DEPARTMENT OF FAMILY AND SUPPORT SERVICES
Youth Services Division
Behavioral Health Services

2020 Scope of Services

Contract Term: **January 1, 2020 through December 31, 2020**

Program and Delegate Information

Program Model: **Behavioral Health Services (BHS)**
Program Name:
PO Number:
Grant Amount:
Number of youth:

Delegate Agency Information
Agency Name:
Agency Address:
City, State, Zip Code:

Executive Director Name:
Executive Director Phone:
Executive Director Email:

Fiscal Contact Name:
Fiscal Contact Phone:
Fiscal Contact Email:

Program Staff Contact Name:
Program Staff Title:
Program Staff Contact Phone:
Program Staff Contact Email:

Facility/Site Information:

List name of facility(ies) and address(es) where services are provided. Also include amount of contract allocated per site and estimated number of clients to be served at each site.

Site Name	Address Number	Direction	Street	Ward	Days of Operation	Community	Hours of Operation	Estimated Amount of Contract allocated for this site	Clients Served

2020 Scope of Services

Description of Program Services:

2020 Scope of Services

SECTION A – GOALS AND OBJECTIVES

Program Goals

The Behavioral Health Services Program (BHS) is a counseling initiative aimed at providing mental, emotional, and behavioral counseling to Chicago's youth who have impairments, disorders, or concerns in these counseling areas. DFSS is contracting with delegate agencies to provide outpatient mental health services. These services include individual, family, and group mental health counseling.

The goal of the counseling services provided under the BHS model is to alleviate mental, emotional or behavioral impairments that prevent youth from functioning in their everyday lives at school, work, and/or in their communities. The counseling should help youth increase their understanding and use of coping mechanisms and skills. The counselor should also help them create an action plan so they can continue to improve their quality of life.

Target Population

Youth eligible for BHS programming are youth ages 10-24. Youth must also be ***Medicaid ineligible***, ***lack medical insurance or lack medical coverage*** (this will be certified in Cityspan). Services delivered under the Behavioral Health Services contract will focus on providing mental, emotional, and behavioral health services to the populations listed below:

- *Black/African American:* According to a 2016 study published in the International Journal of Health Services, Black youth and young adults are half as likely as their white counterparts to get mental health care despite having similar rates of mental health problems. The study also notes the under-provision of mental health care for minority children contrast starkly with the high frequency of punitive sanctions that their behaviors elicit. Black children suffer excessive rates of school discipline such as suspension and expulsions starting at preschool ages.
- *Hispanic/Latino:* The American Psychiatric Association estimates that among Hispanics with a mental disorder, fewer than 1 in 11 contact a mental health specialist. This can have serious consequences for Hispanic youth who, similarly to Black youth, are overrepresented in the criminal justice system while also being underrepresented in the receipt of mental health care. 36% of Hispanic youth have pervasive feelings of sadness and hopelessness, compared to 26% of whites. Additionally, lack of health insurance is a significant barrier for Hispanic youth making access to mental health services, that much more difficult.
- *Homeless/Unstably Housed:* Chicago Public School data for 2016 – 2017 shows that CPS identified 82.9% of its homeless students as Black/African American and 13.2% as Hispanic/Latino. According to a 2015 National Health Care for the Homeless Council (NHCHC), quarterly research review, rates of having at least one psychiatric disorder among homeless youth can be as high as four times the rate of youth in the general population. Additionally, over 50% of homeless youth have made multiple suicide attempts. And, because homeless youth are a diverse population, NHCHC states that "youth may be labeled and further

marginalized by these factors, increasing their risk of poor mental and physical health outcomes."

SECTION B – PERFORMANCE MEASUREMENT

Overview

DFSS intends for Behavioral Health Services programing to provide outpatient mental health counseling for youth who have mental health disorders, behavioral issues, and/or emotional impairments that prevent them from living a healthy life where they can effectively function in school, at work, and in their communities.

A 'healthy life' is characterized as youth achieving developmental and emotional milestones, healthy social development, and effective coping skills. The goal of any of the services provided under the Behavioral Health Services contract is to decrease the youth's impairments, increase their understanding and use of coping mechanisms and skills, and help them create an action plan so they can continue to improve their quality of life.

Unfortunately, many youth and young adults experience mental, emotional, and behavioral disorders, while also lacking access to resources and/or an understanding of what resources are available. Some statistics that highlight this crisis are:

- 48 percent of Americans will have a diagnosable psychiatric illness in the course of their lifetime. 75 percent of those illnesses will begin before the end of adolescence and 50 percent will start before the age of 16. (Source: National Comorbidity Survey Replication, Ronald Kessler, 2005)
- 3.2 million children live in Illinois (Source: 2009 U.S. Census Bureau) and 7.5 percent of Illinois children ages 3-17 are reported to have moderate or severe social or emotional difficulties. For children living in poverty, rates of mental and emotional difficulties are reported even higher, at 14.6 percent. (Source: Voices for Illinois Children, 2007)
- 53 percent of children ages 3-17 have one or more emotional, behavioral, or developmental condition. (Source: ILCHF)
- A survey of child care providers in 10 Chicago centers found 32 percent of children (including toddlers) had behavioral problems. (Source: Illinois Children's Mental Health Task Force, 2003)
- Illinois ranks third in the nation when it comes to states with the highest dollar amounts cut from mental health programs. (Source: Medill Reports Chicago)
- Six of Chicago's 12 mental health care facilities have been closed down by the state, including facilities in the heart of the city's African-American community on the South Side. (Source: Medill Reports Chicago) 35-40 percent of children are likely to screen positive for behavioral/mental health concerns. (Source: American Association of Pediatrics, 2013)
- A recent study in Chicago found that nearly 50 percent of inner-city adolescents demonstrated signs and symptoms of depression. (Source: Illinois Children's Mental Health Task Force, 2003)

- 34 percent of Chicago adolescents suffered signs of depression for two or more consecutive weeks, which prevented them from doing usual activities. (Source: Illinois Children's Mental Health Task Force, 2003)
- Rates of positive depression screening are likely to increase due to the number of foreclosures, unemployment, deportation, crime and school closings; children are among the most affected. (Source: Illinois Children's Mental Health Task Force, 2003)
- Adverse childhood experiences have been related to increased vulnerability to health problems such as chronic obstructive pulmonary disorder. (Source: Centers for Disease Control, 2013)
- 70 percent of the population in the juvenile justice system has mental health problems, the majority of which could have been prevented with intervention earlier in life. (Source: Illinois Children's Mental Health Task Force, 2003)

In order to address the mental health concerns noted above, DFSS has selected six key focus areas for mental health service delivery:

Anger Management

Anger management issues often accompany other markers of instability among youth, such as: high levels of school detentions, suspensions, and expulsions; increased anti-social behavior; as well as, police contact and justice system involvement. Uncontrolled anger can also lead to depression and suicidal thoughts, drug and alcohol abuse, and poor inter-personal relationships. According to NCIB, mood disorders occur in up to 25% of youth who end up in the juvenile justice system. These mood disorders increase the youth's risk of engaging in physically aggressive acts and altercations as well as increasing the risk of self-injurious behaviors. Additionally, Grisso (2008) indicates that there is substantial evidence that youth with disruptive behavior disorders display more physically aggressive behavior.

Learning how to manage emotions and channel anger in a healthy way is one of the hallmarks of a healthy mental and emotional state. DFSS is looking to fund Anger Management programs that have a history of success and proven techniques. Ideal Respondents will also demonstrate a deep understanding of the underlying factors and causes of anger management issues and of the clients they seek to treat.

Care Coordination (no current agency provides this services)

The objective of Care Coordination is to improve the overall engagement and retention of youth who are in mental, emotional, or behavioral health counseling by focusing on both their counseling needs as well as other supportive services. Supportive services are critical components of a behavioral health system and are, in many cases, the missing link to the youth's success. Care Coordination focuses on connecting clients with housing stability, employment, education, and other relevant counseling and supports. This is particularly important when considering that many youth experiences dual or multiple diagnoses. For instance: the Health Resources and Services Administration states that homeless youth suffer mental illness at rates of anywhere from 19-50%; according Youth.gov, 60%-75% of youth with substance abuse problems also have a mental health disorder; research performed by Wagner and Cameto (2004) showed that secondary school students who suffer from mental illness are more likely

to earn failing grades across all subjects and are retained at grade level more often than youth with disabilities as a whole.

Helping youth who are currently receiving counseling and who have other supportive needs, is one of the ways DFSS seeks to simply the youth and their families' experiences in the public system. In many cases, a single point of contact for coordinated care can increase use of existing services. DFSS is looking to fund Care Coordination models that focus on engagement and outreach, service linkage and connection, and intensive case management. Ideal Respondents will be able to clearly articulate their program model and demonstrate their competency at each point in the process – from recruitment and engagement to case management.

Psychiatric Services

Many Chicago youth are in need of psychiatric services and psychotropic medication. In all professionally accepted and current medical research, Black/African American, Hispanic/Latino, and youth who live and poverty, have markedly reduced access to the mental health services they need. Ensuring valuable psychiatric services to eligible youth is one way DFSS aims to significantly reduce the barriers to mental, emotional, and behavioral health services.

Sexual Abuse Counseling

The occurrence of sexual abuse among children is more prevalent that many suspect. According to the Chicago Children's Advocacy Center, in the United States, an estimated 1 in 7 girls and 1 in 25 boys are sexually abused before turning 18. Statistics show that children living without either parent (foster children) are 10 times more likely to be sexually abused than children that live with both biological parents. Justice involved girls were twice as likely as boys to report sexual abuse (32% vs. 16%), and girls were four times more likely than boys to have experienced sexual assault (39% vs. 9%) (OJJDP, 2016). Furthermore, substance abuse and behavioral problems, including physical aggression occur frequently among sexually abused children and adolescents. These emotional and behavioral difficulties can lead to delinquency, poor school performance and dropping out of school as well as other issues that will prevent youth from becoming successful and productive adults.

Sexual Identification and Orientation

Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) youth are more likely to have mental health challenges than the general population of youth due to experiencing fear, hatred, prejudice, rejection in school, with friends and family, and in the community. According to the UC Davis Center, 2009, the most common mental health concerns described by LGBTQ youth were isolation, depression, suicide and drug and alcohol abuse. For LGBTQ youth ages 10-24, suicide is one of the leading causes of death. The National Alliance on Mental Illness says early intervention, comprehensive treatment and family support are the keys to helping LGBTQ youth cope and be successful.

Substance Abuse Counseling

Substance use and addiction are leading national health problems. Research suggests 1 in 10 American adults and teenagers have a Substance Use Disorder. Alcohol, marijuana and tobacco are the most commonly abused substances by teenagers as published by the U.S. Department of Health and Human

Services (HHS) Office of Adolescent Health. Current trends in Substance Use among adolescents suggest that after marijuana, prescription and over the counter medications account for most of the top drugs used by 12th graders in the past year. Abusing drugs at a young age raises many medical and mental health concerns, negatively impacts someone on a social, economic, or interpersonal level, and decreases work or school production. Drug abuse can exacerbate underlying mental health issues and may lead to addiction. According to the National Survey on Drug Use and Health (NSDUH) in 2013, adults were three times more likely to have a substance abuse problem or dependency issue, if they abused marijuana before age 14 as opposed to those who waited until at least 18 to try the drug.

Performance Outcomes

DFSS has identified outcomes that are good core indicators of improvement in the following areas listed below. The expectation is that counseling administered under the Behavioral Health Services contract will help youth achieve positive gains in at least one of the following six areas:

1. ***Family Functioning:*** Youth should show an improvement in their family dynamics; improvement in their interpersonal family relationships; and, an overall improved outlook on their family life.
2. ***Peer Relations:*** Youth should have stronger and healthier peer relations. This can be exhibited in many ways, including: decrease in arguments, fights, or other behavior that results from negative attitudes; associating with an improved group of youth who are involved in positive activities; and, ability to develop healthy social attachments with peers.
3. ***Community Attachment:*** Youth should show an awareness of their place in their community by understanding the effect their actions – positive or negative- have. They should also show an increased interest in adding to their community in positive ways via community service and service-learning projects. In cases where the youth's criminal activity has caused a breach in their community relations, youth should show a desire to restore the community's trust in them and a desire to refrain from similar actions, in the future.
4. ***Individual Behavior:*** Youth should show a decrease in any of numerous negative behaviors they may be exhibiting upon beginning counseling services. Broadly, they should show a desire to make better choices and demonstrate that they have acquired skills and coping mechanisms to help them do so.
5. ***Academic achievement and school readiness:*** Youth should show an improvement in school-related behaviors such as: increased attendance; decreased detentions and suspensions; increased engagement in class and the broader school community; joining any number of school-focused activities and extracurriculars; improvement in grades; increased willingness to exert effort in the achievement of school-related goals; and, an increased likelihood of promotion to the next grade or graduation.
6. ***Reduced recidivism:*** Youth should have reduced contact with police; reduced arrests; and, reduced incarceration incidences.

More specifically, each client's treatment plan will guide performance outcomes due to the individualized sensitive nature of mental health counseling. To track progress toward achieving individual client goals, DFSS will monitor the following:

Outcome	Data Collection Method
100% of youth will complete an initial assessment and individual treatment plan	Cityspan report
85% of eligible youth engage in mental health counseling for at least three months.	Cityspan report
70% of eligible youth will complete at least one of their treatment plan goals.	Cityspan outcome form
100 % of eligible youth who complete mental health counseling will develop a transitional plan with their therapist.	Cityspan outcome form

Data Reporting

Reliable and relevant data is necessary to ensure compliance, inform trends to be monitored, evaluate program results and performance, and adjust program delivery and policy to drive improved results. As such, DFSS reserves the right to request/collect other key data and metrics from delegate agencies, including client-level demographic, performance, and service data, and set expectations for what this collaboration, including key performance objectives, will look like in any resulting contract.

Upon contract award, delegate agencies will be expected to collect, and report client-level demographic, performance, and service data as stated in any resulting contract. These reports must be submitted in a format specified by DFSS and by the deadlines established by DFSS. Delegate agencies must implement policies and procedures to ensure privacy and confidentiality of client records for both paper files and electronic databases. Delegate agencies must have the ability to submit reports electronically to DFSS. The City's Information Security and Information Technology Policies are located at https://www.cityofchicago.org/city/en/depts/doit/supp_info/is-and-it-policies.html.

Meetings

Regular reviews of and conversations around program performance, program results and program data, particularly related to the goals outlined in this agreement, will allow DFSS and the delegate agencies to employ real-time information to track performance, identify good practices, and effectively address any challenges experienced on the ground by delegate agencies and the target population.

At such meetings, the parties will review data and reports to: a) Monitor progress, highlight accomplishments, and identify concerns b) Collaboratively design and implement operational changes to continuously improve processes and outcomes c) Develop strategies on broader systems changes to improve service delivery and coordination between services

Periodic meetings may take place according to a schedule to be established by DFSS, with reasonable notice provided for delegates. Meetings shall include, at least, the DFSS Division Director, or designee, and the delegate agency's chief executive officer, or designee. Each party may be represented by additional representatives as such party deems appropriate. DFSS may request the attendance of additional parties as it deems appropriate. Representatives from delegate agencies will attend all meetings as requested by the Department. Meetings may take place individually or jointly with other delegate agencies**.**

Uses of Data

DFSS reserves the right to use data related to delegate agency performance, including but not limited to data submitted by the delegate agency for the following:
a) To review program performance and develop strategies to improve program quality throughout the term of the contract. In the event of under-performance at the end of the first, second or third quarter (as deemed appropriate by the DFSS Program Manager/Liaison) the delegate agency must submit a Corrective Action Plan (CAP) in writing to indicate how they will improve performance by the next quarter.
b) To guide DFSS program development, evaluate programs, inform policies, and inform contract decisions such as payment rates, contract extensions or renewals, and evaluation of proposals by the delegate agency in response to any future solicitations by DFSS for goods or services.
c) Any other purposes identified by DFSS.

SECTION C – CORE ELEMENTS

Eligibility:

- Counseling should last ***at least*** 3 months and as long as a year
- Counseling should provide ***at least*** 4 hours of service per month and more, if needed
- Counseling should be provided ***in community*** at the agency's office, satellite location, or other appropriate off-site location. Counseling services should not be provided in school.

SECTION D – PAYMENT STRUCTURE

Method of Payment

Agencies should be aware that the City will make payments for services on a reimbursement basis. Payment will be made 30 days after voucher approval. Agencies must be able to proceed with program operations upon award notification. Agencies must be able to demonstrate a **minimum 15% percent in-kind match** within the mentoring budget and administrative costs will be capped at 15% percent. Vouchers must be submitted 15 calendar days after the end of the month in which services were performed.

SECTION E – SUBMITTAL AND APPROVAL

ACKNOWLEDGEMENT

Agency Name:

Agency PO#:

☐ By checking this box your agency certifies that it has read and understands Sections A, B, C, and D of this document.

a) Applicant signature (Original must be signed in blue ink)	
b) Name (typed)	
c) Date submitted	
d) DFSS Staff signature	
e) Name (typed)	
f) Date approved	

****This document must be printed in portrait style and single sided****