1. TITLE PAGE

IPP Organization Name:	Catholic Charities of the East Bay (CCEB)
CDEP Name:	Experience Hope for Teens
Priority Population:	African American Youth
Local Evaluation Time Period:	September 2017 – June 2021
Local Evaluator:	Moira DeNike, Ph.D. (external consultant)

This program and the local evaluation were made possible by the California Department of Public Health (CDPH) through the Phase 2 funding opportunity of the California Reducing Disparities Project (CRDP).

11/1/2021: REVISION

Table of Contents

2. EXECUTIVE SUMMARY

Synopsis of the CDEP purpose/description

Experience Hope for Teens is a school-based intervention that aims to prevent and reduce trauma-related behavior problems for African American students by increasing their access to trauma-informed services, increasing school capacity to respond in a non-punitive, healing-focused and restorative manner to trauma-related behavior, and decreasing students' trauma symptoms, such as Posttraumatic Stress Disorder (PTSD), anxiety, depression, dissociation, internalizing, externalizing, and complicated grief reactions. This Community Defined Evidence Program (CDEP) is designed to create culturally-responsive places of healing in the African American community. The program comprises clinical services delivered by a qualified African American clinician at a school-based setting, nonclinical restorative groups delivered by a trained African American youth engagement/restorative justice specialist, and training and technical assistance to school personnel. The CDEP, Experience Hope for Teens, has been delivered at Montera Middle School, a public 6th-8th grade school in Oakland Unified School District (OUSD), from the 2017-18 school year through the 2020-21 school year. The program serves African American youth in grades 6 through 8 of any gender. Both groups and individual services are offered weekly and operate for the full school year – enrollment is rolling and youth may join as they are referred by self, parent, or school personnel.

The program operated for four years (2017-18, 2018-19, 2019-20, and 2020-21), during which time evaluation measures were taken toward the end of the students' participation in groups or individual clinical services. The number of students served annually averages 26.

Evaluation questions

The questions guiding the evaluation of the CDEP are as follows:

- Is the student referral system working to funnel the right students to the program? (Process)
- What is the average dosage participants are receiving? (Process)
- Are participants in clinical services showing a reduction in trauma symptoms, improvements in safe coping, or an increase in protective factors? (Outcome)
- Are all participants (including those in nonclinical groups) feeling good about the groups and showing improvements in safe coping, or an increase in protective factors? (Outcome)
- How much training and technical assistance (TA) was delivered to teachers and other school personnel? (Process)
- How did school personnel perceive the trainings and TA, and did they have an impact on their practices, especial in relation to African American students? (Process)
- Have indicators of positive school climate (e.g., sense of fairness and connection to adults) improved for African American students during the program period? (Outcome)
- Have suspension rates for African American students improved during the program period? (Outcome)

Evaluation research design

In order to answer the evaluation questions, Moira DeNike, Ph.D., contracted by CCEB as the local evaluator for this CDEP, worked with CCEB to implement the following evaluation design.

- To assess process measures such as the effectiveness of referral system, dosage, and training and technical assistance delivery, the local evaluator reviewed CCEB's internal data management system reports;
- To assess reductions in trauma symptoms among clinical service clients, the local evaluator conducted analyses of CCEB's Retrospective Trauma Symptom Pre-Post (adapted from Posttraumatic Symptom Scale - Self-Report (Foa, et al., 2018));
- To assess improved social-emotional skills and resiliencies among all clients, the local evaluator conducted analyses of the customized CCEB Skills Tool Retrospective Pre-Post (which was designed using questions from WestEd's California Healthy Kids Survey (CHKS) and the SAMHSA National Outcome Measures for Mental Health, then refined using input from Experience Hope youth);
- To assess the impact of training and technical assistance, the local evaluator used post-training questionnaire data as well as school personnel CHKS data;
- To assess school-wide changes among African American students in terms of school culture and climate indicators such as perceived fairness and connection to caring adults, the local evaluator used CHKS results from multiple years; and
- To assess school-wide changes in terms of African American student suspension rates, the local evaluator used OUSD's official suspension data from multiple years.

Additionally, in February of 2019 the local evaluator also worked with students to review and refine evaluation processes and tools. For all program years thereafter local evaluator conducted interviews or focus groups with students to capture qualitative data regarding the program's strengths and areas for growth. In the final program year, the local evaluator interviewed school personnel and some parents regarding program impact, strengths, and challenges.

Key findings

The evidence gathered in this inquiry revealed the following:

- Experience Hope served a total of 103 youth through clinical and nonclinical services combined, with 53 specifically receiving clinical services. The yearly count of students served in the four program years was: 22, 31, 33, and 40.
- Clients in Experience Hope clinical services saw statistically significant reductions in trauma symptoms (the average score declining from 15 to approximately 9).
- A large majority of participants in Experience Hope's clinical and nonclinical supports showed gains in skills and resiliencies (nearly 89%). Mean differences were statistically significant both overall as well as in the three domains of Restorative & Conflict Resolution Skills, Social Emotional Competencies, and Support Resources.
- The program delivered training and technical assistance to Montera staff and faculty in 2018-19, 2019-20, and 2020-21.
- The proportion of Montera Middle School teachers reporting competencies in trauma-informed de-escalation techniques increased from 59% in the baseline school year to 94% in the most recent school year.
- California Healthy Kids Survey (CHKS) student survey results do not show consistent improvements in Black student perceptions of fairness or student-adult connectedness.

- African American suspension rates declined by 38% from the baseline year to the final in-person school year.

Conclusions and recommendations

These data findings point to the following conclusions:

1. That students served by Experience Hope for Teens in both clinical and nonclinical supports have benefitted. On average clinical clients experienced reduced trauma symptoms, and program participants in general experienced improved skills and resiliencies.
2. That school personnel, students, and parents are particularly appreciative of the cultural responsiveness of the program and the fact that it brought skilled Black practitioners into the school setting to support Black students and bridge gaps between faculty and youth.
3. That suspension rates have declined and adult competencies in trauma-informed de-escalation have improved during the program period, demonstrating progress toward increasing school capacity to respond in a non-punitive, healing-focused and restorative manner to youth behavior.
4. That despite these improvements, systemic problems at the school persist. Namely, Black students continue to be suspended at a far higher rate than the school-wide rate, and, according to CHKS results, African American students continue to report that the school does not treat students fairly and that adult connection is inconsistent.

It is recommended that CCEB continue to deliver the model, at the current site and/or at other sites. Future implementations could include a comparison group to help establish the program as an evidence-based model. It is also recommended that CCEB continue to investigate levers that may be effective in moving school climate and culture toward greater racial equity.

3. INTRODUCTION/LITERATURE REVIEW

Catholic Charities of the East Bay's (CCEB's) school-based program, Experience Hope for Teens, addresses traumatic stress as a result of exposure to violence among African American youth – a need specifically described in the CRDP African American Population Report (Woods, et al., 2012). Adolescents confronted with chronic exposure to violence face serious risks to their mental health and, if left untreated, traumatic experiences can lead to the onset or worsening of debilitating mental illness and other mental health consequences.

High levels of community violence, poverty, and trauma exposure are distressingly commonplace among Oakland's African American population. According to congressional briefings by the Centers for Disease Control (CDC) Director of the Division of Violence Prevention, low-income youth living in inner cities show a higher prevalence of post-traumatic stress disorder (PTSD) than soldiers in combat zones. These children are discussed as "living in combat zones," where exposure to violence may be prolonged and repeated in multiple environments, according to Howard Spivak, former Director of the CDC Division of Violence Prevention (Karpman, 2012).

Ongoing, repeated exposure to trauma has extremely negative effects on both individual students and the overall academic environments at local schools. According to The National Child Traumatic Stress Network, up to 40% of K-12 students have experienced, or been witness to, traumatic stressors in their brief lives (Brunzell, Waters, & Stokes, 2015). The childhood trauma may manifest itself as external

problems such as oppositional and defiant behavior or internal problems such as anxiety and depression (Alvarez, et al., 2015). Trauma exposure at an early age may result in impairments to emotional development, behavior regulation, and attention, as well as symptoms of posttraumatic stress and dissociation (Price, et al., 2013). It is not uncommon for children exposed to trauma to exhibit aggression or problems with emotional regulation (Monahon, 1993). Poly-traumatization or complex trauma involves multiple exposures to traumatic events and is more closely associated with trauma symptoms (Alvarez, et al., 2015). Brain development is affected by trauma, which means that students who have experienced trauma may show deficits in memory tasks and verbal declarative memory, emotional regulation in the classroom, less creativity and flexibility in problem-solving, and challenges with abstract reasoning and executive.

According to some definitions of trauma, African Americans and whites have similar lifetime likelihood of exposure to traumatic events, but African Americans are more likely to develop PTSD (Roberts, Gilman, et al., 2011). This research should be considered within the context of racism – research has established that experiencing life in America as a Black person can in and of itself create traumatic stress (Carter, 2007; Hardy, 2013; Williams, 2015). In "The Hidden Wounds of Racial Trauma," Dr. Kenneth Hardy, a psychology professor specializing in treating the trauma of racial oppression, describes how being Black in America often entails repeated experiences of being systematically devalued, which, in turn, result in feeling demonized, unworthy, hyper-vigilant, and exceptionally concerned with "respect" (Hardy, 2013).

This layering of stress factors in the lives of African Americans takes its toll. According to the US Health and Human Services (HHS) Office of Minority Health findings from 2016, African Americans are more likely to have feelings of sadness, hopelessness, and worthlessness, and are 20 percent more likely to report serious psychological distress than whites. HHS also reports that African American teenagers are more likely to attempt suicide than are white teenagers (8.3 percent v. 6.2 percent), and that African Americans of all ages are more likely to be victims of serious violent crime than are non-Hispanic whites (US HHS, Office of Minority Health, 2018). A study based on interviews with 34,653 individuals in the US population found that among all ethnic groups, African Americans had the highest prevalence of PTSD (8.7%) and were more likely to experience maltreatment in childhood (Roberts, Gilman, et al., 2011). According to 2016 data reported by the American Psychological Association, African Americans are also twice as likely as non-Hispanic whites to be diagnosed with schizophrenia (Coleman, et al., 2016).

Despite these prevalence rates, Roberts, Gilman, et al. (2011), also found that racial minorities were less likely to seek treatment as compared to white respondents, with only 35.3% of African Americans with PTSD seeking treatment (compared with 53.3% of whites similarly situated). Another study found that people who reported experiencing frequent or very frequent everyday discrimination are significantly less likely to seek mental health services, with African Americans being the most affected ethnic group (Burgess, et al., 2008). Furthermore, when African Americans engage in mental health services, they are more likely than other ethnic groups to drop out before completing treatment (Snowden, 2001).

High rates of traumatic stress, when combined with school settings that emphasize conformity, are poorly-resourced, and are subject to the same patterns of institutional racism and implicit bias that pervade the rest of American society, create a difficult set of circumstances for African American youth. The National Child Traumatic Stress Network lists behavior problems in school, including disruptive, reckless, and aggressive behavior, as anticipated results of trauma in children and youth (Brunzell,

Waters, & Stokes, 2015). Unfortunately, schools are ill-equipped to address the challenges associated with childhood trauma exposure. School personnel are more likely to punish trauma symptoms in African American youth than provide help; a review of school suspension data from the 2015-16 Civil Rights Data Collection showed that Black students are more likely to receive suspensions, expulsions, or referrals to law enforcement, while white youth are more likely to be offered special education services or medical and psychological treatment for the same sorts of misbehaviors (Riddle & Sinclair, 2019). The Council on State Governments' Consensus Report on School Discipline supports the same finding, asserting that schools punish students of color, and African American students in particular, more harshly than others (Morgan, et al., 2014). Part of the reason for this is that trauma is often misunderstood by school officials who respond in punitive ways to behavior that is the result of a student's exposure to trauma. This report also argues that implicit bias in our schools is a factor that contributes greatly to disproportionate discipline (Morgan, et al., 2014).

These data and patterns indicate that there should be a more trauma-informed response to student behavior among all school personnel, more supportive mental health services available to students where they can access them without barriers, and a more culturally-responsive approach to African American students who exhibit signs of distress, including but not limited to disruptive, reckless, or aggressive behavior.

African American students' experiences in the American school system must also be historically contextualized all the way back to the era of slavery. During that time, it was not legal in many states for an African American to learn to read. While the abolition of slavery changed the legal restrictions on African Americans' freedom to learn, the prejudice and belief systems that allowed the enslavement and de-humanization of Black adults and children did not change so easily. School segregation was a predominant practice, not only in former slave states, but in communities throughout the country. Under that system, schools for non-white students were not resourced at the same level as schools for predominantly white children and youth. With Brown v. Board of Education (Warren & SCOTUS, 1954), that changed, but in came new practices that perpetuated unequal opportunity, including racialized tracking and assignment of less qualified teachers to lower-tracks. The de-segregation movement of the sixties and seventies did serve to place African American and non-African American students in the same schools, but it did not ensure that they would receive the same educational opportunities. The pervasiveness of implicit and explicit bias against African American students still lives in district policies that create newly segregated schools (based this time on "school choice" school assignment systems), exorbitantly high teacher and administrator turnover at low-income schools, and disciplinary practices that consistently result in the highly disproportionate exclusion of African American students from the learning environment.

Nationally, according to data from the Department of Education's Office for Civil Rights, African American students are three-times as likely to be suspended as white students (US DOE OCR, 2016). According to data from Oakland Unified School District, they are eight times as likely. These differences have understandably raised concerns within the African American community.

Advocacy groups in Oakland, including the Black Organizing Project, have identified the disproportionate use of exclusionary discipline on African American students as a key community concern. Suspension from school has been found to have a direct correlation to juvenile and criminal justice involvement, creating the "school-to-prison pipeline." The American Civil Liberties Union (ACLU) defines the school-

to-prison pipeline as, “a disturbing national trend wherein children are funneled out of public schools and into the juvenile and criminal justice systems. Many of these children have learning disabilities or histories of poverty, abuse, or neglect, and would benefit from additional educational and counseling services. Instead, they are isolated, punished, and pushed out” (ACLU, 2021). The data show clearly that the pipeline is disproportionately funneling African American students into the justice system, a significant factor in what is being called the new Jim Crow, leaving millions of people – overwhelmingly men of color – locked out of employment, housing, education, and the right to vote because of a criminal record.

The treatment approach employed through Experience Hope uses a trauma-informed restorative justice framework to address the needs of trauma-impacted African American youth. Restorative principles emphasize healing over retribution, understanding over punishment, and dialogue over silence. By placing behavior in context and seeking to understand the stresses in each student’s life, trauma-informed restorative practice provides an organic cultural-responsiveness that respects individual circumstances and leads to healing, not further traumatization or punishment. Traditional school-based responses to the problematic behaviors of trauma-impacted youth perpetuate cycles of traumatization, with serious long-term consequences for youth, schools, and communities. This is one of the factors which contributes to disproportionate suspension and expulsion of African American students. By approaching trauma-related behavior and mental health issues with a focus on healing rather than punishment, Experience Hope aims to stem the flow of the school-to-prison pipeline for African American students, to promote emotional well-being, and to provide culturally-affirming therapeutic supports to African American students.

4. CDEP PURPOSE, DESCRIPTION & IMPLEMENTATION

CDEP purpose including mental health outcomes

The CDEP, Experience Hope for Teens, has been delivered at Montera Middle School, a public 6th-8th grade school in Oakland Unified School District (OUSD), from the 2017-18 school year through the 2020-21 school year. Approximately 700 students are enrolled at Montera on average (note, enrollment dropped during the program period from 770 to 630), and African American students comprise approximately 30% of the student body on average (note, the African American proportion of the student body dropped during the program period from 37% to 28% - See Table 1 below).

Table 1: Montera Demographics	2017-18	2018-19	2019-20	2020-21	Total
AA population as % of student body	37% (286/774)	33% (240/730)	30% (201/676)	28% (177/634)	32% (904/2814)
Female students as % of AA pop	43% (122)	46% (110)	49% (98)	49% (87)	46% (417)
Male students as % of AA pop	57% (164)	54% (130)	51% (103)	51% (90)	54% (487)

African American students at Montera at the time that the CDEP began were experiencing disproportionate suspensions, and, as in most public schools, there was little capacity among school personnel to understand or respond appropriately to trauma. There were also few on-campus resources for students to access culturally-responsive, trauma-informed, restorative supports for mental health and well-being. Furthermore, members of the school community were expressing concern for how Black students were being treated at Montera.

The CDEP was, therefore, designed to achieve the following outcomes:

- All students participating in any Experience Hope services and supports (including nonclinical groups) will demonstrate improved skills and resiliencies related to emotional well-being;
- Clients receiving clinical services will demonstrate reduced trauma symptoms;
- Trainings/professional development for school personnel will result in improvements in participant skills;
- School-wide African American students will demonstrate an improvement in their perception of key indicators of school culture and climate (e.g, fairness and adult connection); and
- School-wide African American students will be less likely to be subjected to suspension.

CDEP description & implementation process

Catholic Charities of the East Bay (CCEB) established a working partnership with Montera Middle School over the course of the four years that the program was implemented. CCEB put in place Experience Hope staff (one restorative justice practitioner and one mental health clinician) to support African American students at Montera. While there were personnel transitions among the Experience Hope staff, all of the individuals hired for these positions were African American to help ensure cultural resonance with the target population.

Experience Hope incorporates African American values and cultural practices in a number of ways. First, the program is nested in restorative practices which CCEB leverages as a cultural engagement tool, recognizing the importance of relational motivators among African American youth. These restorative practices are centered in the collective spirit of African Americans' ancestors and focused on healing, which is a demonstrated need among African American youth (Hardy, 2013). Experience Hope staff also work to build awareness among youth and school staff around implicit bias, systems of oppression, and the impact of trauma. The program also offers gender-responsive content in groups and individual sessions, focused on toxic masculinity within the context of race and culture and healthy relationships. Discussion topics cover racism, de-funding the police, Black Lives Matter, police-sanctioned homicide, disproportionate impact of trauma and systems on Black individuals and families, and racial disparities within health care systems. The program aims to support Black youth in finding their voices, self-advocacy, and empowerment.

The CDEP constitutes four components: Clinical Treatment, individual (Component 1) and group (Component 2); Nonclinical groups (Component 3), and training and technical assistance for the school (Component 4).

Component 1:

For the Experience Hope program at Montera, CCEB adapted the evidence-based practices (EBP) of Trauma and Grief Component Therapy for Adolescents (TGCTA) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) so that they 1) are specifically geared to be culturally-affirming for African American youth, and 2) can be delivered in a school-based setting. Individual (Component 1) and group clinical treatment (Component 2) sessions were offered during school hours and after school – students could access the therapist during free times (lunch hour), advisory period, and after school, and some students would be pulled out of classes for therapy, as well.

Most clinical service participants had weekly sessions that, while ideally set for 60 minutes, were often shorter (30 to 50 minutes) based on the school schedule. The duration of individual therapeutic engagement could go from referral date to the end of the school year or longer, depending on the needs

and preferences of the client, and their grade in school (i.e., graduating 8th graders could not continue with services once they continued on to high school as Montera is a 6th-8th grade school).

This component reached approximately 5 students per clinical case manager (CCM) at any given time (this program funds 1 FTE CCM). As students rotated through clinical services, the CCM generally maintained 5 clinical clients at any given time (please refer to the table in Section 6 of this report for the full breakdown of participants). Participants were middle school students who identify as Black/African American (including some Black/African American mixed race).

Services were delivered primarily at the school site. Students were welcome, however, to access services at the CCEB office, at their homes, or other locations where the participant felt comfortable, and, during Covid-19-related school closure, services were accessed via video calls.

The CCEB-employed clinical case manager delivered individual treatment in 30-60 minute one-on-one or group sessions with clients, in a private room at the school. The room was decorated to reflect cultural elements for the youth, including through posters, circle centerpieces, etc.

The process for service delivery took place as follows: 1) Students were self-identified or identified by school personnel; 2) students and their parents/guardians were offered the opportunity consent to services, 3) if they consented, they were referred to CCEB CCM; 4) Student and CCM would meet for three or more sessions during a period of engagement and assessment to begin to build an authentic relationship prior to beginning treatment; 5) Students enrolled in continuous (rolling) cycles (which could begin at any time in the school year), and continued throughout the school year or longer, as needed; 6) after enrollment in treatment, CCM facilitated clinical assessments as appropriate – this included the CRDP-required SWE Core Measures tool (clients had the right to refuse to participate in evaluation measures without jeopardizing access to services); 7) At the end of the session or school year, participants were invited to complete the two local evaluation tools: a) the Retrospective Trauma Symptom Pre-Post (adapted from Posttraumatic Symptom Scale - Self-Report (Foa, et al., 2018)), and b) the customized CCEB Skills Tool Retrospective Pre-Post (clients had the right to refuse to participate in evaluation measures without jeopardizing access to services).

Clinical treatment was delivered by an African American clinician who was trained in restorative practices and received specific training in TGCTA and TF-CBT, as well as culturally-affirming practices. TGCTA and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) are psychosocial treatment models designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents ages 3 to 18 years. Cognitive Behavioral Therapy is a long-established treatment approach with adolescents (Benjamin, et al., 2011), shown to be effective in particular with adolescents experiencing anxiety (Garcia & O'Neil, 2020; Villabø, et al., 2018; Wehry, et al., 2015). Component 1 integrates cognitive, behavioral, interpersonal, and family therapy principles as well as trauma interventions. Neither modality has a pre-established number of sessions to be applied for every client. Instead, therapy may range from several months to a year or more. Students who participated in this component received between 6 and 80 hours of treatment services, depending on when in the school year they enrolled, and how long they persisted with services and/or remained enrolled at the school.

The core component of this element of the program model is the integration of restorative practices with evidence-based trauma treatment and culturally-responsive delivery. Restorative practice uses elements of traditional African American cultural discourse, placing emphasis on cultural and

community context. Because evidence suggests that Black students are frequently and consistently discriminated against and marginalized by mainstream culture, CCEB felt it was important to incorporate a critical analysis of greater societal context into treatment, especially when students were referred to the program for being disruptive, defiant, or otherwise nonconforming. CCMs used restorative inquiry to understand the circumstances and help the student understand his/her/their own reactions and feelings in the situation, asking questions like "what happened?" "who was harmed?" "how can the harm be repaired?" and "how are you feeling about the incident now?"

Component 2:

Component 2 is identical to Component 1 except that it therapeutic services are offered in groups. Group size ranged from two to ten participants and had the same time limitations reflected in the above description of Component 1. Students who were not comfortable sharing in a group setting did not participate in Component 2.

Component 3:

Nonclinical restorative groups took place weekly over 30-to-60-minute sessions that were initially designed to continue from a date in mid-September through the end of the semester (mid-December), with a second session (which could involve some students or new students) beginning mid-January and ending at the end of May. In reality, students were often identified mid-session, in which case they would be invited to join on a rolling basis.

This component reached 8-12 students per group. The participants were middle school students who identify as Black/African American (including some Black/African American mixed race). Nonclinical restorative groups were offered during school hours and after school – during free times (lunch hour), advisory period, and after school. Services were delivered at the school site, although during Covid-19-related school closure, services were accessed via video calls.

A CCEB-employed African American youth engagement/restorative justice specialist facilitated nonclinical groups, sometimes in partnership with the CCM, in a private recreational room at the school.

The process for service delivery took place as follows: 1) Students were self-identified or identified by school personnel; 2) students and their parents/guardians were offered the opportunity consent to services, 3) if they consented, they were referred to CCEB youth engagement/restorative justice specialist; 4) Students enrolled in continuous (rolling) cycles (which began at the beginning of each semester but were not closed to new participants who wished to join later), and continued throughout the school year; 5) Once engaged and consented, students were invited to complete the CRDP-required SWE Core Measures baseline tool (clients had the right to refuse to participate in evaluation measures without jeopardizing access to services); 6) At the end of the session or school year, participants were invited to complete the customized CCEB Skills Tool Retrospective Pre-Post as a part of the local evaluation, as well as the SWE Core Measures post tool (clients had the right to refuse to participate in evaluation measures without jeopardizing access to services).

The core component of this element of the program model included implementing a "circles" approach that allows all participants to speak and know they are being heard. The group established ground rules for themselves that call for all participants to respect others' perspectives and allow them to talk. Only the individual holding the "talking piece" could speak, providing an assurance that everyone would have the chance to tell their story or perspective without interruption. In the event of a breach of the group

values and guidelines, it is the group – and not the adult facilitator – to respond to that breach, helping to redistribute and share power. This is a fundamental difference between this CDEP and traditional school-based and therapeutic practices where it is the adult facilitator who holds the power. Other components included the use of an Afrocentric centerpiece – particularly when the topic of the session was weighty or if the group needed to address a conflict, some harm, or create healing. The centerpiece could comprise elements of cultural significance – a cloth or carving – as well as elements of the natural world, such as a plant, water, or a candle. A core element of this component is a recognition of the adaptive nature of trauma responses and skills-building to enable students to succeed in the often-triggering environment of schools. Participants were encouraged to talk about their social and emotional responses to challenging situations at school and at home, with peers, school adults, family members, etc. The focus was on building empathy, compassion, self-regulation, interpersonal skills, and supportive relationships.

Component 4:

The training and technical assistance (TA) component depended on the shifting needs and readiness for change at the school. CCEB delivered around 7.5 hours of training to general school staff in trauma-informed de-escalation, secondary/vicarious trauma, youth Mental Health First Aid, restorative practices, and Implicit Bias. Experience Hope Clinical Case Managers and other CCEB staff additionally provided *ad hoc* psychosocial information and support as need and opportunity arose throughout the school year using the mental health consultation model. The training reached 100% of school administrators, 100% of restorative justice coordinators, and 80% of teachers. The mental health consultation reached a smaller proportion of the faculty – estimated at 10%. The participants in this component vary in terms of demographic features, although the majority is female, and are all adults.

Trainings were generally delivered at the school site by CCEB personnel with expertise in the Experience Hope for Teens model, or by qualified consultants. Trainings as well as ongoing technical assistance were offered annually during the summer and throughout the school year.

The core elements of the training and TA focused on helping school personnel understand the impact of trauma on student behavior, providing them with tools to be more trauma-informed and restorative, and raising their awareness of racial biases and how to dismantle them. Training and TA were meant to be highly relevant to the daily work of school personnel, included the use of data, and provided participants opportunities to practice and reflect upon what they were learning.

In order to establish a presence on campus, Experience Hope staff comingled with Montera faculty and staff, attended staff and faculty meetings, and publicized that they were available to support African American students and, to that end, that they would support faculty and staff with psychosocial information and mental health consultation. TA was *ad hoc* and offered to teachers who were receptive to mental health consultation. The CCA specifically built relationships with the teachers who were working with students in individual and group treatment to ensure coordinated support (without violating client-clinician confidentiality). Both Experience Hope staff members worked with these teachers and other staff to help them build de-escalation skills, adopt universal trauma-informed precautions with students, intentionally dismantle implicit bias, and understand the hidden wounds of racial trauma. Helping school personnel explore their own biases and traumas in a supportive, experiential setting can help shift the lens with which they view Black youth.

Participation

Unfortunately, participant attrition was not tracked as a separate data point. CCEB records do show that the program was generally operating at capacity, however. The table below shows the number of program participants as a proportion of the school's African American population each program year – note that the proportion of the school's African American students that the program engaged increased annually throughout the lifetime of the program, as the program became better known among school personnel, students, and families.

Table 2: Experience Hope Participants as Proportion of Montera African American Pop	2017-18	2018-19	2019-20	2020-21	Total
Experience Hope Participants	22	31	33	40	103
AA Population at Montera	286	240	201	177	904
% AA Students Served	8%	13%	16%	23%	11%

5. LOCAL EVALUATION QUESTIONS

The purpose of the CDEP is to provide culturally-responsive prevention and early intervention supports to African American students, recognizing and responding to trauma, focusing on healing and repairing harm, reducing trauma symptoms, and increasing resiliency, in a school where Black students are disproportionately penalized (suspended) for behaviors that may have an association with experiences of trauma (including racism). The questions guiding the evaluation of the CDEP, therefore, are as follows:

- Is the student referral system working to funnel the right students to the program? (Process)
- What is the average dosage participants are receiving? (Process)
- Are participants in clinical services showing a reduction in trauma symptoms, improvements in safe coping, or an increase in protective factors? (Outcome)
- Are all participants (including those in nonclinical groups) feeling good about the groups and showing improvements in safe coping, or an increase in protective factors? (Outcome)
- How much training and technical assistance was delivered to teachers and other school personnel? (Process)
- How did school personnel perceive the trainings and TA, and did they have an impact on their practices, especial in relation to African American students? (Process)
- Have indicators of positive school climate (e.g., sense of fairness and connection to adults) improved for African American students during the program period? (Outcome)
- Have suspension rates for African American students improved during the program period? (Outcome)

The local evaluator was able to locate data, both qualitative and quantitative, to answer all of the above listed evaluation questions.

6. EVALUATION DESIGN & METHODS

Design

The evaluation uses mixed methods, including both quantitative and qualitative data sources, as noted in Table 3 below which lists out data sources for each evaluation question. Note the evaluation design

does not incorporate a comparison group and does not constitute an experimental or quasi-experimental study.

Table 3: Evaluation Design Table Evaluation Question	Indicator	Measurement Tool	Qualitative (QL) or Quantitative (QT)
Is the student referral system working to funnel the right students to the program?	Program components 1, 2 and 3 are at capacity each year	CCEB data management system reports	QT
What is the average dosage participants are receiving?	Participants receive between 6 and 80 hours of engagement in clinical and/or nonclinical services	CCEB data management system reports	QT
Are participants in clinical services showing a reduction in trauma symptoms, improvements in safe coping, or an increase in protective factors?	Clinical clients show reduced trauma symptoms (and other improvements) between pre and post self-reporting	CCEB's Retrospective Trauma Symptom Pre-Post	QT
Are all participants (including those in nonclinical groups) feeling good about the groups and showing improvements in safe coping, or an increase in protective factors?	All participants show improvements in skills and resiliencies; Students interviewed talk about positive program impacts	CCEB Skills Tool Retrospective Pre-Post; Interviews/focus groups	QT; QL
How much training and technical assistance was delivered to teachers and other school personnel?	A majority of Montera personnel receive training in trauma-informed, restorative, anti-bias principles	CCEB data management system reports	QT
How did school personnel perceive the trainings and TA, and did they have an impact on their practices, especial in relation to African American students?	Post-training questionnaires; Interviewed personnel talk about positive program impacts	Post-training questionnaires; Interviews	QT; QL
Have indicators of positive school climate (e.g., sense of fairness and connection to adults) improved for African American students during the program period? (Outcome)	CHKS questions about perceived fairness and connection to adults show improvement during program years	CHKS data from 2016-17 through 2020-21	QT
Have suspension rates for African American students improved during the program period?	African American suspension rates decrease during program years	Suspension data from 2016-17 through 2020-21	QT

In addition to answering the above listed evaluation questions, the local evaluator aimed to incorporate insights from program participants to both interpret data and to improve evaluation tools and processes. The engagement of youth participants as partners in data interpretation is consistent with Community-Based Participatory Research (CBPR), founded in the principle that opportunities to partner in evaluation can both empower program participants and lend to improved insight (Israel, et al., 1998). Annually the local evaluator gathered a group of Experience Hope participants for a focus group (during the final year, the local evaluator conducted one-on-one interviews via video calls – please see the table in Section 6 of this report for a full breakdown of focus groups and interviews, including the number of participants). Focus groups and interviews were loosely structured and utilized culturally responsive interviewing practices (Hass & Abdou, 2019) – focus group and interview questions are in the Appendix.

In February of 2019, the focus group consisted of two phases: 1) an open discussion about program impacts and ways to improve the program, and 2) a data presentation and tool review session. The purpose of this process was to recognize that the African American youth themselves had valuable insight into how the program could be evaluated, and to incorporate their wisdom into the local evaluation plan. During the data presentation, participants were asked to help interpret findings and offer elaboration on what the quantitative data showed. They were also asked to review the evaluation tools themselves and to guide any revisions they would like to see to make the evaluation more effective at capturing their experiences. The following youth-led recommendations informed the evaluation approach thereafter:

- Youth recommended shortening the tools significantly. They indicated which questions on the CCEB Skills Tool corresponded most closely with their experiences of the program and suggested that the others be eliminated from the evaluation process – the tools were changed accordingly;
- They expressed a preference for a one-time data collection, at the end of the program rather than two points (at baseline and follow-up) – this prompted the conversion of the Trauma Symptom tool to a retrospective pre-post (the CCEB Skills Tool already used this design); and
- They expressed frustration with the SWE Core Measures tool, both its length and its format, which they found confusing – no changes were made to the SWE Core Measures tools as these were not within the purview of the local evaluator.

Sampling methods and size

No sampling methods were applied – the evaluation utilized data from every participant that consented to participate in the evaluation. While some may have chosen to exempt themselves from completing the evaluation tools, the majority chose to participate, at least in providing responses to local evaluation tools (less so in terms of response rates to the SWE Core Measures Tool). While no sampling method applied to the universe of students being served in the program, the select identification of program participants in itself did, in a sense, comprise a purposive sample of the school population. Within that, because the program only served students attending one specific school, of whom program staff had been made aware through school triage systems, and who actually consented to be served by the program, it also, in some sense, met the definition of a convenience sample.

Inclusion and exclusion criteria included the following:

- Participants had to be students at Montera Middle School;
- Participants had to be referred by an adult or self-referred;

- Participants had to identify as Black/African American or mixed race inclusive of Black/African American;
- Participants had to be consented to participate in the program by parents/guardians, and had to assent to participate themselves; and
- Clinical clients had to meet the clinician's assessment that they would benefit from clinical supports and nonclinical participants had to perceive that they would benefit from nonclinical supports.

Those were the only criteria. Participation in the program in previous years did not exclude a participant from participation. School personnel were made aware of the program through Principal announcements, as well as intentional relationship-building between Experience Hope personnel and school personnel. Many youth also heard about the program through peers and self-referred.

All criteria were met for all consenting participants. Data were not kept on potential participants whose parents/guardians did not consent to participation. Below is a breakdown of participants each year:

CRDP Participants from 2017 to 2021							
Table 4: Participant Counts by Year	Nonclinical			Clinical			Unduplicated Total
Gender	Male	Female	Total	Male	Female	Total	
2017-18	2	6	8	4	10	14	22
2018-19	9	15	24	3	7	10	31
2019-20	3	29	32	9	12	21	33
2020-21	18	20	38	2	6	8	40
Total	32	70	102	18	35	53	103

Please note that many clinical clients also participated in nonclinical groups, hence the unduplicated total is not necessarily equal to the sum of nonclinical and clinical participants.

No power analysis was conducted because the aim was to include all program participants as evaluation participants, and evaluation participation was not to be forced.

In the end, the local evaluator received 116 completed CCEB Skills Tool Retrospective Pre-Post across the four years of the project. The number exceeds the total number of unduplicated participants (103), due to the fact that some participants returned for multiple years or sessions and therefore completed the tool more than once. The number of questionnaires received implies a high proportion of participants participated in this aspect of the evaluation, although since the tool was designed to be distributed anonymously, an actual percentage evaluation participation among CDEP participants is unknown. For clinical clients, the local evaluator received 13 completed Retrospective Trauma Symptom Pre-Post tools, representing just under 25% evaluation participation among CDEP clinical participants. This number is likely lower due to difficulty with the original pre-post tool used in the first two years of the program, as discussed elsewhere in this report.

On October 23, 2017, The Committee for the Protection of Human Subjects (CPHS) determined that the Experience Hope evaluation was "Exempt" and did not require CPHS approval to be conducted. This decision was issued under CPHS' Federalwide Assurance #00000681 with the Office of Human Research Protections (OHRP).

Measures & data collection procedures

There were two retrospective pre-post design tools used in the local evaluation of Experience Hope at the client level:

1) The CCEB Skills Tool Retrospective Pre-Post, and
2) The Retrospective Trauma Symptom Pre-Post tool.

The first tool was first created by CCEB (without the input of the local evaluator), utilizing questions from the following commonly utilized tools:

a) WestEd's California Healthy Kids Survey (CHKS), and
b) The SAMHSA National Outcome Measures for Mental Health SAMHSA.

The local evaluator pointed out to the CCEB team the risk of response-shift bias on several of the questions – as the program was likely to raise participants' awareness of social-emotional states and skills, the local evaluator worried that the increased awareness would artificially inflate post-test results, thereby giving the impression that the program had had a negative effect.

The local evaluator suggested a revision of the skills tool to a retrospective pre-post tool rather than a traditional pre-post tool. Research shows that a retrospective pre-post design can reduce response-shift bias and may therefore be a more valid and reliable way to measure impact than traditional pre-post designs (Bhanji, Gottesman, et al., 2012; Drennan & Hyde, 2007; Lang & Savageau, 2017; Skeff, Stratos & Bergen, 1992). Furthermore, in Experience Hope sessions, it was likely that youth would bring up behavior that is sensitive. Scholars show that a retrospective pre-post design can be helpful where social desirability is a factor (Hill & Best, 2005; Robinson & Doueck, 1994; Rosenman, Tennekoon & Hill, 2011), making it suitable for a program wherein youth may be reticent at baseline (before trust is established) to disclose personal and sensitive information that socially undesirable.

The CCEB team agreed, and the tool was adapted. It was a lengthy tool, however, with over 30 questions. This 30+-item retrospective pre-post tool was used the first year. After data from that first year had been processed, the local evaluator assembled a team of Experience Hope participants to inform evaluation design and refinement. The local evaluator presented data findings and asked participants to help interpret findings and offer elaboration on what the quantitative data showed. Participants were also asked to review the evaluation tools themselves and to guide revisions. The youth very clearly indicated that the 30-item tool was excessively long. Based on their input the tool was pared down to 17 items – those items the youth themselves identified as the most relevant and salient.

The CCEB Skills Tool Retrospective Pre-Post includes 13 questions pertaining to how students felt before participating in Experience Hope ("before") and how they felt at the time they were completing the questionnaire ("now"). On the tool, questions are posed as a 5-point Likert scale ("Strongly Disagree" to "Strongly Agree"). The closer the numerical score is to 5, the greater the degree of agreement. Questions ask participants to reflect upon their own skills (e.g., I think before I act, I stand up for myself without putting others down, etc.). It also includes 4 non-numerical questions (the actual tools is in the Appendix).

The second client-level tool used for the local evaluation of Experience Hope at Montera is designed to measure reductions in trauma symptoms. This initially was a true pre-post design using the clinical tool designed to accompany Cognitive Behavioral Intervention for Trauma in Schools (CBITS). The CBITS tool

measures symptoms of trauma, including anxiety, depression, and trouble regulating emotions and responses (e.g., irritability, hyperarousal) (Foa, et al., 2018). A team conducted a study to examine the tool's validity and psychometric properties of the tool. The study population comprised 45% African American youth. The self-report CPSS-5-SR was found to have high internal consistency for total symptom severity (Cronbach's alpha = .924), solid test-retest reliability (r = .800), convergent validity with CPSS-5-I (r = .904), and discriminant validity with another tool, the Multidimensional Anxiety Scale (MASC) for Children and Child Depression Inventory (CDI). The study established a cutoff score of 31 for a probable PTSD diagnosis in children (Foa, et al., 2018).

The original tool is designed to be administered as a true pre-post, wherein a baseline is capture at the beginning of the service term, and then is re-administered after the client has been engaged for several weeks. For this to work, clinicians must record identifying information so that pre-tests and post-tests may be matched for analysis. After using the tool the first year, the CCEB team and the local evaluator discovered a number of challenges:

1) Obtaining a baseline measure on a tool that asks sensitive questions about feelings and behavior is difficult, because:
    a. adolescent youth (especially those with histories of trauma) are notoriously reticent to open up to adults they do not yet know or trust,
    b. taking the time to establish trust can inflate the baseline, and
    c. there is some "social desirability" in answering questions in a way that makes it seem like there's nothing wrong.

    As a result, baseline measures sometimes paint a deceptively positive frame. By the time the follow-up measure is obtained, trust has usually been established, and clients feel more open to disclose the challenges they are experiencing. Ironically, then, pre-post data may show a worsening when in fact what has happened is a dropping of pretense.

2) Matching pre and post data means that identifiers must be tracked consistently, which can be a challenge for practitioners in the field and can translate to a lower number of cases for analysis than there were clients. In this case, matching was not being done with sufficient consistency to ensure a large number of matched pre-post datasets.
3) Experience Hope participants had endorsed a reduction in evaluative tools, especially at baseline.

For these reasons, the trauma symptoms tool for clinical clients was also adapted to conform to the retrospective pre-post design. The Trauma Symptoms Retrospective Pre-Post used in the Experience Hope program is an adaptation of a trauma symptom measurement tool that is used in the evidence-based CBITS model (Foa, et al., 2018). The adapted tool includes 16 questions now structured to ask participants the frequency with which they experienced various trauma symptoms "before" beginning clinical services versus "these days." The trauma symptoms listed on the tool include plain language descriptions of invasive thoughts, sleep interruption, social isolation, anhedonia, emotional dysregulation, and hyperarousal. The frequency scale has four values (never, once or twice a week, several times a week, everyday) – this aspect of the tool was not modified. The more frequent the symptom's occurrence, the higher the client's numerical score, ranging from 0 (never) to 3 (everyday), so that a higher overall score represents more frequent trauma symptoms for each individual, and a

higher average score represents a higher degree of trauma symptoms being experienced by a group overall (the actual tools is attached in the Appendix).

Additionally, the local evaluation uses data that were obtained outside of the program. The California Healthy Kids Survey (CHKS) is distributed annually in OUSD to staff and faculty, as well as students. Findings from both the student and staff/faculty CHKS are used in this report to measure changes in school culture and climate. CHKS is distributed in the spring and is voluntary. Due to school closures in spring of 2020 and 2021, the number of responses on the CHKS for those years was substantially lower than usual. Normally CHKS is distributed on paper, although for those two years it was distributed electronically. CHKS results are entered into a database at the OUSD central office and posted on a dashboard which was accessed for this report. CHKS is designed and operated by WestEd, a privately-run agency in the Bay Area.

Also posted on an OUSD dashboard are the district's suspension data. The dashboard enables disaggregation by race/ethnicity. This report uses those data, as well, to measure changes in suspension.

Focus groups and interviews were conducted annually over the course of the program. Student focus groups and interviews comprised active Experience Hope participants (all African American). Parents interviewed were also African American. School personnel interviewed were white or African American.

No particular recruitment strategies were used. Interview and focus group participants were identified in the following ways:

- All active Experience Hope participants were invited by Experience Hope staff to participate in focus groups and interviews. They were free to decline without any negative consequence. The evaluator came to the school site to conduct focus groups (interviews were conducted via video call). Youth participants were offered a gift card provided by CCEB as a recruitment incentive.
- Parents were identified by the Experience Hope staff and approached by the local evaluator. Participation was voluntary.
- School personnel were identified by the Experience Hope staff and approached by the local evaluator. Participation was voluntary.

Below is the schedule of focus groups and interviews held:

Table 5: Interview and Focus Group Schedule	Type of Informant	Type of Interview	Number of Participants
3/28/18	School Personnel	One-on-One Interviews	1
2/19/19	Student	Focus Group	12
5/13/20	Student	Focus Group	5
5/12/21	Student	Focus Group	3
5/12/21	Student	One-on-One Interviews	4
5/17/21	School Personnel	One-on-One Interviews	2
5/18/21	Parent	One-on-One Interviews	2

Interviews were loosely structured, based on questions co-constructed by the local evaluator and the CCEB Experience Hope team. Questions pertained to the value of the program and ideas for program improvement. In student focus groups, consistent with Community-Based Participatory Research (CBPR) (Israel, et al., 2998), the discussions also included interpretation of aggregate findings from the client-

level tools (focus group/interview protocols are provided in the Appendix). Interviews and focus groups generally took place over an hour at the school site (in a multipurpose room frequently used by the program).

D. Fidelity and flexibility

While the initial evaluation plan laid out the intention to conduct a fidelity assessment, in the end no formal fidelity assessment was conducted. Experience Hope was originally designed to adhere to Trauma and Grief Component Therapy for Adolescents (TGCTA) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). In balancing fidelity and flexibility, however, the Experience Hope clinicians found the TGCTA lessons to be difficult to fit into the limited timeframe they had with students given the school-based nature of the program. They largely abandoned any fidelity to TGCTA, although in regular discussions with the evaluator they stated that they held on to many of the principles and some exercises included in the model – for example clinicians delivered psychoeducation (consistent with Module 1), supported clients in coping with grief and anger (consistent with Module 3), and helped clients develop positive aspirations (consistent with Module 4). Clinicians explained that they were able to maintain fidelity to TF-CBT, although because an external evaluator could not observe client sessions, no formal fidelity assessment was conducted in regard to this practice. With no claim to operating TGCTA with fidelity and with the barrier of confidentiality preventing external fidelity monitoring of TF-CBT, a formal fidelity assessment became unfeasible.

The local evaluation plan did utilize Experience Hope participant interviews (qualitative data) to triangulate findings from the quantitative tools, in consideration of quality of delivery and participant responsiveness. Over the years, focus group/student interview questions included the following:

- What has working with [Therapist/Youth Engagement-Restorative Justice Specialist] been like? Has it helped?
- What do you think improves for students who participate in these services?
- Has participating helped you cope with any personal struggles that you have experienced or that have been happening in the community?
- Did it feel good or different to work with a black therapist/provider?
- Has working with [Therapist/Youth Engagement-Restorative Justice Specialist] helped you feel proud of who you are as a person of color?
- What would make these services/the program better?
- [Looking at data findings]: What do you make of these findings? Does anything surprise you, or not surprise you?
- Finally, how do you find the evaluation process (the forms they ask you to fill out)?

Data from focus groups and interviews were used to triangulate findings from other evaluation tools. These qualitative data generally supported findings from quantitative data sources.

As a result of information gained during focus groups and interviews, the aforementioned changes to evaluation tools were made. Specifically, the use of the SWE Core Measures tool was called into question. Experience Hope staff also lifted up three potential problems they had seen in delivering the tool: 1) they felt administering the tool at baseline interfered with the relationship-building they needed to do early on with clients, especially in a school-based setting where access and time together was sometimes elusive, 2) they lacked confidence that the baseline measurement was accurately capturing

what was going on for clients due to insufficient time to establish provider-participant trust, and 3) they noticed that participants were experiencing assessment fatigue. The adaptation that the program made was to continue to invite participants to complete the SWE Core Measures tools, but to use language that ensured they did not feel coerced into doing so. As a result, the number of completed SWE Core Measure pre-post sets was low. The local evaluation, therefore, does not include data from this tool.

Additionally, youth requested longer periods of time with the Experience Hope staff, so CCEB approached the school to trouble-shoot ways to increase student access to Experience Hope staff, and it was decided that participants could spend their advisory period in group.

Another finding that emerged when the local evaluator was invited to interview school administrators early in the program (during the 2017-18 school year) was the need for professional development to help dismantle implicit racial bias at Montera. To accommodate this finding, CCEB worked with Montera administrators to carve out more time for trainings.

Data Analyses Plan Implemented

The table below lists each evaluation question, the indicator identified in the evaluation design to answer the question, the measurement tool, the analysis method, and the findings.

Table 6: Evaluation Analysis Plan	Indicator	Measurement Tool	Analysis Method	Findings
Is the student referral system working to funnel the right students to the program?	Program components 1, 2 and 3 are at capacity each year	CCEB data management system reports	Assess the number of youth participants over the four program years	The program was generally operating at capacity each year, with Covid affecting numbers in the final year and a half
	Interviewees indicate that the referral system is working, that the students referred are appropriate for program	Interviews	Content analysis of 3 youth focus groups, and 9 one-on-one interviews with a total of 29 youth, staff, and parents	Staff found the program useful in supporting students who were struggling emotionally; Youth felt the program served them well
What is the average dosage participants are receiving?	Participants receive between 6 and 80 hours of engagement in clinical and/or nonclinical services	CCEB data management system reports	Assess the number of youth participants receiving the expected hours of engagement	All participants participated within the expected range
Are participants in clinical services showing a reduction in trauma symptoms, improvements in safe coping, or an increase in protective factors?	Clinical clients show reduced trauma symptoms (and other improvements) between pre and post self-reporting	CCEB's Retrospective Trauma Symptom Pre-Post	Analyze pre-post mean differences on cumulative score on the tool, including *t-test* results with standard deviation and *p* values noted	Mean differences were calculated for the 13 completed tools, with post-data demonstrating significant reductions in trauma symptoms ($p<.024$) (See below for protective factors)
Are all participants (including those in nonclinical groups) feeling good about the groups and showing improvements in safe coping, or an increase in protective factors?	All participants show improvements in skills and resiliencies; Students interviewed talk about positive program impacts	CCEB Skills Tool Retrospective Pre-Post; Interviews/focus groups	Analyze pre-post mean differences on cumulative score on the tool, including *t-test* results with standard deviation and *p* values noted; Content analysis of student interviews/focus groups	Mean differences were calculated for the 116 completed tools, with post-data demonstrating significant improvements in multiple protective factors ($p<.001$): Interviewees and focus group participants articulated the value of the program in terms of feeling heard, cared fo, and culturally-affirmed

Table 6: Evaluation Analysis Plan	Indicator	Measurement Tool	Analysis Method	Findings
How much training and technical assistance was delivered to teachers and other school personnel?	A majority of Montera personnel receive training in trauma-informed, restorative, anti-bias principles	CCEB data management system reports	Tracking of training participation and TA units of service, maintained in CCEB records	In 2017-18, no training & TA was recorded; in 2018-19, 2.5 hours of training was delivered to 35 school personnel; in 2019-20, 5 hours of training & TA was delivered, plus 33 individual mental health consultation sessions with Montera staff & faculty; in 2020-21 no training & TA was recorded
How did school personnel perceive the trainings and TA, and did they have an impact on their practices, especial in relation to African American students?	Post-training questionnaires	Post-training questionnaires; Interviews	Percentage of training participants agreeing with statements on the questionnaire	Majority of training participants in the one training where evaluations were distributed found the training valuable, 80% indicated they would do something differently as a result
Have indicators of positive school climate (e.g., sense of fairness and connection to adults) improved for African American students during the program period? (Outcome)	CHKS questions about perceived fairness and connection to adults show improvement during program years	CHKS data from 2016-17 through 2020-21	Compare across baseline year and program years the percentage of African American students and overall students indicating agreement with key survey statements	The CHKS finding did not support the conclusion that indicators of positive school climate improved for Black students, either in perceived fairness or connection to adults
Have suspension rates for African American students improved during the program period?	African American suspension rates decrease during program years	Suspension data from 2016-17 through 2020-21	Compare suspension rates (# of students per 100 suspended at least once in that school year) across baseline year and program years for all students and Black students	The suspension rates comparison found that suspension rates for both Black students and the whole student body reduced during the years of in-person learning, but that African American students continued to be suspended at a higher rate than the student body as a whole

7. RESULTS

Quantitative data findings

The quantitative data findings presented in this section derive from the tools listed in the table below, which also catalogues the number of responses used in the analysis:

Table 7: Quantitative Tool Inventory		
Quantitative Tool	Respondent Description	# of Responses
Trauma Symptoms Retrospective Pre-Post	Experience Hope Clinical Participants	2019-20: 9 2020-21: 4 (total 13)
CCEEB Skills Tool Retrospective Pre-Post	Experience Hope Participants	2017-18: 24 2018-19: 55 2019-20: 23 2020-21: 14 (total 116)
Post-Training Evaluation Questionnaire	Montera Training Participants	2018-19: 28
California Healthy Kids Survey - Staff	Montera Faculty & Staff	2016-17: 53 2018-19: 43 2020-21: 32
California Healthy Kids Survey - Students	Montera Student Body	2016-17: 382 2017-18: 298 2018-19: 303 2019-20: 265 2020-21: 47
Montera Middle School Suspension Rates	Montera Student Body	Whole School

Trauma Symptoms Reductions

The participant-level tool for measuring the impact of clinical services is the Trauma Symptoms Retrospective Pre-Post, which participants receiving clinical supports are invited to take at the end of their service engagement, or at the end of the school year, whichever comes first. Clinical participants also completed the Skills Tool Retrospective Pre-Post, which measures gains in resiliency such as safe coping and protective factors.

Data Collection

For the first two years of the program, Experience Hope clinicians administered the original, true pre-post design of the tool. At baseline they asked clients who had been identified as appropriate for trauma-focused clinical supports to complete the baseline version of the tool. Then at the end of their clinical engagement they were expected to repeat the procedure with the follow-up version of the tool. Unfortunately, this set of procedures was difficult for both clinicians and clients, and as a result there were no usable data from this time period. In 2019 the decision was made by CCEB program administrators and by the local evaluator to re-design the tool into its current form. Thereafter the clinician only had to ask the clients to complete the tool at the end of their engagement (using paper

and pen, except in 2020-21, when they were administered online). This produced a dataset of 13 completed tools.

Analysis Procedures

The analysis uses pre-post mean comparison of the cumulative score on the tool, including *t-test* results with standard deviation and *p* values noted.

Pre-Post Differences

"Before" and "These days" mean scores were calculated for tool as a whole for the 13 cases. The total possible score on the tool is 48 (16 items X 3 possible points for each question). Among Experience Hope participants who returned questionnaires, the average (mean) "pre" score across all respondents was 15, compared with an average total "post" score of 9.23. The average pre-post difference on the total score was approximately 5.77. As shown in the table below, a *t-test* demonstrated that the pre-post difference is statistically significant (p<.05). The bar graph (Figure 1) shows the pre-post comparison and Table 8 immediately below shows figures pertaining to the *t-test* performed.

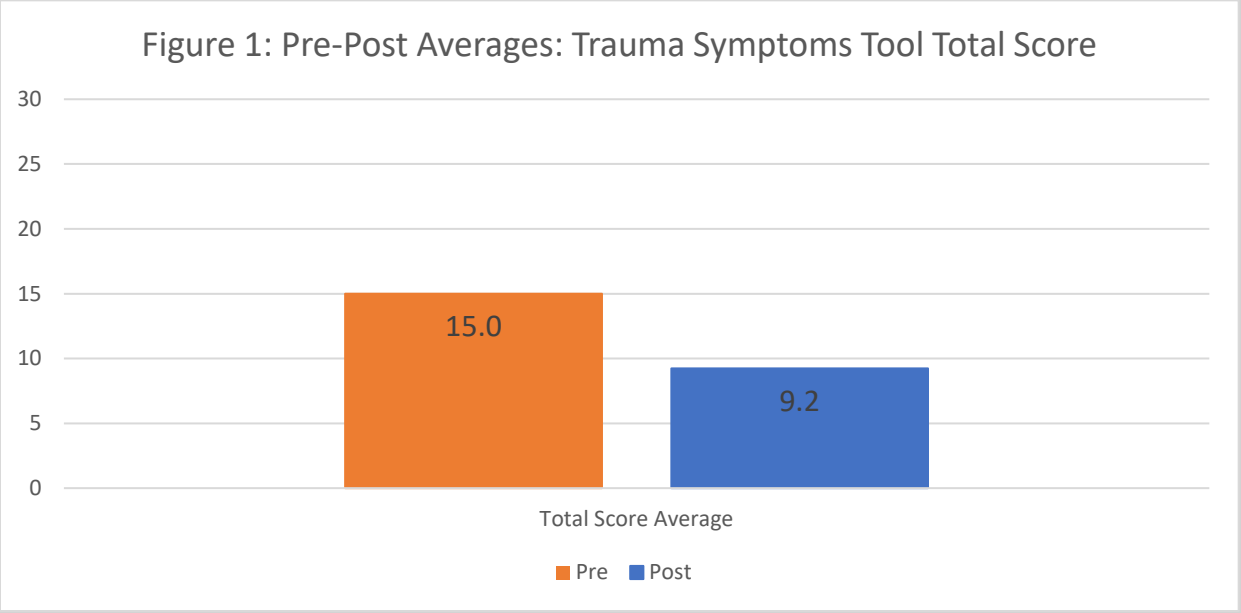


Table 8: Pre-Post Trauma Symptoms					
Pre Mean	Post Mean	Mean Diff	Std Deviation	*t* (df)	p-value
15.0	9.2	5.77	8.03	2.59 (12)	.024

Participant Skills Development

The primary participant-level tool for measuring the impact of Experience Hope is the CCEEB Skills Tool Retrospective Pre-Post, which every participant is invited to complete, irrespective of whether they participate in clinical or nonclinical supports.

Data Collection

Experience Hope staff (the clinician and the youth engagement/restorative justice specialist) distributed this tool at the end of the semester or school year, to both clinical and non-clinical Experience Hope participants. The tool asks for no identifying information to enable respondents to freely disclose personal information and critical commentary. From spring of 2020 through spring 2021, due to the

Covid-19 school closures, the questionnaire was distributed via an online platform. Prior to that the questionnaire was distributed on paper. There was no sampling involved in data collection – 100% of participants were invited to complete the tool (using paper and pen, except in 2020-21, when they were administered online). They were, however, informed that completing the questionnaire was voluntary and that declining to participate would not affect their access to services.

Over the course of four years of programming, 116 questionnaires were collected.

Analysis Procedures

The analysis uses both pre-post mean comparison as well as percentage of respondents who report pre-post growth. The analysis begins with a look at the overall means for the total score and the percentage of respondents showing growth (on the 13 pre-post items) then breaks down the specific question responses which fall into three key domains: Restorative & Conflict Resolution Skills, Social Emotional Competencies, and Support Resources. In all comparisons, cases with a missing pre or post response have been omitted from the calculation. Comparisons of mean include standard deviation and *p* values.

Pre-Post Differences

"Before" and "Now" mean scores were calculated for tool as a whole for the 116 cases. The total possible score on the tool is 65 (13 items X 5 possible points). Among Experience Hope participants who returned questionnaires, the average "pre" score across all respondents was 39.9, compared with an average total "post" score of 47.1 (demonstrated in Figure 2). The average pre-post difference on the total score was approximately 7.2. As shown in Table 9 below, a *t-test* demonstrates that the pre-post difference is statistically significant (p<.001).

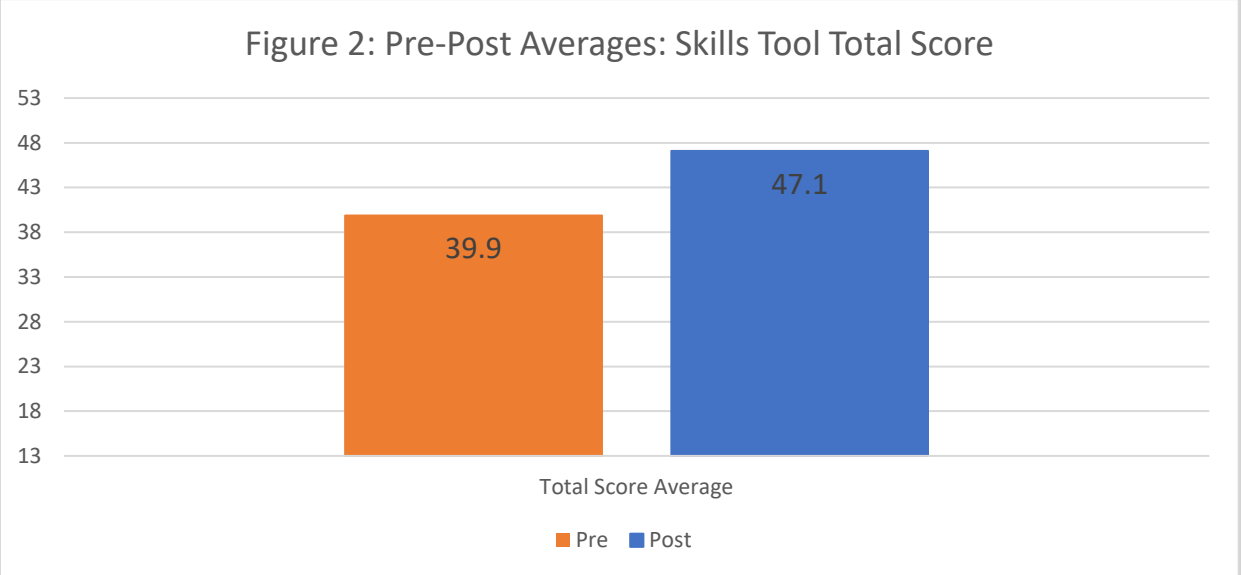
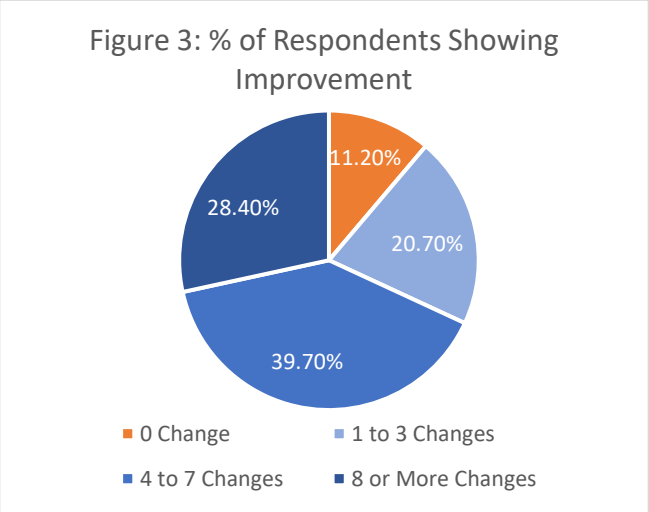


Table 9: Pre-Post Skills Averages (total)					
Pre Mean	Post Mean	Mean Diff	Std Deviation	*t* (df)	p-value
39.9	47.1	7.21	6.58	-11.80 (115)	.000

Additionally, the analysis found that 103 out of 116 respondents showed improvement from pre to post (88.79%), with 79.31% showing growth on four or more questions.

Table 10: Items Showing Improvement (Skills)		
Number of Items Showing Improvement	Number of Respondents	% of Total
0	13	11.2%
1 to 3	24	20.7%
4 to 7	46	39.7%
8 or more	33	28.4%
Total	116	100.0%



Questions on the tool fall into three themes: Restorative & Conflict Resolution Skills, Social Emotional Competencies, and Support Resources.

Questions in the Restorative & Conflict Resolution Skills theme ask participants to reflect on their ability to accept responsibility for their actions, avoid conflicts, and communicate skillfully through differences of opinion. Responses demonstrate that on average participants assess themselves as having grown substantially on all of these indicators. These differences are provided visually in Figure 4. As Table 11 below shows, pre-post differences on each of these indicators is statistically significant (according to *t-tests*), and a fair proportion of respondents report change on each measure.

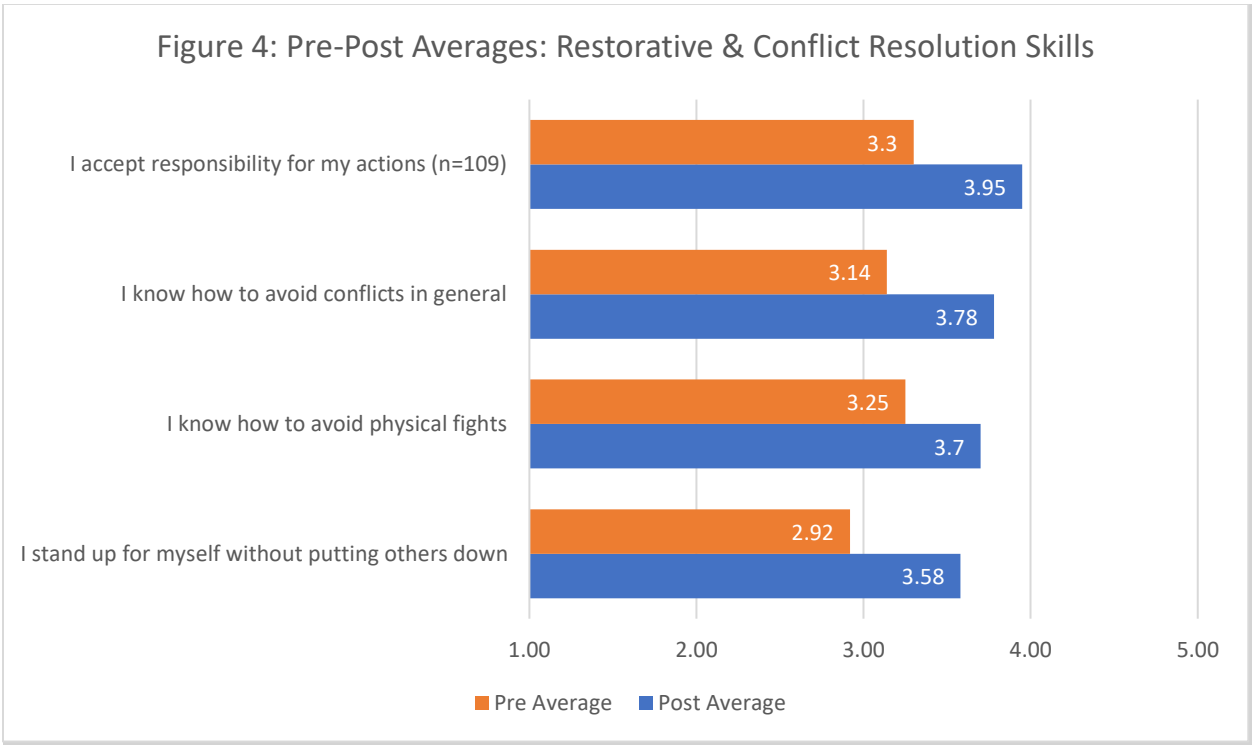


Table 11: Restorative & Conflict Resolution Skills	Pre-Post	Mean	Stand Deviation	N	p-value	% Improved
I accept responsibility for my actions (Before the program) & I accept responsibility for my actions (Now)	Pre	3.30	1.2210	109	.000	46%
	Post	3.95	1.0575			
I know how to avoid conflicts in general (Before the program) & I know how to avoid conflicts in general (Now)	Pre	3.14	1.3842	109	.000	39%
	Post	3.78	1.1576			
I know how to avoid physical fights (Before the program) & I know how to avoid physical fights (Now)	Pre	3.25	1.4864	107	.000	61%
	Post	3.7	1.4223			
I stand up for myself without putting others down (Before the program) & I stand up for myself without putting others down (Now)	Pre	2.92	1.4341	112	.000	46%
	Post	3.58	1.3599			

Questions in the Social Emotional Competencies domain ask participants to reflect on their listening skills, empathy, emotional self-regulation, and goals. Responses demonstrate that on average participants assess themselves as having grown on all of these indicators (See Figure 5). And as Table 12 shows, pre-post differences on each of these indicators is statistically significant (according to *t-tests*), and a fair proportion of respondents report change on each measure.

Figure 5: Pre-Post Averages: Social Emotional Competencies

Table 12: Social Emotional Competencies	Pre-Post	Mean	Stand Deviation	N	p-value	% Improved
I have high goals and expectations for myself (Before the program) & I have high goals and expectations for myself (Now)	Pre	4.05	1.0798	108	.000	29%
	Post	4.41	0.9073			
	Pre	3.26	1.2431	115	.000	44%

I try to understand what other people go through (Before the program) & I try to understand what other people go through (Now)	Post	3.81	1.0994			
I feel bad when someone gets their feelings hurt (Before the program) & I feel bad when someone gets their feelings hurt (Now)	Pre	2.89	1.5081	113	.000	42%
	Post	3.50	1.3033			
I think before I act (Before the program) & I think before I act (Now)	Pre	2.83	1.3867	109	.000	50%
	Post	3.58	1.2641			
I listen to other people's ideas (Before the program) & I listen to other people's ideas (Now)	Pre	2.81	1.2059	115	.000	44%
	Post	3.41	1.1765			
I try to work out problems by talking or writing about them (Before the program) & I try to work out problems by talking or writing about them (Now)	Pre	2.63	1.3412	111	.000	50%
	Post	3.29	1.3644			

Questions in the Support Resources theme ask participants to reflect upon help-seeking, supportive peers, and supportive adults outside of school. Responses demonstrate that on average participants assess themselves as having grown in their knowledge of where to go for help, and their sense that there is an adult outside of the home who really cares about them. There was nominal change on the indicator for supportive peers. As Table 13 below shows, pre-post differences on each of these indicators is statistically significant (according to *t-tests*), and a fair proportion of respondents report change on each measure.

Figure 6: Pre-Post Averages: Support Resources

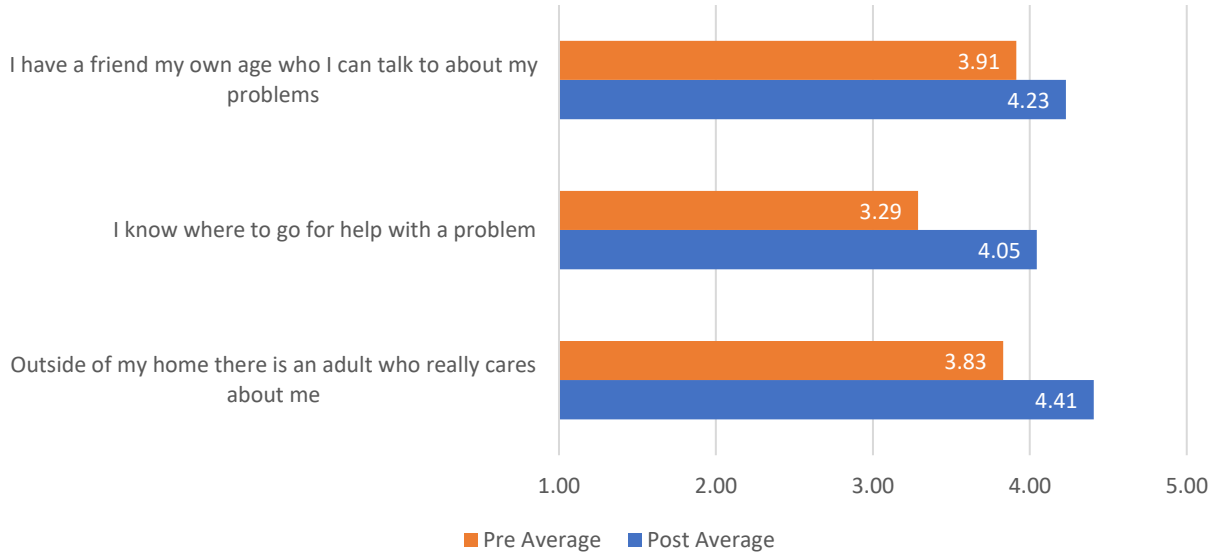


Table 13: Support Resources	Pre-Post	Mean	Stand Deviation	N	p-value	% Improved
I have a friend my own age who I can talk to about my problems (Before the program) & I have a friend my own age who I can talk to about my problems (Now)	Pre	3.91	1.2236	104	.000	25%
	Post	4.23	1.0167			

I know where to go for help with a problem (Before the program) & I know where to go for help with a problem (Now)	Pre	3.29	1.2820	111	.000	46%
	Post	4.05	1.0820			
Outside of my home there is an adult who really cares about me (Before the program) & Outside of my home there is an adult who really cares about me (Now)	Pre	3.83	1.3078	108	.000	36%
	Post	4.41	0.7617			

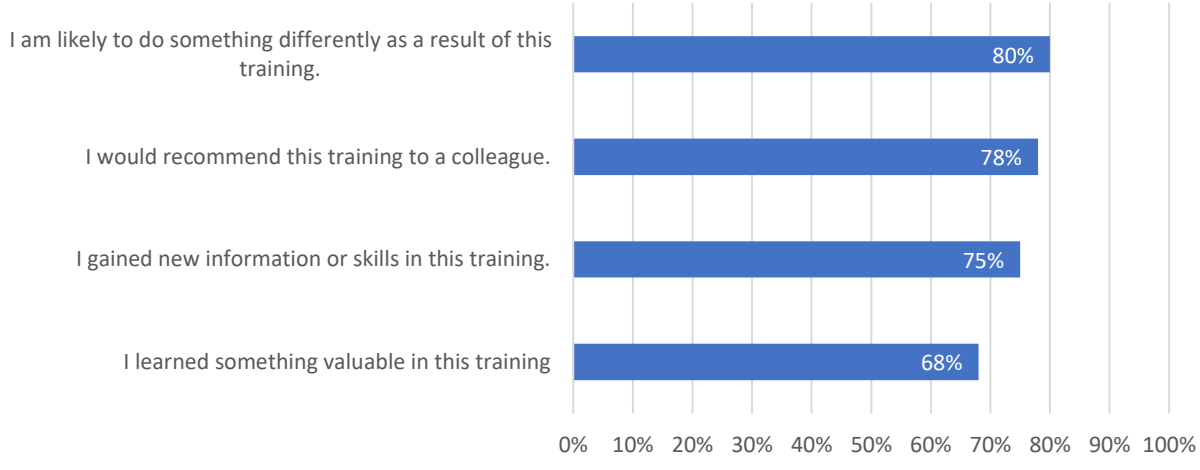
Trainings and Technical Assistance

In 2018-19, 2.5 hours of training was delivered, in 2019-20, 5 hours of technical assistance and training was delivered, plus 33 individual mental health consultation sessions with Montera staff & faculty. In 2021-21, due to Covid and resulting distance learning, support for teachers differed from previous years, with the primary mode being informal mental health consultation and "sitting in" in classes to support virtual classroom engagement and culture. These units of service were not tracked.

One of the areas of training that CCEB delivered at Montera was around Implicit Racial Bias. The training delivered on January 25, 2019, at Montera was followed by an evaluation form – 28 completed forms were collected. Incidentally, this was the only Experience Hope training for which post-training evaluations were collected. Data from these forms show that overall, a majority of Montera participants felt favorably about the training (See Figure 7).

- A large majority (80%) of participants indicated that they were likely to do something differently as a result of the training.
- Most trainees (78%) indicated that they would recommend the training to a colleague.
- Trainees appeared to start at different baselines in terms of what they knew about the topic, with some indicating that the information was all new and valuable, and others stating that they had already been exposed to some of the material presented. This is reflected in 68% and 75% indicating that they had learned something valuable or new, respectively.

Figure 7: % of Training Participants who Agree with Statements



The comments section of the post-training questionnaire showed that participants appreciated the use of data in the presentation, the clarity and ease of language used, and the sequencing of the presentation. They also appreciated the presenter's approachability and facilitation of discussion. They were particularly positive about the presentation's inclusion of solutions.

From the comments sections, however, it is clear that Montera staff and faculty who attended the training would like ***more time*** with the topic (20 people stated that they would have liked for the training to have afforded more time).

The CCEB team also provided training and technical assistance in the area of trauma-informed care and restorative justice principles. While there are no post-training evaluation data from these trainings, the California Healthy Kids Survey staff survey does show that between the baseline year and the most recent data collection year, Montera staff demonstrate a marked increase in their knowledge of how to de-escalate a student using a trauma-informed approach (data visualization provided in Figure 8 with corresponding crosstabulation provided in Table 14).

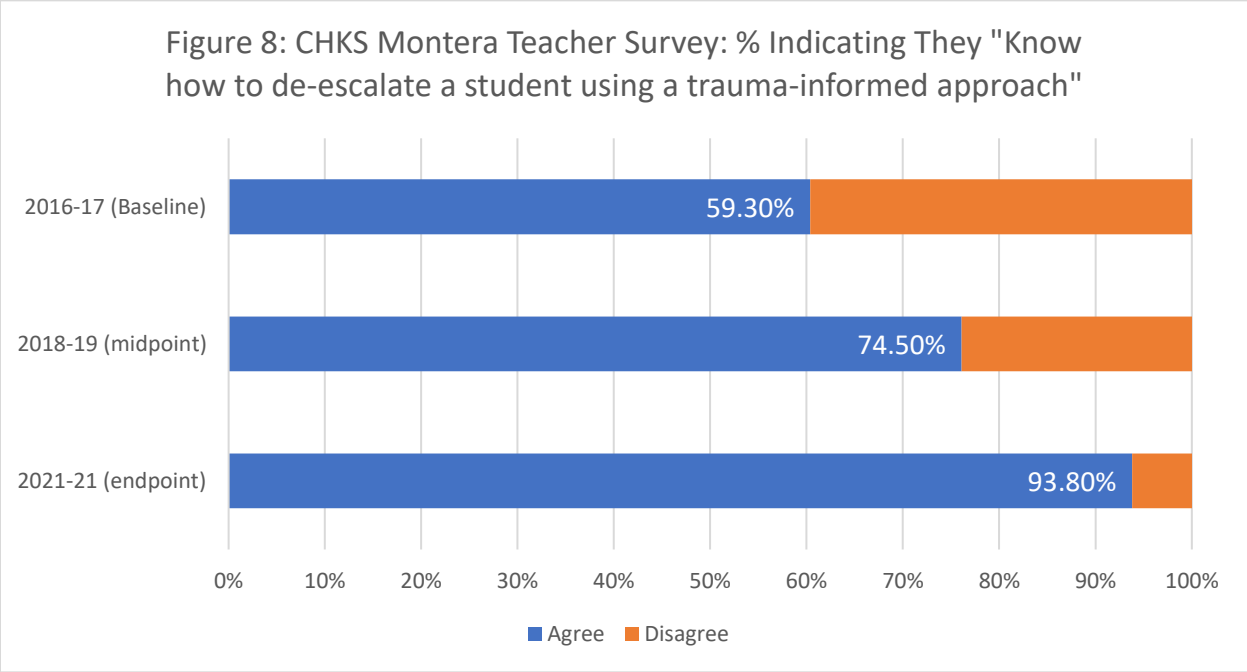


Table 14: CHKS Montera Teacher Survey
% Indicating They "Know how to de-escalate a student using a trauma-informed approach"

Year	Agree	Disagree	Total
2016-17	59.3% (32)	38.9% (21)	100% (53)
2018-19	74.5% (35)	23.4% (11)	100% (46)
2020-21	93.8% (27)	6.2% (5)	100% (32)

Schoolwide Culture and Climate

The findings from the CHKS survey from the baseline year (2016-17) and every programming year do not support the conclusion that Experience Hope has been able to effect widespread culture and climate change throughout the school or with the general population of African American students. Below in Table 15 are agreement rates on four key questions pertaining to perceived fairness and adult

connection. There is no clear pattern across the years that the program was in place. This suggests that, while the program appears to have had a positive impact on the youth that were served directly, it may not have had a similar school-wide impact, at least not as measured by the CHKS survey. It should be noted, though that the number of students responding to the survey is fairly low, especially during 2019-20 and 2020-21 when Covid-19 forced school closures. It is possible that CHKS results cannot therefore be relied upon with a high level of confidence.

Table 15: Montera California Healthy Kids Survey (CHKS) Findings (Student Survey)		
All students are treated fairly when they break school rules		
Year	% Black Students Agree	% Agree Schoolwide
2016-17	33%(33)	34.9%(124)
2017-18	42.1%(16)	48.7%(96)
2018-19	40%(22)	39.7%(106)
2019-20	33.3%(5)	47.1%(73)
2020-21	no data	no data
At my school there is a teacher or some other adult who listens to me		
Year	% Black Students Agree	% Agree Schoolwide
2016-17	76.2%(48)	75.6%(189)
2017-18	58.3%(39)	66.9%(194)
2018-19	67.7%(21)	69.1%(134)
2019-20	75%(18)	65.3%(150)
2020-21	no data	no data
At my school there is a teacher of some other adult who really cares about me		
Year	% Black Students Agree	% Agree Schoolwide
2016-17	64.2%(52)	62.9%(202)
2017-18	58.6%(41)	59.5%(175)
2018-19	55.4%(26)	66.1%(160)
2019-20	70.8%(17)	60%(140)
2020-21	no data	no data
The teachers at this school treat students fairly		
Year	% Black Students Agree	% Agree Schoolwide
2016-17	41.8%(41)	44.1%(167)
2017-18	34.3%(24)	42.9%(127)
2018-19	37.5%(21)	47.4%(127)
2019-20	30.8%(8)	41%(98)
2020-21	72.8%(8)	76.6%(36)

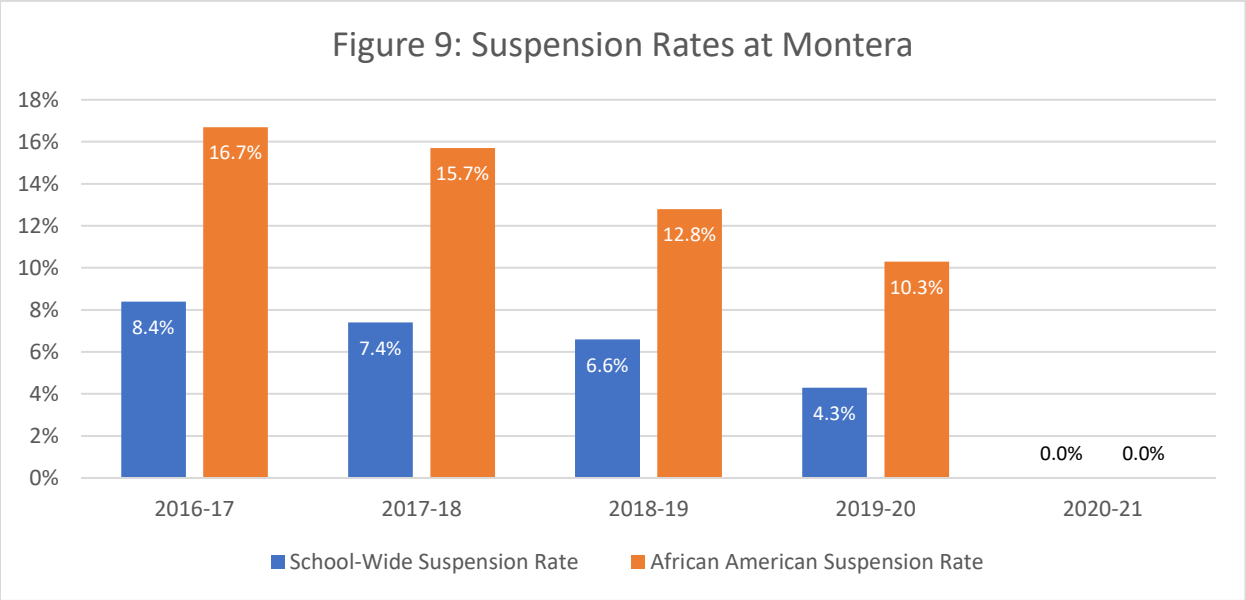
Suspension Rates

The evaluation also considers suspension rates at Montera Middle School, both among African American students and schoolwide. Table 17 and Figure 9 below show the suspension rates by school year (how many students per 100 were suspended at least once in that school year). They include data for the baseline year (2016-17) prior to program implementation, and every subsequent year.

Please note that since school was in distance learning mode during the entirety of 2020-21, the number for that year is not comparable.

Table 17: Suspension Rates		
Years	African American Suspension Rate	Schoolwide Suspension Rate
2016-17	16.7% (54)	8.4% (70)
2017-18	15.7% (47)	7.4% (60)
2018-19	12.8% (32)	6.6% (50)
2019-20	10.3% (22)	4.3% (31)
2020-21	0% (0)	0% (0)

A visual chart helps to demonstrate the downward trend both schoolwide and among Black students. While the numbers are clearly going down over time, it is also clear that Black students continue to be far more likely than their peers to be suspended. In every year of in-person learning Black students were suspended at a far higher rate than the schoolwide rate.



Qualitative data findings

The local evaluation data collection procedures also included qualitative data collection through focus groups and one-on-one interviews. These findings support the participant-level findings from the two retrospective pre-post tools. Specifically, the qualitative data provide evidence demonstrating that the students who were directed to the program benefitted from the perspective of both students and personnel (supporting the idea that the students served were the "right students"), that the cultural affirmation was of particular value, and that without highly effective, culturally-responsive supports built into the school, it is difficult for school personnel to reach their objectives of teaching and supporting the whole child.

Data Collection

Over the years the local evaluator has conducted focus groups and interviews of students (24), Montera school personnel (3), and parents (2). The focus group/interview protocols are provided in the Appendix.

Findings

Students at Montera Middle School who participate in Experience Hope consistently demonstrate improvements in social emotional skills such as self-regulation, conflict management, and help-seeking, according to results from the retrospective pre-post tools used in our local evaluation. Throughout the life of the project, the local evaluator has also run focus groups or interviews with Experience Hope participants from Montera Middle School to understand whether participants' impressions about what is valuable about the program aligns with those findings.

During these focus groups, youth participants 1) indicated that program staff truly listen to them (in contrast to other adults in their lives) and 2) affirmed that the program has helped them with social-emotional needs, including self-regulation and conflict management, and 3) expressed that the program is culturally-affirming for Black students. Interviews with adults align with input from youth and also demonstrate that it is difficult for schools to address the needs of the whole child without the sort of support that Experience Hope staff brought to the school.

Feeling Listened To

In interviews and focus groups, participants consistently and specifically noted that they felt listened to by Experience Hope program staff. This was true across multiple years of interviews, despite transitions in the individuals who held the clinician and youth engagement/restorative justice specialist positions – each position turned over once during the program period – the names of Experience Hope personnel have been omitted from direct quotes. Below are some of the things youth said that embody this theme:

- "We like talking to them because they're nice people. They don't interrupt you. They don't try to say, 'that seems like this,' they let you rant, express yourself the way you want to express yourself. Not all adults do that. Some adults just give you their opinion on things. Sometimes kids don't want your opinion on it. And sometimes if you do what they said, it doesn't end up working. Some counselors tell you to fix the situation, you can say it's fixed but it's not, then it starts even more drama."
- "[The clinician] is actually very fun. I was just stereotyping. I thought she would just be like blah blah. But we have a great time…Someone actually just listening to you instead of just criticizing you. It's really nice having her…Sometimes I would feel like adults are just saying stuff."
- "[She] is a good listener. She always helps me. She tries to get to the root of the problem. When we talk one-on-one, she helps, then she helps outside of that, too, like with homework and stuff like that. She cares and she's a good listener."

Feeling Cared For

On a related note, youth readily offered that they felt cared for by the youth engagement specialist and the clinician.

- "[The youth engagement specialist] has helped a lot with personal problems. Like the support, like 'I'm here if you need me.' Somebody to lean on and stuff."
- "Last year and during school a lot of stuff happened [interviewee lists a number of deaths, losses]. [The clinician] has always been there. Her space was a welcome space. Even if I just wanted to talk to her, she would say just let me know. She was always there for me. She always has my back no matter what."

- "[The youth engagement specialist] always says are you OK? He always makes sure we are OK, and I can call and talk to him about what I need help with outside of school."

Improved Emotional Self-Regulation

Youth focus group participants also talked about the ways that Experience Hope helps them to manage their emotions and responses to conflict:

- "I used to have very bad anger. She helped me out. I learned breathing techniques. It helps me a lot. Usually when I'm getting angry I think about what she's told me."
- "They calm you down first, so you're not just talking out of anger. You can say one thing when you're mad, then when you're calm you say a whole different thing. You can start hearing other points of view. It helped me a lot. I learned how to calm myself down before I say anything I might regret. So I don't lose a friendship over some dumb stuff."
- "If you want to fight someone, group can calm you down."
- "Really it's been helpful with my friendships with people. And with my teachers and with not getting into fights with people…I can go in there and chill out during lunch to avoid a lot of drama."
- "[In the group] I learned how to avoid drama that doesn't concern me, and how to use leadership skills."
- "I know/gained how to filter out all the bad that happens around me and just don't really care about the bad."
- "I think it has [helped me stay out of fights] because I can now control better before going off on someone."

Teacher Perspectives on the Value of Experience Hope

From the perspective of school personnel who were interviewed for the evaluation, youth need to feel cared for, and to have emotional support to build skills and to manage the challenges that are happening in their lives. Without this level of caring and support, the school cannot do what it's meant to do: educate children. Below are quotes from two different school personnel, reflecting the same sentiment:

- "Until you address the social emotional barriers, the instructional minutes are useless. They can't access what they need to access unless the feel loved and safe. That's why having [the youth engagement specialist and clinician] there to intervene is so crucial."
- "[Students] who are very surly, attitudes, cutting class, starting fights, they start working with [the youth engagement specialist], they are getting their work in their getting their grades up…One young woman was having panic attacks, trauma, it was really hard for her. She started working with [the clinician], and she became one of my best students – getting straight As…We literally can't do without [the Experience Hope staff]."

The Value of Racial Affinity

Students, staff, and parents alike also recognized the culturally affirming value of the Experience Hope program. Students said they felt an affinity with the Experience Hope staff and appreciated "having someone the same color" as them.

- "He knows how it is growing up in Oakland and growing up Black. It's tempting to do things one way but you got to do the right thing."
- "[There's] a lot of stuff that me and her can relate on. It's like it feels good to have, I don't want it to come out wrong. It's good to have someone the same color as you who can connect with you on stuff."
- "I always thought down on myself because I saw what police were doing with Black people. With [youth engagement specialist name] I started to man-up about my color and stuff."
- "He shows that you can be anything, help anybody, it doesn't matter what color you are."

A parent who was interviewed echoed what the students were expressing. Here the parent is speaking of the African American female Experience Hope clinician:

- "A Black woman is more understanding because they've been there and done that and have family members, some type of experience that the Black family has been through. When you're not of the same race, it's hard to explain to someone that you can have it easy and I can have it hard. [The clinician] can explain things that a white person couldn't. There's a lot of things that a Black family has experienced that a white family might not have experienced."

Below are some additional quotes from Montera's faculty and staff recognizing that having Black therapeutic staff helped make the Experience Hope program effective and also helped to "bridge" the cultural barriers between Montera faculty (who are largely white) and Black students:

- "[It makes a difference] having people that reflect aspects of their identity that I couldn't, coming from a place of experience, personal experience of feeling they're being treated differently based on race. They are able to provide a reflection to the students and that is critical."
- "Having counselors who are Black, especially a strong male role model, has been huge. Building relationships has been a push from the administration. While that's easy for some of us, there are other teachers who find that difficult. [Experience Hope staff] a bridge that for some of our teachers…I've had kids with real trauma where the father was shot, how do you deal with that. As much as I can provide, [the clinician] provides so much more. That one-on-one, that attention."
- "There was distrust of white people [among students]. That made it harder to build relationships, or it took an understanding that some people [school faculty and staff members] didn't have. Having someone who looks like you, means that there isn't that distrust or wall that needs to be broken down. Then they help bridge that gap for a lot of teachers. We would not have that with a lot of our teachers."

Meeting the Needs of the Whole Child

Overall, among parents as well as faculty and staff, there was an acknowledgement that the youth that the program served, and perhaps middle school students more generally, have needs that a school may be ill-equipped to meet. By meeting those needs Experience Hope not only helped the students themselves, it supported the functioning of the school. Here are the words of one parent:

- "When you get out of elementary school it's a total different ball game. In middle school that's when issues start occurring…It's really good to have someone in middle school because there's a big change from elementary to middle school. These teachers have to deal with the change.

[Clinician name] her role is helping them stay on that path. A lot of times these teachers they don't know how to deal with that change…A lot of these children need this counseling. Sometimes you need a hand hold going up those stairs…It's not just the parents and the students that need the counselors, the teachers need them too. They fill in that gap."

Here is a similar sentiment from a Montera faculty and staff member:

- "It has been excellent… I don't know how we would have gotten through the school year without him. He already had connections with students and that would help a lot when things would come up, and with conflicts. He would sit in and provide support in the classroom. [The clinician] also provides direct support, and I will have students who say I need to talk to her. The support has been invaluable. I sincerely hope they are back next year. The work is so crucial. We have students who have emotional needs that as a teacher I am sometimes powerless to address. It's been life-altering as a teacher…Both are so good personally with the students. They're both really skilled…both of them are professionals who have a lot of skill in building rapport across the board with teachers and students alike."

Synthesis of findings

Below is a summary of the findings from the various data sources organized by the evaluation questions listed earlier in this report.

Is the student referral system working to funnel the right students to the program?

Using program records maintained by CCEB and shared with the local evaluator, it is clear that program components 1, 2 and 3 operated at capacity during the first two and a half program years. During the third year, as programs transitioned from in-person to distance implementation, participation dropped substantially. During the fourth and final year, all of which was in distance learning mode, participation remained lower than usual, although both the clinician and the youth engagement/restorative justice specialist were able to continue services through online meetings and virtual classroom push-in. The performance numbers, especially in light of the circumstances, suggest that yes, the student referral system worked to funnel the right students to the program.

This conclusion is further supported by evidence gathered in interviews with Montera faculty and staff who indicated that the program helped students who were struggling emotionally. Experience Hope staff also reflected in regular informal check-ins with the program evaluator that the referral system, through which school staff referred participants was helpful in directing the right students to the program.

What is the average dosage participants are receiving?

The original aim of Experience Hope was to engage participants for between 6 and 80 hours of in clinical and/or nonclinical services. Program records maintained by CCEB and shared with the local evaluator show that most participants received this range of hours of services.

Are participants in clinical services showing a reduction in trauma symptoms, improvements in safe coping, or an increase in protective factors?

Results from the Trauma Symptoms Retrospective Pre-Post tool revealed statistically significant reductions in trauma symptoms between pre and post self-reporting. Clients overall also showed consistent improvements in safe coping and other protective factors such as help-seeking and

connection to caring adults. These findings were further supported by student reflections gathered in focus groups and interviews regarding the value of the therapeutic relationship with the Experience Hope clinician.

Are all participants (including those in nonclinical groups) feeling good about the groups and showing improvements in safe coping, or an increase in protective factors?

A large majority (88.79%) of participants (including clinical and nonclinical program participants) show improvements in skills and resiliencies. In the three key domains of the tool (Restorative & Conflict Resolution Skills, Social Emotional Competencies, and Support Resources) the group as a whole – all African American youth – experienced significant improvements, according to comparison of means and associated *t-tests*.

The finding of increased skill development, particularly in the area of emotional self-regulation, was supported by students' own reflections on their ability to manage their feelings as well as peer relationships (e.g., avoiding "drama"). Youth also expounded on feeling "cared for" and "listened to" in interviews and focus groups, supporting the conclusion that youth felt good about the program. Adults working at the school further supported this finding, stating in multiple ways that the program helped students improve on a number of social-emotional factors. The culturally-responsive design of the program and the fact that Experience Hope staff were African American themselves contributed substantively to the value of the program according to the views expressed by students, parents, and faculty and staff.

How much training and technical assistance was delivered to teachers and other school personnel?

Program records maintained by CCEB and shared with the local evaluator show that 7.5 hours of training and more than 33 sessions of technical assistance, in addition to informal mental health consultation from program staff to Montera faculty and staff, occurred during the program period. The training reached 100% of school administrators, 100% of restorative justice coordinators, and 80% of teachers. Experience Hope staff estimate that approximately 10% of Montera faculty and staff received technical assistance and informal mental health consultation support.

How did school personnel perceive the trainings and TA, and did they have an impact on their practices, especially in relation to African American students?

Data from post-training questionnaires from one of the trainings show that the professional development offered by the program had value. Unfortunately, there was no post-training evaluation data from the other trainings. Consultation from Experience Hope staff, according to interviews with school personnel, appears to have been valuable. Specifically, school personnel valued the "bridging" of gaps between students and teachers that Experience Hope staff provided.

A secondary indicator that the trainings may have been impactful can be found in the increased self-reported competencies in trauma-informed de-escalation among Montera faculty and staff as measured by the CHKS staff survey.

Have indicators of positive school climate (e.g., sense of fairness and connection to adults) improved for African American students during the program period?

The program appears to have had a powerful impact on participants. But school-wide, the program does not appear to have had a discernable positive impact on African American students' general sense of the school climate. Specifically, CHKS questions about perceived fairness and connection to adults do not in

fact show improvement during program years. This piece of evidence diverges from the other findings. It may be that school climate change is too persistent problem to be changed by a single external program. Or it may be that the survey did not have an adequately large response rate.

Have suspension rates for African American students improved during the program period?

Suspension rates school-wide and for African American students improved during the program years. It is not possible to affirmatively assert that this was a direct result of the Experience Hope program, but it does represent progress in one of the areas that prompted the program in the first place.

Meta-Analysis Data

Table 18: Meta-Analysis										
Measure name	Modified Y/N	Pre Mean score	Pre score SD	Pre N	Post Mean score	Post score SD	Post N	Correlation between Pre and Post Mean scores (r)	Cohort	Age group (child/adol/adult)
Trauma Symptoms Retrospective Pre-Post	Y	15.0	11.55	13	9.2	11.28	13	.753	All*	Adolescent
CCEEB Skills Tool Retrospective Pre-Post	Y	39.9	10.99	116	47.1	10.18	116	.810	All	Adolescent
		40.6	10.50	71	47.9	8.05	71	.752	Female	Adolescent
		40.6	10.78	30	49.6	9.96	30	.821	Male	Adolescent

*Please note that due to the small number of Trauma Symptoms Retrospective Pre-Post tools included in the analysis, the data are not broken down by gender.

8. DISCUSSION AND CONCLUSION

A variety of data sources inform this local evaluation of Experience Hope for Teens at Montera Middle School in Oakland. Most sources support the following conclusions:

1. **That both students receiving Experience Hope clinical and non-clinical services have benefitted:** On average clinical clients experienced reduced trauma symptoms, and program participants in general experienced improved skills and resiliencies.
2. **That school personnel, students, and parents are appreciative of the cultural responsiveness of the program:** Students felt culturally affirmed, staff appreciated how skilled Black practitioners helped bridge gaps between faculty and Black youth, and parents recognized the program's value and the cultural affinity of Experience Hope staff.
3. **That inappropriately punitive and escalating responses from adults toward students have improved:** Over the program period, suspension rates have declined, and Montera staff self-reported competencies in trauma-informed de-escalation have improved.
4. **That despite these improvements, systemic problems at the school persist:** Black students are still being suspended at a far higher rate than the school-wide rate, and, according to CHKS results, African American students continue to report that the school does not treat students fairly and that adult connection is inconsistent.

These findings are important as they indicate that the Experience Hope model can be highly effective with clients. The principal take-aways from this study are as follows:

- The delivery of restorative, trauma-informed, culturally-responsive school-based mental health and supportive nonclinical groups to Black students by Black providers can help youth participants feel seen and heard, helped them develop key skills, and helped them reduce trauma symptoms.
- An Afrocentric, restorative program that includes training, technical assistance, and mental health consultation to staff can also support school personnel in performing their jobs and reaching students more effectively.
- Even a highly effective program may be insufficient to change school climate and eliminate the disparate treatment of African American students.

These results support findings from the literature, particularly past studies which have shown that Black students are disproportionately subjected to exclusionary school discipline (Morgan, et al., 2014; Riddle & Sinclair, 2019). There is also a growing body of literature arguing that restorative justice practices in schools can help address disproportionality in discipline outcomes (Gonzalez, 2015). While suspension data from Montera demonstrate that racial disparity in exclusionary discipline practices persist, the data also show a decrease in the use of these responses in general, concurrent with an increase in trauma-informed de-escalation competencies among Montera personnel.

The qualitative findings pointing to the importance of the cultural responsiveness also has a foundation in existing literature. The literature on mental health care for African American populations points to problems both in terms of misdiagnosis (Bell, et al., 2015; Coleman, et al., 2016) and access (Ward, et al., 2013), including issues of stigma and apprehension (Alvidrez, et al., 2008). Many postulate that the cultural incongruence between mental health providers and African American clientele may be at least

partially responsible for the persistence of these issues (as there is a preponderance of white clinicians), and that providing Black clients with Black treatment providers will improve outcomes (Goode-Cross, et al., 2016), as has been shown in other health fields (Greenwood, et al., 2019). Experience Hope helps address these issues by placing professionals with culturally-affinity at a key access point for vulnerable Black youth: school.

An additional area of learning from this project is the importance of culturally-responsive supports to address trauma. While the recognition of trauma in clinical treatment and nonclinical support is an advancement from previous models of care, approaches that are not contextualized within a social justice model or do not recognize the impact of oppression are bound to fall short (Goodman, 2014). As researcher and psychology professor Rachael Goodman puts it in her 2014 book, "Counselors and psychologists may unintentionally exacerbate systemic oppression and distress by using [DSM] traditional definitions; failure to acknowledge the systemic forces that engender or aggravate trauma means that these types of traumas will not be addressed in clinical practice, nor will counselors and psychologists take social justice action to challenge the sociopolitical elements that harm our clients" (Goodman, 2014: p. 55). Specifically, in the case of Black youth, the sociopolitical context of racial oppression not only contributes to traumatic experiences, but it must also inform clinical and nonclinical supports (Hardy, 2013). Specifically, as Dr. Kenneth Hardy recommends, treatment protocols for youth of color must affirm racial identity, name racialized trauma, intentionally counteract societal devaluation, and help youth re-channel the rage that naturally results from racism (Hardy, 2013). As interview data in this evaluation revealed, youth participating in Experience Hope felt affirmed and gained some perspective on sociopolitical constructs around race. Some of the youth and adults interviewed for this evaluation specifically noted the importance of the cultural connection between providers and youth as increasing trust, easing connection, and helping youth understand their own experiences in a sociopolitical context.

Study Limitations

There are a few limitations to the local evaluation. For example, not all TA was tracked, client attrition was not specifically tracked, and clinical clients' trauma symptom data were not accurately tracked the first two years. It is also worth noting that the CHKS had low student response rates and undermining the reliability of those data. Additionally, some scholars are critical of the retrospective pre-post model (Ingram, et al., 2004), while others find it to be a superior method for tracking pre-post differences (Bhanji, Gottesman, et al., 2012; Drennan & Hyde, 2007; Lang & Savageau, 2017; Skeff, Stratos & Bergen, 1992). The CCEB team and the evaluator concluded that the benefits of the method outweighed any possible downside, but other researchers may disagree. Finally, the findings would be more powerful if there were a comparison group.

Recommendations

The Experience Hope for Teen program model should continue to be implemented at Montera or replicated at other sites, and client impact should continue to be monitored using the tools that were developed for this program. The results of this inquiry do not conclusively determine that the program effected the changes that were measured. If CCEB would like to establish the program model as an evidence-based program, the tool could be administered as a pre-post to similarly-situated youth who are not receiving supports, and differences could be compared and tested.

In future implementation efforts, CCEB could pay particular attention to the types of actions that may result in school-wide culture transformation. It may be that such a change is beyond the abilities of an external program, or it may be that a more concerted and strategic effort may move the needle on school climate and culture.

9. REFERENCES & APPENDICES

Álvarez M.J., Masramon H., Peña C., Pont M., Gourdier C., Roura-Poch P., and Arrufat F. (2015). Cumulative effects of childhood traumas: polytraumatization, dissociation, and schizophrenia. *Community Mental Health Journal*, *51* (1), 54-62.

Alvidrez, J., Snowden, L. R., and Kaiser, D. M. (2008). The Experience of Stigma among Black Mental Health Consumers. *Journal of Health Care for the Poor and Underserved*, *19*, 874-893.

American Civil Liberties Union. (2021). *The School to Prison Pipeline*. Retrieved 8/11/2021: https://www.aclu.org/issues/juvenile-justice/school-prison-pipeline/school-prison-pipeline

Bell C.C., Jackson W.M., and Bell B.H. (2015). Misdiagnosis of African-Americans with Psychiatric Issues - Part II. *Journal of the National Medical Association*, *107*(3):, 35-41.

Bjanji, F., Gottesman, R., de Grave, W. Steinert, Y., and Winer, R. (2012). The retrospective pre-post: a practical method to evaluate learning from an educational program. *Academy of Emergent Medicine*, *19* (2), 189-94.

Brunzell, T., Waters, L., & Stokes, H. (2015). Teaching with strengths in trauma-affected students: A new approach to healing and growth in the classroom. *American Journal of Orthopsychiatry*, 85(1), 3–9.

Burgess D.J., Ding Y., Hargreaves M., van Ryn M., Phelan S. (2008). The association between perceived discrimination and underutilization of needed medical and mental health care in a multi-ethnic community sample. *Journal Health Care among the Poor and Underserved*, *19*(3), 894-911.

Carter, R. (2007). Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress. *Counseling Psychologist*, *35,* 13-105.

Coleman, K.J., Stewart, C., Waitzfelder, B.E., Zeber, J.E., Morales, L.S., Ahmed, A.T., Ahmedani, B.K., Beck, A., Copeland, L.A., Cummings, J.R., Hunkeler, E.M., Lindberg, N.M, Lynch, F., Lu, C.Y., Owen-Smith, A.A., Trinacity, C.M., Whitebird, R.R., Simon, G.E. (2016). Racial-Ethnic Differences in Psychiatric Diagnoses and Treatment Across 11 Health Care Systems in the Mental Health Research Network. *Psychiatric Services*, *67*(7), 749-57.

Drennan, J., and Hyde, A. (2008). 'Controlling response shift bias: The use of the retrospective pre-test design in the evaluation of a master's programme. *Assessment and Evaluation in Higher Education*, *33* (6): 699-709.

Foa, E.B., Asnaani, A,, Zang, Y., Capaldi, S. & Yeh R. (2018). Psychometrics of the Child PTSD Symptom Scale for DSM-5 for Trauma-Exposed Children and Adolescents. *Journal of Clinical Child & Adolescent Psychology, 47,* 38-46.

González, T. (2015). Socializing Schools: Addressing Racial Disparities in Discipline Through Restorative Justice, in *Closing the School Discipline Gap: Equitable Remedies for Excessive Exclusion*, Losen, D.J., et al., eds. New York, NY: Teachers College Press.

Goode-Cross, D. T., & Grim, K. A. (2016). An Unspoken Level of Comfort: Black therapists' experiences working with Black clients. *Journal of Black Psychology*, *42*(1), 29–53.

Goodman, R.D. (2014). A liberatory approach to trauma counseling: decolonizing our trauma-informed practices. In: Goodman R., Gorski P. (eds) *Decolonizing "Multicultural" Counseling through Social Justice. International and Cultural Psychology*. Springer, New York, NY.

Greenwood, B.N., Hardeman, R.R., Huang, L. and Sojourner, A. (2020). Physician–patient racial concordance and disparities in birthing mortality for newborns. *Proceedings of the National Academy of Sciences of the United States of America*, *117*(35), 21194-21200.

Hass, M.R., Abdou, A.S. (2019). Culturally Responsive Interviewing Practices. *Contemporary School Psychology*, *23*, 47–56.

Hardy, K. V. (2013). Healing the hidden wounds of racial trauma. *Reclaiming Children and Youth*, *21* (4).

Hill, L.G., & Betz, D.L. (2005). Revisiting the Retrospective Pretest. *American Journal of Evaluation*, *26* (4), 501-517.

Ingram, M., Staten, L., Cohen, S., Stewart, R., deZapien, J. (2004). The use of the retrospective pre-test method to measure skill acquisition among community health workers. *Internet Journal of Public Health Education, B6*, 1-15.

Israel, B. A.; Schulz, A.J.; Parker, E.A.; Becker, A.B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health, 19*, 173–202.

Karpman, M. (2012). *Kids Living in Combat Zones...in U.S. Cities*. Oakland, CA: Prevention Institute.

Lang, D. (2017). *Starting at the End: Measuring Learning Using Retrospective PrePost Evaluations*. Worcester, MA: University of Massachusetts Medical School.

Monahon, C. (1993). *Children and trauma: a guide for parents and professionals*. San Francisco: Jossey-Bass.

Morgan, E., Salomon, N, Plotkin, M., & Cohen, R. (2014). *The School Discipline Consensus Report: Strategies from the Field to Keep Students Engaged in School and Out of the Juvenile Justice System.* New York: The Council of State Governments Justice Center.

Price, M., Higa-McMillan, C., Kim, S., Frueh, B. (2013). Trauma experience in children and adolescents: An assessment of the effects of trauma type and role of interpersonal proximity. *Journal of Anxiety Disorders, 27,* 652-660.

Riddle, T. & Sinclair, S. (2019). Racial disparities in school-based disciplinary actions are associated with county-level rates of racial bias. *Proceedings of the National Academy of Sciences of the United States of America*, *116* (17) 8255-8260.

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine*, *41*(1), 71–83.

Robinson, E.A.R. & Doueck, H.J. (1994), Implications of the Pre/Post/Then Design for Evaluating Social Group Work. *Research on Social Work Practice*, *4*(2), 224-239.

Rosenman, R., Tennekoon, V., & Hill, L. G. (2011). Measuring bias in self-reported data. International *Journal of Behavioural & Healthcare Research*, *2*(4), 320–332.

Skeff, K.M., Stratos, G.A., Bergen, M.R. (1992). Evaluation of a Medical Faculty Development Program: A Comparison of Traditional Pre/Post and Retrospective Pre/Post Self-Assessment Ratings. *Evaluation & the Health Professions*, *15*(3), 350–366.

Snowden, L.R. Barriers to Effective Mental Health Services for African Americans. *Mental Health Services Research and School of Social Welfare*, 3, 181–187 (2001).

U.S. Department of Education, Office for Civil Rights. (2016). *Civil Rights Data Collection*. Washington, DC: U.S. Department of Education.

U.S. Department of Health and Human Services, Office of Minority Health. (2018). *State and Territorial Efforts to Reduce Health Disparities: Findings of a 2016 Survey by the U.S. Department of Health and Human Services Office of Minority Health*. Washington, DC: U.S. Department of Health and Human Services.

Ward E.C., Wiltshire J.C., Detry M.A., and Brown R.L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nurse Researcher*, *62*(3):185-94.

Warren, E. & Supreme Court Of The United States. (1953). *U.S. Reports: Brown v. Board of Education*, 347 U.S. 483. Retrieved from the Library of Congress, https://www.loc.gov/item/usrep347483/.

Williams, M. (2015). The Link Between Racism and PTSD. *Psychology Today*, September 6, 2015.

Woods, V.D., King, N.J., Hanna, S.M., & Murray, C. (2012). *CRDP African American Population Report - "We Ain't Crazy! Just Coping With a Crazy System" Pathways into the Black Population for Eliminating Mental Health Disparities*. Sacramento, CA: California Department of Mental Health

Wehry, A. M., Beesdo-Baum, K., Hennelly, M. M., Connolly, S. D., & Strawn, J. R. (2015). Assessment and Treatment of Anxiety Disorders in Children and Adolescents. Current Psychiatry Reports, 17(7), 1–11. https://doi.org/10.1007/s11920-015-0591-z

Garcia, I., & O'Neil, J. (2021). Anxiety in Adolescents. *Journal for Nurse Practitioners*, *17*(1), 49–53. https://doi.org/10.1016/j.nurpra.2020.08.021

Benjamin, C. L., Puleo, C. M., Settipani, C. A., Brodman, D. M., Edmunds, J. M., Cummings, C. M., & Kendall, P. C. (2011). History of Cognitive-Behavioral Therapy in Youth. *Child and Adolescent Psychiatric Clinics of North America*, *20*(2), 179–189. https://doi.org/10.1016/j.chc.2011.01.011

Villabø, M. A., Narayanan, M., Compton, S. N., Kendall, P. C., & Neumer, S.-P. (2018). Cognitive-Behavioral Therapy for Youth Anxiety: An Effectiveness Evaluation in Community Practice. *Journal of Consulting and Clinical Psychology*, *86*(9), 751–764. https://doi.org/10.1037/ccp0000326

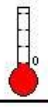
Appendix: Client-Level Tools

Retrospective Trauma Symptoms Pre-Post

NAME_____ **DATE**_____

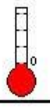
Below is a list of problems that kids sometimes have after experiencing things that scary, bad, or hard.

These questions ask about the thing that bothered you most (whether it was getting hit, beaten up, threatened, or anything else). Listen carefully and circle the words that best describe *how often* these problems used to bother you **before you started working with the counselors** here, and *how often* they bother you **now**.

	0 	1 	2 	3 
A. ***Before*** you started working with the counselors here, how often did you have upsetting thoughts or images that came into your head when you didn't want them to?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days***, how often do you have upsetting thoughts or images that come into your head when you don't want them to?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often did you have bad dreams or nightmares?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days***, how often do you have bad dreams or nightmares?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often did you act or feel like the bad things that happened to you were happening again (for example, feeling as if you were right there again)?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days***, how often do you act or feel like the bad things that happened to you are happening again?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often did you have you had feelings in your body when you thought about or heard about the bad things that have happened to you (for example, breaking out in a sweat, heart beating fast)?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days***, how often do you have feelings in your body when you think about or hear about the bad things that have happened to you (for example, breaking out in a sweat, heart beating fast)?	Never	Once or twice a week	Several times a week	Everyday

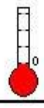
This tool was adapted from Posttraumatic Symptom Scale–Self-Report (Weathers, Blake, et al., 2013) 1

Retrospective Trauma Symptoms Pre-Post

	0 	1 	2 	3 
A. ***Before*** you started working with the counselors here, how often did you try *not* to think about, talk about, or have feelings about the bad things that have happened to you?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often do you try *not* to think about, talk about, or have feelings about the bad things that have happened to you?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often did you try to avoid activities, people, or places that remind you of things that have happened to you (for example, *not* wanting to play outside or go to school)?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often do you try to avoid activities, people, or places that remind you of things that have happened to you (for example, *not* wanting to play outside or go to school)?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often were you unable to remember important parts of bad things that have happened to you?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often are you unable to remember important parts of bad things that have happened to you?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often did you find yourself *not* wanting to do things you used to enjoy?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often do you find yourself *not* wanting to do things you used to enjoy?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often did you avoid the people who are close to you?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often do you avoid the people who are close to you?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often were unable to have strong feelings (for example, being unable to feel very happy)?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often are you unable to have strong feelings (for example, being unable to feel very happy)?	Never	Once or twice a week	Several times a week	Everyday

This tool was adapted from Posttraumatic Symptom Scale–Self-Report (Weathers, Blake, et al., 2013) 2

Retrospective Trauma Symptoms Pre-Post

	0 	1 	2 	3 
A. ***Before*** you started working with the counselors here, how often did you feel hopeless about the future (for example, thinking that you would not have a job or have kids or get an education)?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often do feel hopeless about the future (for example, thinking that you would not have a job or have kids or get an education)?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often have you had trouble falling or staying asleep?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often do you have trouble falling or staying asleep?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often did you feel irritable or have fits of anger?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often do you feel irritable or have fits of anger?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often did you have trouble concentrating (for example, losing track of a story on television, forgetting what you read, not paying attention in class)?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often do you have trouble concentrating (for example, losing track of a story on television, forgetting what you read, not paying attention in class)?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often were you overly careful (for example, checking to see who and what was around you even when you were safe)?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often are you overly careful (for example, checking to see who and what is around you even when you're safe)?	Never	Once or twice a week	Several times a week	Everyday
A. ***Before*** you started working with the counselors here, how often were you jumpy or easily startled (for example, when someone walked up behind you)?	Never	Once or twice a week	Several times a week	Everyday
B. ***These days,*** how often are you jumpy or easily startled (for example, when someone walks up behind you)?	Never	Once or twice a week	Several times a week	Everyday

This tool was adapted from Posttraumatic Symptom Scale–Self-Report (Weathers, Blake, et al., 2013) 3

School:_____Date:_____

For office use (circle):

Tier 2 Tier 3 Individual Group

Completing this questionnaire is voluntary and anonymous, so the answers you provide will not be linked to you, and cannot be shared with your parents, any school personnel, or other officials. Data will only be used to help make the program better and for reports – no names will be included. Your responses will in no way affect your right to access services or supports.

For this questionnaire, we want you to think about *how things were for you before you started participating in this program*, and how things are for you *now*.

Use this guide for choosing a number response: **1**= Not at all true; **2**= Somewhat true; **3**= Neither true or untrue; **4**= True; **5**= Very true.

Please indicate how true these statements were/are for you…	BEFORE you joined the program					NOW				
I think before I act	1	2	3	4	5	1	2	3	4	5
I know where to go for help with a problem	1	2	3	4	5	1	2	3	4	5
I accept responsibility for my actions	1	2	3	4	5	1	2	3	4	5
I know how to avoid conflicts in general	1	2	3	4	5	1	2	3	4	5
I try to work out problems by talking or writing about them	1	2	3	4	5	1	2	3	4	5
Outside of my home there is an adult who really cares about me	1	2	3	4	5	1	2	3	4	5
I stand up for myself without putting others down	1	2	3	4	5	1	2	3	4	5
I try to understand what other people go through	1	2	3	4	5	1	2	3	4	5
I feel bad when someone gets their feelings hurt	1	2	3	4	5	1	2	3	4	5
I know how to avoid physical fights	1	2	3	4	5	1	2	3	4	5
I have a friend my own age who I can talk to about my problems	1	2	3	4	5	1	2	3	4	5
I listen to other people's ideas	1	2	3	4	5	1	2	3	4	5
I have high goals and expectations for myself	1	2	3	4	5	1	2	3	4	5

1. If you feel that working with the counselor(s) has helped you to stay out of fights/conflicts, can you explain how or why you think it helped?

2. Would you participate in this program again if you had another opportunity? Why or why not?

3. Is anything different for you because of the work you did with the counselor(s) (did you learn anything, have you used anything, or did anything change for you)?

4. What would you change about the program?

What is your gender?	**Are you Hispanic or Latino?**	**What race do you consider yourself? You can choose more than one.**
○ Male	○ Yes	○ Black or African American
○ Female	○ No	○ Asian
○ Transgender	○ Decline to answer	○ Native Hawaiian or other Pacific Islander
○ Other		○ American Indian or Alaska Native
○ Decline to answer	**What grade are you in?**	○ White
	_____	○ Other _____
		○ Decline to answer

Focus Group Guides

Student Focus Group

- Why we are here today.
- Introductions: Your name, grade, favorite thing to do on the weekends (normally and now).
- What has working with [Therapist/Youth Engagement-Restorative Justice Specialist] been like? Has it helped?
- What do you think improves for students who participate in these services?
- Has participating helped you cope with any personal struggles that you have experienced or that have been happening in the community?
- Did it feel good or different to work with a black therapist/provider?
- Has working with [Therapist/Youth Engagement-Restorative Justice Specialist] helped you feel proud of who you are as a person of color?
- What would make these services/the program better?
- [Looking at data findings]: What do you make of these findings? Does anything surprise you, or not surprise you?
- Finally, how do you find the evaluation process (the forms they ask you to fill out)?

Final Year Student Focus Group/Interviews

- Why we are here today.
- Introductions: your name, grade, favorite thing to do on the weekends (normally and now).
- What has this year been like?
- Has in-person school shutting down made it harder to connect with teachers and friends?
- What has working with Experience Hope staff been like? Has it helped?
- Has it helped you cope with any personal struggles that you have experienced or that have been happening in the community?
- Have you had experience hope staff join in your zoom classrooms? Has that been helpful?
- How did it feel to work with a black therapist/provider?
- Are there any skills you've developed because of your work with the Experience Hope staff?
- Has being in the program helped you feel proud of who you are as a person of color?
- What can you suggest to improve the program?

Parent/Guardian Interviews

- Why we are here today.
- How has it been working with Experience Hope staff?
- Have you observed any changes in your child since working with Experience Hope staff?
- Do you think it has made a difference for students to have a black therapist/provider to work with?
- Are there any ways you can think of to improve the way that this program (or programs like it) work with youth?
- Any other thoughts?

Teacher/Staff Interviews

- Why we are here today.

- Some challenges this year? How has COVID affected students or your teaching?
- How has it been working with Experience Hope staff?
- Have you observed any changes or improvements among the students with whom Experience Hope staff have been working?
- Do you think it has made a difference for students to have a black therapist/provider to work with?
- Some teachers are reluctant to have mental health providers push in or pull out during instructional time. How have you felt about allowing that and why?
- Are there any ways you can think of to improve the way that this program (or programs like it) partner with your school?
- Any other thoughts?