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COVID School Wellness Initiative (CSWI)

Final Evaluation Report October 2024

Prepared For:
Illinois Children's Healthcare Foundation

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Executive Summary

Illinois Children's Healthcare Foundation (ILCHF) developed the COVID School Wellness Initiative (CSWI) in a statewide effort to address mental health needs of children, their caregivers, and teachers in communities hardest hit by the COVID-19 pandemic. ILCHF awarded 29 total CSWI grants to 22 different organizations across the state of Illinois. The Chicago cohort consisted of 14 grants distributed to 10 unique organizations. The Illinois cohort consisted of 15 grants distributed to 12 unique organizations.

Grantee organizations partnered with local schools or school districts to develop and implement multi-tiered programming for students, caregivers, and/or school staff to increase access to mental health interventions and to improve mental health outcomes across stakeholders. Grantee organizations developed their unique program plan in partnership with caregivers and school leaders in order to ensure resources and activities developed through the CSWI met the unique needs of the community.

Key Findings

The mixed methods approach for CSWI's evaluation included qualitative interviews, focus groups, and quantitative data collection that was conducted throughout the implementation of CSWI. The evaluation sought to describe the different intervention approaches across grantees, explore the impact of interventions across populations served including students, caregivers, and school staff, explore challenges to implementation and outcome achievement, and learn how schools and communities approach sustainability. Below are the key findings that emerged from this process.

- Many grantees intentionally sought out partner schools in communities that experienced disproportionate impacts of COVID and a high need for mental health services. Grantees viewed their presence in schools as a means of alleviating barriers to access for mental healthcare and as an opportunity to embed comprehensive support in the schools and in the local community.

- Grantee organizations provided highly varied services to students, caregivers, and schools to be responsive to unique community needs, school/district priorities, and grantee service strengths and experiences.

- An estimated 19,036 unique students, 4,782 caregivers, and 2,395 school staff were reached and approximately 89,334 direct service hours were provided.

- Students benefited from all tiers of service and there were indicators of gradually improving mental health.
    - For those receiving Tier 2 or Tier 3 services, SDQ data demonstrated 74.6% of clinicians felt that the student's problems had gotten better since providing the services.

- Additionally, 94.8% of clinicians indicated that the Tier 2 or Tier 3 services have been helpful in other ways, e.g., providing information or making the problems more bearable.

- Caregiver programming was challenging; however, grantees created innovative ways to engage and listened to families to understand their needs.
  - Caregivers commonly noted an increase in their child's ability to talk about their emotions, an appreciation for shared space with other caregivers, and how their child's improved mental health was a positive benefit for the whole family.

- Partnerships impacted the school culture as a whole as well as individual staff awareness of mental health.
  - Schools increased their capacity to provide trauma responsive supports as seen through the Trauma Responsive Schools Implementation Assessment (TRS-IA). Schools that completed the assessment grew from the beginning to the end of the grant period across each of the eight domains. Top areas of growth included early intervention trauma programming, targeted trauma programming, whole school trauma programming, and classroom-based strategies.
  - While buy-in continued to vary at the school level, grantee organizations mentioned progress in relationship building and participation in whole-school staff mental health activities.

- Over the course of the grant period, grantee organizations and school partners faced various challenges. However, in most cases they were able to persevere and identify innovative solutions to ensure programming was able to continue.
  - Challenges included: slow initial implementation, coordinating with school partners, hiring and retaining staff, engaging caregivers, and completing the consent process.

- According to final grantee interviews, almost all partnerships were able to continue in some capacity beyond the end of the grant period.
  - According to the Program Sustainability Assessment Tool (PSAT), all programs on average increased across all domains of sustainability over the grant period with the most growth seen in funding stability, organizational capacity, program evaluation and communications.
  - Strong, goal-aligned partnerships between grantee organizations and schools was most frequently mentioned as a key to program success and long-term sustainably. Considerations to build these relationships included understanding school context, involving school leaders, integrating therapists into the school culture, defining roles and responsibilities, and building trust with families.

Considerations and Conclusion

CSWI met its goal of bringing more mental health care services into the schools, but it is clear there remains a high need from students, caregivers, and school staff for these services. Throughout this process, multiple lessons were learned which can be applied to future programming, systems change initiatives, and foundation operations.

- Future programming considerations include encouraging strong school and behavioral health organization partnerships, incorporating innovative ideas from CSWI programming, integrating behavioral health staff in schools with defined roles, supporting the right staff hires, and continuing all tiers of interventions.

- Systems change considerations include supporting creative funding model policies at the state level and developing a strong IL community behavioral health clinician staffing pipeline.

- ILCHF operations considerations include continuing to meet organizations' need to fill funding gaps, continuing to provide flexible grant activities and shared outcomes, and considering the alignment of grant timing and length.

Program & Evaluation Overview

Illinois Children's Healthcare Foundation (ILCHF) developed the COVID School Wellness Initiative (CSWI) in a statewide effort to address mental health needs of children, their caregivers, and school staff in communities hardest hit by the COVID-19 pandemic. ILCHF awarded 29 total CSWI grants to 22 different organizations across the state of Illinois. The Chicago cohort consisted of 14 grants distributed to 10 unique organizations. The Illinois cohort consisted of 15 grants distributed to 12 unique organizations. The grant period began in January 2022 and ended in June 2024. The grants are listed below in Table 1.

Table 1: Covid School Wellness Initiative Grants

Grant	Cohort
Alivio Medical Center	Chicago
Association House of Chicago - Humbolt Park	Chicago
Association House of Chicago - Belmont Cragin	Chicago
Brightpoint	Chicago
Carle	Illinois
Catholic Charities	Chicago
Centerstone - Johnston City	Illinois
Centerstone - Giant City	Illinois
Centerstone - Carterville	Illinois
Chestnut Health Systems	Illinois
Community Health Care	Illinois
Community Counseling Centers of Chicago	Chicago
Community Resource Center - Fayette	Illinois
Community Resource Center - Marion	Illinois
FHN Jane Addams	Illinois
Friend Family Health Center	Chicago
Gateway Family Services	Illinois
GRO Community	Chicago
Heritage Behavioral Health	Illinois
Hillsboro Hospital	Illinois
Hoyleton	Illinois
Juvenile Protective Association - Belmont Cragin	Chicago
Juvenile Protective Association - Roseland	Chicago
Juvenile Protective Association - South Shore	Chicago
Lutheran Social Services of Illinois	Chicago
North Central Behavioral Health	Illinois
UIC OCEAN - Englewood	Chicago
UIC OCEAN - Brighton Park	Chicago
Vermillion Area Special Education	Illinois

Grantee organizations partnered with local school districts to develop and implement programming across at least one level of care:

1. **Tier 1 Activities** are defined as activities targeting students, caregivers, and/or school staff that are available to all members of the target audience.
2. **Tier 2 Activities** are defined as activities targeting students and/or caregivers in a small group setting. For the purposes of the CSWI, this included clinical behavioral health groups targeting students.
3. **Tier 3 Activities** are defined as activities targeting students and/or caregivers in a one-on-one setting. For the purposes of the CSWI, this included individual clinical behavioral health services for students and caregivers.

Within all three tiers of programming, grantee organizations served students, caregivers, and/or school staff. Grantee organizations developed their unique program plan in partnership with school stakeholders and the community in order to ensure resources and activities developed through the CSWI meet the unique needs of the community.

As guided by the evaluation plan found in Appendix A, this evaluation report will:

1. Describe the different intervention approaches across grantee organizations
2. Explore the impact of interventions across populations served including students, school staff, and caregivers/community
3. Explore challenges to implementation and outcome achievement
4. Learn how schools and communities approach sustainability
5. Provide future considerations

Evaluation Methodology

PIE Org conducted a mixed-methods external evaluation of CSWI and leveraged shared measurement across provider audiences (e.g., students, caregivers, school staff) and levels of care (Tier 1, Tier 2, Tier 3). PIE and ILCHF collaborated on the development of evaluation questions to inform the development of data collection instruments. Staff from ILCHF and all CSWI grantees were provided multiple opportunities to revisit the evaluation question for the initiative to ensure that they most accurately aligned with the CWSI goals.

Evaluation Activities & Data Collection

Table 2 below shows each data collection activity, the target population, sample size, and data collection timeline. More detailed descriptions of each data collection activity can be found below the table.

Table 2. Data Collection Activities

Data Collection Activity	Target Population	Sample Size	Timeline
Document Review of CSWI Grant Applications	CSWI Grantees	n = 29	Spring 2022
Grantee Listening Tour Interviews	CSWI Grantees	n = 53	Spring 2022
Learning Community Discussions via Quarterly Grantee Meetings	CSWI Grantees	6 Learning Community Discussions per grantee	July 2022, October 2022, January 2023, July 2023, October 2023 April 2024
Grantee Progress Reports	CSWI Grantees	5 Progress Reports per grantee	August 2022, February 2023, August 2023, February 2024, August 2024
Tier 1 Activity Observations	Students, Caregivers, or School Staff receiving Tier 1 services	n = 17	Fall 2022 – Spring 2024
School Partner Interviews	School Partners	n = 31	Fall 2022
Trauma Responsive Schools Implementation Assessment (TRS-IA)	School Partners	n = 31 Pre/Post	Fall 2022 – Summer 2024
Program Sustainability Assessment Tool (PSAT)	CSWI Grantees	n = 23 Pre/Post	Fall 2022 - Summer 2024
Strengths and Difficulties Questionnaires (SDQ)	Youth receiving Tier 2/Tier 3 services	n = 1,669 Pre, n = 1,329 Post	Spring 2022 – Summer 2024
Caregiver interviews	Caregivers	n = 10	Spring 2024
Final grantee interviews	CSWI Grantees	n = 58	Spring 2024

Original CSWI Applications

PIE reviewed the initial CSWI grant applications of 29 grants completed by 22 grantee organizations to understand program goals and planned activities.

Grantee Listening Tour Interviews

PIE conducted grantee interviews during the Spring of 2022 to learn more about each grantee organization and their approach to CSWI including activities and school partners. The full interview protocol is available in Appendix B.

School Partner Interviews

Interviews were conducted during the Fall of 2022 with personnel including superintendents, principals, deans of students, school counselors, and school social workers from school district CSWI partners. These interviews focused on the origin of the partnership between the schools and the grantee organization and the successes and challenges within the partnership and CSWI implementation thus far. The full interview protocol is available in Appendix C.

Learning Community Discussions Via Quarterly Grantee Meetings

PIE facilitated a total of twenty quarterly grantee meetings, ten each for the Illinois and Chicago cohorts, beginning in January 2022 and ending in April 2024. During these meetings one or more grantees shared about their work, cohorts participated in a learning activity, and/or grantees engaged in small group Learning Community discussions facilitated by PIE staff.

Tier 1 Activity Observations

Observations of Tier 1 activities provided to students, caregivers, and school staff were conducted as an opportunity to understand the diversity and impact of Tier 1 activities across CSWI projects. The observation protocol is available in Appendix D.

Program Sustainability Assessment Tool (PSAT)

The Program Sustainability Assessment Tool (PSAT) is a self-assessment used to evaluate the sustainability capacity of a program across a range of specific organizational and contextual factors. CSWI grantee organizations were asked to complete the PSAT at the beginning and end of their CSWI projects to guide sustainability planning. The full survey is available in Appendix E.

Trauma Responsive Schools Implementation Assessment (TRS-IA) Survey

The Trauma Responsive Schools Implementation Assessment (TRS-IA) is a short self-assessment completed by school administrators to identify domains of strengths, as well as opportunities for improvement in their trauma responsive programming. Schools or districts were asked to complete the TRS at the beginning and end of their CSWI project to examine organization capacity to support trauma. The full survey is available in Appendix F.

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire is a behavioral screening tool used to measure the impact of Tier 2 (group) and/or Tier 3 (one-on-one) clinical behavioral health services for children. The SDQ was completed by the clinician for each student that received Tier 2 or Tier 3 services and participated in a minimum of three sessions with a clinician after an initial assessment. The SDQ is available in Appendix G.

Caregiver Interviews

In April and May of 2024, PIE interviewed 10 caregivers about the activities provided by behavioral health organizations. Caregivers shared about the benefits, challenges, and changes they have experienced or observed as a result of the interventions. The interview protocol is available in Appendix H.

Final Grantee Interviews

In March and April of 2024, PIE interviewed 58 employees from 21 organizations representing 28 CSWI grants to reflect on implementation, outcomes, and future considerations for their CSWI program. Of the 58 people that were interviewed, 30 were in a leadership or supervisory role and 28 provided direct services in schools. The full interview protocol is available in Appendix I.

Program Description

ILCHF awarded 29 total CSWI grants to 22 organizations across the state of Illinois. The Chicago cohort consisted of 14 grants distributed to 10 unique organizations. The Illinois cohort consisted of 15 grants distributed to 12 unique organizations. Within all three tiers of programming, grantee organizations served students, caregivers, and/or school staff. Grantee organizations developed their unique program plan in partnership with school stakeholders and the community to ensure resources and activities developed through the CSWI met the unique needs of the community.

Program Design

Community Need

Illinois Children's Healthcare Foundation (ILCHF) developed the COVID School Wellness Initiative (CSWI) in a statewide effort to address mental health needs of children, their caregivers, and school staff in communities hardest hit by the COVID-19 pandemic. Additionally, many grantees intentionally sought out partner schools in communities where there were disproportionate impacts of COVID-19 and the need for mental health services was high. Grantees in the Chicago Cohort provided services in historically under-resourced neighborhoods such as Back of the Yards, Englewood, Belmont Cragin, South Shore, Portage Park, and Humbolt Park. A grantee in the Illinois Cohort provided services in East St. Louis and many others provided services in rural areas where grantees frequently cited the lack of providers available in their area. In final grantee interviews, several grantees described the needs in their communities by sharing:

> *"[Our] goal was to intervene early in the lives of students in a place they could access the services; [we] are in a rural area so there is limited access and limited public transportation to care, [we] wanted to provide education to the community on how to access care. If we had a student who needed more intensive care than what we could provide, we wanted to help link them to that service."*

> *"We targeted specific zip codes based on the research we had done. We were looking for neighborhoods where the youth had been impacted by high violence in the community, food insecurity, and additional things that impacted the youth in addition to COVID."*

School Context

The concept of bringing grantee organizations into the school to meet the high need for access to mental health services was a vital, and unique component of CSWI. This made it necessary for grantees to regularly engage with school leadership and school personnel throughout the life of the grant. To develop strong partnerships, some behavioral health organizations held regular meetings (for example, monthly meetings) with school or district leadership. Some clinicians were able to join a school's existing monthly behavioral health team meetings, which oftentimes included principals, school social workers, and/or school counselors, to participate in the coordination of mental health services at the school. At other schools, clinicians were invited to attend parent advisory committees or councils, which sometimes also included students, to plan school events such as family nights or

make decisions about school policies (for example, items in the school handbook). Other grantees only met with school leadership once a year or found it challenging to establish a regular cadence for meetings with school leadership but were able to work very closely with other school personnel, such as school counselors or teachers, as often as weekly to coordinate the referral process or communicate about a student's needs or progress.

School Partner Goals

The majority of CSWI grantee and school partnerships began prior to the start of their CSWI grant awards, suggesting longstanding commitment to collaboration between community-based organizations and schools to address youth mental health. Pre-existing partnerships typically started through a previously awarded grant or through mutual efforts to connect students and families to mental health supports.

All school partners identified social and emotional learning or the behavioral health of their students as a priority for their school in the 2022-2023 school year. Multiple schools included mental health as a goal within their school's strategic plan. Schools in the Chicago Public School system typically addressed student mental health needs through a behavioral health team that met weekly and could include school administrators, social workers, and counselors.

However, even with existing structures, school partners recognized that they did not have the resources to adequately respond to the level of behavioral health needs of their students and their families, and therefore, needed assistance from external organizations who have expertise in this area. School partners found that the need for behavioral health support had increased since the onset of the COVID-19 pandemic. School administrators also described budget constraints that prevented them from hiring additional counselors or social workers in order to match the observed level of need.

As a result, schools believed partnerships with community-based organizations was key to responding to the needs of their students, families, and staff and typically had other community partners in addition to the grantee organization. For example, one school leader expressed how highly they valued the partnership with the behavioral health organization in supporting the students,

> *"So many of our students need support and it was just so great to have a support that we could reach out to... [the school] has one social worker, and there are a lot of kids."*

Grantee Goals

The CSWI grant was intentionally developed to allow grantees the flexibility to meet the unique mental health needs of their communities. In their initial grant applications, the majority of grantees anticipated serving all three target populations: students, caregivers, and school staff. In most cases, grantees planned to utilize CSWI resources to expand or enhance existing social and emotional learning or behavioral health services. Some grantees indicated that while their current services for social and emotional learning and/or behavioral health services were of high quality, additional resources would help them more adequately respond to the true need and volume necessary to serve students, caregivers, and staff.

During the final interviews conducted in Spring 2024, behavioral health staff commonly expressed goals such as supporting school staff (n = 13, 59%), offering comprehensive support at multiple levels within schools (n = 13, 59%), and responding to the exacerbated need for mental health that emerged from the pandemic (n = 11, 50%).

Reflecting on their initial CSWI goals, many behavioral health staff hoped to apply their expertise to increase mental health awareness within schools,

> *"We wanted to bring that trauma lens to the forefront. Schools can't do it all. Staff don't always have the training and knowledge to address these issues."*

Many grantees expressed their appreciation for the opportunity to support – not only students– but also caregivers, school staff, and the community through a holistic and multifaceted array of services. One grantee shared:

> *"It was probably the most encompassing opportunity we've had out of any grant we've ever been involved with."*

Others expressed the increased needs their community faced in the wake of COVID-19,

> *"It was an effort to support local schools, youth, and families with mental health due to the influx of needs in response to the pandemic. Although a lot of these concerns and barriers existed prior, there was such an influx."*

Program Implementation

Variety of Services Offered

ILCHF was supportive and flexible, trusting that grantees would shape their partnerships to best respond to their unique communities. Grantees took a wide variety of approaches to support their partner school(s) due to the unique needs of each community. Some of the considerations that shaped programming included the distinctive geographical and cultural populations served, existing priorities and other partnerships in schools, and grantees' specialty services and experiences. Grantee organizations also varied in the number of school or district partners they served through one grant. For example, one grant might have five partner schools and offer services one or two days per week at each school, whereas another grant might have only one partner school where service providers work in the school full-time as if they were school personnel.

Tier 1, 2, and 3 services were provided to students, caregivers, and school staff. Examples of how various grantees implemented these multiple services are shown below in Figure 1. Several grantees changed their initial implementation plans in response to the needs of the schools; for example, some grantees offered a higher ratio of Tier 3 services than initially expected due to the high level of need for individual services in their partner schools. Additionally, when behavioral health organizations had multiple school partners, programming oftentimes varied by school in response to unique school cultures, school priorities, and logistics of implementation.

Figure 1: Examples of Services Provided

Gateway Families Services is located in Vermillion County and uses an approach based in the Neurosequential Model of Therapeutics (NMT) to focus on the science of how trauma impacts the brain. One of the ways they implement this approach is through equine therapy, including rhythmic riding. Gateway partnered with five local school districts to provide both Tier 2 and Tier 3 services to students. They also distributed emotional regulation videos to schools and provided universal supports to kindergarten classrooms to teach social skills and positive behaviors. Caregivers had the opportunity to attend connection groups. School staff were engaged through professional development, Lunch & Learns, and individual services.

GRO Community, located in the Roseland community of South Chicago, partnered with five schools within Chicago Public Schools. GRO specializes in clinical services for males of color and uses a data-driven approach to treatment, including assigning clients to work with a male clinician of color to foster positive identify and male interactions and provide cognitive behavior intervention (CBI) through Tier 2 and Tier 3 services. GRO supported caregivers through family therapy and provided trainings to school staff and parents in areas such as stress reduction techniques and emotional regulation strategies to provide school-wide support for students impacted by complex trauma or chronic stress.

Hillsboro Area Hospital, located in Montgomery County, partnered with Hillsboro Schools prior to the grant to examine youth mental health and found that one in five students thought about suicide in the past twelve months. Through this grant, Hillsboro Area Hospital implemented a universal Tier 1 program called Sources of Strength to the junior high and high school. Led by the David A. Imler Steering Committee, which consisted of key community stakeholders as well as high school students and parents, the program trained adult advisors and student peer leaders in order to change the culture around mental health treatment, teach individuals to leverage the strengths in their life during challenging times, and form a contact chain for students facing a mental health crisis.

UIC OCEAN-HP (Office of Community Engagement and Neighborhood Health Partnerships) held two grants and worked with schools in the Brighton Park and Englewood neighborhoods of Chicago to implement Creating Opportunities for Personal Empowerment (COPE). In addition to providing Tier 3 individual therapy to students, UIC OCEAN engaged students through their participation in an advisory board, attended behavioral health team meetings at each school, offered individual services to caregivers, and distributed food cards to families in need. Finally, UIC OCEAN trained students, caregivers, and school staff in Community Resilience Model (CRM) skills through Tier 2 groups and Tier 1 events such as classroom education, presentations, yoga, or container gardening to develop skills for health-enhancing self-regulation strategies.

Services for Students

Common Tier 1 interventions that were offered to all students included paid, lesson-based SEL curriculums, school-wide mental health awareness campaigns, student calm corners in classrooms,

grantee participation in wellness events, field trips, or drop-in/office hours with a therapist for students who were not officially on their caseload. Lesson topics included art therapy, suicide awareness, emotional regulation, mindfulness meditation, female health and wellness, violence and bullying prevention, stress management, substance use, and healthy relationships. Some grantees mentioned specific curriculums or interventions such as Stress Matters, Sources of Strength, BASE Education, Character Strong, Second Step, CATCH, Habitudes, and Mental Health First Aid.

Tier 2 services occurred in small groups and provided holistic practices to support students in their development of social skills, social-emotional learning, self-care, nutrition and wellness, and peer mentoring. Some interventions were provided to respond to specific challenges children were facing in their lives, including conflict mediation, a support group for youth presenting with suicidal ideation, or talking circles for those facing grief or for those impacted by a divorce. Some organizations implemented interventions such as Supporting Parent-Adolescent Relationships and Communication (SPARC), Cognitive Behavior Intervention (CBI) or Cognitive Behavior Intervention for Trauma in Schools (CBITS), the Community Resiliency Model (CRM), Check-In/Check-Out, and animal-assisted therapy.

Tier 3 student services included one-on-one therapy or one-on-one student check-ins. For many grantees, individual student therapy was a core component of the services they provided to the school.

Services for Caregivers

When providing services to caregivers, grantees commonly distributed brochures or attended school events such as wellness nights or parent-teacher conferences to promote mental health and increase awareness of the services that were offered. Grantees also frequently offered training workshops on topics such as trauma, parenting, stress, or nutrition. Caregivers sometimes participated in student Tier 3 services, received family therapy, were supported in accessing community resources, or were referred for individual therapy. One grantee organization provided a caregiver support group, another conducted home visits to families of students struggling with truancy, and another focused many of their efforts on case management for families.

While caregiver engagement was one of the most challenging aspects of programming, grantee organizations employed several engagement strategies including surveying caregivers to inform programming, creating advisory groups, offering incentives for participation, providing childcare, attending school/community events, holding regular check-ins with Tier 3 caregivers, connecting families with other resources, and increasing partnerships with other local organizations/businesses. To create buy-in they mentioned it was important to understand listen to families about their specific needs.

Services for School Staff

When providing services to teachers or other school staff, grantees commonly offered training on trauma-informed instruction or topics relating to staff wellness, such as self-care, compassion fatigue, and burnout. Grantees also commonly promoted staff wellness in conjunction with staff appreciation activities such as lunch; in a few cases, staff were offered treatment on a massage chair or a candle-

making activity. One grantee focused on creating a calm space in the building and encouraged teachers to visit this space to take breaks during the school day. Some grantees reported formal programs such as Youth Mental Health First Aid (YMHFA) or Connect to Kids (C2K) teacher mentoring. Additionally, service providers frequently collaborated with teachers whose students were receiving Tier 3 services.

Program Impact

CSWI aimed to expand or create new prevention and intervention services to improve the mental health of students, caregivers, and school staff. Bringing grantee organizations into the schools reduced barriers to access and aimed to meet students and families where they were, while at the same time, addressing the ever-growing demand for mental health services. Overall, CSWI met a significant need of schools and communities and was able to support an expanded number of students, caregivers, and school staff. While improved mental health is a journey, both qualitative and quantitative data suggest CSWI had a positive impact on stakeholders served.

Program Reach

Stakeholders Served

Over the course of the grant cycle, grantees served an estimated 19,036 unique children, 4,782 caregivers, and 2,395 school staff through Tier 1, Tier 2, or Tier 3 interventions. Without CSWI funding many of these stakeholders would not have received comparable services. In their final interviews, grantees raised several benefits of working directly in the schools including providing supports to students who have been waitlisted elsewhere, offering group support if caregivers are hesitant about one-on-one support, and alleviating barriers of access for families.

Approximately 75% of the students who received services through the grant were part of the Illinois cohort, whereas only 25% of the students were in Chicago; this is likely because grantee organizations in the Illinois cohort established partnerships at the district level or worked with multiple schools within the county, whereas grantee organizations in the Chicago cohort were more likely to form partnerships at the school level.

While grantees served typically students across all age ranges, grantees in the Illinois cohort served more 6- to 12-year-old students (55.9% of the students served in the Illinois cohort, compared to 43.0% of the students served in the Chicago cohort). Similarly, grantees in the Chicago cohort served more 13- to 18- year-old students (51.3% of the students served in the Chicago cohort, compared to 37.6% of the students served in the Illinois cohort). The distribution of ages of the children who received Tier 1, 2, or 3 services through the grant is shown below in Table 3.

Table 3: Ages of Students Receiving Services through CSWI

Age of Student	Percent of Total Students Served
0 to 5	6.5%
6 to 12	52.7%
13 to 18	40.0%
19 to 21	0.7%

Most grantees provided student services across all intervention Tiers. By definition Tier 1 services have a wide reach, therefore, it is unsurprising that 71% of total students served received Tier 1 services. The percentages of grantees providing each tier of service and students served through each

tier of service are shown below in Table 4.

Table 4: Grantee CSWI Student Services by Tier

	Tier 1 Services	Tier 2 Services	Tier 3 Services
Percentage of Grantees Providing Tier of Service to Students	93%	83%	90%
Percentage of Students Served Through Tier of Service	71%	14%	16%

Services to caregivers and school staff varied widely across the different grants, however, 88% of the services provided to caregivers were Tier 1 interventions such as workshops or grantee attendance at school-led family engagement events and 90% of the services provided to school staff were Tier 1 interventions such as staff trainings or staff wellness events.

Student Impact

Tier 1 Services

Student access to services increased across all tiers, however, since Tier 1 activities are defined as activities available to the entire student population, they provided an opportunity for widespread access to an intervention. Overall, over 70% of students engaged through CSWI activities were reached through Tier 1 services. This is notable because these services are not billable through insurance and therefore are often difficult for grantee organizations to fund and sustain. School staff greatly appreciated this programming as it filled gaps identified by schools and allowed for school staff to focus on other immediate student academic needs. This collaboration between the CSWI grantee and school partners offered a holistic approach to supporting students.

Tier 2 and Tier 3 Services

In the initial listening tour interviews, grantees reported a variety of tools used to measure student improvement while engaged in those services. To standardize measurement and allow for comparison across grantees, CSWI decided to use the Strengths and Difficulties Questionnaire (SDQ) to measure the impact of all Tier 2 and Tier 3 clinical behavioral health services for students. Grantees continued to use their own measurement tools as they deemed appropriate but did not report those results to ILCHF or PIE.

The race or ethnicity and gender of students represented by the SDQ forms received throughout the grant are shown below in Table 5 and Table 6 (n = 2,998 pre and post SDQs). While it does not represent the full population of students served, SDQ student demographics show that the proportion of students of color who received Tier 2/3 services through the CSWI funding was high relative to the population of Illinois. For example, 32.53% of the SDQ's reported services were provided to Black/African American students, while only 14.1% of the population of Illinois identifies as Black/African American according to the 2020 Illinois Census. Similarly, 23.13% of the SDQ's reported services were provided to Hispanic/Latino students, while only 18.2% of the population of

Illinois identifies as Hispanic/Latino according to the 2020 Illinois Census.

Table 5: SDQ Student Race and Ethnicity

Race and Ethnicity	SDQ Demographics by Percent
White/Caucasian	35.56%
Black/African American	32.63%
Hispanic/Latino	23.13%
Multiple selected or blank	4.95%
Indigenous American	1.82%
Rather not say	0.51%
Native Hawaiian or Other Pacific Islander	0.03%

Table 6: SDQ Student Gender

Gender	SDQ Demographics by Percent
Male	48.96%
Female	48.01%
Non-binary or another gender	2.53%
Rather not say	0.51%

The SDQ is a brief behavioral screening questionnaire comprised of 25 items regarding behavioral attributes. The 25 items of the SDQ are divided into five scales:

1. Emotional Symptoms
2. Conduct Problems
3. Hyperactivity/Inattention
4. Peer Relationship Problems
5. Prosocial Behavior

From these categories, three primary scores are generated:

1. Internalizing Score – the sum of the Emotional and Peer Relationship Problems scales
2. Externalizing Score – the sum of the Conduct Problems and Hyperactivity scales
3. Total Difficulties Score – the sum of scores in the first four domains listed above

Clinicians delivering Tier 2 or Tier 3 services completed SDQs for each student on their caseload. During the first year of the CSWI, grantees were asked to complete a retrospective pre/post SDQ as a result of CSWI programming beginning before the SDQ was implemented. After the first year of CSWI, grantees were asked to submit a pre-SDQ at the start of each school year or after at least three sessions and a post-SDQ survey at the end of year school year or at the termination of the services. For confidentiality reasons, rather than calculating individual changes between pre and post SDQs, an aggregated average across all grantees is calculated. The SDQ is available in Appendix G.

In all three score scales (total difficulties, externalizing, and internalizing), scores were slightly raised in the pre SDQ surveys. This suggests that students who are referred for services were experiencing

challenges that were related to both internalizing and externalizing behaviors as observed by their clinician.

Over the course of the grant, the average total difficulties score decreased from 15.35 to 12.67. Similarly, the internalizing and externalizing scores decreased from 6.11 to 4.92 and 8.27 to 6.96, respectively. Post SDQs indicate that the average internalizing score reached average levels.

Since every point increase in the SDQ score is associated with proportionally higher current and future rates of psychopathology, this data suggests that the Tier 2 and Tier 3 services helped students make strides in improving their mental health by reducing the extent to which they were facing difficulties. The comparison of the pre/post SDQ data is shown below in Table 7.

Table 7: Comparison of Pre and Post SDQ Internalizing and Externalizing Scores

	Pre-SDQs		Post-SDQs	
	Score	Category	Score	Category
Internalizing Score	6.11	Slightly Raised	4.92	Average
Externalizing Score	8.27	Slightly Raised	6.96	Slightly Raised
Total Difficulties	15.35	Slightly Raised	12.67	Slightly Raised

Additional questions were included in the post-SDQ surveys that allowed the clinician to assess the changes they saw in the student during their time providing the services. In total, 74.6% of clinicians felt that the child's problems had gotten better since providing the services and 94.8% of clinicians indicated that the Tier 2 or Tier 3 services have been helpful in other ways, e.g., providing information or making the problems more bearable.

While students showed growth over the course of the year or throughout the time they received services, improving mental health is a long-term outcome. Unsurprisingly, students who received services continued to experience difficulties to various degrees. When the post-SDQ was completed, 70.6% of clinicians felt that the student was facing difficulties in one or more of the follow areas over the last month: emotions, concentration, behavior, or being able to get along with other people. Table 8 below shows the ways in which the students were facing difficulties. These response categories were as follows: Not at all (0), Only a little (0), A medium amount (1), and A great deal (2). A student received an Impact Score which was the sum of the points across the three different areas of difficulty. Students who were impacted by difficulties in multiple areas may have experienced compounding effects, and therefore have a higher impact score. A score of 1 is classified as slightly raised, a score of 2 is classified as high, and scores of 3 to 6 are classified as very high. The distribution of the impact scores is shown below in Table 9.

Table 8: Percentage of Students Impacted by Difficulties

	Not at all or only a little	A medium amount	A great deal
Percentage of students upset or distressed by difficulties	57%	31%	12%
Percentage of students whose difficulties interfere with peer relationships	55%	27%	18%
Percentage of students whose difficulties interfere with classroom learning	52%	26%	22%

Table 9: Student Impact Scores

Impact Score	0	1	2	3	4	5	6
Percentage of Students	39%	16%	15%	12%	8%	6%	4%

Equity of Referral Process

Throughout the course of the project, grantees reflected on, and sometimes refined, how their referral processes operated. One consideration around equity is the method by which students are referred for services, i.e., if the students who need the services the most get referred.

Near the start of the grant (October 2022), grantees discussed in the Learning Communities the difficulty they were experiencing receiving referrals for Tier 2 and Tier 3 services. Without referrals, grantees had a limited ability to focus on equity and ensure that the youth who most needed services were involved in CSWI activities. As relationships became more established in the schools, grantees started getting more referrals and were able to fill their caseloads.

As seen in the SDQ data, externalizing behaviors were consistently rated higher than internalizing behaviors. This is unsurprising as classroom behavior is observable, and therefore is more likely to receive a referral. Students with more internalizing behaviors might be less likely to receive a referral unless they confide in an adult how they are feeling. Similarly, post-SDQs indicated that among the 70.6% of students who were experiencing difficulties in one or more areas, 58% were disruptive to the classroom as a whole, to varying degrees.

A few grantees mentioned their efforts for student self-referrals and generally including student voice to understand the needs for programming. Some schools had universal screening processes through check-in questions as part of a paid SEL curriculum or an SEL bellringer every morning where a student could request to speak with someone one-on-one that day. One grantee posted a QR code in the hallway, allowing students to refer themselves for the service. Another set up a channel of communication, starting with peer leaders, to get concerns to the behavioral health team.

Universal screening was mentioned as the ideal state, but it requires lots of time and resources. One grantee organization from the Chicago cohort wanted to do a screening assessment for all students to determine needed services but the tool was not approved by Chicago Public Schools. Another grantee mentioned pending legislation making universal screening a requirement; while they lauded the importance of this, they also expressed concerns they would not have the capacity to service all the needs that would surface.

Success Stories

Every grantee organization shared success stories of individual students or groups of students and how they had grown over the course of CSWI. In a few cases, grantees worked with student leaders through a mental health team, advisory group, peer leadership group, or a "train-the-trainer" model. This gave students ownership over programming at their school and strengthened the conversation around mental health at the schools. The majority of grantees spoke about the change in the mental health landscape and how this had led students to be more open to talking about and addressing mental health. While stigma still exists – especially within historically marginalized communities – a few grantees shared stories of how they have seen the stigma of receiving services decrease among students. Countless other success stories were shared about the impact of supporting students across the various tiers of service, including the following:

- An organization was working with a middle school class during a time when one of the students was battling cancer. The service provider was able to support the class as they were hurting for their friend who was an athlete and was unable to play sports during that time. Thankfully, the student is now in remission.
- A student who received Tier 1 and Tier 2 SEL support and had a history of fighting was getting called names in gym class. They used a learned coping mechanism by walking away and taking deep breaths and proudly shared their accomplishment with the service provider the next week.
- Service providers from another organization, after actively working to fight stigma by giving hoodies to students in a Tier 2 group after they achieved a goal they set, talking about mental health support as "coaching," and using Tier 1 services as an opportunity to reiterate that everyone needs support, saw changes in student perceptions of mental health. Students that initially did not want their friends to know that they were receiving services started recruiting their peers to join the group.
- A student who was considering suicide was able to get connected to mental health services with the help of a peer leader.
- An organization incorporated the book *A Long Walk to Water* into their SEL curriculum, which led to students plan a walkathon to raise money for a drill in South Sudan.
- A student shared how the clinician was there for some of the rockiest moments of their life and helped them understand and heal from their prior experiences.
- A service provider saw that as students learned about mental health, they became more self-aware of how to navigate struggles such as depression or ADHD and began to advocate for themselves with their caregivers and families.

Caregiver Impact

Alleviating Barriers to Mental Health Care

Increasing the services available in schools alleviated barriers of access to mental health care. Transportation challenges were eliminated since all services were in schools and many families were reached who might not have otherwise pursued mental health support. Additionally, service providers often shared that the families were frequently uninsured or underinsured and would not otherwise have access to their services. Grantees worked with school partners to develop referral systems in partnership with local school systems to identify and prioritize students and families most in need of mental health services. During the final grantee interviews, five grantee organizations (23%) cited alleviating barriers for families as a goal for their grant. For example, one grantee shared,

> *"We recognized that families don't always have access to mental health through transportation or online access, so being able to be in schools felt really important."*

Full Family Supports

During caregiver interviews, caregivers discussed how supports not only impacted their child, but also had effects on the entire family. Several caregivers shared how the support helped their child manage their emotions. Caregivers learned tools from their child's therapist/SEL instructor to use at home such as daily affirmations, breathing exercises, and the Rainbow technique. Caregivers also mentioned that children are more open to talking about mental health or that seeking out support has become more normalized. As these conversations happened within the family, it encouraged a few other family members to change their minds about the benefits of mental health support and a couple of family members even started therapy themselves. Through the parent mentor program at one grantee organization, families were able to help one another by sharing resources and building a community of support within the school.

Caregiver Perceptions of Mental Health

Grantees reported some changes in perceptions of mental health among caregivers and community members. Several grantees mentioned caregivers' mental health awareness exists along a continuum, such that some caregivers know the importance of mental health and are open to receiving services, while others remain hesitant.

Grantee organizations and schools who encountered stigma among the families in their community were sometimes able to fight against the stigma by changing the language they chose to use. For example, one grantee organization referred to a Tier 2 service for caregivers as a "connection group" rather than a "support group." Similarly, one school partner shared that their community was more receptive to the terminology "mental health awareness" than they were to "social and emotional learning."

Over time, multiple grantees saw caregivers start to open up and shed stigma especially as relationships were built. A handful of grantees shared that knowing the services were available to

their child increased caregiver receptiveness to mental health support. As the stigma decreased, grantee organizations have seen an increased demand for their services.

Success Stories

Although caregivers were one of the more challenging stakeholder groups to engage, grantees used innovative methods to continue to reach out. When engaged, caregivers shared impact stories including benefits of programming for themselves and their families. Examples of caregiver programming is shown below in Figure 2.

Figure 2: Examples of Caregiver Programming

Community Resource Center (CRC) received two CSWI grants serving two school districts: Vandalia CUSD and Centralia. CRC provided one-on-one therapy as well as SEL curriculum in the school. Caregiver engagement with CRC mostly involved reinforcing tools and strategies with children at home. One caregiver mentioned her child has increased his ability to talk about his feelings and they do daily affirmations together before bed, which he learned in therapy. Another caregiver has used resources sent home by the SEL instructor to implement coping techniques at home. She has developed a positive relationship with the instructor and knows if her family needs additional support, it is available.

Catholic Charities served four schools in the Back of the Yards neighborhood of Chicago and hosted an in-person support group for Spanish speaking families. The support group was caregiver-led and explored topics such as violence in the community. Students of many of the caregivers in the support group were in individual therapy and caregivers mentioned the overall value of both experiences for their families. In some cases, one person in the family starting therapy encouraged others to join as well. It helped students overcome grief, it helped parents deal with stress at home, and it helped build confidence and trust. Other benefits caregivers experienced were help navigating the logistics and paperwork of receiving care and knowing where to find therapy for their child.

Centerstone received three CSWI grants, one of which focuses on wellness and recovery in Johnston City, Illinois. Part of their work in Johnston City schools involved a parent mentor program which equips parent volunteers to support classroom teachers specifically with SEL and behavior up to five days a week. The parent mentors' role is to provide students with extra one-on-one time, take them on walks to regulate emotions and not disrupt the rest of the class, and generally build connections with students. Parent mentors also do a lot more than academics – seeing needs and providing resources such as clothes, hygiene products, and food to students. Over the years, parent mentors have seen students gain more emotional awareness and be able to identify when they are having a bad day or struggling and proactively ask to go see the social worker.

Many success stories were shared about the impact of supporting caregivers across the various tiers of service, including the following:

- A caregiver shared that their child struggles with self-harm and they were able to use the resources sent home to reinforce the lessons and have him talk them through different coping strategies when they notice he is struggling.
- An organization working in a school that experienced a high influx of migrants during the grant cycle had the opportunity to support newcomer families in filling out the forms (and navigating the healthcare system to complete the school physicals) that were needed for families to enroll their children in school. They were also able to offer education and supplemental resources to help these families navigate their new life in Chicago.
- The evaluation team observed a Tier 1 event that had more than 50 attendees. The event was planned in partnership with other community organizations and the target audience was parents/caregivers of children who attend one of eight local schools, including the partner school.
- Caregivers who participated in a support group gained a community and reduced the isolation many were experiencing after the pandemic. They told the facilitator that they used to say hi in front of the school when dropping off their kids, but now they know they can come to each other if they need advice or need to carpool. Many did not have Medicaid and would not have otherwise been able to receive any services.
- One service provider shared how deeply families have appreciated monthly $50 gift cards to supplement the needs they have, including families that are facing homelessness, especially in light of the rising prices due to inflation that occurred during the grant cycle.
- A caregiver shared that her daughter was able to get connected to individual services in the school after their family experienced multiple losses in a short amount of time. Her husband used to not believe in therapy, but he has now realized that it can help because he has seen the difference it has made for the child.

School Impact

Changes in School Capacity

The partnership of an external behavioral health organization not only expanded and diversified the services available to students and caregivers, but also supported school-level priorities around mental health.

The TRS-IA is a short self-assessment completed by school administrators to identify trauma responsive programming and policy domains of strength, as well as opportunities for improvement. The TRS-IA was developed by the Treatment and Services Adaptation Certain for Resilience, Hope, and Wellness in Schools in collaboration with the Center for School Mental Health. The assessment was created using the RAND/UCLA Modified Delphi Approach – a commonly used evidence-based strategy for developing quality measures. Employing this approach, developers engaged a panel of national experts in a consensus process to identify and refine best-practice guidelines for trauma-responsive school implementation. The TRS-IA tool is available in Appendix F.

The TRS-IA measures eight key domains of a trauma-responsive school. Each domain contains multiple questions which are rated on a scale from one (least-trauma responsive) to four (most trauma responsive). The eight key domains include:

1. Whole School Safety Programming
2. Whole School Prevention Programming
3. Whole School Trauma Programming
4. Classroom-Based Strategies
5. Prevention/Early Intervention Trauma Programming
6. Targeted Trauma Programming
7. Staff Self-Care
8. Community Context

School administrators completed the Trauma Responsive Schools Implementation Assessment (TRS-IA) at the beginning of the grant in the fall of 2022 and then at the end of the grant in the spring of 2024. A total of 31 schools or districts served by 18 unique grantee organizations completed the TRS-IA at both timepoints. As seen below in Figure 3, average scores grew from the beginning to the end of the grant period across each of the eight domains. Top areas of growth included early intervention trauma programming, targeted trauma programming, whole school trauma programming, and classroom-based strategies. It is likely grantee programming and internal school staff conversations contributed to these areas of growth.

At both the beginning and end of the CSWI grant, an area of relative strength for the average school was Whole School Safety planning, with an average score of 3.21 at the beginning of the grant cycle and an average score of 3.46 at the end of the grant cycle. An area for growth for the average school at both the beginning and end of the grant was Staff Self-Care for Secondary Traumatic Stress, which averaged 2.10 at the beginning of the grant cycle and 2.32 at the end of the grant cycle.

The individual TRS-IA indicators where schools or districts experienced the most growth, along with their TRI-IA domain, are shown below in Table 10.

Figure 3: Average Pre/Post TRS-IA Scores on a Scale of 1 to 4

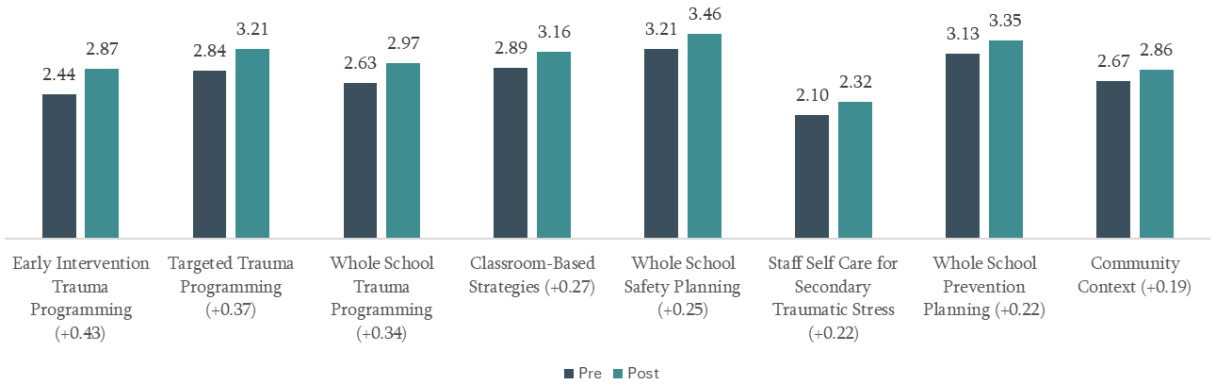

Table 10: TRS-IA Questions with Highest Average School Growth

TRS-IA Domain	TRS-IA Indicator	Change (Scale of 1-4)
Whole School Prevention Planning	To what extent has your staff been educated/trained so that any emergency drills that are conducted are done so in a manner sensitive to students with trauma histories? (alarms that may elicit reaction)	+0.47
Whole School Trauma Programming	To what extent does your school/district educate staff about trauma and its effect on students (impact on brain, behavior and academics)?	+0.45
Classroom-Based Strategies	To what extent has school staff been trained to identify potential triggers for students and ways to de-escalate when a student may become deregulated?	+0.45
Early Intervention Trauma Planning	Does your school/district implement a specific intervention to meet the needs of kids suffering from trauma (i.e., CBITS, SSET, Bounce Back)?	+0.44
Community Context	To what extent does your school/district have partnerships with community-trusted organizations (i.e., churches, health centers) to further support the families in need.	+0.41
Whole School Safety Planning	To what extent does your school/district have a clearly defined strategy to determine when a student may present harm to another student or staff?	+0.41
Whole School Trauma Programming	To what extent have school security personnel (school resource officers, school police, security force) been trained to identify symptoms of trauma and respond using tactics to avoid re-traumatization?	+0.40
Whole School Trauma Programming	To what extent does your school/district train staff in skills for interacting with and supporting traumatized students? (ex. de-escalation, referral)	+0.38
Community Context	To what extent does your school/district identify opportunities to engage families and the broader community about trauma and its impact.	+0.38
Targeted Trauma Programming	To what extent does your school/district have working relationships with external community mental health agencies to refer students who have been exposed to trauma?	+0.37

Success Stories

While many grantees observed that mental health awareness and openness varied among the different schools they worked in, grantees mentioned many instances of shifting perspectives,

increased awareness, and increased capacity to support mental health. Service providers frequently described ways that their role allowed them to support teachers on a day-to-day basis and develop strong relationships in their school buildings. Examples of ways grantee organizations engaged school partners are show below in Figure 4.

Figure 4: Examples of Engagement with School Partners

Juvenile Protective Association held three grants within the Chicago cohort and partnered with schools in Belmont Cragin, Roseland, and South Shore that ranged from an elementary public school to a high school charter school. In addition to services provided to students and caregivers, JPA regularly collaborated with school leadership as they implemented the program. JPA clinicians intentionally built relationships with school principals, deans, and social workers. JPA also provided trauma-informed teacher consultation to teachers and administrators through their Connect to Kids (C2K) program, which uses Teacher Consultation and Professional Development, Focused Observations, and SEL Classroom Groups to embed social-emotional best practices into daily routines.

Heritage Behavioral Health Center, located in Macon County, partnered with the Mt. Zion School District to implement Project BRAVE (Be Resilient and Vocalize Emotions). In addition to other services provided by Heritage, the Project BRAVE Coordinator works with a student-led Mental Health Team to present information to their peers, promote "Mental Health Mondays" and "Thoughtful Thursdays", and organize school activities such as scheduling a comfort dog visit or spreading kind messages by placing post-it notes throughout the school. Heritage also provided school staff with training on student mental health and all school employees were offered free individual counseling.

Examples of success stories among schools including the following:

- A school partner shared how their school was able to have a social worker for the first time in 14 years because of the grant.
- An organization that provided in-school social and emotional supports to students with disabilities saw a decrease in the referrals for social and emotional issues their organization received from schools.
- A service provider shared how teachers initially did not want students pulled from their classroom, but over time, they began to see that the services were needed. Some teachers even began reaching out to them to discuss observations and possible needs of additional students in their classroom.
- An organization was able to expand their services into another school after four students transferred to this school and wanted to continue working with the clinician.

Program Challenges

Over the course of the grant period, grantee organizations and school partners faced various challenges. However, in most cases they were able to persevere and identify innovative solutions to ensure programming was able to continue.

Challenges with Initial Implementation

During the initial implementation of the grant, many of the grant recipients experienced a delayed start to their CSWI project. Many grantees reported challenges in hiring qualified staff to run CSWI programming, which significantly impacted their ability to start CSWI activities or reach their intended number of participants. One grantee articulated how multiple challenges caused the project to start more slowly than anticipated in July of 2022,

> *"We are having a hiring issue. We got the award in January and are just now hiring a clinician. We have also had challenges getting referrals…In spite of the need, there is a large ramp-up that needs to happen to build a caseload."*

The timing of the grant, which started in winter 2022, also contributed to some programming delays. Since schools already had established routines and plans, it was difficult to add school-wide initiatives (Tier 1 activities) midway through the year; therefore, most grantee organizations focused on Tier 2 and 3 supports during the first year of implementation.

Despite the initial delays, most of the grantees were largely able to implement the services outlined in their original proposals without major changes to programming and in some cases, even expanded their programming. For example, when the number of referrals at a partner school was not as high as anticipated, one grantee organization was able to expand their services into a second school to fill a full caseload and service the anticipated number of students. Given the delays, ILCHF offered grantees the opportunity to extend the project from June 30, 2024 to either January 31, 2025 or June 30, 2025, and several grantees chose to take the extension.

Challenges Coordinating with School Partners

The logistics of coordinating with school partners was a reoccurring challenge throughout the life of the grant. Across time, finding dedicated space was one of the top challenges grantees mentioned. As an outside organization coming into schools, therapists from grantee organizations needed dedicated, private space to see clients; however, in many schools, space was limited. In one case, a school partner was unable to provide space for the services to occur; the grantee organization ultimately left that school and established a new school partner to implement the services. Many grantee organizations were able to work with schools to come up with creative solutions to provide services including cleaning out storage closets and traveling between different rooms.

Grantees also mentioned challenges such as school staff turnover, communication from school leaders, buy-in from school staff, and competing school schedules. Five grantee organizations (23%) reported the challenge of school administration changes in at least one of their progress reports. This required grantee organizations to establish new lines of communication, made it difficult to plan upcoming events, and sometimes modified services provided. The turnover of school personnel did

not just happen at the leadership level, but also across all positions in the school building making it difficult to establish and grow working relationships. Overall, building communication is a continual area of improvement. For example, sometimes decisions between the grantee organization and school admin would be made but that would not trickle down to classroom teachers.

Grantee organizations found ways to overcome the complex challenges of coordinating with schools through sustained, intentional efforts to collaborate more closely with school staff and integrate into the school culture. For example, in some cases staffing changes resulted in strengthened relationships as the new staff had more buy-in and were more familiar with the needs of the community. Grantees emphasized that it takes time and perseverance to understand the school culture and establish shared goals.

Challenges with Hiring and Retaining Behavioral Health Staff

Staffing remained a consistent challenge for grantees for the entirety of the CSWI grant. 82% (n = 18) of the grantee organizations reported staffing as a challenge at least once in a bi-annual progress report to ILCHF.

There is a behavioral health workforce shortage across the country making it difficult to hire overall; however, many CSWI grantee organizations had additional expectations beyond licensure. Specifically, many grantees prioritized recruiting and retaining therapists that reflected the identities of the students and families they served to meet both the language and cultural needs of their communities. In total, nine (41%) of the grantee organizations spoke about their efforts to hire bilingual service providers during final interviews or final progress reports. Eight of these organizations were part of the Chicago cohort, while one organization was in the Illinois cohort. While filling these positions was challenging, bilingual service providers were highly valued. One leader within a grantee organization referred to their clinician's Spanish-speaking abilities as a superpower that was critical to the success of their programs. A bilingual service provider shared,

> *"I think the program has created more awareness of mental health especially because we are bilingual. It gives us more outreach and a way to educate families. Sometimes there can be a mistrust among families so being bilingual is helpful."*

Throughout the grant period, grantee organizations continued to hire and search to fill key program roles. In the meantime, some grantees had other staff members fill in for vacant roles as needed. In one case, a supervisor, who typically does not provide direct service within their organization, temporarily stepped in to support the provision of services because of hiring challenges. While hiring remained a challenge for some, most organizations were able to find qualified staff to fill the role as the grant progressed as noted in grantee final interviews.

Challenges with Caregiver Engagement

Caregiver engagement was another ongoing challenge over the grant period. In final grantee interviews, caregiver engagement and buy-in was the second most cited challenge (n = 7, 32%). Grantees identified this challenge early in the grant period and shared ideas during the July 2022 grantee Learning Community meeting such working with their school partners to better understand the experiences of the families they intend to serve to inform how they may attempt to mitigate those

barriers. Creative ways to engage families included additional communications such as a newsletter and events such as parent nights, considering time of day, location, and providing childcare.

> *"I was a little naive because I thought if we invited parents to do cool things, come to events, they would join and then recruit other parents to join. But in reality, it was more of a struggle. Just finding the time alone is going to be hard– parents don't just have the freedom to give up all their time to do this stuff. We enlisted the help of COFI [Community Organizing & Family – an org that supports parent involvement and advocacy]. We started with 18 parents and now we are down to 8 or 9, but these 8 or 9 have been with us consistently. Even though it's a small group, they've been really effective. I've had to change my mindset- we won't get 50 or 60 parents, but it can still be a good thing."*

Challenges with the Consenting Process

Grantee organizations often relied on caregivers to provide consent and complete paperwork following a referral. Sometimes this process was difficult due to the stigma of mental health or fractured relationships between the family and the school. One grantee shared how 88 out of 208 students who were referred did not receive treatment due to factors such as lack of parents follow through, parental refusal for treatment, or students transferring to other schools. Delays in the consenting process oftentimes interfered with the student starting the services.

In some cases, grantee organizations were able to identify solutions to overcome this challenge. One grantee organization revisited their referral process, simplified the number of touchpoints, and focused on a relationship-centered approach for treatment and communication. Another organization, when unable to implement as many Tier 3 services as anticipated, used it as an opportunity to expand Tier 1 and Tier 2 support within the school, which increased the number of students they were able to serve.

Additional Challenges

Grantees mentioned several other challenges throughout the grant period during Learning Community conversations, in their progress reports, and during final interviews. These challenges include:

- A high level of need for mental health services
- The need for a wide variety of community wrap around supports for families including housing stability, drug prevention/intervention, school attendance initiatives, and services for newcomers
- Stigma or lack of openness to mental health services among students and/or families
- Misalignment of goals with the school, including school staff who focus on disruptive student behaviors as opposed to underlying mental health needs
- Difficulty engaging students and families in the summer months which interrupts program consistency
- Funding stability for grantee organizations and schools to sustain programming
- The burden of grant reporting especially needing to coordinate getting information from therapists in schools and feeling that mid school-year reports are redundant

Sustainability

Sustainability was a topic conversation among grantee organizations starting early in the grant period. While the intention of the grant funding was to meet an immediate need, grantee organizations and school partners wanted to make sure students and families were able to continue services after the grant period ended. During an October 2023 Grantee Learning Community meeting, in one of the first large group discussions on sustainability, grantees shared their current efforts, challenges, and emerging learnings. Some of the commonly mentioned sustainability factors included building strong partnerships with schools, being able to hire and retain talent, having space in schools, and finding effective ways to engage parents.

Key to Sustainability: Partnerships with Schools

Strong, goal aligned partnerships between grantee organizations and schools was most frequently mentioned as a key to program success and long-term sustainability. Some of the considerations grantees shared to promote strong partnerships during final interviews included:

- Relationships take time. It is important to get to know the specific school, its context, and school priorities because what might work in one school, might not work elsewhere.
- School leadership involvement is necessary to drive culture and lead communication and coordination.
- Teachers need to be supported on integrating trauma-informed practices into their classroom.
- In-school therapists can seek out ways to build relationships with teachers and administrators while also observing clients in their daily interactions with peers and teachers.
- The strongest partnerships integrated therapists into the schools, providing them with dedicated space for one-on-one counseling and folding them into the school culture.
- Clearly defined roles help everyone do their jobs well. This includes establishing boundaries in terms of expectations in participating in school activities and how they approach their counseling sessions to protect a therapist's time, to value their expertise as a mental health practitioner, and to maintain client relationships.
- Leverage trust that exists between schools and families to support mental health or understand the unique opportunity to establish trust with students or families as a service provider that is external to the school.

Program Sustainability Assessment

The Program Sustainability Assessment Tool (PSAT) is a self-assessment used to evaluate the sustainability capacity of a program across a range of specific organizational and contextual factors. Grantee organizations completed the PSAT initially near the beginning of the grant in winter of 2022. The results of the survey provided grantee organizations with sustainability strengths and challenges that could be used to guide sustainability action planning for their CSWI projects. The PSAT tool is available in Appendix E.

The survey is made up of 40 questions, divided into eight domains:

1. Program Adaptation
2. Organizational Capacity

3. Program Evaluation
4. Environmental Support
5. Strategic Planning
6. Communications
7. Funding Stability
8. Partnerships

Grantee organizations completed the PSAT again near the end of the grant in spring 2024. Figure 5 below shows the pre/post data comparison and the magnitude of change for 23 grants across 18 organizations. On average, all programs increased across all domains of sustainability over the grant period. On average, programs grew over each of the eight domains as their projects developed. Funding stability demonstrated the most growth, likely as a result of the grant itself and also ongoing conversations to braid additional funding to continue programs. Table 11 drills down to individual questions within each domain which showed the most growth as the program developed. This provides additional evidence that resources to keep the program going, including funding and personnel, have increased. Additionally, there are mentions of stronger school and overall community support/champions which will hopefully be able to advocate for sustainability.

Figure 5: Average Pre/Post PSAT Scores on a Scale of 1 to 7

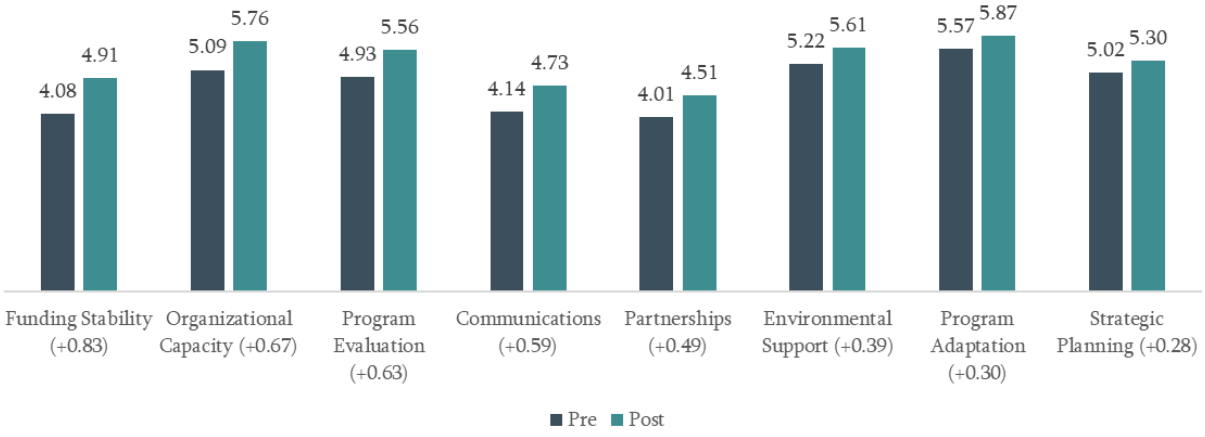

Table 11: PSAT Questions with Highest Average Program Growth

PSAT Domain	PSAT Indicator	Change (Scale of 1-7)
Funding Stability	The program has sustained funding.	+1.23
Organizational Capacity	The program has adequate staff to complete the program's goals.	+1.15
Program Evaluation	The program provides strong evidence to the public that the program works.	+1.05
Funding Stability	The program implements policies to help ensure sustained funding.	+1.01
Program Evaluation	Program evaluation results are used to demonstrate success to funders and other key stakeholders.	+0.92
Partnerships	Community members are passionately committed to the program.	+0.81
Environmental Support	Champions exist who strongly support the program.	+0.78
Organizational Capacity	The program is well-integrated into the operations of the organization.	+0.76
Strategic Planning	The program has a sustainability plan.	+0.74
Partnerships	Community leaders are involved with the program.	+0.69

Final Sustainability Plans

Per final grantee interviews and grantee final reports, most partnerships will continue in some capacity even as the grant period comes to a close. A total of 16 organizations intend to continue their existing partnership model with the school, sometimes in only some of the schools or in a more limited capacity, through additional grants, by billing for Medicaid for Tier 3 services, and/or by having the schools contribute to a portion of the funds especially for Tier 1 and Tier 2 services. The majority of grantees mentioned braiding multiple of these funding sources to be able to continue to provide a variety of services. One organization shared how their capacity to provide services greatly increased during the grant:

> *"A significant part that will allow this project to continue is because the agency received the Behavior Health Clinic status. Additionally, with the BHC status, the agency has hired a Psychiatric Nurse Practitioner, has opened a new clinic space, and plans to begin providing a much-needed service in the community."*

A handful of the grantee organizations turned their programs over to the schools. Two of these grantee organizations mentioned that although the district would reallocate funds towards the program, the district would also seek grants to help support it. Several of these organizations shared how the success of the program lead to willingness for district leadership to continue the program through the reallocation of funds:

> *"[Organizational leaders] were able to support 3 out of 4 of the recipient school districts in successfully re-allocating district funds toward mental health counseling services for future calendar years. Their decision to self-fund additional school-based mental health counselors demonstrates the effectiveness of the program and substantial progress toward the goal of assisting our community in recognizing and better meeting the diverse and growing mental health need of our youth."*

One grantee did not intend to continue to work within the schools, but half of the students on the therapist's caseload requested to meet with her outside of school as a community client. An organization that primarily implemented Tier 1 services has funds to sustain the program for two more years. One organization was not able to sustain their efforts due to the closure of their organization in May of 2024.

Additional Resources Needed in the Community

Sustaining current programs is only one avenue for ensuring the needs of the community are met. When asked about additional resources needed, grantees most commonly shared the need for additional mental health service providers (n = 14, 64%) beyond the services they provide. Not only was there a higher demand for services than service providers capacity, but behavioral health organizations operating in rural areas also cited a need for primary or specialty health care. Grantees in the Chicago cohort hoped for increased mental health support for caregivers. Similarly, access to transportation necessary to access care was also named as a need. Additionally, grantee organizations across both cohorts saw a need for increased access to bilingual services or providers that represent the communities they serve,

> *"We serve the underserved population… We try to do as much as we can to care for that population in-house… but if they need specialty care, where do we send them? A lot of times we send them to Peoria, but it's an hour drive. Same with dental- if they need something specialized, where do we send them and how far do they need to go?"*

Behavioral health staff also commonly identified basic needs, such as food, housing, gas cards, or legal support, as resources needed in their community (n = 10; 45%). Other needs that were mentioned included support for those engaging in substance use, parent education, and in Chicago especially, recreation activities.

Limits of Evaluation

The CSWI evaluation plan was detailed and comprehensive, overall allowing PIE Org and ILCHF to understand the impact of the initiative. However, there were several limitations of the evaluation methodology and implementation that should be taken into consideration when reviewing the results. Some of these limitations and potential future recommendations include:

1. **Unconventional Strengths and Difficulties Questionnaire (SDQ) implementation** – The SDQ is designed for clinicians and/or patients to complete the questionnaire once at the start of Tier 3 treatment and once at case closure. Typically, the scores are kept in the same excel document to be able to compare the change in score across individuals. In the first year of the project, this was how SDQ data were collected; however, this became burdensome for clinicians to track and maintain especially if it was an additional requirement to their organization's notes/screening tools. Instead, clinicians were asked to submit an anonymous pre-SDQ at the beginning of each school year after at least three sessions and then a post-SDQ either upon case closure or at the end of the school year. Since records did not contain student identification information, PIE Org was not able to determine individual student change over time. Instead, PIE Org analyzed the data at an aggregate level, comparing all pre-SDQs received with all post-SDQs received. Sample sizes were not the same for pre and post assessments, indicating that not every student had both time points submitted, likely skewing the data. Additionally, since this grant focused on each school year, there may have been duplicated clients across years. Again, the evaluation team was not able to analyze change over time for those students receiving multiple years of services. If a similar project were to be evaluated in the future, it is recommended to more thoroughly understand the assessment tools clinicians are already using to reduce the data collection burden, increase the use of the assessment tools, and hopefully be able to capture individual change over time.

2. **Inconsistent pre/post data tool competition** – As already mentioned with the SDQ, ensuring a matched set of pre/post data across tools was difficult. The challenge also existed with the TRS (to be completed at the school level) and the PSAT (to be completed at the grant level). For both of these tools, PIE chose to analyze only TRS and PSAT responses that had both a pre and post matched submission to increase data accuracy. This means, however, there was missing data.

   For TRS, several partners changed schools they worked with over the grant period and/or had a delayed start so there was missing pre data. In other cases, the people completing the pre assessment were not the same as those completing the post assessment. This was due to turnover and/or misunderstanding of at what level the assessment should be complete (i.e., does it only focus on one school or the whole district; should one person from the school fill it out, multiple people submit individual forms, or does the grantee fill this out). If the TRS is used again, it is recommended to be very clear from the beginning the intent of the tool is to assess one individual school. Additionally, it might be helpful to indicate a role at the school who is responsible for completing the form, either individually or taking multiple opinions

and aggregating them into one response. Then for the post-test, the evaluation team can communicate with the specific role in charge (even if the individual has changed).

PSAT data entry had similar challenges with matched completion. For using this tool in the future, it is recommended to require only one PSAT entry per organization, even if they have multiple grants. Also, as above, it is recommended to have one role ultimately in charge of the submission and gathering input from the team.

3. **Limited equity data** – In order to maintain client confidentiality and respect district data sharing policies, it was challenging to answer the evaluation questions around equity. The evaluation team did not collect individual student data, nor were we able to track individuals across time. Since data was analyzed at the aggregate it was not possible to disaggregate data across variables of equity including, but not limited to, race, ethnicity, and income status. The evaluation team recommends remaining cautious with confidentiality in future projects; however, we would recommend more conversations with grantees and ILCHF at the beginning of the grant around equity, how to measure equity of implementation and outcomes, and best practices to use data to enhance equity.

4. **Difficulty engaging caregivers** – The evaluation team experienced difficulty engaging caregivers in interviews/focus groups. PIE Org reached out to twelve grantee organizations and heard from most they would not be able to connect the evaluation team with caregivers for various reasons including limited family engagement, policies against having families opine on services, past negative experiences, and changing staff. Ultimately PIE Org and ILCHF decided to shift from interviews to case studies and were successfully able to engage with 10 caregivers across three grantee organizations.

5. **Ongoing turnover at PIE Org and grantee organizations** – Both PIE Org and many grantees experienced one or more staff changes throughout the 2.5-year lifetime of the CSWI project. While this is to be expected in the non-profit space, and especially in community behavioral health, it presented consistency challenges for the evaluation. PIE spent more time than anticipated onboarding new grantees to evaluation requirements. Additionally with internal turnover, additional time was needed for new staff to get up to speed and inevitably some institutional knowledge was not transferred. The data guidance document was incredibly helpful to mitigate this challenge and is a tool that is recommended for other longer-term projects.

Considerations and Conclusion

In conclusion, the COVID School Wellness Initiative met its goal of bringing more mental health care services into the schools. While this grant was in response to an emergency, it is clear there remains a high need from students, families, and school staff for these services. The flexibility of this grant allowed grantees and their school partners to determine the most appropriate implementation methods for their community. Across all grantees challenges existed in terms of staffing, buy-in, and stigma; however, over time, most grantees were able to build strong partnerships with schools to enhance mental health access. Every grantee is exploring an option for at least partial program sustainability in hopes to continue to grow mental health care access and hopefully also increase positive mental health outcomes across the state of Illinois.

Throughout this process, multiple lessons were learned which can be applied to future programming, systems change initiatives, and foundation operations. These considerations include:

Future Programming Considerations

- **Prioritize strong school and behavioral health organization partnerships.** With behavioral health staff integrated into the school building, it was essential to get buy-in from school staff to support the work. Strong partnerships often started with having admin champions. Then, educational opportunities, programming, and informal interactions with teachers helped them understand the purpose of the work, gave them trauma informed skills and created more willing partners. These relationships take time and effort, but the energy is most often worth it for more effective programs and ongoing sustainability.

- **Incorporate innovative ideas from grantees into future programming.** Due to the flexibility from ILCHF to implement programming in a way that met the unique needs of communities and school partners, grantee organizations demonstrated creativity and innovation in the supports they provided through the grant. These can serve as a repository of potential ideas for future programming or possible solutions for future challenges facing behavioral health organizations delivering school-based services.

- **Integrate behavioral health staff into the schools while setting boundaries.** Part of the uniqueness of this program was having behavioral health staff integrated into the school culture. As mentioned above, it was important to be in the building to build relationships with school staff and students. However, several grantees mentioned being a separate organization increased the trust from students and caregivers. While it was beneficial for behavioral health staff to be involved in MTSS meetings and other committees, there should be boundaries established and protected. Since they are not school employees, behavioral health staff should be able to protect their time with the help of their supervisors and not be pulled into school staff duties. Additionally, behavioral health providers should be able to make their treatment goals clear given their expertise and training as opposed to being beholden to teacher direction and requests. All of these things require clear communication between the behavioral health organization and the school and continued assessment of roles

and responsibilities.

- **Encourage the "right" behavioral health hires.** Hiring was one of the most persistent challenges across all grantees. However, the challenge was not only hiring, but hiring for the right fit. School context and need matter in the hiring process. Several grantees found that the right person made all the difference. Ideally the "right fit" might be someone that understands the school context and population, someone that is familiar with the school system/area, and/or someone that meets the needs of their potential clients (i.e., bilingual therapist). In an effort to enhance partnerships, it could be helpful to include members of the school team in the interview process to assess fit.

- **Provide services across all tiers.** CSWI provided Tier 1, 2 and 3 interventions for students. Services across tiers were also offered for caregivers and school staff. The Tier 1 services offered opportunities to reach stakeholders across the school. These services including SEL curriculum, mental health awareness, and wellness days helped shift mindsets and provided everyone with additional tools to promote positive mental health. While this is not a billable service, it is critical to providing the cultural foundation around positive mental health and should continue to be used in conjunction with more intensive interventions.

Systems Change Considerations

- **Support creative funding model policies.** Ultimately, policy change and continued advocacy is needed to ensure all children in Illinois have access to mental health care. Many grantees plan to bill Medicaid for a portion of their services going forward; however, the billable rate is low, tedious, and only applicable to Tier 3 services. While Illinois has made great strides over the past few years, there remains the opportunity for coalitions of funders, organizations, and clinicians to dream of a model that provides equitable access to care not only for more intensive interventions but also for prevention and education.

- **Develop a strong Illinois community behavioral health clinician staffing pipeline.** There is a known behavioral health staffing shortage across the country. Both urban and rural grantees faced the challenge of recruiting and retaining talent. Like the funding model consideration, this will require continued creative thought across players in the mental health ecosystem. A few options to consider might be scholarships for undergraduate/graduate students studying community mental health, funder supported paid internships, operational grants to cover higher staff salaries, and/or partnerships with both secondary and post-secondary institutions to identify and train the next generation of talent.

ILCHF Operations Considerations

- **Understand how ILCHF can meet the need for gap funding.** Although it is different for each grantee, many grantees are planning to bill Medicaid and/or partner with the school to

receive funding to continue services. While both of these are great pathways to continue at least some of the programming CSWI started, there are likely still funding gaps for Tier 1 and Tier 2 services. ILCHF can consider more fully understanding where these gaps exist and help behavioral health organizations use grants or other private funding either directly from the foundation or their contacts to continue services.

- **Continue to provide flexible grant activity with shared outcomes.** One of the strengths of this program was its design to be non-prescriptive in terms of activities. This allowed grantees and their school partners to identify the most pressing needs of their community and design programs in ways that were able to meet these needs. If ILCHF continues to provide common outcomes/goals for their grants while providing the flexibility of activities, it will allow its grantees to be more community-centric and culturally responsive in their program design and implementation which will more likely result in innovative solutions.

- **Consider the alignment of grant timing and length.** The multi-year grant was incredibly helpful to most grantees, especially those that had difficulty hiring and establishing partnerships. By the last year of the grant, most programming was in full swing, which would not have been the case had this been a single year grant. However, several grantees mentioned the challenge of having a grant start in the middle of the school year. While this might have been necessary in response to the COVID crisis, it made it difficult to integrate into the school culture and hire staff in the middle of a school year. For future school-based grants, it is either recommended to start funding in alignment with the school year (summer before the year starts) or to provide a 6-month ramp-up funding period in which organizations can search for and hire staff and start building school partnerships without being required to fully implement programs.

Overall CSWI was a valuable program for schools and communities. It provided many learnings for implementation, impact, and sustainability which can be used going forward to support mental health care for all children in Illinois.

Appendix A: Evaluation Plan

This evaluation plan, which was originally created for the evaluation project proposal, has been updated to reflect our current understanding of the work being done by grantee organizations. This understanding is based on our learning tour conversations and the evaluation plan meetings with grantees that were held in May. The plan continues to reflect our focus on three key areas, which are program implementation, impact and sustainability.

Implementation

Area	Evaluation Questions	Metrics	Tool(s)	Sample	Timeline**
Reach & Fidelity	What was the reach and scope of implementation? Who is being served? Was there equity of implementation?	#students, staff, caregivers and schools served, #activities/dosage intervention, # served by individual and group activities, disaggregated by equity and demographic variables.	Tracking Log	Providers-Population	Quarterly, ongoing
	Was there fidelity of implementation? How was the program adapted in response to emerging needs?		Google Studio Dashboard		
			Learning Community Discussions	Providers-Population	Q4, annually
			Interviews*		
Description & Variation	What are the commonalities and differences in interventions across grantees? What was the variability in intervention by geography and community (i.e., demographics, rural vs. urban)?	#types and kinds of interventions (i.e., early intervention, prevention, and intervention), as well as the specific audiences for the interventions (i.e., students, staff, caregivers).	Grant Application Review	Providers-Population	Q2, 2022
	What are challenges to implementation across grantees? What factors supported overcoming common barriers to implementation?		Learning Community Discussions	Providers-Population	Q2, Q4, annually
			Community Focus Groups	Stratified sample of 2-3 school leaders, 2-3 providers, and 2-3 community	Q2 2022, annually

				members/parents by grantee organization for each cohort.	
			Observations‡	Population, rolled out over time • Plan Phase – 4-5 most established interventions within cohorts • 2023-2023 – 4-5 per cohort • 2023-2024 - 4-5 per cohort	Rolling basis, ongoing
Community	Does the intervention meet the needs of the schools and communities?	#of community engagement events/ activities, and #school, caregivers, and students engaged in feedback for the initiative, %of community engagement events/activities held vs. planned	Tracking Log	Providers- Population	Quarterly, ongoing
	How were school and community engaged before and during the intervention?		Learning Community Discussions	Providers & Caregiver Leaders - Population	Q2, Q4, annually
			Community Focus Groups	Stratified sample of 2-3 school leaders, 2-3 providers, and 2-3 community members/parents by grantee organization for each cohort. Where possible, community members will be invited to engage as data gatherers.	Q2 2022, annually

*Understanding that many organizations have limited capacity, PIE will try to conduct qualitative inquiry within the quarterly Learning Community meetings and only conduct formal interviews if this information is not clarified during these meetings.

**All quarters are on the nonprofit calendar, where Q1= July – September, Q2= October – December, Q3= January – March, and Q4= April- June

‡ Observations would be limited to community engagement events, meetings, and Tier 1 interventions.

Impact

Area	Evaluation Questions	Metrics	Tool(s)	Sample	Timeline**
Outcomes	What was the impact of these intervention on the populations served? What changes in knowledge, attitude, or behavior resulted from these interventions?	#/% changes over time via shared measurement	Strengths and Difficulties Questionnaire	Participants - Population	Q1, Q4, annually
		#/% changes, aggregated across all individual measures of each intervention	Provider-specific assessment, if available	Participants - Population	Q1, Q4, annually
		% change in school practices	Trauma-Responsive School Implementation Assessment#	Schools - Population	Q1, Q4, annually
		%change on of Supportive Environment and Involved Families	5Essentials Survey		Q4, annually
		%teachers retained, #school disciplinary actions	ISBE Tracking		Q4, annually
	What case examples demonstrate the power of these interventions within the school community?	None, qualitative description	Observations	Successful case sampling – Chicago (n=1) & County (n=1)	Quarterly, Y2
			Participant Focus Groups or Interviews	Stratified sample by intervention population and grantee organization for each cohort (i.e., high school students, teachers)	Rolling basis, ongoing
	What were the unintended impacts of this work?	None, qualitative description	Learning Community Discussions, Zoom Polls	Providers-Population	Q4, annually
			Participant Focus Groups	Stratified sample by intervention population and grantee organization for each cohort (i.e., high school students, teachers)	Rolling basis, ongoing
Equity	Was there equity of outcomes?	All metrics above, disaggregated by	Strengths and Difficulties Questionnaire (SDQ)	Participants - Population	Q1, Q4, annually

		demographics and identified equity variables.	Provider-specific assessment#	Participants - Population	
	Did perceptions of well-being and mental health change over time for schools, caregivers, providers, and community? If so, how?	None, qualitative description	Learning Community Discussions, Zoom Polls, Focus Groups (with clinicians)	Providers (clinicians)- Population	Q4, annually
			Community Focus Groups	Stratified sample by intervention population, caregivers, providers, community and grantee organization for each cohort (i.e., high school students, teachers)	

**All quarters are on the nonprofit calendar, where Q1= July – September, Q2= October – December, Q3= January – March, and Q4= April- June
#The Trauma-Responsive School Implementation Assessment should be completed by school staff members. We will explore the feasibility of using this tool with the grantees with the goal of using it where possible.

Sustainability

Area	Evaluation Questions	Metrics	Tool(s)	Sample	Timeline**
Sustainability	How did relationships between schools and mental health providers develop and expand throughout this initiative?	# new contracts, #new hires within community, #expanded programs, #fully funded programs, #added sources of funding for programs	Learning Community Discussions, Zoom Polls, Focus Group Discussions (with school leadership)	Providers (grantee and school staff) - Population	Q3-Q4, annually
	What evidence is there that these relationships will sustain over time?		Program Sustainability Assessment Tool	Providers- Population	Q4, Y2
	What barriers, assets, and contexts supported and hindered the development these relationships?				
	What relationships and collaborations grew at the provider level as a result of				

	the Learning Communities embedded in this initiative?				

**All quarters are on the nonprofit calendar, where Q1= July – September, Q2= October – December, Q3= January – March, and Q4= April- June

Appendix B: Grantee Listening Tour Interview Protocol

Materials: If available, please share your program's logic model, theory of change, or outcome map. If you have any other materials that you think will be useful for the evaluation (e.g., data collection tools, annual reports), please share them as well.

CSWI Interview Protocol

Thank you for taking the time to speak with me today. Our conversations will help us determine the best plan of action for evaluating the COVID School Wellness Initiative. I anticipate this conversation to take approximately 60 minutes. If you have any questions during the course of this meeting, please feel free to ask them.

Program Description

1. To start, please introduce yourself. Tell me about your role.
2. What is the history and context of your program?
    a. Please describe the population served by the program.
    b. Are you developing and implementing a new program or expanding an existing one?
3. What are your program's goals? How would you like to impact the community?
4. What are the program's evaluation goals?
5. What have been this program's successes so far?
6. What have been challenges or barriers to success?
7. What should PIE pay particular attention to as we help to tell your program's story?

Data Collection

Next, let's talk about your data collection plans and needs.

1. Do you have a strategy in place for tracking the implementation of your program? Please describe it.
    a. Please share any data collection tools you have developed.
    b. Who was involved in creating your data collection tools? Were community members/service recipients offered an opportunity to provide feedback about them?
    c. How are efforts to ensure equity infused in your program's data collection practices?
        i. Does your program collect demographic data?
        ii. Does your program collect other data related to equity? If so, what are they?
        iii. Does your program disaggregate data to explore opportunities to improve equity?
2. What other kinds of data do you currently collect or plan to collect?
3. How do you plan to use the data collected?
4. Do you anticipate any challenges to data collection? If so, what are they?

Capacity Needs

5. Do you have any concerns about evaluation capacity or conducting this evaluation?
6. Tell us about any support that your program might need regarding data collection.
7. Are there any other challenges about which we should be aware?

Program Implementation and Community Engagement

1. How have parents/caregivers/families been involved in the planning and implementation of initiatives and their evaluation?
2. How has the inclusion of parents/caregivers/families in the program planning and implementation affected the design, work, and/or results?
3. How can PIE further support your evaluation goals (e.g., capacity-building, dashboarding)?

Evaluation Plan for the COVID School Wellness Initiative (CSWI)

We'd like to get your perspectives on our plans to evaluate the CSWI. Specifically,

1. Tell us how our plans to integrate a well-being assessment might work, given your organization's protocols and processes?
2. We'd like to include some community-based participatory research approaches in the evaluation, such as engaging parents as qualitative data collectors. Is your program amenable to using these kinds of approaches?
3. Tell us about your organization's capacity to support PIE's work by connecting us with school personnel.
4. Here's an early mockup of the implementation tracking dashboard we plan to use. Please share your thoughts on how we might make the dashboard more useful to your program.

Appendix C: School Partner Interview Protocol

Introduction: We're from PIE (Planning, Implementation & Evaluation), which is a Chicago-based national provider of evaluation, strategic planning and capacity-building services for mission-driven organizations. PIE is the external evaluator for the COVID School Wellness Initiative, which is a statewide project that seeks to strengthen social and emotional learning supports in public schools. The Illinois Children's Healthcare Foundation is the grantor. Your school's partner, CSWI GRANTEE, is a grant recipient in this initiative.

Thank you for meeting with us today. We anticipate that this conversation with you will only take about 45 minutes to an hour. Our goal for today is to learn from you about your partnership with CSWI GRANTEE and the impact that partnership has had on you and your school/district. Anything you share during this discussion will not be shared back directly with CSWI GRANTEE. Rather, your insights will be aggregated with the themes we glean from conversations with other schools and school districts across the state and provided to the Illinois Children's Healthcare Foundation, the funder of this initiative.

1. Please start by telling us, generally, about your collaboration with CSWI GRANTEE.
    a. When did this partnership begin?
    b. Did it begin as a result of the CSWI funding or something else?
    c. Do you believe collaboration between the schools and a community-based organization is important?
        i. Have you collaborated with other community-based organizations in the past?
    d. Who is your target population for this collaborative project?
        i. Teachers/staff?
        ii. Students?
        iii. Families?
        iv. Others?

2. What has gone well so far?
    a. Can you provide specific examples?
    b. What do you attribute this success to?

3. What challenges have you experienced so far?
    a. Specifically in terms of implementation of your project?
    b. What has worked well to overcome those challenges?

4. How does your school/district address mental health/social emotional wellbeing of staff, students, and families?
    a. Does your district have any specific goals set for social and emotional wellbeing?
    b. How does this project align with those efforts?
    c. What are your sustainability efforts for this collaborative project?

        i. Particularly after this funding ends after the 2022/23 school year?

5. Are there other individuals you think we should speak to in your school/district?
    a. If interviewee is an administrator/at District level – are there any classroom-based staff we could talk to?

6. Is there anything else you would like to share that we have not already asked about?

Thank you for taking time to share about your work and relationship with CSWI GRANTEE. If you think of any additional feedback that you would like to share, please feel free to e-mail either of us, Barbara at barbara@pieorg.org or Joie at joie@pieorg.org.

Appendix D: Tier 1 Activity Observation Protocol

Observer:	
CSWI grantee and/or organization name:	
Location:	
Date/Time:	
Observation Group (circle one)	School Staff Parents/Caregivers Students Community Other: _____

Program title:	
Target audience and number of participants:	
Brief summary of program goal:	
What activities were facilitated during this segment?	
Who facilitated the activities?	
What facilitation strategies were deployed?	
Describe the engagement levels of participants.	
What components of this program were effective?	
What challenges did the grantee experience while facilitating the program?	

If possible – what is feedback of participants about program?	
Additional notes/comments:	

Appendix E: Program Sustainability Assessment Tool (PSAT)

The Program Sustainability Assessment Tool (PSAT) is a self-assessment used by both program staff and stakeholders to evaluate the sustainability capacity of a program. When you take the assessment online, you will receive a summary report of your overall sustainability, which can be used to help with sustainability planning. The first Program Sustainability Framework was developed with funding from the National Association of Chronic Disease Directors. Revision and distribution of the tool is funded by the Centers for Disease Control, Office on Smoking and Health.

-The assessment is made up of 40 questions and takes about 10-15 minutes to finish.
-You will rate your program or set of activities across 8 sustainability domains.
-The assessment can be used by programs at community, state, and national levels.
-The assessment is used by various programs; public health, social services, and educational programs have all found the assessment to be very relevant to their work.
-The assessment can be taken as an individual or group.

The PSAT is a tool to help articulate your understanding of a program. The numbers are a way for you to conceptualize your program across these domains relative to each other so you can start thinking about where you want to focus your efforts as you work to increase your program's sustainability capacity. The more honest you can be with your answers, the more helpful the report will be in moving forward with your program's sustainability planning.

If you have any questions, please contact Barbara Thomas (barbara@pieorg.org) and Joie Frankovich (joie@pieorg.org).

CSWI Grantee Name

Name of person completing this form

Email of person completing this form (in case we need to follow up with you)

Please list all individuals who contributed to the completion of this form. Include their name, title, and organizational affiliation.

Environmental Support

Having a supportive internal and external climate for your program.

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "Not able to answer." For each statement, choose the number that best

indicates the extent to which your program has or does the following things with 1 representing little to no extent and 7 representing to a very great extent.

	To little or no extent	2	3	4	5	6	To a very great extent	Not able to answer
Champions exist who strongly support the program								
The program has strong champions with the ability to garner resources.								
The program has leadership support from within the larger organization.								
The program has leadership support from outside of the organization.								
The program has strong public support.								

Funding Stability

Establishing a consistent financial base for your program.

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "Not able to answer." For each statement, choose the number that best indicates the extent to which your program has or does the following things with 1 representing little to no extent and 7 representing to a very great extent.

	To little or no extent	2	3	4	5	6	To a very great extent	Not able to answer
The program exists in a supportive state economic climate								
The program implements policies to help ensure sustained funding.								
The program is funded through a variety of sources.								
The program has a combination of stable and flexible funding.								
The program has sustained funding.								

Partnerships

Cultivating connections between your program and its stakeholders.

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "Not able to answer." For each statement, choose the number that best indicates the extent to which your program has or does the following things with 1 representing little to no extent and 7 representing to a very great extent.

	To little or no extent	2	3	4	5	6	To a very great extent	Not able to answer
Diverse community organizations are invested in the success of the program.								
The program communicates with community leaders.								
Community leaders are involved with the program.								
Community members are passionately committed to the program.								
The community is engaged in the development of program goals.								

Organizational Capacity

Having the internal support and resources needed to effectively manage your program and its activities.

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "Not able to answer." For each statement, choose the number that best indicates the extent to which your program has or does the following things with 1 representing little to no extent and 7 representing to a very great extent.

	To little or no extent	2	3	4	5	6	To a very great extent	Not able to answer
The program is well integrated into the operations of the organization.								
Organizational systems are in place to support the various program needs.								
Leadership effectively articulates the vision of the program to external partners.								
Leadership efficiently manages staff and other resources.								
The program has adequate staff to complete the program's goals.								

Program Evaluation

Assessing your program to inform planning and document results.

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "Not able to answer." For each statement, choose the number that best

indicates the extent to which your program has or does the following things with 1 representing little to no extent and 7 representing to a very great extent.

	To little or no extent	2	3	4	5	6	To a very great extent	Not able to answer
The program has the capacity for quality program evaluation.								
The program reports short term and intermediate outcomes.								
Evaluation results inform program planning and implementation.								
Program evaluation results are used to demonstrate successes to funders and other key stakeholders.								
The program provides strong evidence to the public that the program works.								

Program Adaptation

Taking actions that adapt your program to ensure its ongoing effectiveness.

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "Not able to answer." For each statement, choose the number that best indicates the extent to which your program has or does the following things with 1 representing little to no extent and 7 representing to a very great extent.

	To little or no extent	2	3	4	5	6	To a very great extent	Not able to answer
The program periodically reviews the evidence base.								
The program adapts strategies as needed.								
The program adapts to new science.								
The program proactively adapts to changes in the environment.								
The program makes decisions about which components are ineffective and should not continue.								

Communications

Strategic communication with stakeholders and the public about your program.

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "Not able to answer." For each statement, choose the number that best indicates the extent to which your program has or does the following things with 1 representing little to no extent and 7 representing to a very great extent.

	To little or no extent	2	3	4	5	6	To a very great extent	Not able to answer
The program has communication strategies to secure and maintain public support.								
Program staff communicate the need for the program to the public.								
The program is marketed in a way that generates interest.								
The program increases community awareness of the issue.								
The program demonstrates its value to the public.								

Strategic Planning

Using processes that guide your program's direction, goals, and strategies.

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "Not able to answer." For each statement, choose the number that best indicates the extent to which your program has or does the following things with 1 representing little to no extent and 7 representing to a very great extent.

	To little or no extent	2	3	4	5	6	To a very great extent	Not able to answer
The program plans for future resource needs.								
The program has a long-term financial plan.								
The program has a sustainability plan.								
The program's goals are understood by all stakeholders.								
The program clearly outlines roles and responsibilities for all stakeholders.								

Appendix F: Trauma Responsive School Implementation Assessment (TRS-IA)

The Trauma Responsive Schools Implementation Assessment (TRS-IA) was developed by the Treatment and Services Adaptation Center for Resilience, Hope, and Wellness in Schools in collaboration with the Center for School Mental Health. The assessment was created using the RAND/UCLA Modified Delphi Approach—a commonly used evidence-based strategy for developing quality measures. Employing this approach, developers engaged a panel of national experts in a consensus process to identify and refine best-practice guidelines for trauma-responsive school implementation. Furthermore, guided by a community-participatory framework, on the ground school administrators and teachers from various regions of the country were consulted to ensure the assessment was culturally sensitive and could be easily used by busy school personnel. The TRS-IA is an evidence-informed self-assessment that can quickly and efficiently identify trauma-responsive programming and policy domains of strengths, as well as areas with room for improvement.

This assessment measures eight key domains of a Trauma-Responsive School:
(1) Whole School Safety Programming
(2) Whole School Prevention Programming
(3) Whole School Trauma Programming
(4) Classroom-based Strategies
(5) Prevention/Early Intervention Trauma Programming
(6) Targeted Trauma Programming
(7) Staff Self-Care
(8) Community Context

Each domain contains multiple questions that are rated on a scale from 1 (least trauma-responsive) to 4 (most trauma-responsive). This measure can be completed by an administrator and/or other designated school staff member in one sitting. If you are completing this assessment for a district, please answer the questions for the schools in your district.

You can access a PDF version of this tool at: https://www.theshapesystem.com/wp-content/uploads/2020/03/TRS-IA-1-25-18.pdf

If you have questions, contact Barbara Thomas (barbara@pieorg.org) and Joie Frankovich (joie@pieorg.org).

CSWI Grantee Name

Name of School district

Name of school

Name of person completing this form

Email of person completing this form (in case we need to follow up with you)

WHOLE SCHOOL SAFETY PLANNING			
1. How comprehensive is your school's/district's assessment of campus physical safety (e.g., conducted at an appropriate frequency, uses a structured checklist)?			
1 Minimally comprehensive, only addresses immediate dangers	2	3	4 Very comprehensive
2. To what extent are students routinely supervised in a developmentally-appropriate way across campus (including lunch rooms, hallways, playgrounds) recognizing that strategies vary by elementary, middle, and high school?			
1 Staff inconsistently watches students	2	3	4 Routine monitoring across entire campus
3. To what extent does your school/district have a clearly defined strategy to determine when a student may present harm to another student or staff?			
1 No defined process	2	3	4 Clearly defined process
4. To what extent have school staff been trained in bullying prevention strategies?			
1 School staff are encouraged to prevent bullying on campus, but no training has been offered.	2	3	4 There is a school-wide approach with appropriate training for educators in bullying prevention strategies.

WHOLE SCHOOL PREVENTION PLANNING			
1. To what extent does your school/district have a clearly defined process for students to report concerns about peers (e.g., that a peer who may harm themselves or others) to staff?			
1	2	3	4
No defined process exits for students to report concerns about peers.			Both students and staff know the process for students to report concerns about peers.
2. To what extent does your school/district have a clearly defined process for sharing academic, legal, and mental health records among relevant parties (teachers, counselors, law enforcement)?			
1	2	3	4
No defined process exists.			A clearly defined process exists.
3. To what extent do you survey a range of stakeholders (e.g. parents, staff, school resource officers, security officials, and students) about their perceptions of your school's/district's climate?			
1	2	3	4
No assessment of climate.			Assessment of all stakeholders
4. How routinely do you conduct an assessment of your school's/district's climate?			
1	2	3	4
Never			At least some stakeholder groups assessed on a routine basis (at least once per year)
5. To what extent has your staff been educated/trained so that any emergency drills that are conducted are done so in a manner sensitive to students with trauma histories? (alarms that may elicit reaction)			
1	2	3	4
Teachers and staff are encouraged to be sensitive to trauma exposure during emergency drills.			Teachers and schools staff have received training in a specific strategy for being sensitive to trauma exposure during emergency drills.
6. To what extent does your school/district have clearly defined and articulated behavioral expectations for students?			
1	2	3	4
There are no defined school-wide behavioral expectations. Teachers have independent behavioral expectations.			School-wide behavioral expectations have been defined and communicated to students in a consistent and ongoing manner.
7. To what extent has your school staff been trained in a strategy for reinforcing behavioral expectations?			
1	2	3	4
Teachers are encouraged to reinforce behavioral expectations but no defined strategy exists.			School staff are trained in and utilize a clearly defined approach to reinforce behavioral expectations

WHOLE SCHOOL TRAUMA PROGRAMMING			
1. To what extent have teachers and/or other school staff been trained to provide emotional support to students following a traumatic event (i.e Psychological First Aid, PFA-S, NASP PREPaRE)			
1	2	3	4
Teachers and other school staff are encouraged to support students but no organized training has been provided.			Teachers and other school staff have been trained in a specific approach and utilize it when necessary.
2. To what extent does your school/district have clearly defined discipline policies that are sensitive to students exposed to trauma?			
1	2	3	4
Some teachers may take trauma exposure into account when taking disciplinary action.			Clearly defined disciplinary procedures that are trauma sensitive.
3. To what extent have school security personnel (school resource officers, school police, security force) been trained to identify symptoms of trauma and respond using tactics to avoid re-traumatization?			
1	2	3	4
Security staff are encouraged to identify and interact with students using methods that are trauma-informed and avoid re-traumatization.			Security personnel have been trained in a specific approach to identify and interact with students using methods that are trauma-informed and avoid re-traumatization.
4. To what extent has your school/district established and follow a restorative approach to resolving conflicts that arise on campus.			
1	2	3	4
Teachers and other school staff are encouraged to help students resolve conflicts but no single defined strategy exists.			Clearly defined approach.
5. To what extent does your school/district educate staff about trauma and its effect on students (impact on brain, behavior and academics)?			
1	2	3	4
Minimal. Addressed through a brief one-hour in-service			Substantial Attention (ongoing educational opportunities).
6. To what extent does your school/district train staff in skills for interacting with and supporting traumatized students? (ex. de-escalation, referral)			
1	2	3	4
Minimal-Addressed through a brief one-hour in-service.			Substantial Attention (ongoing educational opportunities).

CLASSROOM-BASED STRATEGIES

1. To what extent have teachers been trained in the incorporation of Social Emotional Learning (SEL) principles into their work with students?

1	2	3	4
Teachers are encouraged to incorporate concepts into their work but have not been trained in a specific approach.			Teachers and other school staff have been trained in a specific approach and utilize it when necessary.

2. To what extent has school staff been trained to identify potential triggers for students and ways to de-escalate when a student may become deregulated?

1	2	3	4
Teachers are encouraged to create safe and calm classrooms but have not received training for doing so.			Teachers have received a thorough training in strategies for keeping classrooms safe and calm.

3. To what extent does your school/district have a clearly defined approach for providing behavioral support to students in the classroom?

1	2	3	4
Teachers are encouraged to find ways to support children in the classroom.			Clearly defined approach.

4. To what extent does your school/district have a clearly defined approach to integrate a student's trauma history into the IEP process?

1	2	3	4
Occasionally addressed in IEP process.			Clearly defined strategy for including trauma history into the IEP process.

EARLY INTERVENTION TRAUMA PROGRAMMING

1. How routinely does your school/district incorporate trauma exposure into your mental health assessments?

1	2	3	4
Does not do so at all			Does so routinely for all students receiving mental health assessments.

2. Does your school/district implement a specific intervention to meet the needs of kids suffering from trauma (i.e. CBITS, SSET, Bounce Back)?

1	2	3	4
No specific intervention is implemented.			Routinely implements a specific Evidence-based Practice (EBP) for students who have experienced trauma.

TARGETED TRAUMA PROGRAMMING

1. When multidisciplinary teams meet to address a student's performance, to what extent is there a clearly defined approach for examining trauma exposure as a contributor to student performance?

1	2	3	4
No defined process			Trauma exposure is routinely integrated into these discussions.

2. To what extent does your school/district have working relationships with external community mental health agencies to refer students who have been exposed to trauma?

1	2	3	4
No established relationships. Community providers are found as needed			Strong community partnership exists.

STAFF SELF CARE FOR SECONDARY TRAUMATIC STRESS

1. To what extent does your school/district have a standard approach for building staff awareness of compassion fatigue and STS which include providing tools for self-monitoring and building self-care strategies.

1	2	3	4
No Approach			Standardized approach.

2. To what extent does your school/district facilitate peer support among staff working with students exposed to trauma?

1	2	3	4
No defined strategies. Teachers provide support when they notice a colleague in distress.			Clearly defined strategy for supporting peers.

3. To what extent are there professional resources available for staff on campus?

1	2	3	4
No resources.			Resources specific to secondary traumatic stress

COMMUNITY CONTEXT

1. School staff have been trained to be responsive and considerate of cultural issues (i.e. language barrier, undocumented status)

1	2	3	4
No training			Teachers and other school staff have been trained in a specific approach and utilize it when necessary.

2. To what extent are racially and ethnically sensitive resources and services made available to the families of students receiving tier 2 and 3 interventions.

1	2	3	4
No supports available.			Routine incorporation of supports

3. To what extent does your school/district identify opportunities to engage families and the broader community about trauma and its impact.

1	2	3	4
No engagement			Ongoing engagement (several meetings each school year)

4. To what extent does your school/district have partnerships with community-trusted organizations (i.e churches, health centers) to further support the families in need.

1	2	3	4
No partnerships identified			Contracted partnerships with several organizations

What domain(s) does your school/program consider a priority area? (Check all that apply.)

- ☐ Safety planning
- ☐ Prevention planning
- ☐ Trauma planning
- ☐ Classroom strategies
- ☐ Prevention/early intervention
- ☐ Targeted trauma-informed programming
- ☐ Staff self-care
- ☐ Community context

Appendix G: Strengths and Difficulties Questionnaire (SDQ)

This is a retrospective survey, meaning for some questions, you will be asked to reflect on the child's behavior and emotions before you began providing them Tier 2 or Tier 3 services and again as of today's date now that you have begun providing services. Please answer all questions to the best of your knowledge, even if you are not absolutely certain.

Grantee name: _____

Age of student: _____

Today's date: _____

Preferred gender identity of student:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Prefer not to say
- ☐ Other:_____

Race/ethnicity of student (choose all that apply):

- ☐ Black/African American
- ☐ Hispanic/Latino/a/x
- ☐ Asian
- ☐ White/Caucasian
- ☐ Indigenous American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Rather not say
- ☐ Choose to self describe (by student):_____

Start date of services:

End date of services (if no longer receiving your services as of today's date):

What level of support are you primarily providing to this student?

- ☐ Tier 2 – group setting
- ☐ Tier 3 – one-on-one
- ☐ Other:_____

For each statement below, please mark the box for Not True, Somewhat True or Certainly True for before you began providing Tier 2 or Tier 3 services to the child and again as of today's date. It would help us if you answered all items as best you can even if you are not absolutely certain.

	Before you began providing services			As of today's date		
	Not True	Somewhat True	Certainly True	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐	☐	☐	☐
Shares readily with other children, for example toys, treat, pencils	☐	☐	☐	☐	☐	☐
Often loses temper	☐	☐	☐	☐	☐	☐
If between 4-11 years old: Rather solitary, prefers to play alone OR If over the age of 11: Would rather be alone than with other youth	☐	☐	☐	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐	☐	☐	☐
Many worries or often seems worried	☐	☐	☐	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐	☐	☐	☐
Has at least one good friend	☐	☐	☐	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐	☐	☐	☐
Generally liked by other children	☐	☐	☐	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐	☐	☐	☐

	Before you began providing services			As of today's date		
	Not True	Somewhat True	Certainly True	Not True	Somewhat True	Certainly True
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐	☐	☐	☐
Kind to younger children	☐	☐	☐	☐	☐	☐
Often lies or cheats	☐	☐	☐	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐	☐	☐	☐
Thinks things out before acting	☐	☐	☐	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐	☐	☐	☐
Many fears, easily scared	☐	☐	☐	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐	☐	☐	☐

Do you have any other comments or concerns?

_____

_____

_____

_____

Since providing Tier 2 or Tier 3 services, are this child's problems:

- ☐ Much worse
- ☐ A bit worse
- ☐ About the same
- ☐ A bit better
- ☐ Much better

Has providing Tier 2 or Tier 3 services been helpful in other ways, e.g. providing information or making the problems more bearable?

- ☐ Not at all
- ☐ Only a little
- ☐ A medium amount
- ☐ A great deal

- ☐ Don't know

Over the last month, do you think that this child had difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get along with other people?

- ☐ No
- ☐ Yes – minor difficulties
- ☐ Yes – definite difficulties
- ☐ Yes – severe difficulties

If you have answered "Yes", please answer the following questions about these difficulties:

Do the difficulties upset or distress the child?

- ☐ Not at all
- ☐ Only a little
- ☐ A medium amount
- ☐ A great deal

Do the difficulties interfere with the child's everyday life in the following areas?

- Peer relationships
  - ☐ Not at all
  - ☐ Only a little
  - ☐ A medium amount
  - ☐ A great deal
- Classroom learning
  - ☐ Not at all
  - ☐ Only a little
  - ☐ A medium amount
  - ☐ A great deal
  - ☐ Don't know

As far as you know, do the difficulties disrupt the child's classroom as a whole?

- ☐ Not at all
- ☐ Only a little
- ☐ A medium amount
- ☐ A great deal
- ☐ Don't know

Thank you very much for your help.

This version of the Strengths and Difficulties Questionnaire has been modified from its original form to best fit the needs of this project. The original SDQ was created by Robert Goodman. Additional information about the SDQ is available on the SDQ website.

Appendix H: Caregiver Interview Protocol

Introduction: We're from PIE (Planning, Implementation & Evaluation), which is a Chicago-based national provider of evaluation, strategic planning and capacity-building services for mission-driven organizations. PIE is the external evaluator for the COVID School Wellness Initiative, which is a statewide project that seeks to strengthen social and emotional learning supports in public schools. The Illinois Children's Healthcare Foundation is the grantor. Your school's partner, **CSWI GRANTEE**, is a grant recipient in this initiative.

Thank you for talking with me today. We anticipate that this conversation with you will take about 15-20 minutes. Our goal for today is to learn from you about how the efforts by **GRANTEE** have impacted you, your child(ren), and the broader **COMMUNITY NAME**. Anything you share during this discussion will not be shared directly with **CSWI GRANTEE**. Rather, your insights will be aggregated with the themes we glean from conversations with other schools and school districts across the state and provided to the Illinois Children's Healthcare Foundation, the funder of this initiative.

1. What activities provided by **GRANTEE** have you or your child participated in?
    a. Why did you choose to participate?
2. What benefit have these activities had on you/your child/family/community?
    a. Can you provide specific examples?
3. Have you experienced any challenges when participating in those activities?
4. Did participating in this intervention change the way you or your child thinks about mental health? If so how?
5. What are some of the greatest needs in your community especially around mental health support? What else would you like to see occur in your community?
    a. How can **GRANTEE** support this?
6. Is there anything else you would like to share that we have not already asked about?

Thank you for taking time to share about your experiences with **CSWI GRANTEE**. If you think of any additional feedback that you would like to share, please feel free to email Keirstin McCambridge at keirstin@pieorg.org.

Appendix I: Final Grantee Interview Protocol

Thank you for taking the time to speak with me today. Our conversations will help us understand the impact CSWI funding has had on your organization and the impact your organization has had on the communities you intended to serve. We anticipate this conversation to take approximately 60 minutes. If you have any questions during the course of this meeting, please feel free to ask them.

Anything you share during this discussion will not be shared directly with the IL Children's Healthcare Foundation. Rather, your insights will be aggregated with the themes we glean from all CSWI grantees and provided to the Illinois Children's Healthcare Foundation.

1. *(All)* To start, please introduce yourself.
   a. Name, role in organization, role within the CSWI grant, how long have you been in your role

2. *(Targeted to grant admin)* What were your CSWI program's goals? How did you intend to impact the community?
   a. Do you believe you met these goals?
   b. Why or why not?

3. *(All: admin first and specific about students/families from provider)*What have been your CSWI program's most impactful successes over the past 2.5 years?
   a. Can you provide specific examples?
   b. From a service provider standpoint, what benefit has your work had on the students and families you serve? Can you provide specific examples?

4. *(All)* What have been the largest challenges or barriers to your CSWI success?
   a. Can you provide specific examples?

5. *(Provider first)* How would you describe the community's perceptions of mental health?
   a. How does this impact your work?
   b. How have you seen these perceptions change over the past 2.5 years?

6. *(All)* How, if at all, were parents/caregivers/families involved in the planning and implementation of your CSWI activities?
   a. What about students/youth?
   b. (If applicable)How has the inclusion of parents/caregivers/families in the program planning and implementation affected the design, work, and/or results?

7. *(Admin)* Do you intend to continue your CSWI efforts once the grant ends?
   a. Why or why not?
   b. If yes, how will you sustain these activities? (E.g., new funding?)

8. *(Provider first)* What other resources do you believe are needed to best serve the community?
    a. How can your organization support this?

9. *(Admin first)* What additional resources does your organization need to continue supporting the community?

10. *(All)* Is there anything else you would like to share?

Thank you for taking time to share about your important work. If you think of any additional feedback that you would like to share, please feel free to email Keirstin McCambridge at keirstin@pieorg.org.