School Behavioral Health Expansion Evaluation

Summary of Findings from SY 2020-2021:

Providing Multi-Tiered Support for Behavioral Health During the COVID-19 Pandemic

Child TRENDS

DBH DEPARTMENT OF BEHAVIORAL HEALTH

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Executive Summary

Schools have always played a vital role in promoting academic, social, emotional, and physical growth among students.[1,2] Interventions to promote school connectedness, enhance social and emotional competencies, increase access to high quality and culturally competent behavioral health supports, and support for the well-being of school staff have all been proven to lead to improved health outcomes and better academic performance.[3] The COVID-19 pandemic has highlighted the importance of providing a coordinated set of behavioral health supports in schools at both a national- and local-level. The pandemic has also amplified existing disparities in access to high quality behavioral health supports.

Multiple reports have been published that include a focus on school behavioral health during the COVID-19 pandemic in the District of Columbia (DC).COVID-19's Impact on Student Well-Being, a report published by Empower K12, in partnership with DC charter school networks and local school-based mental health experts from schools and the Center for Health and Health Care in Schools at George Washington University, documented the perceptions of students in Fall and Winter of school year (SY) 2020-2021 and Fall of SY 2021-2022.[4] DC Parents Amplifying Voices in Education (PAVE) collected data from parents at the end of SY 2020-2021 and the beginning of SY 2021-2022 on a range of topics, including their satisfaction with mental health supports provided to students and parents.[5]

This report complements previously published reports by providing detailed information from students, families, and school staff regarding their experiences with school behavioral health during SY 2020-2021, in the midst of the COVID-19 pandemic. Students and families shared their perceptions of school climate, behavioral health supports offered in schools, and potential barriers to accessing supports, in addition to their thoughts on what is working well and what could be improved. School staff shared their perceptions of their work environments and the behavioral health supports for students as well as their satisfaction with employee wellness efforts.

In particular, this report focuses on understanding how aware various stakeholder groups are of the treatment services that are available as a part of the efforts to link public and public charter

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[1] Wyche, J., Nicholson, L., Lawson, E., & Allensworth, D. (Eds.). (1997). Schools and health: Our nation's investment.

[2] Lewallen, T. C., Hunt, H., Potts-Datema, W., Zaza, S., & Giles, W. (2015). The whole school, whole community, whole child model: A new approach for improving educational attainment and healthy development for students. Journal of School Health, 85(11), 729-739.

[3] Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child development, 82(1), 405-432.

[4] https://www.empowerk12.org/blog/ottg60u6rbid6y1kr2tnbbpqy89i25

[5] https://dcpave.org/wp-content/uploads/2021/11/Summer-2021-PAVE-End-of-Year-Parent-Survey-Report.pdf

schools with community-based behavioral health providers. Awareness is a key step towards increasing access to behavioral health treatment, reducing unmet behavioral health need, and ultimately improving behavioral health outcomes for youth across the District of Columbia. In future years, when data are available over time, additional analyses will be conducted to examine patterns with respect to changes in school connectedness, service utilization, and behavioral health outcomes.

Bright spots

Survey and interview data from students, families, school staff, and partner agencies and organizations connected with the Coordinating Council on School Behavioral Health highlight a number of successes. We summarize bright spots here:

- Most students and families feel positively about their connections with schools.
- A majority of students and families would feel comfortable seeking behavioral health support at school when needed.
- Most School Behavioral Health Coordinators (SBHCs) found planning and implementation resources provided to be helpful.
- Most school staff have positive perceptions of behavioral health supports at their school and the role they play in supporting student behavioral health.
- Most school staff believe the treatment services provided to students make a difference.
- Members of the Coordinating Council on School Behavioral Health have built a sense of trust and collaboration among members to support the expansion and most believe the right mix of partners are present on the Coordinating Council.

Challenges & opportunities

We also heard about challenges that students, families, school staff, and partner agencies and organizations experienced with respect to the expansion of school behavioral health supports, as well as opportunities for improvement. We summarize challenges and opportunities here:

- Many students and families do not know how to access school-based behavioral health supports.
- Youth and families rarely play decision-making roles in developing and monitoring plans for schoolwide behavioral health efforts.
- There are differences in behavioral health experiences and outcomes between groups of youth and families; LGBQ youth in particular report higher levels of unmet needs compared to their heterosexual peers.
- Establishing and maintaining connections between schools and providers and effective collaboration among behavioral health team members can be challenging.

- Perceptions about financing of treatment (Tier 3) services have led to some tensions with respect to implementing a public health approach.
- Meetings of the Coordinating Council on School Behavioral Health may not always leverage the expertise represented by the membership.
- School behavioral health teams are not always aware of the resources that are made available to them.
- There is no source of data across all School Behavioral Health Program providers to consistently track provider activities and student outcomes; more can be done to create a culture of continuous quality improvement.

Recommendations

Based on an analysis of data that were collected from students, families, school staff, and partner agencies and organizations as well as published literature on the implementation of high quality, multi-tiered behavioral health supports in schools, we offer the following recommendations. These recommendations are divided across system-level and school-level recommendations and are described in more detail in the recommendations section of the report.

5 system-level recommendations

1. Create a culture of continuous quality improvement.
2. Work with key stakeholders to reassess the current braided funding approach.
3. Set a vision for the Coordinating Council for School Behavioral Health that embraces a clear role for supporting continuous quality improvement.
4. Consider creating a set of orientation resources for new School Behavioral Health Program providers.
5. Invest in efforts to raise awareness about the presence of school-based behavioral health providers in schools.

5 school-level recommendations

1. Dedicate time to establishing and deepening relationships between schools and providers.
2. Find ways to involve students and families in decisions about school behavioral health.
3. Ensure active engagement in the DC Community of Practice among school-based providers and school administrators.
4. Collect and use data to identify gaps and track progress.
5. Embed behavioral health information often in communications with students and families.

Introduction

Schools play a vital role in promoting academic, social, emotional, and physical growth among students (citation).[6,7] The COVID-19 pandemic has highlighted the importance of providing behavioral health supports in schools while simultaneously reifying—and in many cases widening—existing gaps in access to high quality behavioral health supports, especially among Black, Latinx, American Indian, and LGBTQ youth.[8,9]

Prior to the pandemic, the District of Columbia (DC) had begun making incremental, systemic investments in school-based behavioral health to ensure that all public and public charter schools are well-equipped to establish safe and supportive learning and work environments where students and staff can thrive. The expansion of school behavioral health supports emphasizes the value of a Multi-Tiered System of Supports (MTSS; see Figure 1 on the next page), including efforts to promote wellness among school staff. Research suggests that school-based behavioral health supports are most effective when delivered through a multi-tiered system of supports that:

1. equips all students with critical skills to recognize and process emotions, establish and maintain positive relationships, and set and strive towards goals;
2. identifies students that are experiencing challenges early to provide them with culturally responsive behavioral health supports; and
3. offers high quality, evidence-based, and culturally affirming behavioral health treatment services.[10]

Throughout this report, you will see the following acronyms or abbreviations referring to partner organizations and components in the expansion of school-based behavioral health: Community-Based Organizations (CBOs), Community of Practice (CoP), Coordinating Council on School Behavioral Health (the Coordinating Council), Department of Behavioral Health (DBH), Office of the State Superintendent of Education (OSSE), District of Columbia Public Schools (DCPS), District of Columbia Public Charter School Board (DCPCSB), Multi-Tiered Systems of Support (MTSS), School Behavioral Health Coordinator (SBHC).

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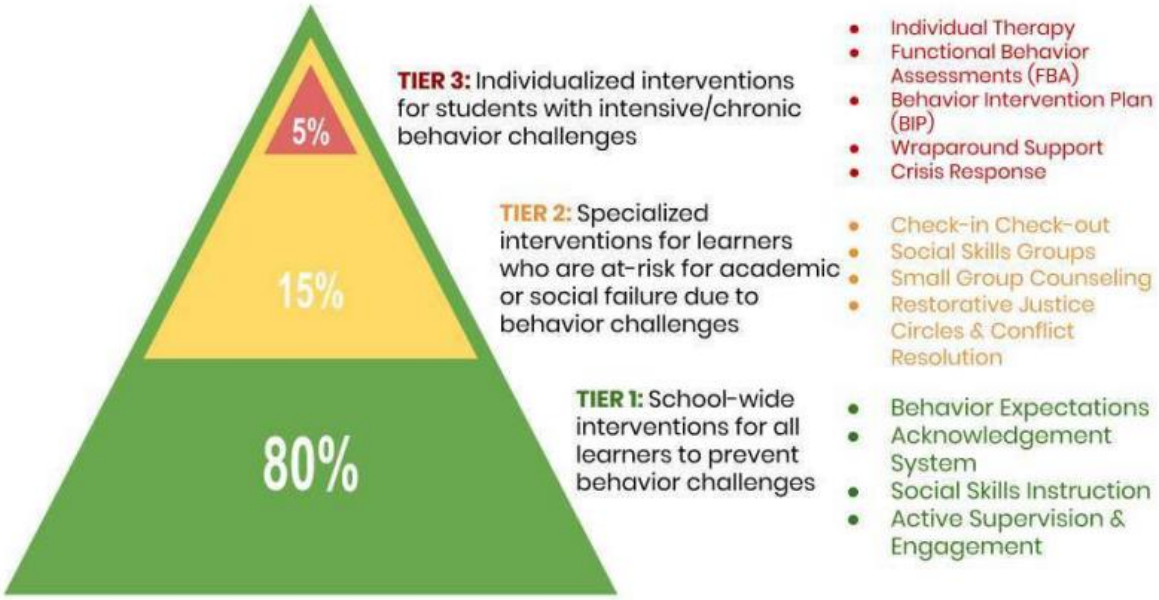
[6] Allensworth, D., Lawson, E., Nicholson, L., & Wyche, J (Eds.). (1997). Schools and health: Our nation's investment.

[7] Lewallen, T. C., Hunt, H., Potts‐Datema, W., Zaza, S., & Giles, W. (2015). The whole school, whole community, whole child model: A new approach for improving educational attainment and healthy development for students. Journal of School Health, 85(11), 729-739. 3. Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B.

[8] Parolin, Z. (2021). What the COVID-19 pandemic reveals about racial differences in child welfare and child well-being: An introduction to the Special Issue. Race and social problems, 13(1), 1-5.

[9] Viner, R., Russell, S., Saulle, R., Croker, H., Stansfield, C., Packer, J., ... & Minozzi, S. (2022). School Closures During Social Lockdown and Mental Health, Health Behaviors, and Well-being Among Children and Adolescents During the First COVID-19 Wave: A Systematic Review. JAMA pediatrics.

[10] Center for Health and Health Care in Schools, School-Based Health Alliance, National Center for School Mental Health (2021). Addressing Social Influencers of Health and Education Using a Multi-Tiered System of Supports Framework. Washington, D.C.: School Health Services National Quality Initiative.



Note: These percentages are based off the recommended nationwide averages an not directly correlated to DC
https://www.pbis.org/pbis/tiered-framework

Figure 1. MTSS Framework

This report describes the experiences of students, family members, and school staff in public and public charter schools across the District of Columbia with school behavioral health supports during a year when schools and families spent much of the time adjusting to remote learning. The surveys were administered in late Spring 2021, mere months after schools in the District of Columbia began to re-open for in-person learning following a year of online learning and tele-behavioral health supports.

The surveys of students, families, and school staff focus on understanding how these different groups perceive behavioral health, their ability to access supports, and their thoughts on what is working and what could be improved in their schools. A separate survey of School Behavioral Health Coordinators (SBHCs) focuses on how school teams set priorities and develop and monitor plans for behavioral health supports, including the resources they have found useful to effectively implement MTSS in their schools.

To better understand how the efforts to expand school behavioral health supports have been perceived at a citywide level, we conducted interviews with a dozen representatives of partner organizations affiliated with the Coordinating Council on School Behavioral Health (the Coordinating Council) during Fall 2021. These interviews focused on the role of the Coordinating Council in supporting the expansion and partner organizations' perceptions of how

the expansion was unfolding, including notable accomplishments, lessons learned, and opportunities for improvement.

Specific evaluation questions that are addressed in this report include:

- What are the barriers and facilitators associated with the expansion of school-based behavioral health supports?
- What is the quality and uptake of the school-based behavioral health supports implemented through the expansion?

In future years, when data are available over time, additional analyses will be conducted to examine patterns with respect to changes in school connectedness, service utilization, and behavioral health outcomes.

Methods

Data collection

The evaluation team coordinated with school administrators and district agencies to distribute web-based surveys and connect with key stakeholders for interviews in May and June of 2021. The evaluation team also obtained administrative data related to Community of Practice (CoP) attendance and self-reports of the application of knowledge and skills acquired through CoP participation during the 2020-2021 school year.

Surveys

Brief, web-based surveys were distributed by schools to students in grade 4 and up, families, and school staff. Student and family surveys were available in English, Spanish, and Amharic. The surveys asked about participants' experiences in schools, perceptions of mental and behavioral health challenges and help-seeking, and thoughts about mental and behavioral health needs and available supports (see Appendix A for survey questions). Staff surveys also asked about staff wellness. Child Trends staff administered a web-based survey to School Behavioral Health Coordinators that focused on their perceptions of behavioral health supports at their school, including their planning process and their perceptions of resources. Child Trends staff also administered a brief, web-based survey to members of the Coordinating Council on School Behavioral Health to learn about their experiences on the Coordinating Council and their overall perceptions of the expansion.

Interviews

Semi-structured interviews were conducted with members of partner organizations during Fall 2021 to hear their perspectives on the overall purpose and structure of the expansion as well as

how it is being implemented citywide. All interviews were conducted virtually. Most were conducted as one-on-one conversations; however, at their request, one interview included several individuals at one partner organization. These interviews varied in length, but most lasted approximately 1-1.5 hours.

Community of Practice

The evaluation team obtained administrative data on monthly CoP meetings held from September 2020 through May 2021, including participant affiliation and attendance.

Sample characteristics

A total of 7,632 surveys across 150 schools were completed, including 4,122 student surveys, 1,346 family surveys, and 2,164 staff surveys. Sample characteristics reflect all respondents, including those who selected prefer not to answer, not sure/don't know, do not understand, or something other than listed. However, to facilitate interpretation, these response categories were excluded from data analysis.

Student and family demographics

Most student survey respondents identified as Black, followed by Hispanic/Latino and students who identify as more than one race (see Table 1). Most students identified as heterosexual, although a large minority identified as LGBQ. Students categorized as LGBQ included students who selected "not sure" regarding their sexuality. More students identified as female compared to male; very few identified as transgender or non-binary. Student survey respondents were nearly evenly split across elementary, middle, and high schools.

Most family survey respondents identified as Black, followed by White and Hispanic/Latino (see Table 1). Nearly all family survey respondents identified as heterosexual. With respect to gender, most identified as female; very few identified as transgender or non-binary. Approximately half of family survey respondents indicated they had a child in elementary school and one-third indicated they had a child in high school; fewer indicated they had a child in pre-K or middle school.

Student survey sample compared to DC enrollment

Student survey respondents reflect District of Columbia racial/ethnic demographics with Black students followed by Hispanic/Latino students as the largest respondent groups. However, Hispanic/Latino and White students are underrepresented in the survey sample and students who identify as more than one race are overrepresented (see Table 2).

Table 1. Student and Family Survey Respondent Characteristics (%)		
	Students	Families
Race/ethnicity		
Black	65%	62%
Hispanic/Latino	12%	11%
White	6%	16%
Two or more races	10%	4%
Other	3%	3%
Gender		
Girl/Woman (cisgender)	52%	87%
Boy/Man (cisgender)	42%	11%
Transgender	2%	<1%
Non-binary	2%	<1%
Sexual orientation		
Heterosexual	62%	85%
LGBQ	23%	6%
Do not understand question	7%	N/A
Prefer not to answer	8%	9%
Grade		
Prekindergarten through Kindergarten	N/A	3%
Elementary (Grades 1-5)	35%	51%
Middle (Grades 6-8)	35%	12%
High (Grades 9-12)	31%	35%

Table 2. Student Race/Ethnicity and Grade (%) Survey Sample compared to DC Enrollment		
	Survey sample	District
Race/Ethnicity		
Black	65%	64%
Hispanic/Latino	12%	20%
White	6%	12%
Two or more races	10%	3%
Other	3%	2%
Grade		
Prekindergarten through Kindergarten	N/A	21%
Elementary (Grades 1-5)	35%	34%
Middle (Grades 6-8)	35%	17%
High (Grades 9-12)	31%	20%

Note. District estimates are based on 2020-2021 OSSE Enrollment Audit report and reflect public and public charter school enrollment data. "Other" includes American Indian or Alaska Native (n = 42), Asian (n=49), Middle Eastern or North African (n < 20), Native Hawaiian or Other Pacific Islander (n < 20), A different race/ethnicity not listed (n < 20); sample sizes yielded concerns about representativeness and interpretation. Students preferring not to answer the race/ethnicity question (n = 194) are also included in the "Other" category. The survey was designed for students in Grades 4 and above. Grade level information is not comparable in some cases as some schools were categorized as serving both elementary and middle grades for the survey.

School staff characteristics

The majority of staff survey respondents reported having been in their current school between two to five years and most identified their role as that of a classroom teacher (see Table 3). Staff categorized as "other" listed roles such as paraprofessional, dedicated aid, or educational aid. Several respondents that selected other listed a behavioral health role, which will be added as a separate category in school year 2021-2022. Few principals and school nurses responded.

Table 3. Staff Survey Respondent Characteristics (%)	
Time at school	
1 year or less	21%
2 to 5 years	51%
6 to 10 years	18%
More than 10 years	10%
Current role	
Classroom teacher	63%
Principal	1%
Other school administrator	8%
School nurse	1%
Other	23%
Prefer not to answer	4%

School Behavioral Health Coordinators in 125 schools completed a survey describing their schools' efforts to plan, implement, and monitor behavioral health supports. The amount of time at their school was fairly evenly split across tenure categories, with a small minority reporting they had been at their school less than a year (see Table 4). Respondents to the SBHC survey primarily reported serving in a behavioral health professional role at their school, although some reported serving in another administrative role.

Table 4. SBHC Survey Respondent Characteristics (%)	
Time at school	
Less than 1 year	8%
1 to 2 years	27%
3 to 5 years	31%
More than 5 years	33%
Current role	
Behavioral health professional	63%
Principal/Head of School	2%
Other school administrator	10%
Other	25%

Data analysis

Survey items were averaged overall and disaggregated to examine differences in response patterns across different characteristics. Based on research suggesting that youth who identify as LGBTQ often experience poorer behavioral health and significant barriers to accessing treatment

due to experiences of discrimination and stigma, student data were disaggregated by sexual orientation. To determine whether group differences were statistically significant, a series of binary logistic regression analyses were conducted to examine likelihood of responding more positively or negatively based on characteristics of respondents. Although in some cases survey questions had multiple response options, for the analysis, they were modified to be dichotomous (e.g., strongly agree and agree were combined into one "agree" category while strongly disagree and disagree were combined into one "disagree" category). Open-ended survey responses and interview transcripts were analyzed to identify themes. Text topic modelling, a machine learning technique, supported this process by identifying topics within short answer survey responses based on patterns of words or groups of words that occurred together frequently.

General Findings

These data were collected in May and June of 2021, in the midst of the global COVID-19 pandemic and a few months after schools in the District of Columbia re-opened for in-person learning. It is important to note that the percentages of students attending school in-person varied by school and were also influenced by public health measures that included quarantining. In this section, we present findings on how students, families, and staff perceived their ties to their school as well as their experiences with help-seeking and their awareness of behavioral health supports offered through the school. A complete summary of data across all surveys can be found in Appendix B.

School environment

Most students reported a strong sense of belonging at school and indicated there is a teacher or other adult they could talk to if they had a problem. Family members also reported mostly positive sentiments about school environments. Nearly all family members reported that they feel welcome at their child's school and that they would feel comfortable talking to school staff about their child's behavior.

Table 5. Student experiences within school environment (%)

Students	
Feel like you belong (% Quite a Bit, Completely)	67%
Have trusted adult (% Yes)	73%
Families	
Feel welcome at school (% Strongly agree, Agree)	95%
Comfortable talking to staff about student behavior (% Strongly agree, Agree)	94%

Perceptions of behavioral health

It is important to recognize that while stigma about behavioral health treatment can create barriers for accessing treatment, negative perceptions may also be the result of harmful experiences with behavioral health treatment. In other words, mistrust of the behavioral health

system is not always linked to stigma related to behavioral health; it can also be a response to negative experiences. We asked students and family members about their perceptions of mental health disorders as well as their thoughts related to help-seeking.

Although most students did not believe their peers would make fun of someone for seeing a therapist or counselor, one in four indicated that students probably or definitely would get made fun of at their school. Many students and families endorsed positive views of help-seeking. Nearly two-thirds of students said they would definitely or probably be comfortable talking to a therapist or counselor at school if they had a mental/behavioral health challenge. Nearly all family members agreed that they would want their child to see a therapist if they had been sad, worried, or upset for a long period of time.

Table 6. Student and family perceptions of behavioral health (% endorsing item; i.e., agree/strongly agree, definitely/probably yes)

	Students	Families
Would students at your school make fun of someone who sees a therapist or counselor	25%	N/A
Would feel comfortable talking to a counselor	62%	N/A
Would want child to see therapist or counselor	N/A	94%
Know how to get help	49%	47%

Behavioral health needs and experience with help-seeking

Understanding how common it is for student behavioral health needs to go unmet in the District of Columbia is an important metric for prioritizing behavioral health investments. In our surveys of students and family members, we asked them whether there had been a time when they (students) or their child (family members) experienced a behavioral health challenge and didn't get the help they needed. The question about unmet behavioral health need did not ask about school experiences specifically; therefore,responses likely reflect experiences with behavioral health services both in and out of school. We also asked family members if they themselves had experienced a behavioral health challenge which was unmet.

Nearly one in five students and family members reported unmet behavioral health needs. Notably, a smaller percentage of family survey respondents indicated their child had unmet behavioral health needs when compared to student reports.

Table 7. Unmet behavioral health needs (% yes)

	Students	Families
Had unmet behavioral health need (self)	21%*	20%
Child had unmet behavioral health need	N/A	12%

*18% of students chose not to answer this question

The rejection of not being able to actually get in touch with and make an appointment with the right person makes kids feel their mental health doesn't matter to their school -Caregiver

If respondents told us they/their child had experienced unmet behavioral health needs, we asked them why they weren't able to get the help they needed. It is important to note that we did not specify barriers to getting help in school or out of school, so it is possible that some families and students might be reporting on barriers they had accessing treatment services outside of school. Notably, the top reasons for both caregivers and students not accessing the care they needed were the same and suggest that stigma plays a role for both adults and youth.

Table 8. Top reasons for behavioral health needs not being met reported by families

Barrier for child (in or out of school)	Barrier for self
1. Did not know where to get help (27%)	1. Thought problem would go away on its own (46%)
2. Logistical challenges like insurance, transportation, childcare (27%)	2. Not wanting other to know they had a problem (22%)
3. Not able to get an appointment (20%)	3. Logistical challenges like insurance, transportation, childcare (20%)

Table 9. Top reasons for behavioral health needs not being met reported by students

Barrier (in or out of school)
1. Thought problem would go away on its own (52%)
2. Not wanting anyone to know they had a problem (51%)

Staff perceptions of behavioral health supports

School staff were generally positive in their assessment of the prevention, early intervention, and treatment supports offered at their schools, and they believed that treatment services make a difference (see Table 10). When comparing school staff survey responses to the SBHC survey responses, both surveys suggest high levels of satisfaction with the behavioral health supports that are provided across the three MTSS tiers (i.e., promotion/prevention, early intervention, treatment). However, a larger proportion of SBHCs had positive perceptions of treatment (Tier 3) supports compared to respondents of the staff survey. Among staff who had referred a student for Tier 3 services, most agreed they had seen improvements among students they referred (see Table 10), although approximately 20 percent reported that they were not sure about any changes in the students they had referred and between 10 and 15 percent did not agree that students had experienced improvements. While most school staff reported feeling confident in their ability to identify warning signs of behavioral health problems in students, one in five would like more professional development to build these skills.

Table 10. Staff perceive behavioral health supports are adequate (% Strongly agree, Agree)	
Promotion/prevention (Tier One) are adequate	
School staff survey	81%
School Behavioral Health Coordinator survey	86%
Early intervention (Tier Two) are adequate	
School staff survey	76%
School Behavioral Health Coordinator survey	82%
Treatment (Tier Three) are adequate	
School staff survey	70%
School Behavioral Health Coordinator survey	90%
Perception of student improvements (among staff who made a referral)*	
Improved behavior	65%
Reduced symptoms	65%
More coping skills	68%
More positive school connections	70%
Staff perceptions of mental health knowledge	
Able to identify warning signs or symptoms of behavioral health problems in students	65%
Would like more professional development related to behavioral health	65%

* Approximately 20% of staff reported that they were not sure about changes in students after making a referral for behavioral health services.

Stakeholder involvement in planning and monitoring in schools

Respondents to the SBHC survey reported on whether and how a variety of school stakeholder groups were involved in planning and monitoring behavioral health supports (see Table 11). Findings indicate that behavioral health professionals and school administrators were the most frequently involved stakeholders in both developing and monitoring school behavioral health plans while students, families, and teachers rarely played a decision-making role.

Table 11. Percentage of SBHCs reporting involvement of various stakeholders in planning			
Involvement in planning	Decision-maker	Involved	Not involved
Behavioral health provider	95	3	1
Other admin	68	15	17
Principal	67	21	10
Community partner	63	14	20
Health provider	50	15	33
Teachers	28	45	25
Families	17	42	38
Students	3	41	54
Involvement in monitoring	Decision-maker	Involved	Not involved
Behavioral health provider	93	7	0
Other admin	67	17	13
Principal	64	19	13
Community partner	52	31	14
Health provider	44	16	37
Teachers	20	36	41
Families	5	33	56
Students	1	27	66

School employee wellness

The school staff survey asked staff about their wellness as well as their assessment of the supports offered at their school. While a majority of staff reported feeling engaged and hopeful, nearly half reported frequently or almost always feeling exhausted and slightly more than one-third reported frequently or almost always feeling stressed (see Table 12). Nearly three-quarters of staff reported that the staff wellness supports at their school were adequate, although one-quarter of respondents had not participated in those supports. Among staff who had participated in wellness supports, only half were "quite" or "extremely" satisfied with those supports.

Table 12. School employee wellness (%)

Endorsement of feelings experienced in the past 2 weeks (% Frequently or Almost Always)	
Engaged	77%
Hopeful	63%
Exhausted	48%
Stressed	38%
'Offered staff wellness supports are adequate'	
Agree or Strongly Agree	71%
Utilization of offered wellness supports	
Participated (% Yes)	71%
Satisfied (among those that participated, % Quite or Extremely)	52%

Spotlight on LGBQ+ Youth

Research suggests that lesbian, gay, bisexual, questioning, queer, and transgender (LGBTQ+) youth tend to report poorer behavioral health outcomes, due in large part to experiences of discrimination and stigma based on their sexual orientation and gender identity.[11] For example, data from the Centers for Disease Control and Prevention (CDC) indicate that lesbian, gay, and bisexual students are twice as likely as their heterosexual peers to report feeling unsafe at school, including being bullied at school or being threatened or injured with a weapon at school.[12]

Among students completing the survey, nearly one in four (23%) identified as lesbian, gay, bisexual, questioning, or another non-heterosexual identity. We found that while some risk and protective factors differed by sexual orientation, others were similar for LGBQ+ youth and their heterosexual peers (see Table 13). Due a low number of survey respondents who identified as transgender, we are not able to identity differences in their experiences.

[11] Russell, S. T., & Fish, J. N. (2016). Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annual review of clinical psychology*, *12*, 465-487.

[12] Johns MM, Lowry R, Haderxhanaj LT, Rasberry CN, Robin L, Scales L, Stone D, Suarez NA. Trends in Violence Victimization and Suicide Risk by Sexual Identity Among High School Students - Youth Risk Behavior Survey, United States, 2015-2019. MMWR Suppl. 2020 Aug 21;69(1):19-27.

Several protective factors were similarly positive across LGBQ+ youth and their heterosexual peers. For example, nearly three-quarters of youth in both groups reported having a trusted adult at school and feeling comfortable talking to a counselor or therapist at school. Unfortunately, nearly half of youth in both groups were not sure who to go to for help with a behavioral health problem at school.

There were also some notable, and alarming, differences between LGBQ+ youth and their heterosexual peers. For example, a smaller percentage of LGBQ+ youth reported a strong sense of belonging to their school, which is an important protective factor for positive behavioral health. Additionally, the percentage of LGBQ+ youth who reported having had unmet behavioral health needs was more than double the percentage of heterosexual youth who reported unmet needs.

Table 13. Experiences with behavioral health by sexual orientation

	LGBQ+	Heterosexual
School belonging (% belonging "a lot" or "completely")	56%	71%
Have a trusted adult at school (% yes)	72%	75%
Had a behavioral health challenge and didn't get the help needed (% yes)	36%	16%
Would be comfortable talking to a counselor or therapist at school (% "definitely" or "probably" comfortable)	72%	70%
Know who to go to at school to get help with a behavioral health problem (% yes)	43%	52%

While most LGBTQ+ youth are resilient—and many have supportive relationships with their families, peers, and school staff—it is important to keep in mind that they also tend to have more negative experiences in school due to identity-based discrimination. School behavioral health providers can support LGBTQ+ students by working to ensure that schools are safe and supportive, including fair and consistent enforcement of anti-bullying policies. Given that it is impossible to know which students in a school identify as LGBTQ+, behavioral health providers should work to ensure that all students at their school are aware of how to access behavioral health treatment services. Finally, providers can attend trainings and leverage peer learning opportunities—including those offered by the CoP—to increase their capacity to serve as allies and supportive, affirming behavioral health providers for LGBTQ+ youth.

System-level findings

A total of 17 survey responses were received from Coordinating Council members. This brief survey, administered during August and September 2021, asked respondents to describe their experiences serving on the Coordinating Council. In addition, 16 individuals from expansion partner organizations, the Coordinating Council, and the CoP participated in interviews to share their perspectives on the overall purpose and structure of the expansion as well as how it is being implemented citywide. Interviews took place during September and October 2021. Below is a summary of the findings from these survey responses and interviews.

Coordination at the system-level

The Collective Impact Forum has defined collective impact as "a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems-level change."[13] Below we present findings related to how the District of Columbia has gone about expanding school behavioral health supports through a partnership of public agencies and non-profit organizations.

Many expansion partners feel that strong personal and organizational ties have been established among partners. Most of the individuals who were interviewed in Fall 2021 remarked on the deep commitment among member organizations to increase access to behavioral health supports. Many also commented on the sense of trust and collaboration that has developed over time among members, despite differences in opinion along the way about the best path forward. However, some community-based organizations (CBOs) feel a stronger sense of connection and collaboration with one another than with other partner organizations. Although they feel welcome to voice their concerns to other partners, they highlighted an absence of support to help them navigate challenges that are common to all CBOs in the expansion. As a result, they support one another and rely on collective problem-solving.

When you try to reach out to someone from a partner organization, at the city level, everyone picks up the phone immediately and is happy to plan and talk. It doesn't ever feel like, "Don't worry about it. This is ours. We got it." - Partner organization member

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Most members of the Coordinating Council believe the right mix of perspectives are included on the Council. More than three-quarters of survey respondents agreed or strongly agreed that the Coordinating Council includes the right mix of perspectives. Further, several interview participants commented that a key strength of the expansion is having "the right people at the table," including representatives from both charter and DCPS schools, community-based providers, parents, and parent-facing organizations, as well as engagement at different points in time from the Council of the District of Columbia and different offices within the executive branch. Participants perceive that having these diverse perspectives has yielded robust feedback and facilitated appropriate course corrections when needed. However, several interview participants noted that the expansion would benefit from having teachers, school behavioral

[13] https://www.collectiveimpactforum.org/blogs/700/redefining-collective-impact

health coordinators, and clinicians at the table. Some participants also expressed a desire for DC Council to have more sustained engagement.

Some Coordinating Council members feel that meetings do not provide opportunities for authentic engagement, in particular for student and parent members. More than one-third of survey respondents disagreed or strongly disagreed with the statement, "The Coordinating Council effectively leverages the expertise of its members." Several interview participants noted that although parents and students have a seat on the Coordinating Council, they often cannot attend meetings because they are held during the school or work day. Individuals we spoke with shared concerns that reading a student's prepared statement is not the same as having student voice in the discussion and in decision-making. Several interviewees also shared the perception that meetings of the Coordinating Council have shifted away from collaborative problem-solving to focus more on updates, and that this has undermined the engagement of some members.

We have people on the list, but we're still not hearing the voice…. [When somebody reads a prepared statement from a student], I think that statement and that student represent something for the Council so we can check that box. - Partner organization member

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Sustained effort, small wins, and visible progress

Research from the National Implementation Research Network suggests that it can take two to four years to fully implement a well-constructed, well-defined, and well-researched program.[14] Complex interventions that have not been fully tested previously and that involve coordination across many partners can take even longer. Because sustained efforts and data-driven adjustments are an important part of achieving full implementation of an intervention, it can be helpful to document and celebrate small wins to maintain motivation.

Many expansion partners agree there has been sustained commitment for and momentum around the expansion, even when it could have been sidelined. Several interviewees described examples from the past in which city leaders had given up on initiatives and gravitated towards new approaches when challenges had been encountered or evidence of effectiveness had not yet been generated. Given this history and context, expansion partners we spoke with felt very positively that the pandemic did not result in expansion efforts being sidelined. On the contrary, one noted,

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[14] Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature An Integrated Stage-Based Framework for Implementation of Early Childhood Programs and Systems (FMHI Publication No. 231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network

"We actually managed to expand during COVID and actually get new clinicians into schools that they never set foot in, some of them all year. That's pretty remarkable." Partners attribute these sustained efforts to a deep commitment on the part of the city to a coordinated and comprehensive approach to increase access to behavioral health supports.

Many expansion partners believe that implementation has strengthened over time, and small wins are visible at multiple levels of the expansion. Individuals who were interviewed in Fall 2021 reflected on process-related improvements that they have observed since the expansion first began in SY 2018-2019. These include, for example, changes to the District of Columbia Public Schools (DCPS) matching process, which streamlined the CBO options given to each school and thereby reduced the amount of time CBOs spent interviewing; greater understanding among school leaders and SBHCs regarding the coordinator role as a logical fit for a mental health professional, rather than just another responsibility being added to someone's plate; and a new joint training for school mental health staff (e.g., social workers, psychologists, counselors) and partners (i.e., DBH and CBO clinicians), which clarified specific roles they should be playing within the public health model and also helped to build understanding, trust, and accountability among team members.

Implementation challenges

Researchers from the National Implementation Research Network have identified several factors that are critical to high quality implementation of an intervention.[15] One important factor is a data-driven process of adaptation as challenges arise. Below we present interview findings related to key implementation challenges, which expansion partners and the Coordinating Council are already working to problem-solve and address.

Expansion partners noted that establishing and maintaining connections between schools and providers can be challenging. Once matched, it takes time for schools and CBO clinicians to establish a common understanding of how they will work together. Expectations commonly differ regarding what types of services clinicians will provide and how often, and the extent to which and how the school mental health team will collaborate—both in general and in addressing individual student needs. In schools with a full-time DBH clinician, there also may be questions about whether and how clinicians' roles differ.

[15] Fixsen, D. L., & Blase, K. A. (2009). Implementation brief: Vol. 1. Chapel Hill, NC: National Implementation Research Network.

It's gone great when the school administration, or the people that have been designated to really partner closely with us, are on board, are enthusiastic, see the value of it. Other schools, our clinicians have had to kind of chase the school people down. -CBO director

CBOs perceived that partnerships tend to go more smoothly when principals make time early-on to be involved in discussions, have mechanisms in place to clearly communicate expectations to all school staff, and bring their CBO clinician on as an "essential partner" who is fully integrated into the school team to help with planning and implementing services. Partnerships also go more smoothly when SBHCs are well-established members of the school mental health team—with their "finger on the pulse" of student needs and how they are being met—and are fully onboarded to their own roles so they can help a new CBO clinician become integrated into the school.

It really takes a year to be able to feel comfortable in the school and have your relationships built. -Partner organization member

Expansion partners noted that perceptions about financing of Tier 3 services have led to some tensions with respect to implementing a public health approach. Almost all interview participants discussed challenges related to the financial structure of the expansion. CBO clinicians are expected to deliver school-based services across all three tiers of support; however, given their business model, they can generally only bill for Tier 3 services. As a result, some CBOs feel they are in a financially untenable situation where they want to remain in the expansion but worry it is unsustainable—particularly in schools that utilize them heavily at the Tier 1 and Tier 2 levels, which may happen for a variety of reasons. This also creates a tension within many school-CBO partnerships and among partner organizations in the expansion more generally. Some schools and partner organizations perceive that some CBOs resist providing Tier 1 and Tier 2 services, while some providers and CBOs feel misunderstood and seen as being more interested in money than in addressing the needs of students. Some partner organizations perceive that the fact that CBOs have not fled the expansion *en masse* suggests this may be more of a mindset challenge than an actual business challenge. However, one CBO director explained that it is much easier to stay in their current schools than to add new schools, because in their current schools they are finally getting referrals for Tier 3 services after a substantial investment of uncompensated

relationship-building time. One interviewee suggested that this tension may be contributing to the challenges of placing providers into all Cohort 4 schools, as these schools have the lowest levels of need and therefore CBOs anticipate delivering primarily Tier 1 and Tier 2 services. This tension may also contribute to provider turnover. One CBO director explained that new clinicians may choose to leave if they are spending most of their time on activities that do not help them hone their clinical skills.

A lot of our other business carries the cost of the program. That's not fiscally responsible. So, do we stay in this and do the work we are poised to do because our babies need it? Or do we make a business decision? -CBO Director

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Many expansion partners discussed the need for more or better data, particularly for tracking provider activities. There is no source of data across all School Behavioral Health Program providers to consistently track provider activities and student outcomes. Some interviewees emphasized the need to track Tier 1 and Tier 2 activities for CBO clinicians, as is already tracked for DBH clinicians, to understand how well provider activities are being driven by the needs identified at their school and the extent to which DBH and CBO clinicians are providing different services. Others discussed the limited value of what is currently tracked, even at Tier 3. For instance, while clinicians currently report the total number of students on their caseload at any given point in time, there is no single source for the unique number of students seen over time or for information on how long students are being seen.

The unified monthly reporting for DBH and CBO clinicians that is still in the planning stages may still have some shortcomings, in part because it is inherently challenging to track prevention activities; however, it is anticipated to be "leaps and bounds" better than what is currently in place. There is also widespread agreement that objective measures of effectiveness are needed to determine if children's behavioral health needs are being addressed adequately. Several individuals acknowledged that progress has been made in this area, for instance with recent training on the Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool and Early Childhood Functional Assessment Scale (PECFAS), which will be used as an outcome tool. However, expansion partners expressed a desire to be further along with the data aspect of the expansion.

It's hard for us to even say how many kids we've touched. - Partner organization member

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DC Community of Practice (DC CoP)

The DC School Behavioral Health Community of Practice (CoP) focuses on supporting individuals working within and across all Washington, DC school-based behavioral health systems by providing collaborative spaces and supporting their ability to deliver comprehensive school behavioral health services and supports to students, families, and the school community. The CoP facilitates several different types of supports:

- *monthly CoP meetings*, each of which focus on a specific topic and include skill development as well as peer-learning;
- *skill-building chats* which are intended to allow individuals who are interested in going deeper on a topic to engage with others to share resources and engage in joint problem-solving;
- *trainings* to build knowledge and awareness;
- *working groups* that are established among individuals interested in exploring an emerging issue or addressing a persistent problem that requires some sustained attention to address (e.g., staff wellness, suicide prevention, Kognito trainings, Coordination between primary care and behavioral health, connecting with students)
- *practice groups* that foster ongoing collaboration among members focused on: crisis response and intervention, family and youth engagement, positive school climate and social and emotional learning, and trauma-informed practices in schools

Participation

The CoP tracks attendance at monthly meetings and chats. When registering, participants are asked to indicate the setting in which they work: community-based organization providing school-based supports, DC Department of Behavioral Health, DC Public Schools, DC Public Charter Schools, or another affiliation. At this time, attendance at working groups and practice groups that are primarily peer-led is not consistently reported. Below we summarize attendance data for monthly meetings, skill-building chats, and trainings.

Monthly meetings and skill-building chats

Skill-building chats averaged an attendance of 10 participants, ranging from a low of seven participants in April to a high of 15 participants in March. More than half of participants each month identified as something other than a school-based provider. On average, two CBO providers and one DBH provider attended each skill-building chat.

CoP meetings averaged 104 participants, although attendance ranged from a high of 133 in October to a low of 60 in May (see Table 14). On average, 25 CBO providers and 10 DBH providers attended monthly CoP meetings. Topics covered included: creating safe and welcoming schools (September); grief, loss, and trauma (October); partnering with families

(November); impact of COVID-19 on student wellness (December); promoting a positive school climate (January); building strong crisis response teams (February); ethics and multiculturalism (March); preventing youth suicide (April); and a review of school strengthening workplans (May).

Table 14. CoP Attendance in 2020-2021 by Participant Group Affiliations (N)

Affiliations	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOTAL
CBO	30	27	33	18	20	35	24	27	15	229
DBH	7	5	8	13	7	9	15	15	7	86
DCPCS	4	11	12	7	11	18	10	3	5	81
DCPS	32	25	19	5	44	27	35	27	15	229
Other	51	65	25	35	30	28	29	28	18	309
Total	**124**	**133**	**97**	**78**	**112**	**117**	**113**	**100**	**60**	**934**

Trainings

The CoP facilitated three trainings:

1. School Mental Health teaming offered in collaboration with the National Center for School Mental Health and the Central East Mental Health Technology Transfer Center. Total attendance was 122, with 32 CBO providers and 19 DBH providers in attendance.
2. Using Youth Risk Behavior Survey (YRBS) data to understand patterns and trends in school behavioral health in collaboration with OSSE. Total attendance was 19, with five CBO providers and one DBH provider in attendance.
3. A three-part training on grief, loss, and trauma among children and youth delivered in partnership with the Wendt Center for Loss and Healing. A total of 129 providers and 60 school leaders/staff participated in the training series.

Awareness and satisfaction among SBHCs

In the survey of SBHCs described in the previous section of this report, respondents were asked about participation in, or use of, various resources and their perception of the utility of those resources (see Table 15). Most SBHC survey respondents participated in the CoP and approximately two-thirds of SBHC respondents found the CoP useful. A small percentage of SBHC survey respondents participated in the CoP and did not find it useful; a similar proportion were aware of the CoP but had not participated. Very few SBHC survey respondents were not familiar with the CoP. When comparing awareness and satisfaction with the CoP to other resources that were provided to SBHCs and school teams, the assessment of the CoP was similar to that of other professional development offerings that survey respondents had participated in related to behavioral health.

Table 15. SBHC Survey items about the CoP and related resources				
	Useful	Not Useful	Did Not Use	Not Familiar
Participation in CoP	69%	12%	12%	8%
Tip sheets	53%	10%	24%	14%
Training on planning tools	55%	7%	26%	12%
Training on collecting, submitting, and using data	37%	6%	31%	26%
Professional Development on Behavioral Health	71%	8%	12%	10%

Continuous Quality Improvement

During the 2020-2021 school year, DBH leaders and evaluation staff from Child Trends worked to develop a comprehensive, multi-phase plan for building the capacity of DBH to collect and analyze data. The plan is based on understanding of DBH priorities, best practices for using data to monitor and improve programs, and insights from Child Trends' conversations with community stakeholders since March 26, 2020 (e.g., focus groups held with clinicians, school staff, youth, etc.). A major focus of the plan is developing infrastructure as well as inclusive data analysis processes to ensure consistency in the data that are available for monitoring efforts across providers who are hired by DBH directly as well as those hired by CBOs that have been partnered with schools as a part of the expansion. Engaging in a process of CQI will enable DBH to identify aspects of the expansion that appear to be working well and opportunities for improvement; flag specific schools and CBOs, including school-CBO partnerships, where issues are arising in order to provide tailored supports; and make a data-informed case for ongoing support of the initiative.

The plan outlines a phased approach for developing the Expansion CQI system. In each phase, DBH will oversee the CQI cycle by collecting data from multiple sources, inputting them into a central data system, summarizing data, reviewing and discussing summaries with key stakeholders, identifying next steps, and monitoring implementation. Phase 1 (Establish) will begin in Spring 2021 and accomplish the goal of setting up processes and data system and asking questions of initial data on top priority measures. Phase 2 (Refine) will begin in Fall 2021 (or when Phase 1 is complete), refine processes and data system set up in Phase 1, and collect additional existing data for additional schools/CBOs or on additional measures. Lastly, Phase 3 (Expand) is planned for Spring 2023 and will expand the CQI system and track additional measures from new data sources and/or additional schools to answer further questions about the Expansion's performance. Additional details about this phased approach, the potential data sources, and Child Trends' other recommendations are provided in the final CQI plan (Appendix C).

Recommendations

Based on an analysis of data that were collected from students, families, school staff, and partner agencies and organizations as well as published literature on the implementation of high quality, multi-tiered behavioral health supports in schools, we offer the following recommendations, which are divided across system-level and school-level recommendations.

5 system-level recommendations

1. **Create a culture of continuous quality improvement.** The Department of Behavioral Health has already taken steps to establish consistent program activity and collect outcomes data across School Behavioral Health Program providers working in public and public charter schools. Once there is consistent collection of data across providers, it is important to leverage these investments to help schools and providers work together to make data-informed decisions in order to set priorities and monitor progress. Data should also be used to direct resources and training efforts to address common challenges and to identify and highlight successes with potential for scaling-up.

2. **Work with key stakeholders to reassess the current braided funding approach.** The current evaluation focuses on understanding how school behavioral health supports are being delivered in schools and to what extent those supports are resulting in improved outcomes. However, we heard from several stakeholders about the need to better understand how financial models influence implementation of a public health approach to school behavioral health. In particular, there is interest in understanding how seeking third-party reimbursement for Tier 3 services might influence the capacity for some providers to implement prevention and early intervention supports.

3. **Set a vision for the Coordinating Council for School Behavioral Health that embraces a clear role for supporting continuous quality improvement.** The members of the Coordinating Council for School Behavioral Health should consider whether membership needs to change as the work transitions from expansion to continuous quality improvement and sustainability. It is critical to ensure that the voices of students, families, and school staff are included and reflected in decision-making.

4. **Consider creating a set of orientation resources for new School Behavioral Health Program providers.** Few clinical degree programs prepare clinicians to apply the public health approach that is called for in schools. Orientation resources could include access to existing, high-quality training from trusted partners but should be integrated with structured, on-the-job support and peer learning opportunities. Further, additional efforts could be made to increase the capacity of school behavioral health teams to integrate new

team members, especially providers that are not employed by the school. Such a program could potentially be housed within the DC CoP.

5. **Invest in efforts to raise awareness about the presence of school-based behavioral health providers in schools.** The data in this report highlight a lack of awareness about school-based behavioral health supports among students and families and how to access them. While some of this work must be done at the school level, a citywide awareness campaign could help to normalize conversations about behavioral health. A centralized source of information—such as a webpage with contact information for each school or hotline—could also streamline the process families go through when trying to identify a first point of contact.

5 school-level recommendations

1. **Dedicate time to establishing and deepening relationships between schools and providers.** Forming partnerships between School Behavioral Health Program providers and schools can be extremely rewarding but can also present challenges. Schools and providers should plan to dedicate time to establish shared expectations and co-develop a plan. Many resources are available through the DC CoP, the Department of Behavioral Health, and other partner agencies to support schools and CBOs in establishing an effective partnership.

2. **Find ways to involve students and families in decisions about school behavioral health.** Many students and families in schools across the city are unaware of how to access school-based supports. Engaging students and families in planning can help to identify strategies for increasing awareness and reducing barriers to accessing supports.

3. **Ensure active engagement in the DC Community of Practice among school-based providers and school administrators.** The DC CoP is a resource for all members of a school behavioral health team, including school administrators. Involvement in the DC CoP can facilitate access to helpful resources and connect team members to peer learning opportunities.

4. **Collect and use data to identify gaps and track progress.** The Strengthening School Behavioral Health surveys are one source of data on school behavioral health, but many school teams have access to other data as well, including school climate surveys and school attendance and behavior reports. Reviewing these data can help identify who is, and who is not, benefitting from supports in order to help set priorities and monitor progress towards goals. Ensuring widespread participation in data collection, such as the Strengthening School Behavioral Health Surveys, is critical to ensuring the data are

meaningful and represent the experiences of diverse groups of students, families, and staff.

5. **Embed behavioral health information often in communications with students and families.** Some students and families shared that communication about behavioral health supports seems to come most often when there is a challenge to be addressed. They noted that sharing information about behavioral health in general, prior to experiencing a specific challenge, can make it easier to absorb. In particular, students noted that it is easier to hear about behavioral health from staff that they see as having made an effort to get to know them. Engaging providers in prevention activities can help to normalize behavioral health supports and ensure that students know how to access treatment services.

Conclusion

The District of Columbia has made significant investments in increasing access to high quality behavioral health supports in schools across the city. The expansion of those services has leveraged a complex and dynamic public-private partnership and has required coordination across a number of government agencies and community-based organizations. All of this has taken place during a global pandemic, when schools have also been required to juggle multiple urgent priorities, including the promotion of academic, social, and emotional growth for students while also maintaining a safe and supportive environment for students and staff. As demonstrated in this report, the ability to scale up in the midst of these circumstances is due in no small part to the commitment of the partner organizations and, ultimately, the school leaders, school staff, behavioral health professionals, students, and families across the city who have demonstrated great resilience and tenacity.

At the same time, this report also highlights several opportunities for improvement, both at the larger system level and at the school level. The executive summary of this report outlines ten recommendations. The first five recommendations focus on ways to strengthen the system-level supports critical to ensuring improvements are sustained and the benefits are equitably distributed to students, families, and schools with the greatest need. System-level supports must be the foundation of efforts to achieve citywide improvements. The second five recommendations focus on strategies to enhance the quality of behavioral health supports within schools. Those recommendations emphasize the importance of building strong partnerships and ensuring a culture of continuous quality improvement.

In this report, we have attempted to paint a picture of the experiences of students, families, and staff, with an eye towards assessing whether particular groups are reporting systematic differences in their experiences. When highlighting disparities, we did so in order to support leaders across the city in their efforts to achieve equitable improvements through data-driven

decision-making. That said, we also recognize that these analyses are limited by the data that were available. While survey participation was strong for a year in which schools and families were juggling many urgent priorities, we recognize that there are bound to be important perspectives that have gone unheard. In future years, we will explore changes over time to better understand what is working and for whom, and to continue to reach out to students, families, and staff to help us gain insights into the data. We know that average improvements do not accurately reflect the lived experiences of students, families, and communities at the margins, especially those students, families, and schools experiencing the greatest need. Ultimately, we hope that this report will serve to inform and expand the ongoing dialogue about behavioral health in the District of Columbia and to invite more diverse voices to the decision-making table.

Limitations

In this report, we have aimed to provide insight and recommendations around how the expansion is being experienced and how supports might be strengthened to meet the needs of those within schools and those coordinating or supporting expansion efforts. Notably, though, reported data are primarily descriptive and rely on the perspectives of those who participated in surveys or for whom other administrative data were available. As such, data may not fully capture varied experiences within and across those groups, including roles, lived experiences, and contexts. However, the demographics of our student sample closely mirror the demographics of students enrolled in DC schools. Additionally, these data have been shared in meetings with groups connected to the expansion of school-based behavioral health supports and participants of those meetings have confirmed that these trends reflect their experiences and those of people they work with. Future analysis of survey and expansion support data will examine patterns across years and account for school characteristics and implementation factors.

Appendices

Appendix A: Surveys

Appendix B: Data tables

Appendix C: Continuous Quality Improvement Plan

Appendix A: Surveys

Strengthening Schools Youth Survey

We want to hear your thoughts about mental/behavioral health. This survey is not a test. You will not be asked to share your name, so your responses will not be connected to you. Please share your honest thoughts and experiences. Your responses will help your school to improve mental/behavioral health services for students and families.

About You

Please tell us about yourself.

How old are you?

_____

What is your race/ethnicity?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ A different race/ethnicity not listed
- ☐ I prefer not to answer

(You can select more than one answer for this question)

Please describe your race/ethnicity.

_____

Please select which gender that best describes you.

- ◯ Boy
- ◯ Girl
- ◯ Non-binary
- ◯ A gender not listed here
- ○ I prefer not to answer

Please describe your gender.

_____

Are you transgender?

- ◯ Yes
- ◯ No
- I prefer not to answer
- ○ I do not understand this question

Which of the following best describes you?

- ◯ Heterosexual (straight)
- ◯ Gay or Lesbian
- ◯ Bisexual
- ◯ Not Sure
- ◯ A sexuality not listed here
- I prefer not to answer
- ◯ I do not understand this question

Please describe your sexuality.

_____

Your School

Please share how you feel about your school.

Where do you go to school?

- Aiton Elementary School Amidon-
- Bowen Elementary School
- Anacostia High School
- Ballou High School Ballou
- STAY High School
- Bancroft Elementary School
- Bard High School Early College DC (Bard DC)
- Barnard Elementary School
- Beers Elementary School
- Benjamin Banneker High School
- Lawrence E. Boone Elementary School
- Brent Elementary School
- Brightwood Education Campus
- Brookland Middle School
- Browne Education Campus
- Bruce-Monroe Elementary School @ Park View
- Bunker Hill Elementary School
- Burroughs Elementary School
- Burrville Elementary School
- C.W. Harris Elementary School
- Capitol Hill Montessori School @ Logan
- Cardozo Education Campus
- Cleveland Elementary School
- Columbia Heights Education Campus
- Coolidge High School
- Deal Middle School
- Dorothy I. Height Elementary School
- Drew Elementary School
- Duke Ellington School of the Arts
- Dunbar High School
- Eastern High School
- Eaton Elementary School
- Eliot-Hine Middle School
- Excel Academy
- Garfield Elementary School
- Garrison Elementary School
- H.D. Cooke Elementary School
- Hardy Middle School
- Hart Middle School
- Hearst Elementary School
- Hendley Elementary School
- Houston Elementary School
- Hyde-Addison Elementary School
- Ida B. Wells Middle School
- Inspiring Youth Program
- J.O. Wilson Elementary School
- Janney Elementary School
- Jefferson Middle School Academy
- Johnson Middle School
- Kelly Miller Middle School
- Ketcham Elementary School
- Key Elementary School
- Kimball Elementary School
- King Elementary School
- Kramer Middle School
- Lafayette Elementary School
- Langdon Elementary School
- Langley Elementary School
- LaSalle-Backus Education Campus
- Leckie Education Campus Ludlow-
- Taylor Elementary School Luke C.
- Moore High School MacFarland
- Middle School
- Malcolm X Elementary School @ Green
- Mann Elementary School
- Marie Reed Elementary School
- Maury Elementary School
- McKinley Middle School
- McKinley Technology High School

- ◯ Miner Elementary School
- ◯ Moten Elementary School
- ◯ Murch Elementary School
- ◯ Nalle Elementary School
- ◯ Noyes Elementary School
- ◯ Oyster-Adams Bilingual School
- ◯ Patterson Elementary School
- ◯ Payne Elementary School
- ◯ Peabody Elementary School (Capitol Hill Cluster)
- ◯ Phelps Architecture, Construction and Engineering High School
- ◯ Plummer Elementary School
- ◯ Powell Elementary School
- ◯ Randle Highlands Elementary School
- ◯ Raymond Education Campus
- ◯ River Terrace Education Campus
- ◯ Ron Brown College Preparatory High School
- ◯ Roosevelt High School
- ◯ Roosevelt STAY High School
- ◯ Ross Elementary School
- ◯ Savoy Elementary School
- ◯ School Without Walls @ Francis-Stevens
- ◯ School Without Walls High School School-
- ◯ Within-School @ Goding
- ◯ Seaton Elementary School
- ◯ Shepherd Elementary School
- ◯ Simon Elementary School
- ◯ Smothers Elementary School
- ◯ Sousa Middle School
- ◯ Stanton Elementary School
- ◯ Stoddert Elementary School Stuart-
- ◯ Hobson Middle School (Capitol Hill Cluster)
- Takoma Education Campus
- ◯ Thaddeus Stevens Early Learning Center
- ◯ Thomas Elementary School
- ◯ Thomson Elementary School
- ◯ Truesdell Education Campus
- ◯ Tubman Elementary School
- ◯ Turner Elementary School
- ◯ Tyler Elementary School
- ◯ Van Ness Elementary School
- ◯ Walker-Jones Education Campus
- ◯ Watkins Elementary School (Capitol Hill Cluster)
- ◯ West Education Campus
- ◯ Wheatley Education Campus
- ◯ Whittier Education Campus
- ◯ Woodrow Wilson High School
- ◯ H.D. Woodson High School
- ◯ Youth Services Center
- ◯ Academy of Hope Adult PCS [Southeast]
- ◯ Academy of Hope Adult PCS [18th Place]
- ◯ Achievement Preparatory PCS [Wahler Place]
- ◯ AppleTree Early Learning PCS - Parklands
- ◯ AppleTree Early Learning PCS - Columbia Heights
- ◯ AppleTree Early Learning PCS - Southeast [Douglas Knoll]
- ◯ AppleTree Early Learning PCS - Lincoln
- ◯ AppleTree Early Learning PCS - Oklahoma Avenue
- ◯ BASIS DC PCS
- ◯ Breakthrough Montessori PCS [Taylor Street]
- ◯ Montessori PCS [Eastern Avenue]
- ◯ Bridges PCS [Mamie D. Lee]
- ◯ Briya PCS [13th Street/Sharpe]
- ◯ Briya PCS [Gallatin Street/Fort Totten]
- ◯ Briya PCS [Ontario Road/Adams Morgan/Main]
- ◯ Briya PCS [Georgia Avenue/Petworth]
- ◯ Capital City PCS
- ◯ Carlos Rosario International PCS [Harvard Street]
- ◯ Carlos Rosario International PCS [Sonia Gutierrez]
- ◯ Cedar Tree Academy PCS

- ◯ Center City PCS - Brightwood
- ◯ Center City PCS - Capitol Hill
- ◯ Center City PCS - Congress Heights
- ◯ Center City PCS - Petworth
- ◯ Center City PCS - Shaw
- ◯ Center City PCS - Trinidad
- ◯ Cesar Chavez PCS for Public Policy - Parkside
- ◯ Community College Preparatory Academy PCS [MC Terrell]
- ◯ Community College Preparatory Academy PCS [DCIA]
- ◯ Community College Preparatory Academy PCS [Main]
- ◯ Creative Minds International PCS
- ◯ DC Bilingual PCS
- ◯ DC Prep PCS - Benning Elementary
- ◯ DC Prep PCS - Benning Middle
- ◯ DC Prep PCS - Anacostia Elementary School [V Street]
- ◯ DC Prep PCS - Edgewood Elementary School
- ◯ DC Prep PCS - Edgewood Middle School
- ◯ DC Scholars PCS
- ◯ Digital Pioneers Academy PCS [12th Street]
- ◯ District of Columbia International School [Walter Reed]
- ◯ E.L. Haynes PCS Elementry & High School
- ◯ E.L. Haynes PCS Middle School
- ◯ Eagle Academy PCS - Congress Heights
- ◯ Eagle Academy PCS - Fairlawn
- ◯ Eagle Academy PCS - Fairlawn [Capitol Riverfront]
- ◯ Early Childhood Academy PCS [Barnaby Street]
- ◯ Elsie Whitlow Stokes Community Freedom PCS - East End
- ◯ Elsie Whitlow Stokes Community Freedom PCS - Brookland
- ◯ Friendship PCS - Collegiate Academy
- ◯ Friendship PCS - Armstrong
- ◯ Friendship PCS - Blow Pierce
- ◯ Friendship PCS - Online
- ◯ Friendship PCS - Woodridge
- ◯ Friendship PCS - Southeast Academy
- ◯ Friendship PCS - Technology Preparatory
- ◯ Friendship PCS - Chamberlain
- ◯ Friendship - Ideal Academy PCS
- ◯ Goodwill Excel Center PCS
- ◯ Harmony DC PCS - School of Excellence
- ◯ Hope Community PCS - Tolson
- ◯ Howard University Middle School of Mathematics and Science PCS
- ◯ IDEA PCS
- ◯ Ingenuity Prep PCS
- ◯ Inspired Teaching Demonstration PCS
- ◯ Kingsman Academy PCS
- ◯ KIPP DC PCS - Aim, Discover, Heights [Douglass Campus]
- ◯ KIPP DC PCS - Arts and Tech, Quest, Valor [Smilow]
- ◯ KIPP DC PCS - College Preparatory Campus
- ◯ KIPP DC PCS - Connect, Northeast, Spring [Webb]
- ◯ KIPP DC PCS - Grow, Lead, Will [Shaw]
- ◯ KIPP DC PCS - Key, Leap, Promise, [Benning]
- ◯ KIPP DC - Connect Academy PCS
- ◯ KIPP DC PCS - Honor, [Somerset]
- ◯ Latin American Montessori Bilingual PCS [South Dakota Avenue]
- ◯ Latin American Montessori Bilingual PCS [Missouri Avenue]
- ◯ Latin American Montessori Bilingual PCS [Walter Reed]
- ◯ LAYC Career Academy PCS [16th Street]
- ◯ Lee Montessori PCS [St. Paul's College]
- ◯ Lee Montessori PCS [Martin Luther King Jr. Avenue]
- ◯ Mary McLeod Bethune PCS [Main]
- ◯ Mary McLeod Bethune PCS [16th Street]

	◯ Maya Angelou PCS ◯ Meridian PCS - Elementary School ◯ Meridian PCS - Middle School ◯ Monument Academy PCS ◯ Mundo Verde Bilingual PCS - J.F. Cook Campus ◯ Mundo Verde Bilingual PCS - Ocho Calle Campus ◯ National Collegiate Preparatory PCHS ◯ Paul PCS ◯ Perry Street Preparatory PCS ◯ Richard Wright PCS for Journalism and Media Arts ◯ Rocketship PCS - Legacy Prep ◯ Rocketship PCS ◯ Roots PCS [Kennedy Street] ◯ SEED PCS of Washington, DC ◯ Sela PCS ◯ Shining Stars Montessori Academy PCS [Randolph Street] ◯ St. Coletta Special Education PCS ◯ Statesmen College Preparatory Academy for Boys ◯ The Children's Guild DC PCS ◯ The Family Place PCS ◯ The Next Step/El Proximo Paso PCS ◯ Thurgood Marshall Academy PCS ◯ Two Rivers PCS - 4th Street [Middle] ◯ Two Rivers PCS - Young ◯ Two Rivers PCS - 4th Street [Elementary] ◯ Washington Global PCS ◯ Washington Latin PCS ◯ Washington Leadership Academy PCS ◯ Washington Yu Ying PCS ◯ YouthBuild PCS ◯ Sojourner Truth Montessori Public Charter School (Begin typing the name of your school and it will begin to fill in.)
Overall, how much do you feel like you belong at your school?	◯ Do not belong at all ◯ Belong a little bit ◯ Belong somewhat ◯ Belong quite a bit ◯ Completely belong ◯ 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?	◯ Yes ◯ No ◯ I prefer not to answer

Mental/behavioral health

Please let us know your thoughts about mental/behavioral health challenges and needs.

Mental and behavioral health is the way we handle our feelings, get along with others, and make decisions. While everyone can experience difficulty with these things from time to time, mental and behavioral health challenges are when a person has more trouble than usual with handling their feelings or getting along with others or when it is causing serious problems for them.

Do you think it is embarrassing to have a mental/behavioral health challenge?	◯ Very embarrassing ◯ Somewhat embarrassing ◯ A little bit embarrassing ◯ Not at all embarrassing ◯ 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?	◯ Definitely Yes ◯ Probably Yes ◯ Probably No ◯ Definitely No ◯ I prefer not to answer
Would you feel comfortable talking to a therapist or counselor at school if you had a mental/behavioral health challenge?	◯ Definitely Yes ◯ Probably Yes ◯ Probably No ◯ Definitely No ◯ I prefer not to answer
Would you feel comfortable talking to a therapist or counselor outside of school if you had a mental/behavioral health challenge?	◯ Definitely Yes ◯ Probably Yes ◯ Probably No ◯ Definitely No ◯ I prefer not to answer

Getting Help

Please share your thoughts about and experiences with getting help with a mental/behavioral health challenge.

If you needed help with a mental/behavioral health challenge, do you know who to go to in order to get help?

- ◯ 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?

- ◯ Yes
- ◯ No
- ◯ Maybe/Not sure
- ◯ I prefer not to answer

Does your school have a therapist or counselor?

- ◯ Yes
- ◯ No
- ◯ I don't know
- ○ I prefer not to answer

Who do you usually go to about problems when you are upset?

- ☐ Teacher at school
- ☐ A cafeteria/foodservice worker at school
- ☐ A cleaning/custodian worker at school
- ☐ A club or sports coach at school
- ☐ A close family member
- ☐ A friend
- ☐ Someone not listed here
- ☐ I do not go to anyone about problems or when I'm upset
- ☐ I prefer not to answer

(You can select more than one answer for this question)

Please describe who you usually go to about problems when you are upset. _____

Was there any time you had a mental/behavioral health challenge but didn't get the help you needed?

- ◯ Yes
- ◯ No
- ◯ I prefer not to answer

Why did you not get the help you needed?

- ☐ I thought the problem would get better by itself
- ☐ I did not want anyone to know I was having a problem
- ☐ I did not know where to get help
- ☐ I didn't think counseling would help
- ☐ People in my family didn't think counseling would help
- ☐ I went to counseling before and it did not work
- ☐ I had trouble getting to my counseling sessions
- ☐ I could not get an appointment
- ☐ Other
- ☐ I prefer not to answer

(You can select more than one answer for this question)

Please describe the other reason(s) you did not get the help you needed.

_____

Feeling better

Please share about what you do to make yourself feel better when you have a problem.

Please list anything you do to make yourself feel better when you are feeling scared, angry, or sad.

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

(You can select more than one answer for this question)

Please describe the other thing(s) you do to make yourself feel better when you are feeling scared, angry, or sad.

_____

Recommendations

Please share about what you think your school could do to help students handle their feelings, get along with others, and make good decisions.

How could your school better support the mental/behavioral health of **all students**?

_____

How could your school better support students with mental/behavioral health needs?

_____

What is one thing that you like about how your school supports the mental/behavioral health of students?

_____

What could make students feel more comfortable talking to a counselor or therapist at school when they have a mental/behavioral health challenge?

_____

How did you learn about the survey?

☐ My school
☐ Other

Please share how you learned about the survey (e.g., the name of the organization or program that shared the survey link).

_____

Thank you for your time!

Strengthening Schools Family Member Survey

This is a survey to hear your thoughts about and experiences with mental/behavioral health. You will not be asked to share your name, so your responses will not be connected to you. Please share your honest thoughts and experiences. Your responses will help schools in D.C. to improve mental/behavioral health services for students and families.

About you

Please tell us about yourself.

What is your race/ethnicity?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ A different race/ethnicity not listed here
- ☐ Prefer not to answer

(Select all that apply)

Please describe your race/ethnicity.

_____

Please select the gender that best describes you.

- ◯ Woman
- ◯ Man
- ◯ Non-binary
- ◯ A gender not listed here

Prefer not to answer

Please describe your gender.

_____

Are you transgender?

- ◯ Yes
- ◯ No

Prefer not to answer

Which of the following best describes you?

- ◯ Heterosexual (straight)
- ◯ Gay or Lesbian
- ◯ Bisexual
- ◯ Not sure
- ◯ A sexuality not listed here

Prefer not to answer

Please describe your sexuality.

_____

In what ward do you live in?

- ◯ I don't know
- ◯ Ward 1
- ◯ Ward 2
- ◯ Ward 3
- ◯ Ward 4
- ◯ Ward 5
- ◯ Ward 6
- ◯ Ward 7
- ◯ Ward 8
- ◯ I prefer not to answer

(Select "I don't know" if not sure)

Your Child(rens)'s School

Please share how you feel about your child(ren)'s school.

How many children do you have attending a public or public charter school in D.C.?

_____

(If you prefer not to answer, feel free to leave blank.)

Please answer the remaining questions about only one of your children attending a public or public charter school.

What school does your child attend? Begin typing the name of your school and it will begin to fill in.

- Aiton Elementary School
- Amidon-Bowen Elementary School
- Anacostia High School
- Ballou High School
- Ballou STAY High School
- Bancroft Elementary School
- Bard High School Early College DC (Bard DC)
- Barnard Elementary School
- Beers Elementary School
- Benjamin Banneker High School
- Lawrence E. Boone Elementary School
- Brent Elementary School
- Brightwood Education Campus
- Brookland Middle School
- Browne Education Campus
- Bruce-Monroe Elementary School @ Park View
- Bunker Hill Elementary School
- Burroughs Elementary School
- Burrville Elementary School
- C.W. Harris Elementary School
- Capitol Hill Montessori School @ Logan
- Cardozo Education Campus
- Cleveland Elementary School
- Columbia Heights Education Campus
- Coolidge High School
- Deal Middle School
- Dorothy I. Height Elementary School
- Drew Elementary School
- Duke Ellington School of the Arts
- Dunbar High School
- Eastern High School
- Eaton Elementary School
- Eliot-Hine Middle School
- Excel Academy
- Garfield Elementary School
- Garrison Elementary School
- H.D. Cooke Elementary School
- Hardy Middle School
- Hart Middle School
- Hearst Elementary School
- Hendley Elementary School
- Houston Elementary School
- Hyde-Addison Elementary School
- Ida B. Wells Middle School
- Inspiring Youth Program
- J.O. Wilson Elementary School
- Janney Elementary School
- Jefferson Middle School Academy
- Johnson Middle School
- Kelly Miller Middle School
- Ketcham Elementary School
- Key Elementary School
- Kimball Elementary School
- King Elementary School
- Kramer Middle School
- Lafayette Elementary School
- Langdon Elementary School
- Langley Elementary School
- LaSalle-Backus Education Campus
- Leckie Education Campus Ludlow-
- Taylor Elementary School Luke C.
- Moore High School MacFarland
- Middle School
- Malcolm X Elementary School @ Green
- Mann Elementary School
- Marie Reed Elementary School
- Maury Elementary School
- McKinley Middle School
- McKinley Technology High School

- ◯ Miner Elementary School
- ◯ Moten Elementary School
- ◯ Murch Elementary School
- ◯ Nalle Elementary School
- ◯ Noyes Elementary School
- ◯ Oyster-Adams Bilingual School
- ◯ Patterson Elementary School
- ◯ Payne Elementary School
- ◯ Peabody Elementary School (Capitol Hill Cluster)
- ◯ Phelps Architecture, Construction and Engineering High School
- ◯ Plummer Elementary School
- ◯ Powell Elementary School
- ◯ Randle Highlands Elementary School
- ◯ Raymond Education Campus
- ◯ River Terrace Education Campus
- ◯ Ron Brown College Preparatory High School
- ◯ Roosevelt High School
- ◯ Roosevelt STAY High School
- ◯ Ross Elementary School
- ◯ Savoy Elementary School
- ◯ School Without Walls @ Francis-Stevens
- ◯ School Without Walls High School School-
- ◯ Within-School @ Goding
- ◯ Seaton Elementary School
- ◯ Shepherd Elementary School
- ◯ Simon Elementary School
- ◯ Smothers Elementary School
- ◯ Sousa Middle School
- ◯ Stanton Elementary School
- ◯ Stoddert Elementary School Stuart-
- ◯ Hobson Middle School (Capitol Hill Cluster)
- ◯ Takoma Education Campus
- ◯ Thaddeus Stevens Early Learning Center
- ◯ Thomas Elementary School
- ◯ Thomson Elementary School
- ◯ Truesdell Education Campus
- ◯ Tubman Elementary School
- ◯ Turner Elementary School
- ◯ Tyler Elementary School
- ◯ Van Ness Elementary School
- ◯ Walker-Jones Education Campus
- ◯ Watkins Elementary School (Capitol Hill Cluster)
- ◯ West Education Campus
- ◯ Wheatley Education Campus
- ◯ Whittier Education Campus
- ◯ Woodrow Wilson High School
- ◯ H.D. Woodson High School
- ◯ Youth Services Center
- ◯ Academy of Hope Adult PCS [Southeast]
- ◯ Academy of Hope Adult PCS [18th Place]
- ◯ Achievement Preparatory PCS [Wahler Place]
- ◯ AppleTree Early Learning PCS - Parklands
- ◯ AppleTree Early Learning PCS - Columbia Heights
- ◯ AppleTree Early Learning PCS - Southeast [Douglas Knoll]
- ◯ AppleTree Early Learning PCS - Lincoln
- ◯ AppleTree Early Learning PCS - Oklahoma Avenue
- ◯ BASIS DC PCS
- ◯ Breakthrough Montessori PCS [Taylor Street]
- ◯ Montessori PCS [Eastern Avenue]
- ◯ Bridges PCS [Mamie D. Lee]
- ◯ Briya PCS [13th Street/Sharpe]
- ◯ Briya PCS [Gallatin Street/Fort Totten]
- ◯ Briya PCS [Ontario Road/Adams Morgan/Main]
- ◯ Briya PCS [Georgia Avenue/Petworth]
- ◯ Capital City PCS
- ◯ Carlos Rosario International PCS [Harvard Street]
- ◯ Carlos Rosario International PCS [Sonia Gutierrez]
- ◯ Cedar Tree Academy PCS

- ◯ Center City PCS - Brightwood
- ◯ Center City PCS - Capitol Hill
- ◯ Center City PCS - Congress Heights
- ◯ Center City PCS - Petworth
- ◯ Center City PCS - Shaw
- ◯ Center City PCS - Trinidad
- ◯ Cesar Chavez PCS for Public Policy - Parkside
- ◯ Community College Preparatory Academy PCS [MC Terrell]
- ◯ Community College Preparatory Academy PCS [DCIA]
- ◯ Community College Preparatory Academy PCS [Main]
- ◯ Creative Minds International PCS
- ◯ DC Bilingual PCS
- ◯ DC Prep PCS - Benning Elementary
- ◯ DC Prep PCS - Benning Middle
- ◯ DC Prep PCS - Anacostia Elementary School [V Street]
- ◯ DC Prep PCS - Edgewood Elementary School
- ◯ DC Prep PCS - Edgewood Middle School
- ◯ DC Scholars PCS
- ◯ Digital Pioneers Academy PCS [12th Street]
- ◯ District of Columbia International School [Walter Reed]
- ◯ E.L. Haynes PCS Elementry & High School
- ◯ E.L. Haynes PCS Middle School
- ◯ Eagle Academy PCS - Congress Heights
- ◯ Eagle Academy PCS - Fairlawn
- ◯ Eagle Academy PCS - Fairlawn [Capitol Riverfront]
- ◯ Early Childhood Academy PCS [Barnaby Street]
- ◯ Elsie Whitlow Stokes Community Freedom PCS - East End
- ◯ Elsie Whitlow Stokes Community Freedom PCS - Brookland
- ◯ Friendship PCS - Collegiate Academy
- ◯ Friendship PCS - Armstrong
- ◯ Friendship PCS - Blow Pierce
- ◯ Friendship PCS - Online
- ◯ Friendship PCS - Woodridge
- ◯ Friendship PCS - Southeast Academy
- ◯ Friendship PCS - Technology Preparatory
- ◯ Friendship PCS - Chamberlain
- ◯ Friendship - Ideal Academy PCS
- ◯ Goodwill Excel Center PCS
- ◯ Harmony DC PCS - School of Excellence
- ◯ Hope Community PCS - Tolson
- ◯ Howard University Middle School of Mathematics and Science PCS
- ◯ IDEA PCS
- ◯ Ingenuity Prep PCS
- ◯ Inspired Teaching Demonstration PCS
- ◯ Kingsman Academy PCS
- ◯ KIPP DC PCS - Aim, Discover, Heights [Douglass Campus]
- ◯ KIPP DC PCS - Arts and Tech, Quest, Valor [Smilow]
- ◯ KIPP DC PCS - College Preparatory Campus
- ◯ KIPP DC PCS - Connect, Northeast, Spring [Webb]
- ◯ KIPP DC PCS - Grow, Lead, Will [Shaw]
- ◯ KIPP DC PCS - Key, Leap, Promise, [Benning]
- ◯ KIPP DC - Connect Academy PCS
- ◯ KIPP DC PCS - Honor, [Somerset]
- ◯ Latin American Montessori Bilingual PCS [South Dakota Avenue]
- ◯ Latin American Montessori Bilingual PCS [Missouri Avenue]
- ◯ Latin American Montessori Bilingual PCS [Walter Reed]
- ◯ LAYC Career Academy PCS [16th Street]
- ◯ Lee Montessori PCS [St. Paul's College]
- ◯ Lee Montessori PCS [Martin Luther King Jr. Avenue]
- ◯ Mary McLeod Bethune PCS [Main]
- ◯ Mary McLeod Bethune PCS [16th Street]

	◯ Maya Angelou PCS ◯ Meridian PCS - Elementary School ◯ Meridian PCS - Middle School ◯ Monument Academy PCS ◯ Mundo Verde Bilingual PCS - J.F. Cook Campus ◯ Mundo Verde Bilingual PCS - Ocho Calle Campus ◯ National Collegiate Preparatory PCHS ◯ Paul PCS ◯ Perry Street Preparatory PCS ◯ Richard Wright PCS for Journalism and Media Arts 8 ◯ Rocketship PCS - Legacy Prep ◯ Rocketship PCS ◯ Roots PCS [Kennedy Street] ◯ SEED PCS of Washington, DC ◯ Sela PCS ◯ Shining Stars Montessori Academy PCS [Randolph Street] ◯ St. Coletta Special Education PCS ◯ Statesmen College Preparatory Academy for Boys ◯ The Children's Guild DC PCS ◯ The Family Place PCS ◯ The Next Step/El Proximo Paso PCS ◯ Thurgood Marshall Academy PCS ◯ Two Rivers PCS - 4th Street [Middle] ◯ Two Rivers PCS - Young ◯ Two Rivers PCS - 4th Street [Elementary] ◯ Washington Global PCS ◯ Washington Latin PCS ◯ Washington Leadership Academy PCS ◯ Washington Yu Ying PCS ◯ YouthBuild PCS ◯ Sojourner Truth Montessori Public Charter School
How old is your child?	_____ (If you prefer not to answer, feel free to leave blank.)
I feel welcome at my child's school.	◯ Strongly Agree ◯ Somewhat Agree ◯ Somewhat Disagree ◯ Strongly Disagree ◯ I prefer not to answer
I feel comfortable talking to someone at my child's school about my child's behavior.	◯ Strongly Agree ◯ Somewhat Agree ◯ Somewhat Disagree ◯ Strongly Disagree ◯ I prefer not to answer

Mental/behavioral health

Please let us know your thoughts about mental/behavioral health challenges and needs.

Mental and behavioral health is the way we handle our feelings, get along with others, and make decisions. While everyone can experience difficulty with these things from time to time, mental and behavioral health challenges are when a person has more trouble than usual with handling their feelings or getting along with others or when it is causing serious problems for them.

Having a mental health disorder is nothing to be ashamed of.	◯ Strongly Agree ◯ Somewhat Agree ◯ Somewhat Disagree ◯ Strongly Disagree ◯ I prefer not to answer
People with mental health disorders scare me.	◯ Strongly Agree ◯ Somewhat Agree ◯ Somewhat Disagree ◯ Strongly Disagree ◯ I prefer not to answer
People with mental health disorders are dangerous.	◯ Strongly Agree ◯ Somewhat Agree ◯ Somewhat Disagree ◯ Strongly Disagree ◯ 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.	◯ Definitely Yes ◯ Probably Yes ◯ Probably No ◯ Definitely No ◯ I prefer not to answer
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.	◯ Definitely Yes ◯ Probably Yes ◯ Probably No ◯ Definitely No ◯ I prefer not to answer

Getting Help

Please share your thoughts about and experiences with getting help.

If you needed help with a mental/behavioral health challenge, do you know where to get help?

- ◯ Definitely Yes
- ◯ Probably Yes
- ◯ Probably No
- ◯ Definitely No
- ◯ I prefer not to answer

If your child needed help with a mental/behavioral health challenge, do you know where to get help?

- Definitely Yes
- Probably Yes
- Probably No
- Definitely No
- I prefer not to answer

If your child needed help with a mental/behavioral health challenge at school, do you know who to contact for help?

- Definitely Yes
- Probably Yes
- Probably No
- Definitely No
- I prefer not to answer

Does your child's school have a therapist or counselor?

- ◯ Yes
- ◯ No
- ◯ I don't know
- ◯ I prefer not to answer

Was there any time you had a mental/behavioral health challenge but didn't get the help you needed?

- ◯ Yes
- ◯ No
- ◯ I prefer not to answer

Why did you not get the help you needed?

- ☐ I thought the problem would get better by itself
- ☐ I did not want anyone to know I was having a problem
- ☐ I did not know where to get help
- ☐ I didn't think counseling would help
- ☐ People in my family didn't think counseling would help
- ☐ I went to counseling before and it did not work
- ☐ I had trouble getting to my counseling sessions
- ☐ I could not get an appointment
- ☐ Other (e.g., insurance, metro fare, childcare)
- ☐ I prefer not to answer

(Please check all that apply.)

Please use the space provided to describe the other reason(s) you did not get the help you needed.

_____

Was there any time your child had a mental/behavioral health challenge but didn't get the help they needed?

- ◯ Yes
- ◯ No
- ◯ I prefer not to answer

Why did your child not get the help they needed?

- ☐ I thought my child's problem would get better by itself
- ☐ I did not want anyone to know my child was having a problem
- ☐ I did not know where to get help for my child
- ☐ I didn't think counseling would help my child
- ☐ My child did not think counseling would help
- ☐ People in my family didn't think counseling would help my child
- ☐ My child went to counseling before and it did not work
- ☐ I had trouble getting my child to counseling sessions
- ☐ I could not get an appointment for my child
- ☐ Other (e.g., insurance, metro fare, childcare)
- ☐ I prefer not to answer

(Please check all that apply.)

Please use the space provided to describe the other reason(s) your child did not get the help they needed.

_____

Recommendations

Please share about what you think your school could do to help students handle their feelings, get along with others, and make good decisions.

How could your child's school better support the mental/behavioral health of **all students**?

_____

How could your child's school better support students with mental/behavioral health needs?

_____

What is one thing that you like about how your child's school supports the mental/behavioral health of students?

_____

What could make students feel more comfortable talking to a counselor or therapist at school when they have a mental/behavioral health challenge?

_____

What could make families feel more comfortable with their child talking to a counselor or therapist at school when they have a mental/behavioral health challenge?

_____

How did you learn about the survey?

- ☐ My child's school
- ☐ Other

Please share how you learned about the survey (e.g., the name of the organization or program that shared the survey link).

_____

Thank you for your time! If you have any questions, feel free to contact Sarah Her at sher@childtrends.org

Strengthening Schools Staff Survey

Thank you for taking the time to complete our survey. The Department of Behavioral Health (DBH) is partnering with Child Trends, a nonprofit research organization, to better understand the experiences of all public and public charter schools in DC with regard to behavioral health services and supports. This survey is a first step in understanding schools' experiences. There are no right or wrong answers, and we are not evaluating you or your school. We are hoping to learn just a little bit about the planning, delivery, and monitoring of behavioral health services and supports at your school.

This survey should take no more than 15 minutes to complete. Your responses to this survey will be reviewed by Child Trends researchers and will be kept confidential. When sharing our findings with DBH, information from all the surveys will be summarized and will not include individual names or other identifiable information.

Respondent information

Please select your CURRENT school.

- Aiton Elementary School Amidon-
- Bowen Elementary School
- Anacostia High School
- Ballou High School
- Ballou STAY High School
- Bancroft Elementary School
- Bard High School Early College DC (Bard DC)
- Barnard Elementary School
- Beers Elementary School
- Benjamin Banneker High School
- Lawrence E. Boone Elementary School
- Brent Elementary School
- Brightwood Education Campus
- Brookland Middle School Browne
- Education Campus
- Bruce-Monroe Elementary School @ Park View
- Bunker Hill Elementary School
- Burroughs Elementary School
- Burrville Elementary School
- C.W. Harris Elementary School
- Capitol Hill Montessori School @ Logan
- Cardozo Education Campus
- Cleveland Elementary School
- Columbia Heights Education Campus
- Coolidge High School
- Deal Middle School
- Dorothy I. Height Elementary School
- Drew Elementary School
- Duke Ellington School of the Arts
- Dunbar High School
- Eastern High School
- Eaton Elementary School
- Eliot-Hine Middle School
- Excel Academy
- Garfield Elementary School
- Garrison Elementary School
- H.D. Cooke Elementary School
- Hardy Middle School
- Hart Middle School
- Hearst Elementary School
- Hendley Elementary School
- Houston Elementary School
- Hyde-Addison Elementary School
- Ida B. Wells Middle School
- Inspiring Youth Program
- J.O. Wilson Elementary School
- Janney Elementary School
- Jefferson Middle School Academy
- Johnson Middle School
- Kelly Miller Middle School
- Ketcham Elementary School
- Key Elementary School
- Kimball Elementary School
- King Elementary School
- Kramer Middle School
- Lafayette Elementary School
- Langdon Elementary School
- Langley Elementary School
- LaSalle-Backus Education Campus
- Leckie Education Campus Ludlow-
- Taylor Elementary School Luke C.
- Moore High School MacFarland
- Middle School
- Malcolm X Elementary School @ Green
- Mann Elementary School
- Marie Reed Elementary School
- Maury Elementary School
- McKinley Middle School
- McKinley Technology High School

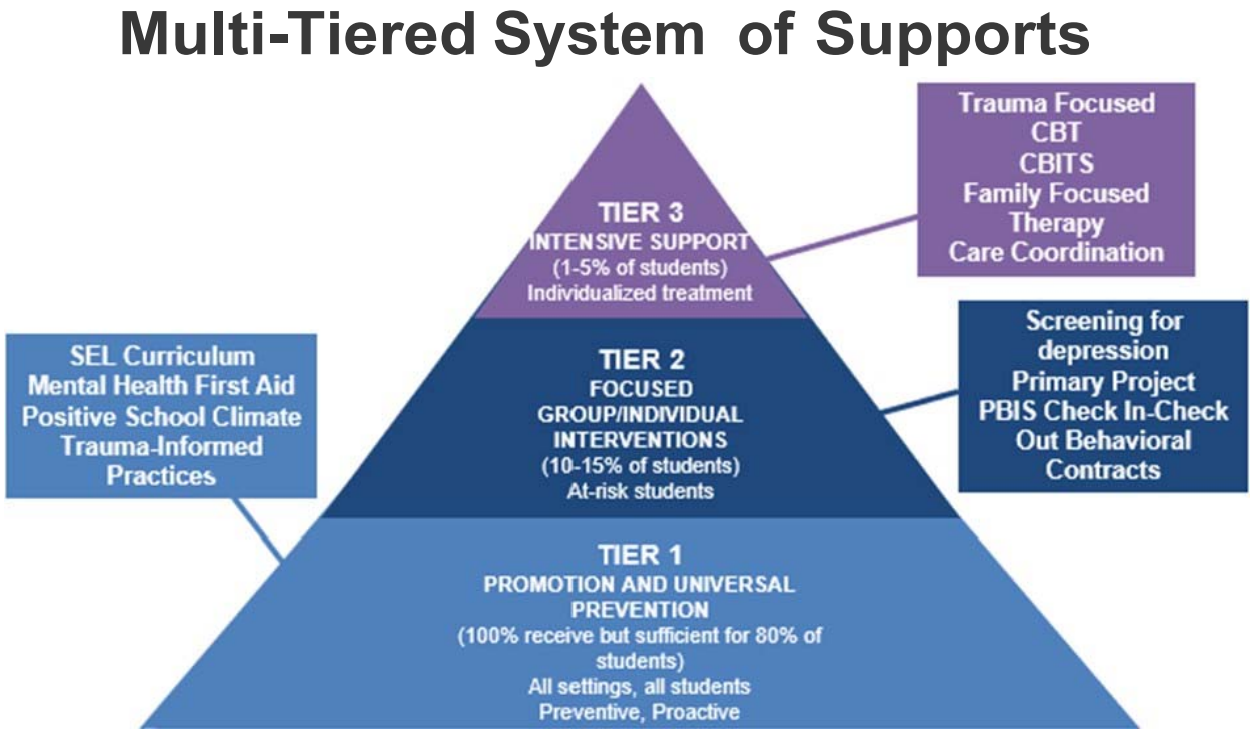
- ◯ Miner Elementary School
- ◯ Moten Elementary School
- ◯ Murch Elementary School
- ◯ Nalle Elementary School
- ◯ Noyes Elementary School
- ◯ Oyster-Adams Bilingual School
- ◯ Patterson Elementary School
- ◯ Payne Elementary School
- ◯ Peabody Elementary School (Capitol Hill Cluster)
- ◯ Phelps Architecture, Construction and Engineering High School
- ◯ Plummer Elementary School
- ◯ Powell Elementary School
- ◯ Randle Highlands Elementary School
- ◯ Raymond Education Campus
- ◯ River Terrace Education Campus
- ◯ Ron Brown College Preparatory High School
- ◯ Roosevelt High School
- ◯ Roosevelt STAY High School
- ◯ Ross Elementary School
- ◯ Savoy Elementary School
- ◯ School Without Walls @ Francis-Stevens
- ◯ School Without Walls High School School-
- ◯ Within-School @ Goding
- ◯ Seaton Elementary School
- ◯ Shepherd Elementary School
- ◯ Simon Elementary School
- ◯ Smothers Elementary School
- ◯ Sousa Middle School
- ◯ Stanton Elementary School
- ◯ Stoddert Elementary School Stuart-
- ◯ Hobson Middle School (Capitol Hill Cluster)
- ◯ Takoma Education Campus
- ◯ Thaddeus Stevens Early Learning Center
- ◯ Thomas Elementary School
- ◯ Thomson Elementary School
- ◯ Truesdell Education Campus
- ◯ Tubman Elementary School
- ◯ Turner Elementary School
- ◯ Tyler Elementary School
- ◯ Van Ness Elementary School
- ◯ Walker-Jones Education Campus
- ◯ Watkins Elementary School (Capitol Hill Cluster)
- ◯ West Education Campus
- ◯ Wheatley Education Campus
- ◯ Whittier Education Campus
- ◯ Woodrow Wilson High School
- ◯ H.D. Woodson High School
- ◯ Youth Services Center
- ◯ Academy of Hope Adult PCS [Southeast]
- ◯ Academy of Hope Adult PCS [18th Place]
- ◯ Achievement Preparatory PCS [Wahler Place]
- ◯ AppleTree Early Learning PCS - Parklands
- ◯ AppleTree Early Learning PCS - Columbia Heights
- ◯ AppleTree Early Learning PCS - Southeast [Douglas Knoll]
- ◯ AppleTree Early Learning PCS - Lincoln
- ◯ AppleTree Early Learning PCS - Oklahoma Avenue
- ◯ BASIS DC PCS
- ◯ Breakthrough Montessori PCS [Taylor Street]
- ◯ Montessori PCS [Eastern Avenue]
- ◯ Bridges PCS [Mamie D. Lee]
- ◯ Briya PCS [13th Street/Sharpe]
- ◯ Briya PCS [Gallatin Street/Fort Totten]
- ◯ Briya PCS [Ontario Road/Adams Morgan/Main]
- ◯ Briya PCS [Georgia Avenue/Petworth]
- ◯ Capital City PCS
- ◯ Carlos Rosario International PCS [Harvard Street]
- ◯ Carlos Rosario International PCS [Sonia Gutierrez]
- ◯ Cedar Tree Academy PCS

- ◯ Center City PCS - Brightwood
- ◯ Center City PCS - Capitol Hill
- ◯ Center City PCS - Congress Heights
- ◯ Center City PCS - Petworth
- ◯ Center City PCS - Shaw
- ◯ Center City PCS - Trinidad
- ◯ Cesar Chavez PCS for Public Policy - Parkside
- ◯ Community College Preparatory Academy PCS [MC Terrell]
- ◯ Community College Preparatory Academy PCS [DCIA]
- ◯ Community College Preparatory Academy PCS [Main]
- ◯ Creative Minds International PCS
- ◯ DC Bilingual PCS
- ◯ DC Prep PCS - Benning Elementary
- ◯ DC Prep PCS - Benning Middle
- ◯ DC Prep PCS - Anacostia Elementary School [V Street]
- ◯ DC Prep PCS - Edgewood Elementary School
- ◯ DC Prep PCS - Edgewood Middle School
- ◯ DC Scholars PCS
- ◯ Digital Pioneers Academy PCS [12th Street]
- ◯ District of Columbia International School [Walter Reed]
- ◯ E.L. Haynes PCS Elementry & High School
- ◯ E.L. Haynes PCS Middle School
- ◯ Eagle Academy PCS - Congress Heights
- ◯ Eagle Academy PCS - Fairlawn
- ◯ Eagle Academy PCS - Fairlawn [Capitol Riverfront]
- ◯ Early Childhood Academy PCS [Barnaby Street]
- ◯ Elsie Whitlow Stokes Community Freedom PCS - East End
- ◯ Elsie Whitlow Stokes Community Freedom PCS - Brookland
- ◯ Friendship PCS - Collegiate Academy
- ◯ Friendship PCS - Armstrong
- ◯ Friendship PCS - Blow Pierce
- ◯ Friendship PCS - Online
- ◯ Friendship PCS - Woodridge
- ◯ Friendship PCS - Southeast Academy
- ◯ Friendship PCS - Technology Preparatory
- ◯ Friendship PCS - Chamberlain
- ◯ Friendship - Ideal Academy PCS
- ◯ Goodwill Excel Center PCS
- ◯ Harmony DC PCS - School of Excellence
- ◯ Hope Community PCS - Tolson
- ◯ Howard University Middle School of Mathematics and Science PCS
- ◯ IDEA PCS
- ◯ Ingenuity Prep PCS
- ◯ Inspired Teaching Demonstration PCS
- ◯ Kingsman Academy PCS
- ◯ KIPP DC PCS - Aim, Discover, Heights [Douglass Campus]
- ◯ KIPP DC PCS - Arts and Tech, Quest, Valor [Smilow]
- ◯ KIPP DC PCS - College Preparatory Campus
- ◯ KIPP DC PCS - Connect, Northeast, Spring [Webb]
- ◯ KIPP DC PCS - Grow, Lead, Will [Shaw]
- ◯ KIPP DC PCS - Key, Leap, Promise, [Benning]
- ◯ KIPP DC - Connect Academy PCS
- ◯ KIPP DC PCS - Honor, [Somerset]
- ◯ Latin American Montessori Bilingual PCS [South Dakota Avenue]
- ◯ Latin American Montessori Bilingual PCS [Missouri Avenue]
- ◯ Latin American Montessori Bilingual PCS [Walter Reed]
- ◯ LAYC Career Academy PCS [16th Street]
- ◯ Lee Montessori PCS [St. Paul's College]
- ◯ Lee Montessori PCS [Martin Luther King Jr. Avenue]
- ◯ Mary McLeod Bethune PCS [Main]
- ◯ Mary McLeod Bethune PCS [16th Street]

	◯ Maya Angelou PCS ◯ Meridian PCS - Elementary School ◯ Meridian PCS - Middle School ◯ Monument Academy PCS ◯ Mundo Verde Bilingual PCS - J.F. Cook Campus ◯ Mundo Verde Bilingual PCS - Ocho Calle Campus ◯ National Collegiate Preparatory PCHS ◯ Paul PCS ◯ Perry Street Preparatory PCS ◯ Richard Wright PCS for Journalism and Media Arts 8 ◯ Rocketship PCS - Legacy Prep ◯ Rocketship PCS ◯ Roots PCS [Kennedy Street] ◯ SEED PCS of Washington, DC ◯ Sela PCS ◯ Shining Stars Montessori Academy PCS [Randolph Street] ◯ St. Coletta Special Education PCS ◯ Statesmen College Preparatory Academy for Boys ◯ The Children's Guild DC PCS ◯ The Family Place PCS ◯ The Next Step/El Proximo Paso PCS ◯ Thurgood Marshall Academy PCS ◯ Two Rivers PCS - 4th Street [Middle] ◯ Two Rivers PCS - Young ◯ Two Rivers PCS - 4th Street [Elementary] ◯ Washington Global PCS ◯ Washington Latin PCS ◯ Washington Leadership Academy PCS ◯ Washington Yu Ying PCS ◯ YouthBuild PCS ◯ Sojourner Truth Montessori Public Charter School (Begin typing the name of your school and the list will refine as you type.)
What is your current position at your school?	◯ Principal ◯ Other school administrator ◯ Classroom teacher ◯ School nurse/health staff ◯ Other o Prefer not to answer
If answering Other, please specify here.	_____
How long have you been at your current school?	◯ Less than 1 year ◯ 1 year ◯ 2 years ◯ 3 to 5 years ◯ 6 to 10 years ◯ More than 10 years

Staff perspective on behavioral health services/support in school

The District's expansion of comprehensive school behavioral health services and supports is designed to help strengthen the planning, coordination, delivery, and monitoring of school-based behavioral health services for students, families, and staff. The goal of the expansion is for all schools to provide Tier 1, 2, and 3 services and supports for students and families, as well as staff wellness programming, to meet the needs of their communities.



Please indicate how much you agree with each of the following statements about behavioral health services/supports available at your school.

	Strongly disagree	Disagree	Agree	Strongly agree	Don't know	N/A - My school does not provide this
My school provides ADEQUATE promotion and universal prevention (Tier 1) programming to all/most students.	○	○	○	○	○	○
My school provides ADEQUATE group/individual interventions (Tier 2) to students who are exhibiting risk factors.	○	○	○	○	○	○
My school provides ADEQUATE intensive support/individualized treatment (Tier 3) to students who have identified behavioral health needs.	○	○	○	○	○	○

Please indicate how often you felt the following emotions at work during the past week.

	Almost never	Once in a while	Sometimes	Frequently	Almost always
Engaged	○	○	○	○	○
Exhausted	○	○	○	○	○
Hopeful	○	○	○	○	○
Stressed out	○	○	○	○	○

What kinds of services/supports, if any, are available at your school to promote staff wellness? (Select all that apply)

- ☐ Wellness days off
- ☐ Themed wellness challenges (e.g., water challenge, sleep challenge)
- ☐ Counseling or one-on-one support from school-based mental/behavioral health staff
- ☐ School leadership communicates and/or models the importance of wellness
- ☐ Peers/colleagues check in with one another to provide support
- ☐ Regular wellness check-ins, either by school leadership or mental/ behavioral health team
- ☐ Scheduling enhancements (e.g., intentional breaks, shorter days)
- ☐ Self-care strategies are taught, facilitated, or otherwise promoted (e.g., journaling, mindfulness, yoga)
- ☐ My school does not provide staff wellness supports
- ☐ Other

Please use the space provided to briefly describe any services/supports that promote staff wellness at your school, not listed above.

_____

Have you participated in any of the services/supports offered at your school that promote staff wellness?

- ○ Yes
- ○ No

How satisfied are you with the services/supports you have used?

- o Not at all satisfied
- o Slightly satisfied
- o Somewhat satisfied
- o Quite satisfied
- o Extremely satisfied

Please indicate how much you agree with each of the following statements about services/supports that promote staff wellness at your school.	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.	○	○	○	○	○
I think the services/supports offered at my school to promote staff wellness are adequate.	○	○	○	○	○

Staff feelings/perceptions about the school community	
Overall, how positive is the working environment at your school?	◯ Not at all positive ◯ Slightly positive ◯ Somewhat positive ◯ Quite positive ◯ Extremely positive
How supportive are students in their interactions with each other?	◯ Not at all supportive ◯ Slightly supportive ◯ Somewhat supportive ◯ Quite supportive ◯ Extremely supportive
How respectful are the relationships between teachers/school staff and students?	◯ Not at all respectful ◯ Slightly respectful ◯ Somewhat respectful ◯ Quite respectful ◯ Extremely respectful

Please indicate how much you agree with each of the following statements about your knowledge, attitude, and skills related to behavioral health.

	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).	○	○	○	○	○
I think non-clinical staff (e.g., teachers) play an important role in identifying and/or referring students with behavioral health problems.	○	○	○	○	○
I can identify warning signs or symptoms of behavioral health problems in students (e.g., depression, anxiety, trauma, eating disorder).	○	○	○	○	○
I feel knowledgeable about the behavioral health services/supports available at my school.	○	○	○	○	○
I know how to refer a student for behavioral health services/supports at my school.	○	○	○	○	○
I have a good working relationship with a mental health clinician at our school.	○	○	○	○	○
I value having behavioral health services/supports available at my school.	○	○	○	○	○

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.

	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
The behavioral health services/supports available at my school are relevant to the needs of our students.	○	○	○	○	○
The behavioral health services/supports available at my school are culturally/linguistically responsive and appropriate.	○	○	○	○	○
Students at my school are aware of the behavioral health services/supports available to them.	○	○	○	○	○
Families at my school are aware of the behavioral health services/supports available to support their children.	○	○	○	○	○
Students at my school can easily access the behavioral health services/supports available to them, if they choose to do so.	○	○	○	○	○
Families at my school can easily access the behavioral health services/supports available to support their children, if they choose to do so.	○	○	○	○	○
Students at my school utilize the behavioral health services/supports available to them, when needed.	○	○	○	○	○
Families at my school utilize the behavioral health services/supports available to support their children, when needed.	○	○	○	○	○
Students at my school are satisfied with the behavioral health services/supports available to them.	○	○	○	○	○

Families at my school are satisfied with the behavioral health services/supports available to support their children.	◯	◯	◯	◯	◯

Staff perceptions of the effectiveness of services/supports

In the PREVIOUS school year, how many times did you refer students to behavioral health services/supports at your school?

- ◯ Never
- ◯ Once
- ◯ 2-5 times
- ◯ 6-10 times
- ◯ More than 10 times

While you may be unsure of whether or not a student is receiving behavioral health services/supports, thinking about a student or students you have referred, please indicate how much you agree or disagree with the following statements.

Since the student(s) started receiving behavioral health services/supports...

	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
They have had a decrease in behavioral incidents.	◯	◯	◯	◯	◯
They have experienced reduced behavioral health symptoms.	◯	◯	◯	◯	◯
They have demonstrated increased coping skills.	◯	◯	◯	◯	◯
They are more connected to the school community (teachers, students, other staff).	◯	◯	◯	◯	◯

Feedback and Recommendations

We are interested in learning about how the behavioral health supports and resources in schools could be sustained and/or improved.

What resources or supports at your school are working well? Please share your thoughts in the space provided.

What changes, if any, are needed to better support schools? Please share your thoughts in the space provided. Please consider any changes needed to address the challenges of public health emergencies like COVID-19.

Appendix B: Complete Data Tables

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%	

Student Survey (continued)

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

Student Survey (continued)

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%

Family Survey (continued)

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

Family Survey (continued)

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%

Staff Survey (continued)

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%

Staff Survey (continued)

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%

Staff Survey (continued)

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%

Staff Survey (continued)

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%

Appendix C: Continuous Quality Improvement Plan

Continuous Quality Improvement

Recommendations for a phased approach to developing a Continuous Quality Improvement (CQI) system for the District of Columbia's School Behavioral Health Program

March 26, 2021

Child TRENDS

Executive Summary

This document summarizes Child Trends' recommendations as of the end of the first contract year for developing a Continuous Quality Improvement (CQI) system for the School Behavioral Health (SBH) Expansion. Engaging in a process of CQI will enable the Department of Behavioral Health (DBH) to (1) identify aspects of the Expansion that appear to be working well and opportunities for improvement; (2) flag specific schools and community-based organizations (CBOs), including school-CBO partnerships, where issues are arising in order to provide tailored supports; and (3) make a data-informed case for ongoing support of the initiative.

Recommendations

Child Trends recommends that DBH develop the Expansion CQI system using a phased approach. In each phase, DBH will oversee the CQI cycle by: (1) collecting data from multiple sources, (2) inputting them into a central data system, (3) summarizing data, (4) reviewing and discussing summaries with key stakeholders to identify next steps, and (5) monitoring implementation. Child Trends' researchers will serve in an advisory capacity, working to support DBH staff in establishing a process for compiling and reviewing data and trouble-shooting challenges as they arise. DBH will oversee the CQI system, including developing the relationships between Expansion partners necessary to enable systematic data collection about behavioral health activities and outcomes in DC schools and convening partners to engage in data-driven decision-making.

- **Phase 1 (CQI Establishment):** Operationalize the plan by setting priorities for the CQI data system and establishing processes for data collection and data review. Track a few priority measures from existing data sources. Garner buy-in from Expansion partners. We anticipate Phase 1 would start in spring 2021 and take about 12-18 months to complete, although collection and review of data would be ongoing during this time.

- **Phase 2 (CQI Refinement):** Continue to refine the CQI processes. Track additional priority measures from existing data sources after successfully completing a cycle of collecting, summarizing, reviewing, and monitoring data from Phase 1.

- **Phase 3 (CQI Expansion):** Expand the CQI system. Track additional measures from new data sources, measures or sources provided by Expansion partners, and/or additional schools to answer further questions about the Expansion's performance.

Next steps

Child Trends will work with DBH in the spring of 2021 to set up and begin to implement the CQI system. Specific questions that DBH staff should consider in a final review and continue to ask as the CQI system is developed include:

1. Does the timeline seem realistic?
2. What challenges with implementation of the plan do you foresee?
3. Does the proposed CQI system seem to be designed to answer DBH's highest priority questions?
4. Which 3–5 data sources should be prioritized to create the initial centralized dataset for the CQI system?

Purpose of Continuous Quality Improvement (CQI)

CQI, or performance management, is essentially the process of collecting data on key components of an initiative, reviewing those data to identify where the initiative is working as expected and where it is not, and adjusting the initiative based on those data. The process does not have a defined start and end point and is a continuous cycle of tracking, monitoring, and adjusting. As suggested in the Expansion evaluation plan, we recommend using the Collective Impact framework to guide evaluation—including ongoing CQI efforts—for the Expansion. Collective impact is a "structured approach to problem solving" used by multiple organizations or actors from different sectors to achieve a common goal.[1] Collective impact is defined by five core components; one of which is an entity that serves in a backbone function—coordinating other agencies and organizations—a role similar to DBH's role in the Expansion. Part of what makes collective impact initiatives successful is a commitment to ongoing learning and to adapting as challenges are identified. To enable this kind of learning, collective impact initiatives use a shared measurement system to track program implementation and outcomes to ensure consistent data collection and measurement of results across partners as well as a shared system of accountability for progress toward the common goal. Establishing a CQI system will benefit the Expansion and support DBH, as the backbone organization, in managing and overseeing the initiative by helping to: [2]

- **Identify aspects of the Expansion that appear to be working well and opportunities for improvement.** For example, CQI data might reveal that planning tools and professional development opportunities are widely used and seen as effective but that few schools have been successful in implementing Tier 2 activities.

- **Flag specific schools and CBOs (or school-CBO partnerships) where issues are arising to provide tailored supports.** For example, if there are schools where outcomes are not improving, the CQI data can point to what aspects of implementation quality (such as coordination, high-quality implementation of evidence-based programs, etc.) are also not happening. DBH and partners could then offer tailored support for those schools to address their specific challenges.

- **Make a data-informed case for ongoing support of the initiative.** A CQI system will allow DBH and other partnering agencies to use data to drive conversations about growing, sustaining, or changing the Expansion.

Key CQI questions for SBH Expansion

- Are behavioral health activities being planned, coordinated, and staffed as expected within schools?
- Are professional development and continuous learning resources being utilized by staff across the city?
- To what extent are students being referred to and receiving services?
- To what extent are students receiving Tier 3 services experiencing improved outcomes?

[1] For more information about collective impact, see the Collective Impact Forum (https://www.collectiveimpactforum.org/).
[2] National Center for School Mental Health (2020). *School Mental Health Quality Guide: Impact.* NCSMH, University of Maryland School of Medicine. Retrieved from https://dm0gz550769cd.cloudfront.net/shape/ad/adc885587f996b5ef3e63d656e4d4c60.pdf

Best practices in CQI

There are several best practices that inform the CQI plan laid out in this memo.

Examine both *what* is working and *why* it is working. Track information about the key components of the Expansion in order to understand not just *what* is working (or not working) but *why*. Using the Expansion logic model to guide decisions about what information to measure will ensure that the most critical activities and outcomes of the Expansion are included. The Expansion logic model is on the following page and outlines how the Expansion works, that is, the ways that resources are used to conduct the activities that are expected to drive outcomes.

Get input from end users like clinicians, students, and families. Involve staff and community members in the design of a CQI system and in the ongoing review of data collected as part of that system. Anyone involved in collecting or reviewing data as part of a CQI system needs to buy into that system, or else they will see data collection as a burden rather than a valuable tool for program improvement. This includes DCPS, DC PCS, DBH, and CBO clinicians and staff.

Establish clear roles, responsibilities, and timelines. Build and codify (i.e., in writing) clear processes and timelines for collecting and reviewing data, along with clear roles and responsibilities for people involved in the different components of the CQI system.

Start small to establish a strong foundation. CQI systems are not built overnight, and organizations often start their CQI efforts by focusing on describing an intervention before collecting data on outcomes. Start with collecting data on a few key metrics that will answer important initial questions about the Expansion. Use that data to test and refine the CQI tracking system before scaling it up to include a more comprehensive set of measures that will require data from other partners (such as Office of the State Superintendent for Education [OSSE], DC PCS, and DCPS) or data from new sources (such as surveys of families and students). Starting small will allow for early successes that can establish critical buy-in from stakeholders.

Focus on improvement and avoid using data punitively. Use CQI data to create opportunities for learning, to identify areas in which staff need support, and to engender a culture of continuous improvement; do not use CQI data for punitive purposes. As the CQI processes are being developed, it will be important to consider what public reporting, if any, will use CQI data in order to make sure schools, CBOs, and other partners have a clear understanding of how the data will be used.

Additional resources on CQI

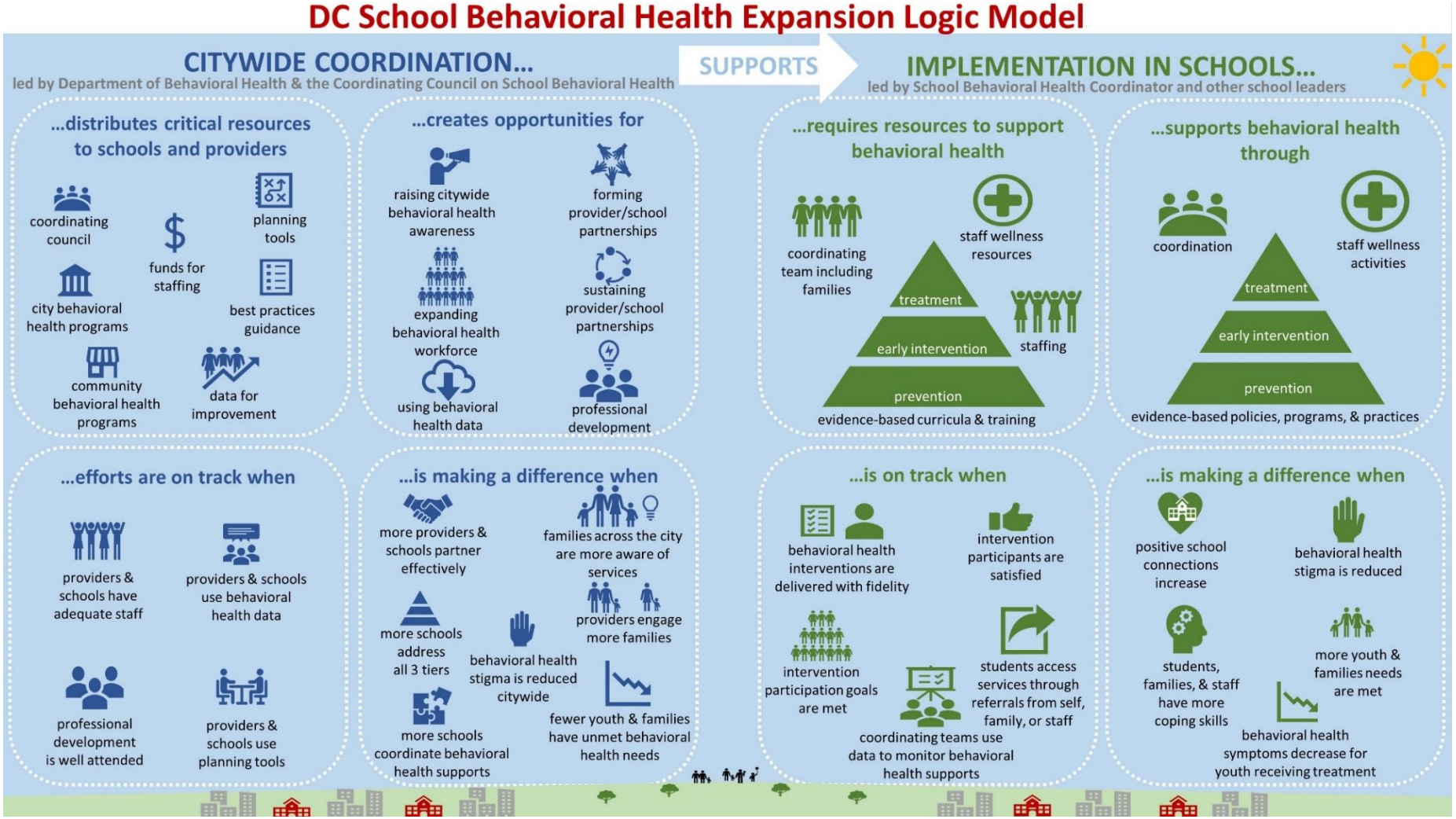
- Building Evidence for Effective Programs
  This is a series of brief videos. In addition to describing key concepts, the videos also illustrate the concepts through a case study. The final video includes a conversation with the former Director of Evaluation at the Latin American Youth Center. The webpage also includes links to several practical resources.

- Working Hard and Working Well: A Practical Guide to Performance Management
  This is a book with practical guidance about using data to monitor and improve programs that serve children, adults, and families. The author makes a case for the importance of performance management and outlines a process for establishing a culture of improvement.

- Making Data Pay Off
  This is a practical guide that outlines several different uses for data with respect to program quality and improvement. For each potential use, the guide includes a brief, real life example of an organization that sought to apply data to solve a problem or otherwise improve their program effectiveness.

Logic model

The Expansion logic model visually depicts how the initiative works, including describing the inputs, activities, outputs, and outcomes that make up the Expansion at both the systems-level (i.e., city-wide components of the Expansion) and the school-level (i.e., implementation of the Expansion in the schools). The logic model guides the CQI plan, in that it identifies the most important resources, outputs, and outcomes that should be tracked and monitored on an ongoing basis. As the logic model evolves and/or is refined (for example, based on lessons learned through ongoing data collection and review), the CQI plan should also be updated.



SBH Expansion CQI Plan

Overview

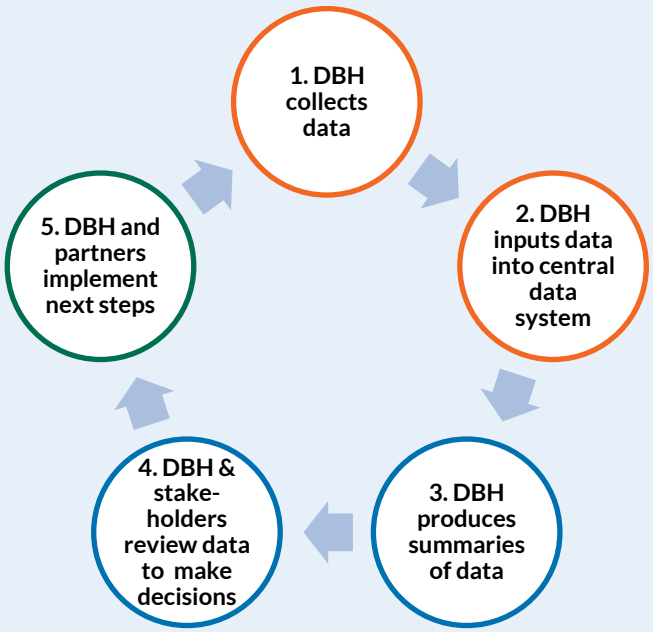
The SBH Expansion CQI system can be implemented using a phased approach that will enable DBH to gather input from and generate interest among key stakeholders to ensure that the system is set up to answer DBH and its partners' most important questions about the Expansion.

Phase 1: DBH will spend the first several months operationalizing the plan, including identifying DBH staff for each role, selecting measures, and developing and codifying processes for data collection and data review. These initial steps will require a fair amount of effort from DBH and the Expansion partners and are critical steps to ensure that the CQI system is user-friendly, informative, and functional. In Phase 1, a few priority measures from existing data sources will be tracked (see Table 1 for a list of measures for which Child Trends is aware of an existing data source; note that Child Trends recommends starting with a small number of data sources from Table 1). DBH has identified three data sources as the priority for Phase 1: (a) DBH and CBO clinician self-reported activities, (b) school principal satisfaction surveys, and (c) behavioral health outcome data for students receiving Tier 3 services from DBH and CBO clinicians. These data can be used by DBH and its partners to engage in the CQI process outlined in Figure 1 in order to demonstrate the ways CQI can support the implementation and improvement of the Expansion, although the data may not provide a complete picture of all behavioral health supports in all schools. Data from DCPS or other Expansion partners could be added gradually during Phase 1.

Phases 2 & 3: Once the system is running smoothly with a few initial measures, additional data can be added (see Table 2 for a list of potential measures). As other partners see the value of the CQI system for monitoring the Expansion as demonstrated in Phase 1, they may be increasingly motivated to find ways to collect and input data on additional schools and clinicians into the system. DBH can then continue to expand and refine the CQI system, adding data to answer additional questions about the Expansion's performance.

In implementing the CQI plan, DBH will engage in a cycle of continuous data collection and review. The first step is to collect data from multiple sources and input them into a central data system; those data are then summarized into charts, graphs, tables, and/or reports; those summaries are used to guide conversations about what is happening in the expansion with key stakeholders including the Coordinating Council, OSSE, DCPS, DC PCS, DC CoP, clinicians, school principals, youth, and families; those conversations help identify next steps (which could include collecting additional data); those next steps are then implemented; and data are monitored to see whether improvements are happening after changes are made.

Figure 1. The SBH Expansion CQI Cycle



In its role as the backbone of a collective impact strategy, DBH is the driver of the CQI system and is responsible for supporting the collection of data, synthesizing that data, and presenting that data to the other organizations and decision makers across the Expansion. To create a culture of continuous learning, staff at all levels across organizations involved in the Expansion need to use data to inform their work and need to be supported in developing capacity for data-driven decision-making (for example, through DC CoP trainings and/or by providing summaries of data collected back to school teams). Another key role in collective impact frameworks is the oversight group or steering committee, such as the Coordinating Council for School Behavioral Health, which is responsible for overseeing progress of the entire initiative.

The key roles in operating a CQI system include:

- **CQI manager** – oversees process, ensures process is codified, involves stakeholders in review sessions, and communicates next steps.
- **Data manager** – sets up CQI data system, coordinates getting data from respective "owners," compiles data into the CQI data system, and checks data for quality (e.g., following up on missing data, flagging when there are unexpected values).
- **Reporting manager** – works with CQI manager and data manager to determine format for summaries of data and produces summary charts, tables, and written overviews.
- **CQI advisory group** – this group of stakeholders from across the initiative provides input on what data to collect (or the most important questions to be answered, which, in turn, determines what data to collect), reviews data summaries, and advises DBH and its partners on course corrections or actions to take in response to that data.

One person could fulfill multiple roles, for example, someone could be both the data and reporting manager and serve on the advisory group. Identifying staff to fill these roles and clearly defining their responsibilities will be a key activity during Phase 1. This includes coordinating with Expansion partners, such as OSSE, DC PCS, and DCPS, to identify who will be on the CQI advisory group responsible for reviewing data and making decisions about next steps and further defining the scope of this advisory group, particularly to clarify how its role is different or overlaps with the roles of other improvement-focused bodies in DC working to address school behavioral health.

Data Collection (Steps 1 & 2)

The Expansion CQI system should track the system- and school-level outputs ("on track when…") and outcomes ("making a difference when…") laid out in the logic model in order to identify what parts of the Expansion are happening as expected (i.e., outputs) and where progress is being made toward the goals of the Expansion (i.e., outcomes). Although eventually the ideal CQI system will track all aspects of the Expansion that are identified in the logic model, the process of collecting data for all schools on every component will be resource- and time-intensive. Instead, we recommend that DBH start by identifying one or two priority measures of each of the Expansion's key components that can be monitored using existing data that is collected either by DBH or by DBH contractors or data that would take a relatively minimal effort to collect (see Table 1 for a full list of measures that meet these criteria to consider for Phase 1 and 2). DBH has identified three data sources as the priority for Phase 1: (a) DBH and CBO clinician self-reported activities, (b) school principal satisfaction surveys, and (c) behavioral health outcome data for students receiving Tier 3 services from DBH and CBO clinicians (the timing for collecting these data are outlined in Table 3). Data will need to be collected from various sources, then combined and stored in a central database. DBH may want to consider investing in a data management system; starting with a limited set of data at the beginning could possibly allow DBH to start by storing data in spreadsheets if there are concerns about the process of acquiring a data management system taking too long. For school-level data, the database should allow for sorting data by school (and possibly also by CBO) and tracking data over time in order to examine trends. Since the data will be coming from several different sources, before data can be uploaded into the CQI data system, the data manager will need to review data for quality (e.g., checking for missing data or values that are impossible such as reporting an unreasonable number of sessions given reported caseloads) and may need to aggregate data up from the clinician or student level to

the school level. Data systems may be able to reduce some of this data management burden, for example, if schools enter data directly into the CQI data system.

Data Review and Reporting (Steps 3 & 4)

Once data have been compiled into a CQI data system, they need to be reviewed regularly by multiple stakeholders in review sessions that allow for reflection and discussion of the data to identify the important messages and next steps indicated by the data. This process is sometimes referred to as "sense making." It is during this time that stakeholders practice "asking questions" of the data. Initially, questions may be more about understanding what is happening city-wide and in schools related to the Expansion. After the CQI system has been in place for some time, questions may become more granular and specifically focused on areas of challenge or follow up on how course corrections appear to be working.

At a minimum, the CQI advisory group should be included in data review sessions, and members of the group should help the DBH CQI manager facilitate discussion of the data, asking questions of the group and guiding the group to define actionable next steps (one of which may be to gather additional information in order to better understand some aspect of the Expansion). The advisory group should include stakeholders from across the Expansion, including representatives from the Coordinating Council, DC CoP (such as the DC CoP facilitators), OSSE, DCPS, DC PCS, CBOs, school staff, and clinicians. At times, students and families should be included in data review sessions to help interpret that data and to help shape decisions about next steps. The recommendations that come out of these sessions should not always be to make changes to some part of the Expansion; often, next steps will be to reach out to schools and/or CBOs to offer additional support and resources or to engage in conversation and collaboration around an issue identified in the data.

To make these sessions productive and facilitate discussion, DBH should produce summaries of the data in the form of brief written reports (e.g., bulleted high-level descriptions on PowerPoint slides), tables of data, or graphs that lay out the descriptive statistics (e.g., average percent of students at schools who receive Tier 2 interventions) and any patterns or themes (e.g., schools with high quality workplans have higher numbers of youth self-referrals).

Potential stakeholder discussion questions

- Is this what we would have expected, given what we know about how the Expansion was designed and how we think it is going?
- Are different schools implementing the Expansion differently? For example, are some schools doing more of one component and less of the other? What do those schools have in common?
- Are behavioral health services happening at all three tiers? If not, are interventions being offered more as part of one tier than others? What do we know about why that is?
- What questions do we have about the Expansion that cannot be answered with the data we have? What information do we need to answer those questions?

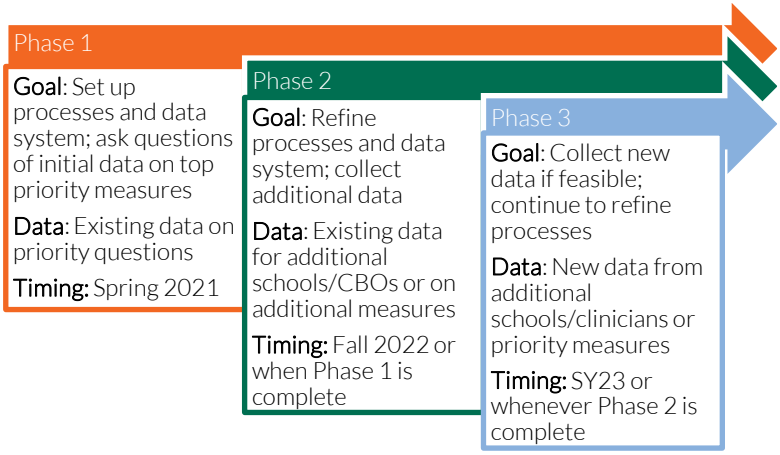
Implement and monitor changes (Step 5 → Step 1)

When DBH and its partners determine next steps to be implemented (e.g., offering additional supports to a set of schools with a particular challenge or implementing a citywide campaign to address behavioral health stigma), the planning process should include consideration of which data will be needed to determine whether the change was effective. When existing data are not sufficient, DBH and its partners should determine what data to collect and develop a joint plan for collecting and reviewing those data.

Timeline

Building a strong CQI system takes time. Many of the things that we most want to know about school behavioral health in DC—in particular, the overall behavioral and emotional health of students, staff, and families—are not easily known with the data that is immediately available. However, there are several existing sources of data that, when compiled into a single system, can give DBH and its partners a sense of how the Expansion is being implemented in schools, without having to develop extensive new systems for data collection and monitoring. In the recommended phased approach to developing a CQI system for the Expansion, data that is more readily available is collected into a centralized system and reviewed first. Data that will require additional effort to collect or that are already collected but would be difficult to gather into a single data system could be incorporated in later phases over the course of several school years. An overview of the phases is in Figure 2.

Figure 2. Overview of CQI system phases



A detailed description of the phases starts on page 9, with a checklist of major tasks for each phase. The timeline for data collection for Phase 1 is in Table 3, and the detailed workplan timeline for the initial months of Phase 1 is in Table 4. An overall timeline for the CQI system rollout is in Table 5. We do not recommend that Phase 2 begin until DBH has completed an entire cycle of collecting, summarizing, reviewing, and drawing conclusions from Phase 1 data. This may take longer than is laid out in the suggested timeline, but it is important that the CQI system and processes are in place and running smoothly before scaling it up. The timeline was developed with the specific phased approach of collecting data from existing sources first; should DBH and its partners decide not to use this approach and instead prioritize gathering new data in Phase 1, the Phase 1 timeline would have to be adjusted and the installation of the CQI system would likely need to be extended.

Information to Guide Planning for SBH Expansion CQI

The information and tables on the following pages provide additional details that can inform the further development and operationalization of the CQI plan.

- **Phases at a glance** describes each phase in more detail, including a checklist of the major tasks to be accomplished.
- **Tables 1 and 2** list measures of the Expansion components and outcomes. Table 1 is the list of measures for which Child Trends is aware of an existing data source for at least some schools, but Child Trends is not aware of an existing data source collected by DBH that includes every school in DC. The reader can use the information in these tables to:
    - Guide discussion about what measures are a priority to include in the CQI data system.
    - Assess if there are any questions of interest that would not be addressed by at least one of these measures.
    - Consider how each measure would help Expansion partners monitor the initiative. For example, if you learn that only 20% of schools have workplans that address all three tiers, what would be some possible next steps? What information would still be needed to determine next steps?
- **Table 3** is an overview of the data collection timeline for Phase 1 for the data sources that were identified by DBH as the top priority for Phase 1.
- **Table 4** is a timeline for the first six months of Phase 1.
- **Table 5 is** timeline for the phases and rollout of the CQI system.

Phases at a glance: Phase 1

Level of effort considerations

The more measures selected for Phase 1, the more effort will be needed to compile them into the CQI data system and summarize them.

Questions to be answered about behavioral health supports in select schools*:

- What components of the expansion are happening as planned?
- What components of the expansion are not happening as planned?
- What schools and/or CBOs appear to need additional support to implement the expansion, and in what areas do they need support?
- What are the behavioral health outcomes of youth receiving Tier 3 services from DBH clinicians?

Existing data collected by or easily accessible to DBH (Table 1)*:

- DBH records of expansion activities
- DBH clinician data submitted monthly to iCAMs
- DBH and CBO clinician monthly survey data
- DC CoP records of activities such as number of sessions held & satisfaction
- Student behavioral health data for students receiving Tier 3 services from DBH clinicians
- Surveys of school staff being collected by Child Trends as part of the evaluation
- Surveys of families being collected by Child Trends as part of the evaluation
- Surveys of youth being collected by Child Trends as part of the evaluation

Checklist of key tasks

- ☐ Operationalization of the CQI plan
  - Develop detailed timeline for Phase 1
  - Designate staff for CQI roles including advisory group
  - Codify CQI staff responsibilities in writing
  - Prioritize questions and objectives for Phase 1, 2, and 3
  - Confirm data sources for Phase 1 measures
  - Develop a detailed plan for how data will be collected, aggregated, and cleaned
  - Codify CQI data collection procedures in writing
- ☐ Design and build CQI data system
- ☐ Collect data on Phase 1 measures
- ☐ Enter/upload data on Phase 1 measures into CQI data system
- ☐ Review data quality
- ☐ Develop templates for data summaries
- ☐ Produce data summaries for Phase 1 data
- ☐ Hold CQI advisory group meeting(s) to review data summaries
- ☐ Make plans based on data, such as identifying schools in need of support
- ☐ Identify data needed to monitor results of plans
- ☐ Implement plans and monitor progress
- ☐ Develop new questions for existing surveys for Phase 2 measures as needed

* The exact questions and data sources for each phase will depend on which measures DBH prioritizes for Phase 1, 2, and 3.

Phases at a glance: Phase 2

Level of effort considerations

Continuing to use only data for schools with a DBH clinician and/or a CBO clinician would require the least additional effort. Collecting data for schools with DCPS clinicians would require additional effort but would enable a more complete picture of the expansion and outcomes across the city as well as identify more DCPS schools in need of support.

Questions to be answered about behavioral health supports in additional schools:

- What components of the expansion are happening as planned and has this changed year over year?
- What components of the expansion are not happening as planned?
- Is there evidence of improvement after adjustments were made or support was provided based on Phase 1 CQI cycle?
- What schools and/or CBOs appear to need additional support to implement the expansion, and in what areas do they need support?
- What are the behavioral health outcomes of youth receiving Tier 3 services from DBH clinicians and how have they changed year over year?

Existing data collected by or easily accessible to DBH (Table 1):

- Additional measures from the same data sources as Phase 1, with the possible addition of data on DCPS clinician activities

Checklist of key tasks

- ☐ Review Phase 1 measures and refine or drop any that have not been informative
- ☐ Collect data for Phase 2 measures (this could include setting up data sharing agreements with partners or adding questions to existing surveys)
- ☐ Enter/upload data on Phase 2 measures into CQI data system
- ☐ Review data quality
- ☐ Produce data summaries of Phase 1 and 2 data
- ☐ Hold CQI advisory group meeting(s) to review data summaries
- ☐ Make plans based on data, such as identifying schools in need of support
- ☐ Identify data needed to monitor results of plans
- ☐ Implement plans and monitor progress
- ☐ Work with partners to develop data sharing agreements for Phase 3 measures as needed
- ☐ Develop new surveys or data collection tools for Phase 3 measures as needed

* The exact questions and data sources for each phase will depend on which measures DBH prioritizes for Phase 1, 2, and 3.

Phases at a glance: Phase 3

Level of effort considerations

Same considerations as Phase 2. Collecting new data (e.g., through new surveys) will require additional effort but will provide information on a wide range of additional measures, which will allow DBH and partners to answer more questions about the expansion.

Questions to be answered about behavioral health supports in all schools:

At all schools in DC:

- What components of the expansion are happening as planned?
- What components of the expansion are not happening as planned?
- What schools and/or CBOs need additional support and in what areas?
- What are the behavioral health outcomes of youth receiving Tier 3 services?

Existing and new data sources (Table 1 and 2):

Same sources as Phase 1 and 2, plus potential additional data sources:

- Surveys of CBO supervisors
- Surveys of DCPS clinicians
- DCPS data on clinician activities

Checklist of key tasks

- ☐ Review Phase 1 and 2 measures and refine or drop any that have not been informative
- ☐ Collect data for Phase 3 measures (this could include setting up data sharing agreements with partners and fielding new surveys)
- ☐ Enter/upload data on Phase 3 measures into CQI data system
- ☐ Review data quality
- ☐ Produce data summaries of Phase 1, 2, 3 data
- ☐ Hold CQI advisory group meeting(s) to review data summaries
- ☐ Make plans based on data, such as identifying schools in need of support
- ☐ Identify data needed to monitor results of plans
- ☐ Implement plans and monitor progress

* The exact questions and data sources for each phase will depend on which measures DBH prioritizes for Phase 1, 2, and 3.

Table 1. CQI measures from logic model recommended for Phase 1 and 2.

In order to ensure the CQI system will be able to answer questions about what is happening in the SBH Expansion as well as why things are happening the way they are, it is important to include a mix of implementation-focused data and outcomes-focused data. We have proposed a phased approach to building the CQI system, starting with existing data that answer high-priority questions. Because establishing those priorities will likely require some discussion among DBH and its partners in the Expansion, we have provided a list of potential data points for consideration along with information related to what each data point might contribute to the CQI system and likely existing sources of data. This data comes from various sources, but it is our understanding that it is all accessible to DBH or would be assessable with minimal effort (such as adding a question to an existing survey). DBH may be able to identify additional measures for which there is data. There are other existing data sources such as the Health and Physical Education Assessment (HPEA), the Youth Risk Behavior Survey (YRBS), and Panorama survey that contain some measures of behavioral health outcomes, including mental health knowledge and school climate, but Table 1 does not include those sources because DBH would most likely need to enter into a data sharing agreement in order to gain access to the data. The priority measures identified for Phase 1 by DBH are bolded below. Data sources being collected by Child Trends for the SBH Expansion evaluation are marked with an asterisk.

Level	**Measure of implementation or outcomes?** • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	**Logic model component** *Which component of the logic model this measures*	**Metric** *The type of information that addressed by the measure related to components of the logic model.*	**Measure** *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*	**Youth survey***	**Family survey***	**Staff survey***	**Principal satisfaction survey**	**DBH records/admin. data**	**DBH clinician iCAMS data**	**DBH & CBO clinician survey**	**DC CoP records/admin. data**	**DC CoP participant survey**
System	Implementation	Providers and schools have adequate staff	DBH-CBO coordination	# of joint DBH/CBO supervisor meetings					X				
System	Implementation	Providers and schools have adequate staff	Quality of staffing supports	# of positions filled via portal					X				
System	Implementation	Providers and schools have adequate staff	Use of staffing supports	# of resumes/profiles submitted via workforce portal					X				
System	Implementation	Providers and schools have adequate staff	Use of staffing supports	# of CBOs/employers accessing portal					X				
System	Outcomes	Providers and schools have adequate staff	Adequate clinician staffing levels	# of clinicians in schools with high levels of need or ratio of clinicians to students in schools with high level of need					X				
System	Outcomes	Providers and schools have adequate staff	Adequate clinician staffing levels	% CBOs assign clinician to a school within 3 months of matching and prior to the start of school					X				

Level	Measure of implementation or outcomes? • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	Logic model component *Which component of the logic model this measures*	Metric *The type of information that addressed by the measure related to components of the logic model.*	Measure *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*	Youth survey*	Family survey*	Staff survey*	Principal satisfaction survey	DBH records/admin. data	DBH clinician iCAMS data	DBH & CBO clinician survey	DC CoP records/admin. data	DC CoP participant survey
System	**Outcomes**	**Providers and schools have adequate staff**	**Adequate clinician staffing levels**	**% of principals satisfied with staffing levels**				**X**					
System	Implementation	Professional development is well attended	Participation in DC CoP	# of school-based participants in DC CoP								X	
System	Implementation	Professional development is well attended	Participation in DC CoP	# of DBH, DCPS, DCPCS, and CBO participants in CoP								X	
System	Implementation	Professional development is well attended	Participation in DC CoP	% of participants in DC CoP representing diverse roles (e.g., DBH, CBO, and DCPS clinicians, administrators, school staff)								X	
System	Implementation	Professional development is well attended	Quality of DC CoP activities	% satisfied with DC CoP activities/ sessions									X
System	Implementation	Professional development is well attended	Reach of DC CoP	# DC CoP sessions held								X	
System	**Implementation**	**Providers and schools have adequate staff**	**Quality of matching process**	**# of schools/CBOs satisfied with matching process**				**X**					
System	Implementation	Providers and schools use planning tools	Reach of TA supports	Average # interactions with TA/DBH clinical specialist across all school teams					X				
System	Outcomes	Providers and schools use planning tools	Quality of SBH plans	% of schools that complete planning activities/documents					X				
System	Outcomes	Providers and schools use planning tools	Quality of SBH plans	% of schools with plans that address all Tiers					X				
System	Outcomes	Providers and schools use planning tools	Quality of SBH plans	% of schools with clearly documented referral pathway					X				

Level	Measure of implementation or outcomes? • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	Logic model component *Which component of the logic model this measures*	Metric *The type of information that addressed by the measure related to components of the logic model.*	Measure *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*	Youth survey*	Family survey*	Staff survey*	Principal satisfaction survey	DBH records/admin. data	DBH clinician iCAMS data	DBH & CBO clinician survey	DC CoP records/admin. data	DC CoP participant survey
System	**Outcomes**	**Reduced behavioral health stigma**	**Student perceptions of behavioral health**	**% of students reporting behavioral health stigma**	**X**								
System	**Outcomes**	**Reduced behavioral health stigma**	**Family perceptions of behavioral health**	**% of families reporting behavioral health stigma**		**X**							
System	**Outcomes**	**Increased awareness of services**	**Student awareness of services**	**% of students reporting awareness of services**	**X**								
System	**Outcomes**	**Increased awareness of services**	**Family awareness of services**	**% of families reporting awareness of services**		**X**							
System	**Outcomes**	**Fewer youth and families have unmet behavioral health needs**	**Family behavioral health needs**	**% of families reporting unmet behavioral health needs**		**X**							
School	Implementation	Coordinating teams use data to monitor behavioral health supports	Quality of SBH plans	% of schools with workplans deemed high quality using rubric					X				
School	Implementation	Coordinating teams use data to monitor behavioral health supports	Quality of SBH plans	% of schools with workplan that clearly supports integration of all clinicians					X				
School	**Implementation**	**Coordinating teams use data to monitor behavioral health supports**	**Integration of clinicians into SBH team**	**% of clinicians that perceive support among other clinicians**							**X**		
School	**Implementation**	**Coordinating teams use data to monitor behavioral health supports**	**Integration of clinicians into school staff**	**% of clinicians that perceive support from staff/leadership**							**X**		
School	**Implementation**	**Intervention participation goals are met**	**Tier 1 service delivery**	**% of students, staff, and families exposed to Tier 1 activities**						**X**	**X**		
School	**Implementation**	**Intervention participation goals are met**	**Tier 1 service delivery**	**# of Tier 1 sessions delivered**						**X**	**X**		

Level	Measure of implementation or outcomes? • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	Logic model component *Which component of the logic model this measures*	Metric *The type of information that addressed by the measure related to components of the logic model.*	Measure *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*	Youth survey*	Family survey*	Staff survey*	Principal satisfaction survey	DBH records/admin. data	DBH clinician iCAMS data	DBH & CBO clinician survey	DC CoP records/admin. data	DC CoP participant survey
School	Implementation	Intervention participation goals are met	Tier 2 service delivery	% of students, staff, and families exposed to Tier 2 interventions (ideally, this will be 15-20% of students at the most)						X	X		
School	Implementation	Intervention participation goals are met	Tier 2 service delivery	# of Tier 2 sessions delivered						X	X		
School	Implementation	Intervention participation goals are met	Tier 3 service delivery	% of students receiving Tier 3 intervention						X	X		
School	Implementation	Intervention participation goals are met	Tier 3 service delivery	# of Tier 3 sessions delivered						X	X		
School	Implementation	Behavioral health interventions are delivered with fidelity	Tier 1 service delivery	% of clinicians adequately prepared to deliver Tier 1 activities							X		
School	Implementation	Behavioral health interventions are delivered with fidelity	Tier 2 service delivery	% of clinicians adequately prepared to deliver Tier 2 activities							X		
School	Implementation	Behavioral health interventions are delivered with fidelity	Tier 3 service delivery	% of clinicians adequately prepared to deliver Tier 3 activities							X		
School	Outcomes	Behavioral health symptoms decrease for youth receiving treatment	Youth behavioral health outcomes	% of students in Tier 3 treatment with positive BH outcomes (e.g., reduced symptoms over time)					X				
School	Outcomes	Reduced behavioral health stigma	Student perceptions of behavioral health	% of students reporting behavioral health stigma	X								
School	Outcomes	Reduced behavioral health stigma	Family perceptions of behavioral health	% of families reporting behavioral health stigma		X							

Level	**Measure of implementation or outcomes?** • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	**Logic model component** *Which component of the logic model this measures*	**Metric** *The type of information that addressed by the measure related to components of the logic model.*	**Measure** *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*	**Youth survey***	**Family survey***	**Staff survey***	**Principal satisfaction survey**	**DBH records/admin. data**	**DBH clinician iCAMS data**	**DBH & CBO clinician survey**	**DC CoP records/admin. data**	**DC CoP participant survey**
School	**Outcomes**	**Increased awareness of services**	**Student awareness of services**	**% of students reporting awareness of services**	X								
School	**Outcomes**	**Increased awareness of services**	**Family awareness of services**	**% of families reporting awareness of services**		X							
School	**Outcomes**	**Increased staff wellness**	**Perceived wellness among staff**	**% of staff reporting positive well-being**			X						
School	**Outcomes**	**Increased staff wellness**	**Perception of staff wellness supports**	**% of staff reporting positive perception of wellness supports**			X						

Table 2. CQI measures from logic model recommended for consideration in Phase 3.

Table 2 describes the outputs and outcomes from the Expansion logic model that are recommended for consideration for Phase 3 because they will require additional data collection effort. For some of these measures, data is likely being collected by DCPS, OSSE, DC PCS, or other Expansion partners. For other measures, there is no known existing data source, and these data would need to be collected through new processes such as surveys of school staff, families, and students. An initial step for DBH is to review the measures in Table 2 to determine if there are existing data sources accessible to DBH that include these measures, in which case, they could be considered for Phase 1 or 2.

Level	**Measure of implementation or outcomes?** • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	**Logic model component** *Which component of the logic model this measures*	**Metric** *The type of information that addressed by the measure related to components of the logic model.*	**Measure** *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*
System	Implementation	Professional development is well attended	Quality of DC CoP activities	% of DC CoP participants that perceive DC CoP materials to be high quality
System	Implementation	Professional development is well attended	Quality of DC CoP activities	% of DC CoP participants that report opportunities to collaborate across roles
System	Implementation	Providers and schools have adequate staff	Financial sustainability	% of CBOs satisfied with financial support
System	Implementation	Providers and schools have adequate staff	Quality of clinician supervision	% of CBO supervisors that meet regularly with clinicians
System	Implementation	Providers and schools have adequate staff	Quality of DBH-CBO coordination	% of staff satisfied with joint DBH/CBO supervisor meetings
System	Implementation	Providers and schools have adequate staff	Quality of staffing supports	% of candidates and employers satisfied with the portal
System	Implementation	Providers and schools have adequate staff	Quality of staffing supports	% of CBOs satisfied with qualifications of candidates
System	Implementation	Providers and schools use behavioral health data	Use of shared data	# of city agencies and school leaders that report using the resource map for planning
System	Implementation	Providers and schools use behavioral health data	Use of shared data	# of schools/CBOs that are familiar with data requests related to Tier 1/2/3 services
System	Implementation	Providers and schools use behavioral health data	Use of shared data	% satisfied with data that is provided by DBH and OSSE to schools/CBOs for quality improvement
System	Implementation	Providers and schools use behavioral health data	Use of shared data	% of schools submit data on delivery of Tier 1/2/3 EBPs
System	Implementation	Providers and schools use behavioral health data	Use of shared data	% of CBOs submit data on delivery of Tier 1/2/3 EBPs
System	Implementation	Providers and schools use planning tools	Participation in SBH training	# of clinicians reporting attendance to school behavioral health-related training
System	Implementation	Providers and schools use planning tools	Quality of planning supports	% of staff satisfied with training on planning tools

Level	**Measure of implementation or outcomes?** • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	**Logic model component** *Which component of the logic model this measures*	**Metric** *The type of information that addressed by the measure related to components of the logic model.*	**Measure** *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*
System	Implementation	Providers and schools use planning tools	Use of planning supports	# of school teams that complete training on planning tools
System	Outcomes	Behavioral health stigma is reduced citywide	Stigma	% of families with positive perceptions of help-seeking
System	Outcomes	Behavioral health stigma is reduced citywide	Stigma	% of youth with positive perceptions of help-seeking
System	Outcomes	Families across the city are aware of more services	Behavioral health awareness	# of youth and families that are familiar with the SBH Expansion
System	Outcomes	Fewer youth and families have unmet behavioral health needs	Unmet needs	% of families reporting unmet behavioral health needs
System	Outcomes	Fewer youth and families have unmet behavioral health needs	Unmet needs	% of youth reporting unmet behavioral health needs
System	Outcomes	More providers and schools partner effectively	Financial sustainability	% of CBOs achieve target billing amount
System	Outcomes	More providers and schools partner effectively	Partnership satisfaction	% of schools satisfied with CBO supports
System	Outcomes	More schools address all 3 tiers	Support for all 3 tiers	% of CBOs with professional development plans that address Tier 1/2/3 services and emphasize family engagement, trauma, and cultural relevance
System	Outcomes	More schools address all 3 tiers	Support for all 3 tiers	% of CBO supervisors with knowledge of school-based EBPs across all Tiers
System	Outcomes	More schools coordinate behavioral health supports	Cross-school learning	% of schools with School Behavioral Health teams that engage in cross-school sharing of best practices
System	Outcomes	Providers engage more families	Quality of clinician supervision	% of CBO supervisors with knowledge of family engagement strategies
School	Outcomes	More youth and family needs are being met	Unmet needs	% of families reporting unmet needs
School	Implementation	Behavioral health interventions are delivered with fidelity	Clinician knowledge	% of clinician with high family engagement capacity
School	Implementation	Behavioral health interventions are delivered with fidelity	Quality of staff wellness services	% of staff wellness activities delivered with fidelity
School	Implementation	Behavioral health interventions are delivered with fidelity	Quality of Tier 1 services	% of Tier 1 activities delivered with fidelity
School	Implementation	Behavioral health interventions are delivered with fidelity	Quality of Tier 2 services	% of Tier 2 activities delivered with fidelity
School	Implementation	Behavioral health interventions are delivered with fidelity	Quality of Tier 3 services	% of Tier 3 activities delivered with fidelity

Level	**Measure of implementation or outcomes?** • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	**Logic model component** *Which component of the logic model this measures*	**Metric** *The type of information that addressed by the measure related to components of the logic model.*	**Measure** *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*
School	Implementation	Behavioral health interventions are delivered with fidelity	Staff behavioral health knowledge	% of staff with knowledge of EBP Tier 1/2 strategies
School	Implementation	Coordinating teams use data to monitor behavioral health supports	Family engagement in planning	# of families and youth that participate in planning/monitoring quality
School	Implementation	Coordinating teams use data to monitor behavioral health supports	Integration of clinicians into school BH team	% of staff with positive perceptions of integration of clinicians
School	Implementation	Coordinating teams use data to monitor behavioral health supports	Quality of SBH plans	% of SSTs that are adequately thorough
School	Implementation	Coordinating teams use data to monitor behavioral health supports	SBH plans in place	% of stakeholders familiar with SBH plans
School	Implementation	Coordinating teams use data to monitor behavioral health supports	Use of shared data	SBH/wellness teams collected data on Tier 1/2/3 EBPs
School	Implementation	Intervention participants are satisfied	Quality of staff wellness services	% of staff satisfied with wellness activities
School	Implementation	Intervention participants are satisfied	Quality of Tier 1 services	% satisfied with Tier 1 activities (students, family members, staff)
School	Implementation	Intervention participants are satisfied	Quality of Tier 2 services	% satisfied with Tier 2 activities (students, family members, staff)
School	Implementation	Intervention participants are satisfied	Quality of Tier 3 services	% satisfied with Tier 3 activities (students, family members, staff)
School	Implementation	Intervention participation goals are met	Staff wellness service delivery	% of staff exposed to staff wellness interventions
School	Implementation	Intervention participation goals are met	Staff wellness service delivery	# of staff wellness activities / exposure
School	Implementation	Intervention participation goals are met	Exposure to Tier 1 services	Dosage of Tier 1 activities (e.g., hours of exposure)
School	Implementation	Intervention participation goals are met	Exposure to Tier 2 services	Dosage of Tier 2 activities (e.g., hours of exposure)
School	Implementation	Intervention participation goals are met	Exposure to Tier 3 services	Dosage of Tier 3 intervention (e.g., hours of exposure)
School	Implementation	Intervention participation goals are met	Adequate staffing levels	% of clinicians with optimal caseload
School	Implementation	Students access services through referrals from self, family, or staff	Referral system in place	# of family referrals to Tier 2 and 3 services
School	Implementation	Students access services through referrals from self, family, or staff	Referral system in place	% of staff familiar with referral pathways to Tier 2 and 3 services
School	Implementation	Students access services through referrals from self, family, or staff	Referral system in place	# of youth self-referrals to Tier 2 and 3 services

Level	**Measure of implementation or outcomes?** • *Implementation: related to outputs from the logic model* • *Outcomes: related to outcomes from the logic model*	**Logic model component** *Which component of the logic model this measures*	**Metric** *The type of information that addressed by the measure related to components of the logic model.*	**Measure** *How the metric will actually be measured. This is generally in the form of an increase or decrease in the amount (#) or proportion (%) of a given metric.*
School	Implementation	Students access services through referrals from self, family, or staff	SBH plans in place	% of referrals that follow referral pathways
School	Outcomes	Behavioral health stigma is reduced	Behavioral health stigma	% of students with positive perceptions of help seeking
School	Outcomes	Behavioral health stigma is reduced	Behavioral health stigma	% of staff with positive perceptions of help seeking
School	Outcomes	Coordinating teams use data to monitor behavioral health supports	Integration of clinicians into school BH team	% of CBOs participating in monitoring quality
School	Outcomes	Coordinating teams use data to monitor behavioral health supports	Staff collaboration with clinicians	% of staff reporting collaboration with clinicians
School	Outcomes	More youth and family needs are being met	Youth and family leadership	% of families in leadership positions
School	Outcomes	More youth and family needs are being met	Staff behavioral health knowledge	% of staff with knowledge of family engagement skills
School	Outcomes	More youth and family needs are being met	Youth and family leadership	% of youth in leadership positions
School	Outcomes	Positive school connections increase	Attendance	% of students chronically absent
School	Outcomes	Positive school connections increase	Clinician turnover	% of clinicians who leave the school each year
School	Outcomes	Positive school connections increase	Discipline	% of students suspended
School	Outcomes	Positive school connections increase	Family engagement	# of families actively participating in school activities
School	Outcomes	Positive school connections increase	School climate	% of students with positive perceptions of school climate
School	Outcomes	Positive school connections increase	Staff turnover	% of staff that leave the school each year
School	Outcomes	Positive school connections increase	Trusted adult	% of students that report having a trusted adult at school
School	Outcomes	Students, families, and staff have more coping skills	Family behavioral health outcomes	Families' behavioral health literacy /awareness
School	Outcomes	Students, families, and staff have more coping skills	Staff behavioral health outcomes	Staff behavioral health literacy/awareness
School	Outcomes	Students, families, and staff have more coping skills	Staff stress	% of staff reporting high stress levels
School	Outcomes	Students, families, and staff have more coping skills	Youth behavioral health outcomes	Youth behavioral health literacy/awareness
School	Outcomes	Students, families, and staff have more coping skills	Youth behavioral health outcomes	Youth coping skills

Table 3. Overview of Phase 1 data collection timeline for data sources identified by DBH as priority for Phase 1

	2021										2022					
Domain **Data source**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**	**June**
Student outcomes																
CAFAS (DBH clinicians)																
TBD assessment tool (CBO clinicians)																
Student survey*																
Family outcomes																
Caregiver survey*																
Teacher outcomes																
Staff survey*																
Partnership quality																
Principal satisfaction survey																
Clinician activity																
iCAMs (DBH clinicians)																
Self-report survey (CBO clinicians)																

** Data being collected by Child Trends for the SBH Expansion evaluation that can also be used for CQI purposes. Surveys will be sent to as many schools as possible, but response rates will likely vary and data may not be available for all schools.*

Table 4. Timeline for first five months of Phase 1 (Spring and Summer 2021)

	March		April		May		June		July	
	1-15	16-31	1-15	16-30	1-15	16-31	1-15	16-30	1-15	16-31
Data collection										
DBH sends CAFAS and iCAMs data to CT for Aug 2020-Feb 2021										
DBH sends CAFAS and iCAMs data to CT for previous month										
DBH identifies common student assessment tool										
DBH trains clinicians on common student assessment tool										
CT works with SBHCs to collect teacher survey as part of evaluation activities										
CT works with SBHCs to collect student survey as part of evaluation activities										
CT works with SBHCs to collect caregiver survey as part of evaluation activities										
DBH sends Principal satisfaction survey										
Operationalize CQI plan										
DBH and CT develop detailed timeline for Phase 1										
DBH identifies staff for key CQI roles										
CT meets with DBH CQI staff to plan Phase 1										
DBH begins to plan for CQI technology system/database										
Data reporting and review										
DBH identifies staff for CQI Advisory Committee										
CT works with DBH staff to aggregate, clean, analyze data										
DBH and CT prepare for 1st review meeting										
1st review meeting (data from DBH clinicians only)										
DBH prepares for 2nd review meeting with CT support										
2nd review meeting (data from DBH and CBO clinicians)										

Table 5. Suggested timeline for CQI phases.

	SY21		SY22			SY23			SY24	
Phase	**Spring 2021**	**Summer 2021**	**Fall 2021**	**Spring 2022**	**Summer 2022**	**Fall 2022**	**Spring 2023**	**Summer 2023**	**Fall 2023**	**Spring 2024**
1	Gather existing Phase 1 data	Input data into system, hold initial review meetings	Collect/review Phase 1 SY22 data on rolling basis 	Collect/review Phase 1 SY22 data on rolling basis 	Make any adjustments to Phase 1 measures					
2*				Add Phase 2 SY22 data into system	Review Phase 2 SY 22 data across schools	Collect/review Phase 2 SY23 data 	Collect/review Phase 2 SY23 data 	Make any adjustments to Phase 2 measures		
3					Plan for rollout of Phase 3 measures	Start to collect Phase 3 data	Add Phase 3 SY23 data into system	Review Phase 3 data across schools	Collect/ review Phase 3 SY24 data 	Collect/ review Phase 3 SY24 data 
Data in the CQI data system			Phase 1	Phase 1 Phase 2	Phase 1 Phase 2	Phase 1 Phase 2	Phase 1 Phase 2 Phase 3	Phase 1 Phase 2 Phase 3	Phase 1 Phase 2 Phase 3	Phase 1 Phase 2 Phase 3

** Phase 2 should only begin once DBH and partners have gone through an entire cycle of collecting, summarizing, and reviewing Phase 1 data. See Tables 1 and 2 as well as Phases at a glance for more information on data in the CQI system at each phase.*