspectives (i.e., students, families, staff, and School Behavioral Health Coordinators) strengthen the validity of the key findings and implications presented in this report.

Appendix A. Data Tables (SY 2020-21 through SY 2023-24)

School Year 2020-2021

Student Survey

Question	Total responses	Not at all	A little bit	Somewhat	Quite a bit	Completely	I prefer not to answer
Overall, how much do you feel like you belong at your school?	4122	3%	7%	18%	28%	38%	5%

Question	Total responses	Not at all	A little bit	Somewhat	Very	I prefer not to answer
Do you think it is embarrassing to have a mental/behavioral health challenge?	3990	58%	22%	7%	4%	9%

Question	Total responses	Definitely Yes	Probably Yes	Probably No	Definitely No	I prefer not to answer
Would kids at your school make fun of someone who sees a therapist or counselor about a mental/behavioral health challenge?	3989	5%	20%	41%	26%	8%
Would you feel comfortable talking to a therapist or counselor at school if you had a mental/behavioral health challenge?	3990	25%	37%	18%	13%	8%
Would you feel comfortable talking to a therapist or counselor outside of school of school if you had a mental/behavioral health challenge?	3990	30%	39%	14%	10%	7%

Question	Total responses	Yes	No	I prefer not to answer
Is there a teacher or some other adult at your school who you would feel comfortable talking to if you had a problem?	4121	73%	17%	10%

Question	Total responses	Yes	No	Maybe/Not sure	I prefer not to answer
If you needed help with a mental/behavioral health challenge, do you know who to go to in order to get help?	3873	55%	11%	30%	4%
If you needed help with a mental/behavioral health challenge at school, do you know who to go to in order to get help?	3873	49%	17%	29%	5%
Does your school have a therapist or counselor?	3873	56%	4%	2%	38%

Who do you usually go to about problems when you are upset?	Number of respondents
Teacher at school	1297
A cafeteria/food service worker at school	61
A cleaning/custodian worker at school	36
A club or sports coach at school	201
A close family member	1872
A friend	1862
Someone not listed here	416
I do not go to anyone about problems or when I'm upset	936
I prefer not to answer	222

Question	Total responses	Yes	No	I prefer not to answer
Was there any time you had a mental/behavioral health challenge but didn't get the help you needed?	3869	21%	62%	18%

Why did you not get the help you needed?	Number of respondents
I thought the problem would get better by itself	414
I did not want anyone to know I was having a problem	410
I did not know where to get help	105
I didn't think counseling would help	136
People in my family didn't think counseling would help	51
I went to counseling before and it did not work	84
I had trouble getting to my counseling sessions	27
I could not get an appointment	20
Other	85
I prefer not to answer	1467

Please list anything you do to make yourself feel better when you are feeling scared, angry, or sad.	Number of respondents
Talk with a close adult family member	1467
Spend time with my friends to get my mind off of whatever is bothering me	1811
Talk with my friends, or with a family member around my age (e.g., sibling/cousin), about whatever is bothering me	1554
Talk with a teacher or another adult at school that I trust	739
Go somewhere to calm down, cool off, take a break, or relax (e.g., my bedroom, bathroom, somewhere at school)	1985
Do breathing exercises (e.g., take deep breaths) or calming exercises (e.g., think of things that make me happy)	685
Play sports, dance, exercise, or do another activity where I move around	1152
Listen to music	2320
Watch TV/videos, play video games, or get on social media	2155
Sleep	1858
Cry	1173
Read, draw, or write/journal	1239
Something not listed here	180
Nothing makes me feel better when I am feeling scared, angry, or sad	74
I prefer not to answer	153

Family Survey

Question	Total responses	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	I prefer not to answer
I feel welcome at my child's school.	1346	75%	20%	2%	2%	2%
I feel comfortable talking to someone at my child's school about my child's behavior.	1346	72%	22%	2%	3%	2%
Having a mental health disorder is nothing to be ashamed of.	1288	84%	9%	2%	3%	3%
People with mental health disorders scare me.	1288	4%	9%	20%	62%	5%
People with mental health disorders are dangerous.	1288	3%	16%	32%	42%	7%

Question	Total responses	Definitely Yes	Probably Yes	Probably No	Definitely No	I prefer not to answer
I would want to see a therapist or counselor for help if I were sad, worried, or upset for a long period of time.	1288	59%	29%	6%	3%	4%
I would want my child to see a therapist or counselor for help if they were sad, worried, or upset for a long period of time.	1287	74%	20%	2%	3%	2%
If you needed help with a mental/behavioral health challenge, do you know where to get help?	1262	58%	28%	9%	4%	1%
If your child needed help with a mental/behavioral health challenge, do you know where to get help?	1261	59%	28%	8%	4%	1%
If your child needed help with a mental/behavioral health challenge at school, do you know who to contact for help?	1261	47%	30%	15%	7%	1%

Question	Total responses	Yes	No	I don't know	I prefer not to answer
Does your child's school have a therapist or counselor?	1261	60%	13%	27%	1%

Question	Total responses	Yes	No	I prefer not to answer
Was there any time you had a mental/behavioral health challenge but didn't get the help you needed?	1261	20%	74%	6%

What was the reason that you did not get the help you needed?	Number of Respondents
I thought the problem would get better by itself	113
I did not want anyone to know I was having a problem	55
I did not know where to get help	59
I didn't think counseling would help	47
People in my family didn't think counseling would help	20
I went to counseling before and it did not work	34
I had trouble getting to my counseling sessions	18
I could not get an appointment	41
Other (e.g., insurance, metro fare, childcare)	51
I prefer not to answer	7

Question	Total responses	Yes	No	I prefer not to answer
Was there any time your child had a mental/behavioral health challenge but didn't get the help they needed?	1261	12%	84%	4%
What was the reason that your child did not get the help needed?			Number of Respondents	
I thought my child's problem would get better by itself			27	
I did not want anyone to know my child was having a problem			1	
I did not know where to get help for my child			41	
I didn't think counseling would help my child			3	
My child did not think counseling would help			25	
People in my family didn't think counseling would help my child			6	
My child went to counseling before and it did not work			20	
I had trouble getting my child to counseling sessions			28	
I could not get an appointment for my child			30	
Other (e.g., insurance, metro fare, childcare)			41	
I prefer not to answer			8	

Staff Survey

Question	Total responses	Strongly disagree	Disagree	Agree	Strongly agree	Don't know	My school does not provide this
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.	1970	4%	7%	50%	31%	7%	1%
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.	1971	4%	11%	49%	27%	9%	1%
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.	1968	4%	11%	44%	26%	14%	1%
Please indicate how often you felt the following emotions at work during the past week.	Total responses	Almost never	Once in a while	Sometimes	Frequently	Almost always	Don't know
Engaged	1886	1%	4%	16%	36%	41%	1%
Exhausted	1890	6%	15%	31%	29%	19%	1%
Hopeful	1890	2%	9%	25%	33%	30%	1%
Stressed out	1882	10%	22%	28%	23%	15%	1%

What kinds of services/supports, if any, are available at your school to promote staff wellness?	Number of respondents
Wellness days off	673
Themed wellness challenges (e.g., water challenge, sleep challenge)	425
Counseling or one-on-one support from school-based mental/behavioral health staff	572
School leadership communicates and/or models the importance of wellness	939
Peers/colleagues check in with one another to provide support	1128
Regular wellness check-ins, either by school leadership or mental/behavioral health	629
Scheduling enhancements (e.g., intentional breaks, shorter days)	474
Self-care strategies are taught, facilitated, or otherwise promoted (e.g., journaling, mindfulness, yoga)	1085
My school does not provide staff wellness supports	98
Other	56

Question	Total responses	Yes	No
Have you participated in any of the services/supports offered at your school that promote staff wellness?	1898	71%	29%

Please indicate how much you agree with each of the following statements about services/supports that promote staff wellness at your school.	Total responses	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
I think the services/supports offered at my school to promote staff wellness are relevant to the needs of our school staff	1883	5%	17%	50%	19%	9%
I think the services/supports offered at my school to promote staff wellness are adequate	1884	7%	26%	44%	15%	8%
Question	Total responses	Not at all	Slightly	Somewhat	Quite	Extremely
Overall, how positive is the working environment at your school?	1815	3%	11%	25%	46%	15%
How supportive are students in their interactions with each other?	1815	1%	8%	35%	47%	10%
How respectful are the relationships between teachers/school staff and students?	1815	0%	4%	20%	56%	19%
Please indicate how much you agree with each of the following statements about your knowledge, attitude, and skills related to behavioral health.	Total responses	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
My school provides me with adequate professional development opportunities or trainings to increase my understanding of student behavioral health (e.g., to help staff recognize the signs/symptoms of behavioral health issues).	1813	3%	16%	52%	26%	3%
I think non-clinical staff (e.g., teachers) play an important role in identifying and/or referring students with behavioral health problems.	1813	1%	3%	39%	55%	2%
I can identify warning signs or symptoms of behavioral health problems in students (e.g., depression, anxiety, trauma, eating disorder).	1812	1%	5%	58%	33%	4%
I feel knowledgeable about the behavioral health services/supports available at my school.	1811	2%	15%	53%	27%	3%

Please indicate how much you agree with each of the following statements	Total responses	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
I know how to refer a student for behavioral health services/supports at my school.	1811	1%	8%	51%	37%	4%
I have a good working relationship with a mental health clinician at our school.	1813	2%	9%	43%	40%	6%
I value having behavioral health services/supports available at my school.	1813	1%	2%	36%	58%	3%
The behavioral health services/supports available at my school are relevant to the needs of our students.	1812	1%	7%	51%	33%	8%
The behavioral health services/supports available at my school are culturally/linguistically responsive and appropriate.	1812	2%	9%	50%	28%	12%
Students at my school are aware of the behavioral health services/supports available to them.	1812	2%	15%	44%	19%	20%
Families at my school are aware of the behavioral health services/supports available to support their children.	1811	2%	14%	46%	18%	20%
Students at my school can easily access the behavioral health services/supports available to them, if they choose to do so.	1811	2%	10%	48%	24%	16%
Families at my school can easily access the behavioral health services/supports available to support their children, if they choose to do so.	1811	2%	10%	47%	23%	17%
Students at my school utilize the behavioral health services/supports available to them, when needed.	1812	2%	12%	48%	18%	20%
Families at my school utilize the behavioral health services/supports available to support their children, when needed.	1811	2%	13%	45%	17%	24%
Students at my school are satisfied with the behavioral health services/supports available to them.	1810	1%	6%	38%	16%	38%
Families at my school are satisfied with the behavioral health services/supports available to support their children.	1810	1%	5%	38%	16%	39%

Question	Total responses	Never	Once	2-5 times	6-10 times	More than 10 times
In the PREVIOUS school year, how many times did you refer students to behavioral health services/supports at your school?	1802	38%	15%	37%	6%	4%
Question	Total responses	Not at all	Slightly	Somewhat	Quite	Extremely
How satisfied are you with the services/supports you have used?	1343	3%	13%	33%	40%	12%
Since the student(s) started receiving behavioral health services/supports...	Total responses	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
They have had a decrease in behavioral incidents.	1121	2%	13%	54%	12%	20%
They have experienced reduced behavioral health symptoms.	1121	2%	12%	54%	12%	21%
They have demonstrated increased coping skills.	1121	2%	12%	54%	14%	18%
They are more connected to the school community (teachers, students, other staff).	1121	2%	10%	54%	15%	18%

SBHC Survey

Question	Total Responses	Administrator	Behavioral health professional	Other
What is your current position at your school, aside from your role as the school behavioral health coordinator?	107	12%	63%	25%

Question	Total Responses	Less than 3 years	3 to 5 years	6 to 10 years	More than 10
How long have you been at your current school?	107	36%	31%	22%	11%

Question	Total Responses	We are just getting started, or don't have a plan yet	Our plan is currently in development	We have a fully developed plan (although it may be revised later)	I don't know
Which of the following statements best characterizes your school's plan for providing a full array of behavioral health services and supports to meet the needs of your school community? Please remember that we are NOT evaluating your school, so please answer as honestly as you can.	106	3%	28%	69%	0%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
Our plan adequately addresses the needs at our school.	102	2%	10%	59%	29%	0%
Our plan adequately addresses the resources at our school.	101	2%	8%	65%	25%	0%
We are following the plan.	103	2%	10%	68%	18%	2%

Based on your knowledge, please indicate how involved each group was with developing your school's plan.						
Question	Total Responses	Actively involved in a decision-making role	Involved, but not in a decision-making role	Not involved		Don't Know
Students	102	3%	41%	54%		2%
Families	102	17%	42%	38%		3%
Classroom teachers	102	27%	45%	25%		3%
Principal/head of school	102	69%	21%	10%		1%
Other school administrators	102	68%	15%	17%		1%
School behavioral health professionals	101	95%	3%	1%		2%
School health professionals	101	50%	15%	33%		3%
Community partners	102	63%	14%	20%		4%
Question		Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	NA – My school does not provide this
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.		104	3%	12%	45%	40%	0%
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.		104	1%	17%	54%	28%	0%
Question Cont.		Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.		105	2%	7%	43%	48%	1%
My school offers ADEQUATE services/supports that promote staff wellness.		105	2%	14%	55%	29%	0%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
Behavioral health staff members at my school coordinate effectively to deliver services.	103	2%	4%	39%	54%	1%
At my school, there is a clear and easy process in place to refer students who may benefit from behavioral health services/supports.	102	2%	6%	49%	43%	0%
Staff at my school appropriately utilize the referral process when they have concerns about a student.	103	5%	21%	54%	19%	0%
Students at our school are aware of the behavioral health services and supports we offer.	103	2%	12%	64%	19%	3%
Students at our school access the behavioral health services and supports we offer.	102	4%	14%	61%	19%	3%
Families at our school are aware of the behavioral health services and supports we offer.	103	1%	12%	73%	15%	0%
Families at our school access the behavioral health services and supports we offer.	101	2%	21%	68%	9%	0%
Our school team collects and reviews data to monitor the implementation of services/supports (e.g., time between referral and intake, number of students served, number of sessions provided).	101	3%	23%	56%	17%	1%
Our school team collects and reviews data to monitor the appropriateness of services/supports (e.g., student/family/staff satisfaction).	103	3%	30%	46%	17%	4%
Our school team collects and reviews data to monitor the effectiveness of services/supports (e.g., changes in knowledge, behaviors, or symptoms).	103	2%	29%	51%	17%	0%
We have made significant progress toward achieving our behavioral health goals.	103	1%	15%	66%	13%	6%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know	NA – My school does not have this type of clinician
Our CBO clinician is well integrated into our school behavioral health team.	102	4%	9%	30%	54%	0%	3%
Our CBO clinician is seen as a valuable resource by our school community.	104	4%	11%	34%	46%	2%	4%
Our DBH clinician is well integrated into our school behavioral health team.	104	4%	10%	27%	25%	0%	35%
Our DBH clinician is seen as a valuable resource by our school community.	104	5%	9%	24%	26%	2%	35%

Based on your knowledge, please indicate how involved each group is in monitoring implementation of your school's plan.

Question	Total Responses	Actively involved in a decision-making role	Involved, but not in a decision-making role	Not involved	Don't Know
Students	101	1%	27%	66%	6%
Families	101	5%	33%	56%	6%
Classroom teachers	100	20%	36%	41%	3%
Principal/head of school	101	64%	19%	13%	4%
Other school administrators	101	67%	17%	13%	3%
School behavioral health professionals	101	93%	7%	0%	0%
School health professionals	101	44%	16%	37%	4%
Community partners	101	51%	31%	14%	4%

Next, we'd like to learn about the resources your school has utilized since joining the expansion to help strengthen and/or expand the behavioral health services and support offered to students, families, and staff. Please select the response that best matches your experience with each of the following resources:

Question	Total Responses	Used it and found useful	Used it and didn't find it useful	I didn't use it	I am not familiar with this resource
Participation in the DC Community of Practice (e.g., meetings, webinars, trainings)	103	69%	12%	12%	8%
Tip sheets (e.g., on teaming), and other best practices guidance provided by DBH & partners including the DC Community of Practice	101	52%	10%	24%	14%
Training on planning tools provided by DBH & partners including the DC Community of Practice	103	55%	7%	26%	12%
Training on collecting, submitting, and using data provided by DBH & partners including the DC Community of Practice	103	37%	6%	31%	26%
Professional development/training on behavioral health provided by DBH & partners including the DC Community of Practice	103	71%	8%	12%	10%
Interactions with the DBH Clinical Specialists and Technical Assistance Managers	103	64%	20%	6%	10%
CQI data provided by DBH & partners	103	20%	5%	19%	55%
Support from community partner organizations (excluding staffing of the CBO clinician)	103	55%	11%	17%	18%

School Year 2021-2022

Student Survey

Question	Total responses	Not at all	A little bit	Somewhat	Quite a bit	Completely	I prefer not to answer
Overall, how much do you feel like you belong at your school?	4,899	6%	10%	17%	25%	35%	7%

Question	Total responses	Very	Somewhat	A little	Not at all	I prefer not to answer
Do you think it is embarrassing to have a mental/behavioral health challenge?	4,803	7%	8%	21%	48%	16%

Question	Total responses	Definitely Yes	Probably Yes	Probably No	Definitely No	I prefer not to answer
Would kids at your school make fun of someone who sees a therapist or counselor about a mental/behavioral health challenge?	4,802	9%	21%	33%	28%	9%
Would you feel comfortable talking to a therapist or counselor at school if you had a mental/behavioral health challenge?	4,802	28%	33%	15%	13%	11%

Question	Total responses	Yes	No	I prefer not to answer
Is there a teacher or some other adult at your school who you would feel comfortable talking to if you had a problem?	4,898	74%	16%	10%

Question	Total responses	Yes	No	Maybe/ Not sure	I prefer not to answer
If you needed help with a mental/behavioral health challenge at school, do you know who to go to in order to get help?	4,686	52%	13%	29%	7%
Does your school have a therapist or counselor?	4,686	67%	5%	25%	4%

Who do you usually go to about problems when you are upset?	Number of respondents
A friend	2,208
A family member	2,104
Teacher at school	1,957
I do not go to anyone about problems or when I'm upset	864
Someone not listed here	495
I prefer not to answer	353
A club or sports coach at school	263
A cleaning/custodian worker at school	93
Cafeteria/food service worker at school	87

Question	Total Responses	Yes	No	I prefer not to answer
Was there any time this school year you had a mental/behavioral health challenge but didn't get the help you needed?	4,681	21%	59%	21%

Why did you not get the help you needed?	Number of respondents
I thought the problem would get better by itself	441
I did not want anyone to know I was having a problem	397
I did not know where to get help	153
I didn't think counseling would help	171
People in my family didn't think counseling would help	60
I went to counseling before and it did not work	93
I had trouble getting to my counseling sessions	38
I could not get an appointment	43
Other	71
I prefer not to answer	153

During this school year, how would you describe your experiences with each of the activities listed below?	Total Responses	I participated and it was helpful	I participated and it wasn't helpful	I did not participate	I prefer not to answer
One-on-one meetings with school mental/behavioral health staff	4,505	26%	6%	47%	21%
Meetings with school mental/behavioral health staff and my family	4,496	20%	7%	52%	21%
Small group meetings with school mental/behavioral health staff and with other students	4,495	23%	9%	48%	20%
Activities during class led by school mental/behavioral health staff	4,494	27%	10%	41%	22%
Whole school activities like an assembly with school mental/behavioral health staff	4,496	23%	10%	43%	24%

Question	Total responses	Strongly Agree	Agree	Disagree	Strongly Disagree	I prefer not to answer
Teachers at my school do a good job helping students learn to deal with their feelings, get along with others, and make good decisions.	4,507	30%	45%	10%	5%	11%
Principals and other school leaders at my school do a good job helping students learn to deal with their feelings, get along with others, and make good decisions.	4,506	27%	42%	12%	6%	14%

Please list anything you do to make yourself feel better when you are feeling scared, angry, or sad.	Number of respondents
Listen to music	2,633
Spend time with my friends to get my mind off of whatever is bothering me	2,315
Watch TV/videos, play video games, or get on social media	2,293
Go somewhere to calm down, cool off, take a break, or relax (e.g., my bedroom, bathroom, somewhere at school)	2,193
Sleep	2,186
Talk with a close adult family member	1,918
Talk with my friends, or with a family member around my age (e.g., sibling/cousin), about whatever is bothering me	1,812
Read, draw, or write/journal	1,581
Cry	1,425
Play sports, dance, exercise, or do another activity where I move around	1,412
Talk with a teacher or another adult at school that I trust	1,328
Do breathing exercises (e.g., take deep breaths) or calming exercises (e.g., think of things that make me happy)	895
Something not listed here	306
I prefer not to answer	299
Nothing makes me feel better when I am feeling scared, angry, or sad	187

Family Survey

Question	Total responses	Strongly Agree	Agree	Disagree	Strongly Disagree	I prefer not to answer
I feel welcome at my child's school.	1,656	68%	23%	5%	3%	2%
I feel comfortable talking to someone at my child's school about my child's behavior.	1,654	70%	21%	5%	2%	2%
People with mental health disorders are dangerous.	1,596	8%	18%	29%	36%	9%
Overall, my child's school does a good job meeting their students' mental and behavioral health needs.	1,514	31%	42%	9%	4%	14%

Question	Total responses	Definitely Yes	Probably Yes	Probably No	Definitely No	I prefer not to answer
I would want to see a therapist or counselor for help if I were sad, worried, or upset for a long period of time.	1,595	57%	30%	6%	3%	4%
I would want my child to see a therapist or counselor for help if they were sad, worried, or upset for a long period of time.	1,595	72%	20%	3%	2%	3%
If you needed help with a mental/behavioral health challenge, do you know where to get help?	1,525	53%	30%	9%	5%	2%
If your child needed help with a mental/behavioral health challenge, do you know where to get help?	1,525	48%	34%	12%	5%	2%
If your child needed help with a mental/behavioral health challenge at school, do you know who to contact for help?	1,525	44%	32%	14%	8%	2%

Question	Total responses	Yes	No	I don't know	I prefer not to answer
Does your child's school have a therapist or counselor?	1,525	56%	12%	32%	1%

Question	Total responses	Yes	No	I prefer not to answer
Was there any time you had a mental/behavioral health challenge but didn't get the help you needed?	1,524	17%	77%	6%

What was the reason that you did not get the help you needed?	Number of Respondents
I thought the problem would get better by itself	100
I did not want anyone to know I was having a problem	29
I did not know where to get help	60
I didn't think counseling would help	29
People in my family didn't think counseling would help	9
I went to counseling before and it did not work	21
I had trouble getting to my counseling sessions	22
I could not get an appointment	67
Other (e.g., insurance, metro fare, childcare)	81
I prefer not to answer	23

Question	Total responses	Yes	No	I prefer not to answer
Was there any time your child had a mental/behavioral health challenge but didn't get the help they needed?	1,525	12%	83%	5%

What was the reason that your child did not get the help needed?	Number of Respondents
I thought my child's problem would get better by itself	42
I did not want anyone to know my child was having a problem	8
I did not know where to get help for my child	44
I didn't think counseling would help my child	3
My child did not think counseling would help	20
People in my family didn't think counseling would help my child	6
My child went to counseling before and it did not work	9
I had trouble getting my child to counseling sessions	27
I could not get an appointment for my child	60
Other (e.g., insurance, metro fare, childcare)	54
I prefer not to answer	10

During this current school year, which of the following best describes your child's experience with mental/behavioral health services at school?	Number of Respondents
I haven't tried to access mental/behavioral health services for my child at their school	924
My child has seen a mental/behavioral health professional at school	245
My child is on a waitlist to see a mental/behavioral health professional at school	17
I have tried, but my child has not been able to access mental/behavioral health services at school	63
I am seeking mental/behavioral health support for my child outside of school	88
My child is receiving mental/behavioral health support outside of school	120
Prefer not to answer	184

Staff Survey

Question	Total responses	Strongly agree	Agree	Disagree	Strongly disagree	N/A – Not Provided	Don't Know
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.	1,843	25%	49%	14%	4%	1%	8%
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.	1,843	22%	47%	18%	5%	1%	8%
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.	1,843	21%	40%	18%	7%	1%	13%

Please indicate how often you felt the following emotions at work during the past week.	Total responses	Almost never	Once in a while	Sometimes	Frequently	Almost always	Don't know
Engaged	1,773	2%	4%	18%	34%	41%	1%
Exhausted	1,770	3%	10%	24%	30%	32%	1%
Hopeful	1,765	4%	12%	32%	29%	23%	1%
Stressed out	1,765	7%	14%	25%	26%	28%	1%

What kinds of services/supports, if any, are available at your school to promote staff wellness?	Number of respondents
Wellness days off	446
Themed wellness challenges (e.g., water challenge, sleep challenge)	227
Counseling or one-on-one support from school-based mental/behavioral health staff	358
School leadership communicates and/or models the importance of wellness	590
Peers/colleagues check in with one another to provide support	1,032
Regular wellness check-ins, either by school leadership or mental/behavioral health	345
Scheduling enhancements (e.g., intentional breaks, shorter days)	257
Self-care strategies are taught, facilitated, or otherwise promoted (e.g., journaling, mindfulness, yoga)	640
My school does not provide staff wellness supports	230
Other	72

Question	Total Responses	Yes	No
Have you participated in any of the services/supports offered at your school that promote staff wellness?	1,780	60%	40%

Question	Total Responses	Not at all satisfied	Slightly	Somewhat	Quite	Extremely
How satisfied are you with the services/supports you have used?	1,647	4%	16%	43%	29%	8%
Overall, how positive is the working environment at your school?	1,647	6%	20%	34%	33%	7%
How supportive are students in their interactions with each other?	1,647	4%	19%	39%	33%	5%
How respectful are the relationships between teachers/school staff and students?	1,647	2%	14%	33%	41%	9%

Please indicate how much you agree with each of the following statements about services/supports that promote staff wellness at your school.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
I think the services/supports offered at my school to promote staff wellness are relevant to the needs of our school staff.	1,759	12%	39%	25%	11%	13%
I think the services/supports offered at my school to promote staff wellness are adequate.	1,759	8%	33%	34%	14%	11%
My school provides me with adequate professional development opportunities or trainings to increase my understanding of student behavioral health (e.g., to help staff recognize the signs/symptoms of behavioral health issues).	1,646	16%	49%	25%	6%	4%
I think non-clinical staff (e.g., teachers) play an important role in identifying and/or referring students with behavioral health problems.	1,646	55%	38%	3%	2%	2%
I can identify warning signs or symptoms of behavioral health problems in students (e.g., depression, anxiety, trauma, eating disorder).	1,645	34%	54%	7%	1%	3%
I feel knowledgeable about the behavioral health services/supports available at my school.	1,646	26%	48%	19%	3%	4%
I know how to refer a student for behavioral health services/supports at my school.	1,646	36%	49%	10%	2%	3%
I have a good working relationship with a mental health clinician at our school.	1,646	42%	41%	9%	3%	5%
I value having behavioral health services/supports available at my school.	1,646	60%	33%	2%	1%	4%

Please indicate how much you agree with each of the following statements about the experiences of students and families at your school with behavioral health services/supports.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
The behavioral health services/supports available at my school are relevant to the needs of our students.	1,646	29%	48%	10%	3%	10%
The behavioral health services/supports available at my school are culturally/linguistically responsive and appropriate.	1,647	26%	49%	8%	3%	13%
Students at my school are aware of the behavioral health services/supports available to them.	1,646	18%	46%	15%	4%	18%
Families at my school are aware of the behavioral health services/supports available to support their children.	1,647	13%	44%	14%	3%	25%
Students at my school can easily access the behavioral health services/supports available to them, if they choose to do so.	1,647	21%	48%	12%	4%	15%
Families at my school can easily access the behavioral health services/supports available to support their children, if they choose to do so.	1,647	19%	43%	11%	3%	24%
Students at my school utilize the behavioral health services/supports available to them, when needed.	1,646	20%	49%	10%	2%	17%
Families at my school utilize the behavioral health services/supports available to support their children, when needed.	1,646	13%	42%	13%	3%	28%
Students at my school are satisfied with the behavioral health services/supports available to them.	1,646	15%	38%	9%	2%	36%
Families at my school are satisfied with the behavioral health services/supports available to support their children.	1,647	12%	35%	8%	2%	43%
Question	Total Responses	Never	Once	2-5 times	6-10 times	More than 10 times
During the PREVIOUS school year, how many times did you refer students to behavioral health services/supports at your school?	1,626	34%	16%	37%	7%	6%
While you may be unsure of whether a student is receiving behavioral health services/supports, when thinking about a student or students you have referred, please indicate how much you agree or disagree with the following statements.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
They have had a decrease in behavioral incidents.	1,626	8%	42%	15%	4%	30%
They have experienced reduced behavioral health symptoms.	1,626	9%	40%	15%	4%	32%
They have demonstrated increased coping skills.	1,625	10%	46%	12%	3%	28%
They are more connected to the school community (teachers, students, other staff).	1,625	12%	45%	11%	3%	29%

SBHC Survey

Question	Total Responses	Administrator	Behavioral health professional	Other
What is your current position at your school, aside from your role as the school behavioral health coordinator?	99	13%	62%	25%

Question	Total Responses	Less than 3 years	3 to 5 years	6 to 10 years	More than 10
How long have you been at your current school?	98	20%	39%	23%	17%

Question	Total Responses	Less than 1 hour	1 to 2 hours	3 to 4 hours	5 or more hours
In a typical week, how much time do you spend on your responsibilities as a School Behavioral Health Coordinator?	89	12%	48%	25%	15%

Question	Total Responses	Very dissatisfied	Dissatisfied	Satisfied	Very Satisfied
How satisfied are you with the resources you receive to fulfill your role as School Behavioral Health Coordinator?	87	3%	15%	69%	13%

Question	Total Responses	We are just getting started, or don't have a plan yet	Our plan is currently in development	We have a fully developed plan (although it may be revised later)	I don't know
Which of the following statements best characterizes your school's plan for providing a full array of behavioral health services and supports to meet the needs of your school community? Please remember that we are NOT evaluating your school, so please answer as honestly as you can.	83	2%	36%	60%	1%

Question	Total Responses	Yes	No	Don't know
Did you receive a school data report from last year's data?	83	24%	31%	45%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
Our plan adequately addresses the needs at our school.	74	0%	3%	72%	24%	1%
Our plan adequately addresses the resources at our school.	75	0%	15%	69%	15%	1%
We are following the plan.	73	1%	14%	68%	15%	1%

Based on your knowledge, please indicate how involved each group was with developing your school's plan.					
Question	Total Responses	Actively involved in a decision-making role	Involved, but not in a decision-making role	Not involved	Don't Know
Students	75	3%	37%	59%	1%
Families	76	12%	42%	45%	1%
Classroom teachers	75	23%	49%	27%	1%
Principal/head of school	74	66%	19%	14%	1%
Other school administrators	74	59%	27%	11%	3%
School behavioral health professionals	74	91%	7%	3%	0%
School health professionals	74	42%	20%	35%	3%
Community partners	74	58%	19%	18%	5%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	NA – My school does not provide this
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.	78	3%	14%	49%	35%	0%
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.	78	3%	14%	53%	31%	0%

Question Cont.	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	NA – My school does not provide this
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.	78	3%	10%	41%	45%	1%
My school offers ADEQUATE services/supports that promote staff wellness.	78	5%	32%	46%	17%	0%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
Behavioral health staff members at my school coordinate effectively to deliver services.	76	1%	3%	51%	45%	0%
At my school, there is a clear and easy process in place to refer students who may benefit from behavioral health services/supports.	77	0%	6%	51%	45%	0%
Staff at my school appropriately utilize the referral process when they have concerns about a student.	77	0%	25%	52%	23%	0%
Students at our school are aware of the behavioral health services and supports we offer.	77	0%	10%	64%	22%	4%
Students at our school access the behavioral health services and supports we offer.	76	0%	10%	60%	30%	0%
Families at our school are aware of the behavioral health services and supports we offer.	76	0%	5%	76%	14%	4%
Families at our school access the behavioral health services and supports we offer.	77	3%	6%	70%	18%	3%
Our school team collects and reviews data to monitor the implementation of services/supports (e.g., time between referral and intake, number of students served, number of sessions provided).	77	0%	25%	49%	26%	0%
Our school team collects and reviews data to monitor the appropriateness of services/supports (e.g., student/family/staff satisfaction).	77	3%	26%	51%	21%	0%
Our school team collects and reviews data to monitor the effectiveness of services/supports (e.g., changes in knowledge, behaviors, or symptoms).	77	1%	19%	61%	18%	0%
We have made significant progress toward achieving our behavioral health goals.	77	0%	14%	68%	16%	3%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know	NA – My school does not have this type of clinician
Our CBO clinician is well integrated into our school behavioral health team.	77	5%	8%	29%	43%	1%	14%
Our CBO clinician is seen as a valuable resource by our school community.	77	5%	5%	30%	43%	3%	14%
Our DBH clinician is well integrated into our school behavioral health team.	75	3%	8%	19%	20%	3%	48%
Our DBH clinician is seen as a valuable resource by our school community.	74	3%	5%	20%	19%	3%	50%

Based on your knowledge, please indicate how involved each group is in monitoring implementation of your school's plan.					
Question	Total Responses	Actively involved in a decision-making role	Involved, but not in a decision-making role	Not involved	Don't Know
Students	73	0%	22%	77%	1%
Families	73	1%	23%	71%	4%
Classroom teachers	72	13%	29%	56%	3%
Principal/head of school	72	60%	19%	19%	1%
Other school administrators	72	50%	26%	21%	3%
School behavioral health professionals	72	92%	7%	1%	0%
School health professionals	72	46%	17%	33%	4%
Community partners	72	56%	15%	25%	4%

Next, we'd like to learn about the resources your school has utilized since joining the expansion to help strengthen and/or expand the behavioral health services and support offered to students, families, and staff. Please select the response that best matches your experience with each of the following resources:					
Question	Total Responses	Used it and found useful	Used it and didn't find it useful	I didn't use it	I am not familiar with this resource
Participation in the DC Community of Practice (e.g., meetings, webinars, trainings)	74	51%	5%	34%	9%
Tip sheets (e.g., on teaming), and other best practices guidance provided by DBH & partners including the DC Community of Practice	76	54%	3%	25%	18%
Training on planning tools provided by DBH & partners including the DC Community of Practice	76	49%	5%	30%	16%
Training on collecting, submitting, and using data provided by DBH & partners including the DC Community of Practice	76	37%	4%	30%	29%
Professional development/training on behavioral health provided by DBH & partners including the DC Community of Practice	76	58%	4%	28%	11%
Interactions with the DBH Clinical Specialists and Technical Assistance Managers	77	48%	12%	22%	18%
CQI data provided by DBH & partners	75	12%	3%	40%	45%
Support from community partner organizations (excluding staffing of the CBO clinician)	76	50%	9%	22%	18%

School Year 2022-2023

Student Survey

Question	Total Responses	Not at all	A little bit	Somewhat	Quite a bit	Completely	I prefer not to answer
Overall, how much do you feel like you belong at your school?	4,546	6%	10%	19%	25%	34%	6%

Question	Total Responses	Not at all	A little bit	Somewhat	Very	I prefer not to answer
Do you think it is embarrassing to have a mental/behavioral health challenge?	4,414	52%	20%	8%	6%	14%

Question	Total Responses	Definitely Yes	Probably Yes	Probably No	Definitely No	I prefer not to answer
Would kids at your school make fun of someone who sees a therapist or counselor about a mental/behavioral health challenge?	4,414	11%	24%	32%	25%	8%
Would you feel comfortable talking to a therapist or counselor at school if you had a mental/behavioral health challenge?	4,413	26%	33%	17%	15%	9%

Question	Total Responses	Yes	No	I prefer not to answer
Is there a teacher or another adult at your school who you would feel comfortable talking to if you had a problem?	4,547	72%	19%	9%

If you needed help with a behavioral health challenge at school, who would you go to?	Number of respondents
A friend	1,807
A family member	1,807
Teacher at school	2,005
I do not go to anyone about problems or when I'm upset	313
Someone not listed here	322
I prefer not to answer	345
A club or sports coach at school	418
A cleaning/custodian worker at school	71
Cafeteria/food service worker at school	102
Therapist or counselor	1,464
School resource officer (SRO)/School safety officer	279
Principal or school administrator	894

Question	Total Responses	Yes	No	I prefer not to answer
Was there any time this school year you had a mental/behavioral health challenge or need?	4,320	45%	42%	13%
If yes, did you get the help you need at school?	1,956	56%	33%	11%
If no, why did you not get the help you needed?			Number of respondents	
I got the help I needed, just not at school			174	
I thought the problem would get better by itself			268	
I did not want anyone to know I was having a problem			262	
I did not know where to get help			98	
I didn't think counseling would help			131	
Why did you not get the help you needed? Cont.			Number of respondents	
People in my family didn't think counseling would help			17	
I went to counseling before and it did not work			55	
I had trouble getting to my counseling sessions			18	
I could not get an appointment			23	
Other			62	
I prefer not to answer			55	

During this school year, how would you describe your experiences with each of the activities listed below?	Total Responses	I participated and it was helpful	I participated and it wasn't helpful	I did not participate	I prefer not to answer
One-on-one meetings with school mental/behavioral health staff	4,138	27%	7%	46%	19%
Meetings with school mental/behavioral health staff and my family	4,132	20%	8%	53%	19%
Small group meetings with school mental/behavioral health staff and with other students	4,128	22%	9%	50%	19%
Activities during class led by school mental/behavioral health staff	4,122	23%	10%	45%	21%
Whole school activities like an assembly with school mental/behavioral health staff	4,121	23%	11%	44%	21%

Question	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	I prefer not to answer
Teachers at my school do a good job helping students learn to deal with their feelings, get along with others, and make good decisions.	4,141	22%	46%	13%	6%	12%

Question	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	I prefer not to answer
Principals and other school leaders at my school do a good job helping students learn to deal with their feelings, get along with others, and make good decisions.	4,142	22%	43%	14%	7%	15%

Please list anything you do to make yourself feel better when you are feeling scared, angry, or sad.	Number of respondents
Listen to music	2,416
Watch TV/videos, play video games, or get on social media	1,965
Go somewhere to calm down, cool off, take a break, or relax (e.g., my bedroom, bathroom, somewhere at school)	1,919
Sleep	2,094
Talk with a close adult family member	1,738
Talk with my friends, or with a family member around my age (e.g., sibling/cousin), about whatever is bothering me	1,759
Read, draw, or write/journal	1,173
Cry	1,231
Play sports, dance, exercise, or do another activity where I move around	1,355
Talk with a teacher or another adult at school that I trust	1,144
Do breathing exercises (e.g., take deep breaths) or calming exercises (e.g., think of things that make me happy)	699
Something not listed here	214
I prefer not to answer	299
Nothing makes me feel better when I am feeling scared, angry, or sad	152

Family Survey

Question	Total responses	Strongly agree	Agree	Disagree	Strongly disagree	Prefer not to answer
I feel welcome at my child's school.	1375	65%	25%	5%	3%	1%
I feel comfortable talking to someone at my child's school about my child's behavior.	1373	66%	24%	5%	4%	1%
People with mental health disorders are dangerous.	1327	7%	15%	31%	39%	8%
Overall, my child's school does a good job meeting their students' mental and behavioral health needs.	1252	28%	41%	11%	5%	15%

Question	Total responses	Definitely Yes	Probably Yes	Probably No	Definitely No	I prefer not to answer
I would want to see a therapist or counselor for help if I were sad, worried, or upset for a long period of time.	1327	59%	30%	5%	2%	4%
I would want my child to see a therapist or counselor for help if they were sad, worried, or upset for a long period of time.	1327	73%	20%	2%	1%	3%
If you needed help with a mental/behavioral health challenge, do you know where to get help?	1261	54%	33%	7%	4%	3%

Question	Total responses	Yes	No	I prefer not to answer
Was there any time this year you had a mental/behavioral health challenge or need?	1259	27%	68%	5%
If yes, did you get the help you needed?	339	71%	24%	5%

If no, what was the reason that you did not get the help needed?	Number of Respondents
I thought the problem would get better by itself	24
I did not want anyone to know I was having a problem	9
I did not know where to get help	21
I didn't think counseling would help	4
People in my family didn't think counseling would help	2
I went to counseling before and it did not work	9
What was the reason that you did not get the help needed? Cont.	Number of Respondents
I had trouble getting to my counseling sessions	8
I could not get an appointment	27
Other (e.g., insurance, metro fare, childcare)	20
I prefer not to answer	1

Question	Total responses	Yes	No	I prefer not to answer
Was there any time this school year your child had a mental/behavioral health challenge or need?	1259	34%	62%	4%
If yes, did they get the help they needed at school?	425	50%	45%	5%
If no, what was the reason that your child did not get the help needed?				Number of Respondents
My child got the help they needed, just not at school				85
I thought my child's problem would get better by itself				17
I did not want anyone to know my child was having a problem				1
I did not know where to get help for my child				29
My child did not think counseling would help				10
People in my family didn't think counseling would help my child				3
My child went to counseling before and it did not work				8
I had trouble getting my child to counseling sessions				27
I could not get an appointment for my child				41
Other (e.g., insurance, metro fare, childcare)				25
I prefer not to answer				6
During this current school year, which of the following best describes your child's experience with mental/behavioral health services at school?				Number of Respondents
I haven't tried to access mental/behavioral health services for my child at their school				730
My child has seen a mental/behavioral health professional at school				231
My child is on a waitlist to see a mental/behavioral health professional at school				19
I have tried, but my child has not been able to access mental/behavioral health services at school				60
I am seeking mental/behavioral health support for my child outside of school				84
My child is receiving mental/behavioral health support outside of school				128
Prefer not to answer				143

Staff Survey

Question	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	N/A - Not Provided	Don't know
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.	1,680	22%	54%	12%	5%	1%	6%
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.	1,680	18%	50%	18%	6%	1%	7%
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.	1,680	17%	43%	20%	8%	1%	11%
Question	Total Responses	Almost never	Once in a while	Sometimes	Frequently	Almost always	Don't know
Engaged: Please indicate how often you felt the following emotions at work during the past week.	1,605	2%	5%	18%	34%	40%	0%
Exhausted: Please indicate how often you felt the following emotions at work during the past week.	1,606	2%	12%	27%	29%	30%	0%
Hopeful: Please indicate how often you felt the following emotions at work during the past week.	1,599	4%	12%	32%	30%	22%	1%
Stressed out: Please indicate how often you felt the following emotions at work during the past week.	1,609	7%	16%	28%	24%	25%	0%
What kinds of services/supports, if any, are available at your school to promote staff wellness?						Number of Respondents	
Wellness days off						409	
Themed wellness challenges (e.g., water challenge, sleep challenge)						287	
Counseling or one-on-one support from school-based mental/behavioral health staff						314	
What kinds of services/supports, if any, are available at your school to promote staff wellness?						Number of Respondents	
School leadership communicates and/or models the importance of wellness						485	
Peers/colleagues check in with one another to provide support						917	
Regular wellness check-ins, either by school leadership or mental/behavioral health staff						284	
Scheduling enhancements (e.g., intentional breaks, shorter days)						266	
Self-care strategies are taught, facilitated, or otherwise promoted (e.g., journaling, mindfulness, yoga)						448	
My school does not provide staff wellness supports						249	
Other						73	

Question	Total Responses	Yes	No
Have you participated in any of the services/supports offered at your school that promote staff wellness?	1,616	58%	42%

Question	Total Responses	Not at all satisfied	Slightly	Somewhat	Quite	Extremely
How satisfied are you with the services/supports you have used?	934	6%	17%	41%	30%	6%
Overall, how positive is the working environment at your school?	1,496	6%	20%	36%	32%	6%
How supportive are students in their interactions with each other?	1,496	6%	20%	40%	30%	4%
How respectful are the relationships between teachers/school staff and students?	1,496	5%	15%	34%	39%	8%

Please indicate how much you agree with each of the following statements about services/supports that promote staff wellness at your school.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
I think the services/supports offered at my school to promote staff wellness are relevant to the needs of our school staff.	1,597	9%	40%	27%	13%	11%
I think the services/supports offered at my school to promote staff wellness are adequate.	1,598	6%	32%	36%	16%	9%
My school provides me with adequate professional development opportunities or trainings to increase my understanding of student behavioral health (e.g., to help staff recognize the signs/symptoms of behavioral health issues).	1,496	15%	50%	24%	8%	4%
I think non-clinical staff (e.g., teachers) play an important role in identifying and/or referring students with behavioral health problems.	1,495	52%	41%	3%	1%	2%
I can identify warning signs or symptoms of behavioral health problems in students (e.g., depression, anxiety, trauma, eating disorder).	1,495	34%	57%	5%	1%	3%
I feel knowledgeable about the behavioral health services/supports available at my school.	1,496	26%	51%	16%	3%	4%
I know how to refer a student for behavioral health services/supports at my school.	1,496	34%	54%	7%	2%	4%
I have a good working relationship with a mental health clinician at our school.	1,495	42%	44%	6%	3%	5%
I value having behavioral health services/supports available at my school.	1,496	57%	36%	1%	1%	4%

Please indicate how much you agree with each of the following statements about the experiences of students and families at your school with behavioral health services/supports.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
The behavioral health services/supports available at my school are relevant to the needs of our students.	1,494	27%	52%	10%	3%	8%
The behavioral health services/supports available at my school are culturally/linguistically responsive and appropriate.	1,494	25%	52%	10%	3%	11%
Students at my school are aware of the behavioral health services/supports available to them.	1,495	17%	49%	15%	4%	15%
Families at my school are aware of the behavioral health services/supports available to support their children.	1,493	14%	47%	16%	3%	21%
Students at my school can easily access the behavioral health services/supports available to them, if they choose to do so.	1,494	21%	49%	14%	3%	13%
Families at my school can easily access the behavioral health services/supports available to support their children, if they choose to do so.	1,493	18%	46%	13%	3%	20%
Students at my school utilize the behavioral health services/supports available to them, when needed.	1,494	19%	52%	11%	3%	15%
Families at my school utilize the behavioral health services/supports available to support their children, when needed.	1,494	13%	43%	14%	3%	26%
Students at my school are satisfied with the behavioral health services/supports available to them.	1,495	14%	41%	9%	3%	33%
Families at my school are satisfied with the behavioral health services/supports available to support their children.	1,495	12%	38%	9%	3%	39%
Question	Total Responses	Never	Once	2-5 times	6-10 times	More than 10 times
During the PREVIOUS school year, how many times did you refer students to behavioral health services/supports at your school?	1,478	26%	15%	41%	10%	8%
While you may be unsure of whether a student is receiving behavioral health services/supports, when thinking about a student or students you have referred, please indicate how much you agree or disagree with the following statements.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
They have had a decrease in behavioral incidents.	1,478	9%	45%	16%	5%	25%
They have experienced reduced behavioral health symptoms.	1,477	9%	46%	14%	4%	27%
They have demonstrated increased coping skills.	1,477	10%	49%	13%	4%	25%
They are more connected to the school community (teachers, students, other staff).	1,477	12%	49%	11%	3%	25%

SBHC Survey

Question	Total Responses	Administrator	Behavioral health professional	Other
What is your current position at your school, aside from your role as the school behavioral health coordinator?	107	27%	57%	23%

Question	Total Responses	Less than 3 years	3 to 5 years	6 to 10 years
How long have you been at your current school?	107	27%	35%	45%

Question	Total Responses	Less than 1 hour	1 to 2 hours	3 to 4 hours	5 or more hours
In a typical week, how much time do you spend on your responsibilities as a School Behavioral Health Coordinator?	100	18%	32%	31%	19%

Question	Total Responses	Very dissatisfied	Dissatisfied	Satisfied	Very Satisfied
How satisfied are you with the resources you receive to fulfill your role as School Behavioral Health Coordinator?	99	5%	22%	55%	18%

Question	Total Responses	We are just getting started, or don't have a plan yet	Our plan is currently in development	We have a fully developed plan (although it may be revised later)	I don't know
Which of the following statements best characterizes your school's plan for providing a full array of behavioral health services and supports to meet the needs of your school community? Please remember that we are NOT evaluating your school, so please answer as honestly as you can.	93	4%	27%	67%	2%

Question	Total Responses	Yes	No	Don't know
Did you receive a school data report from last year's data?	92	27%	29%	43%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
Our plan adequately addresses the needs at our school.	85	1%	8%	58%	31%	2%
Our plan adequately addresses the resources at our school.	85	4%	14%	56%	22%	4%
We are following the plan.	85	1%	12%	61%	26%	0%

Based on your knowledge, please indicate how involved each group was with developing your school's plan.						
Question	Total Responses	Actively involved in a decision-making role	Involved, but not in a decision-making role	Not involved	Don't Know	
Students	85	7%	42%	47%	4%	
Families	84	14%	40%	42%	4%	
Classroom teachers	84	26%	43%	27%	4%	
Principal/head of school	85	67%	19%	13%	1%	
Other school administrators	84	60%	20%	18%	2%	
School behavioral health professionals	84	86%	13%	0%	1%	
School health professionals	85	51%	19%	27%	4%	
Community partners	84	43%	20%	30%	7%	
Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	NA – My school does not provide this
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.	89	4%	10%	53%	30%	2%
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.	88	3%	13%	55%	27%	2%
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.	89	2%	13%	42%	39%	3%
My school offers ADEQUATE services/supports that promote staff wellness.	89	3%	31%	43%	19%	3%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
Behavioral health staff members at my school coordinate effectively to deliver services.	86	1%	3%	42%	51%	2%
At my school, there is a clear and easy process in place to refer students who may benefit from behavioral health services/supports.	86	1%	2%	45%	50%	1%
Staff at my school appropriately utilize the referral process when they have concerns about a student.	86	1%	21%	48%	29%	1%
Students at our school are aware of the behavioral health services and supports we offer.	84	0%	8%	54%	35%	4%
Students at our school access the behavioral health services and supports we offer.	86	1%	9%	58%	29%	2%
Families at our school are aware of the behavioral health services and supports we offer.	86	0%	10%	64%	21%	5%
Families at our school access the behavioral health services and supports we offer.	86	1%	15%	55%	26%	3%
Our school team collects and reviews data to monitor the implementation of services/supports (e.g., time between referral and intake, number of students served, number of sessions provided).	86	2%	24%	51%	20%	2%
Our school team collects and reviews data to monitor the appropriateness of services/supports (e.g., student/family/staff satisfaction).	86	1%	26%	49%	21%	3%
Our school team collects and reviews data to monitor the effectiveness of services/supports (e.g., changes in knowledge, behaviors, or symptoms).	86	1%	22%	55%	17%	5%
We have made significant progress toward achieving our behavioral health goals.	86	1%	16%	58%	20%	5%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	NA – My school does not have this type of clinician
Our CBO clinician is well integrated into our school behavioral health team.	86	10%	7%	19%	38%	26%
Our CBO clinician is seen as a valuable resource by our school community.	85	12%	6%	19%	39%	25%
Our DBH clinician is well integrated into our school behavioral health team.	84	7%	8%	14%	26%	44%
Our DBH clinician is seen as a valuable resource by our school community.	84	7%	12%	12%	25%	44%

Based on your knowledge, please indicate how involved each group is in monitoring implementation of your school's plan.					
Question	Total Responses	Actively involved in a decision-making role	Involved, but not in a decision-making role	Not involved	Don't Know
Students	79	4%	22%	73%	1%
Families	79	6%	25%	65%	4%
Classroom teachers	79	18%	33%	49%	0%
Principal/head of school	79	67%	16%	16%	0%
Other school administrators	78	59%	21%	19%	1%
School behavioral health professionals	79	82%	11%	5%	1%
School health professionals	79	48%	18%	32%	3%
Community partners	79	42%	18%	34%	6%

Next, we'd like to learn about the resources your school has utilized since joining the expansion to help strengthen and/or expand the behavioral health services and support offered to students, families, and staff. Please select the response that best matches your experience with each of the following resources:					
Question	Total Responses	Used it and found useful	Used it and didn't find it useful	I didn't use it	I am not familiar with this resource
Participation in the DC Community of Practice (e.g., meetings, webinars, trainings)	85	53%	11%	29%	7%
Tip sheets (e.g., on teaming), and other best practices guidance provided by DBH & partners including the DC Community of Practice	85	56%	5%	19%	20%
Training on planning tools provided by DBH & partners including the DC Community of Practice	85	39%	6%	31%	25%
Training on collecting, submitting, and using data provided by DBH & partners including the DC Community of Practice	85	31%	4%	34%	32%
Question Cont.	Total Responses	Used it and found useful	Used it and didn't find it useful	I didn't use it	I am not familiar with this resource
Professional development/training on behavioral health provided by DBH & partners including the DC Community of Practice	84	49%	6%	29%	17%
Interactions with the DBH Clinical Specialists and Technical Assistance Managers	85	39%	19%	27%	15%
CQI data provided by DBH & partners	84	12%	4%	35%	50%
Support from community partner organizations (excluding staffing of the CBO clinician)	85	41%	9%	21%	28%

School Year 2023-2024

Student Survey

Question	Total Responses	Not at all	A little bit	Somewhat	Quite a bit	Completely	I prefer not to answer
Overall, how much do you feel like you belong at your school?	4,207	5%	9%	19%	30%	32%	5%

Question	Total Responses	Not at all	A little bit	Somewhat	Very	I prefer not to answer
Do you think it is embarrassing to have a mental/behavioral health challenge?	4,087	53%	22%	9%	5%	11%

Question	Total Responses	Definitely Yes	Probably Yes	Probably No	Definitely No	I prefer not to answer
Would kids at your school make fun of someone who sees a therapist or counselor about a mental/behavioral health challenge?	4,086	8%	20%	36%	28%	8%
Would you feel comfortable talking to a therapist or counselor at school if you had a mental/behavioral health challenge?	4.086	24%	34%	18%	15%	9%

Question	Total Responses	Yes	No	I prefer not to answer
Is there a teacher or another adult at your school who you would feel comfortable talking to if you had a problem?	4,207	75%	16%	8%

If you needed help with a behavioral health challenge at school, who would you go to?	Number of respondents
A friend	1,686
A family member	1,640
Teacher at school	1,889
I do not know who to go to about problems or when I'm upset	262
Someone not listed here	329
I prefer not to answer	323
A club or sports coach at school	371
A cleaning/custodian worker at school	74
Cafeteria/food service worker at school	103
Therapist or counselor	1,443
School resource officer (SRO)/School safety officer	268
Principal or school administrator	684

Question	Total Responses	Yes	No	I prefer not to answer
Was there any time this school year you had a mental/behavioral health challenge or need?	4,014	44%	43%	13%
If yes, did you get the help you needed at school?	1,766	53%	37%	10%
If no, why did you not get the help you needed?			Number of respondents	
I got the help I needed, just not at school			239	
I thought the problem would get better by itself			260	
I did not want anyone to know I was having a problem			245	
I did not know where to get help			82	
I didn't think counseling would help			119	
Why did you not get the help you needed? Cont.			Number of respondents	
People in my family didn't think counseling would help			25	
I went to counseling before and it did not work			57	
I had trouble getting to my counseling sessions			26	
I could not get an appointment			18	
Other			51	
I prefer not to answer			49	

During this school year, how would you describe your experiences with each of the activities listed below?	Total Responses	I participated and it was helpful	I participated and it wasn't helpful	I did not participate	I prefer not to answer
One-on-one meetings with school mental/behavioral health staff	3,855	28%	7%	50%	15%
Meetings with school mental/behavioral health staff and my family	3,850	20%	9%	56%	15%
Small group meetings with school mental/behavioral health staff and with other students	3,851	20%	9%	55%	15%
Activities during class led by school mental/behavioral health staff	3,844	22%	11%	50%	17%
Whole school activities like an assembly with school mental/behavioral health staff	3,848	23%	14%	45%	18%

Question	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	I prefer not to answer
Teachers at my school do a good job helping students learn to deal with their feelings, get along with others, and make good decisions.	3,860	20%	50%	13%	5%	12%
Principals and other school leaders at my school do a good job helping students learn to deal with their feelings, get along with others, and make good decisions.	3,859	18%	46%	15%	6%	15%

Please list anything you do to make yourself feel better when you are feeling scared, angry, or sad.	Number of respondents
Listen to music	2,308
Watch TV/videos, play video games, or get on social media	1,958
Go somewhere to calm down, cool off, take a break, or relax (e.g., my bedroom, bathroom, somewhere at school)	1,924
Sleep	2,009
Talk with a close adult family member	1,676
Talk with my friends, or with a family member around my age (e.g., sibling/cousin), about whatever is bothering me	1,667
Read, draw, or write/journal	1,188
Cry	1,249
Play sports, dance, exercise, or do another activity where I move around	1,340
Talk with a teacher or another adult at school that I trust	1,039
Do breathing exercises (e.g., take deep breaths) or calming exercises (e.g., think of things that make me happy)	676
Something not listed here	238
I prefer not to answer	254
Nothing makes me feel better when I am feeling scared, angry, or sad	128

Family Survey

Question	Total responses	Strongly agree	Agree	Disagree	Strongly disagree	Prefer not to answer
I feel welcome at my child's school.	1,011	70%	21%	5%	3%	1%
I feel comfortable talking to someone at my child's school about my child's behavior.	1,011	68%	20%	6%	4%	1%
People with mental health disorders are dangerous.	970	7%	16%	32%	38%	7%
Overall, my child's school does a good job meeting their students' mental and behavioral health needs.	917	30%	41%	12%	5%	11%

Question	Total responses	Definitely Yes	Probably Yes	Probably No	Definitely No	I prefer not to answer
I would want to see a therapist or counselor for help if I were sad, worried, or upset for a long period of time.	971	59%	30%	6%	2%	3%
I would want my child to see a therapist or counselor for help if they were sad, worried, or upset for a long period of time.	971	74%	21%	2%	1%	2%
If you needed help with a mental/behavioral health challenge, do you know where to get help?	925	61%	26%	8%	4%	1%

Question	Total responses	Yes	No	I prefer not to answer
Was there any time this year you had a mental/behavioral health challenge or need?	923	30%	65%	5%
If yes, did you get the help you needed?	280	74%	20%	6%

If no, what was the reason that you did not get the help needed?	Number of Respondents
I thought the problem would get better by itself	17
I did not want anyone to know I was having a problem	8
I did not know where to get help	17
I didn't think counseling would help	3
People in my family didn't think counseling would help	1
I went to counseling before and it did not work	5
What was the reason that you did not get the help needed? Cont.	Number of Respondents
I had trouble getting to my counseling sessions	10
I could not get an appointment	8
Other (e.g., insurance, metro fare, childcare)	21
I prefer not to answer	4

Question	Total responses	Yes	No	I prefer not to answer
Was there any time this school year your child had a mental/behavioral health challenge or need?	923	36%	61%	4%
If yes, did they get the help they needed at school?	331	54%	42%	4%
If no, what was the reason that your child did not get the help needed?				Number of Respondents
My child got the help they needed, just not at school				60
I thought my child's problem would get better by itself				7
I did not want anyone to know my child was having a problem				2
I did not know where to get help for my child				25
My child did not think counseling would help				13
People in my family didn't think counseling would help my child				3
My child went to counseling before and it did not work				8
I had trouble getting my child to counseling sessions				14
I could not get an appointment for my child				26
Other (e.g., insurance, metro fare, childcare)				34
I prefer not to answer				6
During this current school year, which of the following best describes your child's experience with mental/behavioral health services at school?				Number of Respondents
I haven't tried to access mental/behavioral health services for my child at their school				511
My child has seen a mental/behavioral health professional at school				211
My child is on a waitlist to see a mental/behavioral health professional at school				15
I have tried, but my child has not been able to access mental/behavioral health services at school				49
I am seeking mental/behavioral health support for my child outside of school				84
My child is receiving mental/behavioral health support outside of school				111
Prefer not to answer				85

Staff Survey

Question	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	N/A - Not Provided	Don't know
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.	2,152	21%	50%	15%	7%	0%	7%
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.	2,153	19%	47%	18%	7%	0%	9%
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.	2,152	18%	42%	18%	10%	1%	12%
Question	Total Responses	Almost never	Once in a while	Sometimes	Frequently	Almost always	Don't know
Engaged: Please indicate how often you felt the following emotions at work during the past week.	2,045	3%	5%	19%	33%	39%	1%
Exhausted: Please indicate how often you felt the following emotions at work during the past week.	2,043	4%	10%	25%	29%	32%	1%
Hopeful: Please indicate how often you felt the following emotions at work during the past week.	2,043	6%	12%	32%	27%	21%	1%
Stressed out: Please indicate how often you felt the following emotions at work during the past week.	2,039	7%	14%	26%	25%	27%	1%
What kinds of services/supports, if any, are available at your school to promote staff wellness?							Number of Respondents
Wellness days off							456
Themed wellness challenges (e.g., water challenge, sleep challenge)							232
Counseling or one-on-one support from school-based mental/behavioral health staff							489
What kinds of services/supports, if any, are available at your school to promote staff wellness?							Number of Respondents
School leadership communicates and/or models the importance of wellness							545
Peers/colleagues check in with one another to provide support							1,076
Regular wellness check-ins, either by school leadership or mental/behavioral health staff							310
Scheduling enhancements (e.g., intentional breaks, shorter days)							281
Self-care strategies are taught, facilitated, or otherwise promoted (e.g., journaling, mindfulness, yoga)							531
My school does not provide staff wellness supports							386
Other							119

Question	Total Responses		Yes		No	
Have you participated in any of the services/supports offered at your school that promote staff wellness?	2,056		51%		49%	
Question	Total Responses	Not at all satisfied	Slightly	Somewhat	Quite	Extremely
How satisfied are you with the services/supports you have used?	1,052	7%	17%	35%	31%	10%
Overall, how positive is the working environment at your school?	1,898	9%	21%	33%	30%	6%
How supportive are students in their interactions with each other?	1,898	5%	22%	38%	29%	5%
How respectful are the relationships between teachers/school staff and students?	1,898	4%	16%	35%	38%	8%
Please indicate how much you agree with each of the following statements about services/supports that promote staff wellness at your school.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
I think the services/supports offered at my school to promote staff wellness are relevant to the needs of our school staff.	2,026	11%	38%	23%	13%	15%
I think the services/supports offered at my school to promote staff wellness are adequate.	2,026	7%	32%	33%	16%	12%
My school provides me with adequate professional development opportunities or trainings to increase my understanding of student behavioral health (e.g., to help staff recognize the signs/symptoms of behavioral health issues).	1,898	14%	47%	27%	7%	5%
I think non-clinical staff (e.g., teachers) play an important role in identifying and/or referring students with behavioral health problems.	1,898	49%	42%	4%	2%	3%
I can identify warning signs or symptoms of behavioral health problems in students (e.g., depression, anxiety, trauma, eating disorder).	1,898	33%	55%	7%	2%	4%
I feel knowledgeable about the behavioral health services/supports available at my school.	1,898	23%	52%	17%	4%	4%
I know how to refer a student for behavioral health services/supports at my school.	1,898	33%	51%	9%	3%	4%
I have a good working relationship with a mental health clinician at our school.	1,898	38%	44%	8%	3%	6%
I value having behavioral health services/supports available at my school.	1,898	55%	38%	2%	1%	4%

Please indicate how much you agree with each of the following statements about the experiences of students and families at your school with behavioral health services/supports.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
The behavioral health services/supports available at my school are relevant to the needs of our students.	1,898	26%	51%	10%	3%	9%
The behavioral health services/supports available at my school are culturally/linguistically responsive and appropriate.	1,897	22%	50%	10%	4%	13%
Students at my school are aware of the behavioral health services/supports available to them.	1,898	18%	47%	14%	4%	17%
Families at my school are aware of the behavioral health services/supports available to support their children.	1,898	13%	44%	16%	4%	23%
Students at my school can easily access the behavioral health services/supports available to them, if they choose to do so.	1,897	22%	47%	11%	4%	16%
Please indicate how much you agree with each of the following statements about the experiences of students and families at your school with behavioral health services/supports. Cont.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Families at my school can easily access the behavioral health services/supports available to support their children, if they choose to do so.	1,897	17%	45%	11%	4%	23%
Students at my school utilize the behavioral health services/supports available to them, when needed.	1,898	20%	50%	11%	3%	17%
Families at my school utilize the behavioral health services/supports available to support their children, when needed.	1,898	12%	42%	14%	3%	28%
Students at my school are satisfied with the behavioral health services/supports available to them.	1,896	13%	38%	9%	3%	36%
Families at my school are satisfied with the behavioral health services/supports available to support their children.	1,895	10%	36%	8%	3%	42%
Question	Total Responses	Never	Once	2-5 times	6-10 times	More than 10 times
During the PREVIOUS school year, how many times did you refer students to behavioral health services/supports at your school?	1,864	28%	16%	40%	10%	6%
While you may be unsure of whether a student is receiving behavioral health services/supports, when thinking about a student or students you have referred, please indicate how much you agree or disagree with the following statements.	Total Responses	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
They have had a decrease in behavioral incidents.	1,864	7%	44%	16%	5%	28%
They have experienced reduced behavioral health symptoms.	1,864	7%	45%	15%	4%	30%
They have demonstrated increased coping skills.	1,864	9%	48%	13%	3%	27%
They are more connected to the school community (teachers, students, other staff).	1,864	10%	47%	10%	3%	29%

SBHC Survey

Question	Total Responses	Administrator	Behavioral health professional	Other
What is your current position at your school, aside from your role as the school behavioral health coordinator?	138	22%	58%	17%

Question	Total Responses	Less than 3 years	3 to 5 years	6 to 10 years	More than 10 years
How long have you been at your current school?	138	31%	30%	24%	14%

Question	Total Responses	Less than 1 hour	1 to 2 hours	3 to 4 hours	5 or more hours
In a typical week, how much time do you spend on your responsibilities as a School Behavioral Health Coordinator?	124	11%	44%	25%	20%

Question	Total Responses	Very dissatisfied	Dissatisfied	Satisfied	Very Satisfied
How satisfied are you with the resources you receive to fulfill your role as School Behavioral Health Coordinator?	121	2%	21%	70%	7%

Question	Total Responses	We are just getting started, or don't have a plan yet	Our plan is currently in development	We have a fully developed plan (although it may be revised later)	I don't know
Which of the following statements best characterizes your school's plan for providing a full array of behavioral health services and supports to meet the needs of your school community? Please remember that we are NOT evaluating your school, so please answer as honestly as you can.	115	4%	30%	63%	2%

Question	Total Responses	Yes	No	Don't know
Did you receive a school data report from last year's data?	113	31%	30%	39%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
Our plan adequately addresses the needs at our school.	112	1%	3%	70%	22%	4%
Our plan adequately addresses the resources at our school.	111	0%	11%	63%	21%	5%
We are following the plan.	112	0%	9%	65%	21%	5%

Based on your knowledge, please indicate how involved each group was with developing your school's plan.					
Question	Total Responses	Actively involved in a decision-making role	Involved, but not in a decision-making role	Not involved	Don't Know
Students	105	3%	50%	44%	4%
Families	103	4%	50%	41%	5%
Classroom teachers	104	20%	44%	30%	6%
Principal/head of school	105	61%	26%	10%	4%
Other school administrators	103	59%	24%	14%	3%
School behavioral health professionals	104	90%	8%	0%	2%
School health professionals	105	39%	18%	38%	5%
Community partners	104	48%	26%	22%	4%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't know	NA – My school does not provide this
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.	104	3%	14%	60%	23%	0%	0%
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.	103	0%	20%	48%	29%	1%	2%

Question Cont.	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't know	NA – My school does not provide this
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.	103	1%	15%	42%	39%	2%	2%
My school offers ADEQUATE services/supports that promote staff wellness.	104	1%	28%	47%	20%	3%	1%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't Know
Behavioral health staff members at my school coordinate effectively to deliver services.	102	1%	9%	39%	50%	1%
At my school, there is a clear and easy process in place to refer students who may benefit from behavioral health services/supports.	103	0%	7%	52%	39%	2%
Staff at my school appropriately utilize the referral process when they have concerns about a student.	103	0%	22%	56%	20%	1%
Students at our school are aware of the behavioral health services and supports we offer.	101	0%	10%	61%	25%	4%
Students at our school access the behavioral health services and supports we offer.	102	0%	7%	60%	32%	1%
Families at our school are aware of the behavioral health services and supports we offer.	102	1%	13%	63%	20%	4%
Families at our school access the behavioral health services and supports we offer.	102	1%	21%	60%	15%	4%
Our school team collects and reviews data to monitor the implementation of services/supports (e.g., time between referral and intake, number of students served, number of sessions provided).	102	1%	25%	53%	20%	1%
Our school team collects and reviews data to monitor the appropriateness of services/supports (e.g., student/family/staff satisfaction).	103	0%	29%	54%	15%	2%
Our school team collects and reviews data to monitor the effectiveness of services/supports (e.g., changes in knowledge, behaviors, or symptoms).	103	0%	30%	49%	18%	3%
We have made significant progress toward achieving our behavioral health goals.	103	0%	21%	57%	17%	4%

Question	Total Responses	Strongly disagree	Disagree	Agree	Strongly Agree	Don't know	NA – My school does not have this type of clinician
Our CBO clinician is well integrated into our school behavioral health team.	102	5%	4%	28%	38%	0%	25%
Our CBO clinician is seen as a valuable resource by our school community.	101	5%	5%	21%	44%	1%	25%
Our DBH clinician is well integrated into our school behavioral health team.	102	3%	10%	16%	22%	4%	46%
Our DBH clinician is seen as a valuable resource by our school community.	102	2%	11%	16%	23%	3%	46%

Based on your knowledge, please indicate how involved each group is in monitoring implementation of your school's plan.					
Question	Total Responses	Actively involved in a decision-making role	Involved, but not in a decision-making role	Not involved	Don't Know
Students	101	1%	31%	62%	6%
Families	101	3%	29%	62%	6%
Classroom teachers	102	14%	42%	42%	2%
Principal/head of school	102	62%	19%	17%	3%
Other school administrators	102	61%	18%	20%	2%
School behavioral health professionals	101	88%	10%	1%	1%
School health professionals	100	37%	22%	37%	4%
Community partners	100	42%	20%	34%	4%

Next, we'd like to learn about the resources your school has utilized since joining the expansion to help strengthen and/or expand the behavioral health services and support offered to students, families, and staff. Please select the response that best matches your experience with each of the following resources:					
Question	Total Responses	Used it and found useful	Used it and didn't find it useful	I didn't use it	I am not familiar with this resource
Participation in the DC Community of Practice (e.g., meetings, webinars, trainings)	101	52%	10%	31%	7%
Tip sheets (e.g., on teaming), and other best practices guidance provided by DBH & partners including the DC Community of Practice	99	45%	6%	25%	23%
Training on planning tools provided by DBH & partners including the DC Community of Practice	100	45%	3%	37%	15%
Training on collecting, submitting, and using data provided by DBH & partners including the DC Community of Practice	100	28%	5%	42%	25%
Question Cont.	Total Responses	Used it and found useful	Used it and didn't find it useful	I didn't use it	I am not familiar with this resource
Professional development/training on behavioral health provided by DBH & partners including the DC Community of Practice	102	55%	2%	31%	12%
Interactions with the DBH Clinical Specialists and Technical Assistance Managers	100	38%	10%	30%	22%
CQI data provided by DBH & partners	100	14%	5%	30%	51%
Support from community partner organizations (excluding staffing of the CBO clinician)	99	42%	6%	24%	27%