MEMORANDUM

TO: **MARTHA GUERRERO, CRISTINA OCON, ANDREW FERNANDEZ**

FROM: **RICH HOROWITZ, LCSW, ACSW**

RE: **TRUMAN GRANT PROPOSAL**

DATE: **19 MAY 2021**

Here is the updated version of the grant proposal for Truman. Please amend figures highlighted in red on p. 3 and enter financial data on p. 12.

A PROPOSAL FOR

CLINICAL SERVICES

TO

CITY COLLEGES OF CHICAGO

TRUMAN MIDDLE COLLEGE HIGH SCHOOL

FROM AUGUST 31, 2021 THROUGH JUNE 23, 2022

BY

SGA YOUTH & FAMILY SERVICES
11 EAST ADAMS, SUITE 1500
Chicago, IL 60603

MARTHA GUERRERO

PRESIDENT

SUBMITTED xxxx, 2021

PROJECT ABSTRACT

SGA Youth & Family Services, formerly Scholarship and Guidance Association, proposes to provide group and individual counseling to students, training to faculty, and consultation with the Principal of Truman Middle College High School (TMCHS).

SGA's goals are to assist this at-risk student population to cope more adequately with the problems that have brought about drop-out behavior and poor academic functioning, to work with the parents, to network with other social service agencies to create a positive support system for the adolescents, and to consult with staff in building and maintaining a unified learning strategies/behavioral intervention approach. SGA's ultimate purpose is to assist in the retention of these students in the Middle College system so they can graduate and function more constructively and with greater satisfaction as young adults.

SGA will supply a part time (60%) Licensed Clinical Social Worker.

The 8/24/21 through 6/23/22 contract proposal requests $75,000 for clinical and supportive services to be provided to 104 students at the site.

Detail of Contract Services:
Subcontract :Youth Connection Charter School: 8/24/21 - 1/27/22 (on Behalf of Truman Middle College) = $37,500 PAID

Contract: City Colleges of Chicago: 1/31/22 - 6/23/22 = $37,500 (Balance through 6.23.22)

OVERVIEW OF PROJECT

From the inception of the project in March 1986 through June 2021, SGA Youth & Family Services has continued to provide clinical services to the alternative education program. SGA has had a strong identification with and commitment to the Middle College program throughout these years. This commitment remained steadfast through the financial crisis in the fall of 1987 when all funding for clinical services was eliminated. In response to the urgent need, SGA decided, at its own expense, to continue to deploy a Clinical Social Worker one day per week at each school, i.e., at Olive-Harvey Middle College High School and at TMCHS. This continued until the partial reinstatement of funds in January 1988. During FY 89 Olive-Harvey declined clinical services, but SGA continued to provide a Clinical Social Worker at TMCHS until November 1, 1988, when services were expanded to three days per week. In addition, faculty training sessions began on a monthly basis at that time. During FY 94 the Social Worker‘s hours increased to four days per week. During 2018-19, the number of days was trimmed from four to three. The 2020-21 academic year brought a further reduction in hours from 24 to 21.

SGA has a specific philosophical orientation to clinical counseling with students. SGA’s experience of 110 years (35 of those with TMCHS) continues to confirm the view that the majority of dropouts are burdened with varying degrees of disturbances in their emotional lives that constitute impediments to the educational process. SGA addresses these disturbances by working with the student in an individual and group psychological context as well as in an environmental context. Environmental factors include interactions with nuclear and extended family members, significant others such as foster parents, and larger systems such as juvenile justice and child welfare. Accordingly, SGA works with parents, probation officers, day care resources and others. The student is viewed from a number of developmental models which enable SGA to explain and account for the difficulties that the student experiences. SGA believes there is a strong urge toward normalcy in everyone and sees a high school education as one of the most important foundation ingredients in a well-adjusted adult.

With this agency orientation as background, four basic services will be provided. They are group/individual counseling to students, staff training, clinical support regarding student concerns, and consultation with the Principal. Based on the concentration of student drop-outs and on last year’s experience, SGA plans to provide a three days per week 60% Clinical Social Worker at TMCHS who will offer both planned and spontaneous clinical social work interventions to the students.

PROGRAM

The program SGA Youth & Family Services proposes is fundamentally a continuation and an elaboration of the current effort. Specifically, SGA proposes a combination of direct services to students, consultation to the Principal, and clinical training to faculty and staff. Direct services will include individual and group counseling with students (see Exhibit A - Life Skills). Student counseling services will be initiated in one of the following manners: referral from school personnel and/or student's self-referral, either of which will be followed up by a screening interview. The Life Skills group experience will be integrated into the academic curriculum. For the 29th consecutive year, the life skills groups have been helpful in:

- Facilitating developmental transitions
- Improving goal setting and stress management as well as enhancing coping skills and building resilience
- Aiding in the early identification of problems affecting members in this group

SGA has also found that a significant number of these students wish to be involved in the traditional long-term treatment program in addition to Life Skills groups. For FY21 20% of Life Skills students participated in individual counseling or Active Minds. Students in crisis will continue to be seen upon referral by a faculty member. Students already involved in the school program will be briefly re-screened and provided appropriate service.

Students for whom group counseling is not appropriate and/or who require additional clinical involvement will be offered individual counseling on site. Outside referral will be made when appropriate.

Students must feel the combined, coordinated support of all educational, psychological and social resources. The helping process, as a team effort, is often complicated because of the different perspectives and orientations of the assembled professionals. This is addressed by consultation and training which will involve informal and formal collaborative work. Formal training (see Exhibit B) followed by discussions is a necessary component to an integrated and cohesive team approach. The nature of the consultation and training will again be based on a faculty needs assessment conducted early in the school year.

One 60% - time Clinical Social Worker will be able to serve the student body at TMCHS. Clinical services will be offered by the Clinical Social Worker three days per week, Tuesday through Thursday, on site. The Clinical Social Worker will spend Fridays at SGA's Loop office in specialized training activities, supervision, and other responsibilities.

Number of Students to be Served and Amount of Service

A. Group Counseling

In anticipation of serving 104 (unduplicated) students, SGA plans to see 24 students in individual treatment and about 80 in Life Skills groups. The Life Skills groups will be woven into the regular school curriculum and include club meetings. Based on these projections, we anticipate amassing 380 units or hours comprised of 180 units in Life Skills and 200 units in individual counseling.

B. Individual Counseling

Individual counseling will be offered to students requiring more intensive support and/or as an adjunct to group counseling. Most new students will be individually screened. This will enable us to gain better contact with students in the program and provide SGA with comprehensive background information, which is invaluable in counseling this population. Approximately 200 hours of individual counseling are anticipated.

EVALUATION

Evaluation of the program's effectiveness is measured in two ways (see Exhibit C):

1. Clients participating in psychotherapy services fill out client satisfaction surveys at the completion of their counseling sessions.

2. All psychotherapy participants determine goals to be achieved through counseling. At three-month intervals each client assesses progress towards those goals. Comparisons indicate changes in functioning during treatment.

A SUMMARY OF CLINICAL ACTIVITY
AT
TRUMAN MIDDLE COLLEGE HIGH SCHOOL (TMCHS)

From 10/27/20 through 5/19/21

Student Services

A. Group Psychotherapy: During the 2020-2021 school year, a total of 20 Life Skills (LS) seminars (*Mental Health Awareness* and *Stress Management and Mental Health: Ten Best Practices*) were run at TMCHS and two workshops in conjunction with SGA's Higher Sights program (see below). In addition, students were seen in a school club - Active Minds. 82 students were served in 178 group counseling hours. As has been the custom in previous years, a significant number of students (see p. 5 for the data) in the LS groups were also seen in longer-term counseling.

The all-school workshops noted above were:
Strategies for Wellness: Self-Care Amid the Pandemic and
Strengthening Resilience: Its Importance for Emotional Well-Being

B. Individual Psychotherapy: During the 2020-2021 school year, 181 individual counseling and screening hours were logged. In total, 19 students had individual therapeutic contact with the Clinical Social Worker. Individual counseling was comprised of ongoing psychotherapy, individual screening, crisis intervention, family therapy, and collateral contact.

B. Life Skills (LS) Groups

The purpose of these groups is to encourage discussion about social skills topics pertinent to adolescents and to familiarize students with the counseling services available to them at the school. Among the topics reviewed in the past year were mental health awareness and stress management. The Life Skills groups have met during advisory seminars. The intent is to lend emotional support and devise strategies to ease the transition into a college environment.

For more than twenty-seven years now, the social worker has been an integral part of Truman Middle College.

Summary of Students Served
and
Amount of Service Rendered
Through 5/19/21

STUDENTS SERVED	**Totals** 10/27/20-5/19/21	**Projected** 8/24/21-6/16/22
# of students in LS groups	80	80
# of students with individual therapeutic contact	19	24
Total # of students (unduplicated)	94	104
PSYCHOTHERAPY HOURS		
# of hours in life skills groups &clubs	178	180
# of hours in individual counseling	181	200
Total # of counseling hours	359	380
NUMBER OF GROUPS		
Life Skills Seminars	20	15
Clubs	1	1

Interpretation of Statistics

The total units of service delivered in the current academic year were comparable with the revised figures calculated after a contract negotiation resulted in a two-month delay in the delivery of social work services. Despite losing that critical period at the outset of the school year and facing sharp reductions in overall school attendance stemming from the ongoing pandemic, the overall figures came remarkably close to the original projections.

The faculty and staff have remained unfailingly supportive of the social worker who has been at the school for more than twenty-seven years. We look forward to another fruitful year that will build on the longstanding relationship between SGA Youth & Family Services and Truman Middle College.

CLINICAL SERVICES TO THE FACULTY

A. Training

Case Presentation and Team Building

Two presentations (Exhibit B) were made to the faculty and staff.

Our first, on *Suicide Prevention* (November 11, 2020), underscored the enormous complexities of the problem compounded by a once-in-a-century pandemic deepening social isolation. The latest CDC report covering June 24-30, 2020 reveals that the percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7%) was significantly higher among respondents aged 18–24 years (25.5%) and minority racial/ethnic groups (Hispanic respondents [18.6%], non-Hispanic black respondents [15.1%]).

We underlined the high likelihood that psychiatric disorders will emerge during high school years and the importance of faculty and staff to stay alert to changes in presentation and empathize with students who may fear reaching out for support. We also stressed the importance of creating a climate that openly acknowledges the importance of mental health in school performance and overall well-being. The Middle College then becomes a major protective factor in ensuring mental health.

Our second presentation dealt with *LGBTQ Youth: Identity Formation and Meanings for Schools* (November 19, 2020). We devoted special attention to cyberbullying, an increasingly common phenomenon. According to a CDC report, fifteen percent of high school students reported being cyberbullied in the past year. Cyberbullying is associated with anxiety, depression, suicidal ideation and suicide attempts, somatic complaints and compromised physical health, symptoms of post-traumatic stress disorder (PTSD), and academic difficulties. Schools can work towards preventing cyberbullying by directly tackling the issue through the school's curriculum in age-appropriate fashion. Social emotional learning is one of the core supports effective anti-bullying programs are founded on.

In addition, two presentations on *Emotional Well-Being Amid the Pandemic* were made to parents on December 15, 2020 and March 23, 2021.

B. Consultation

Ad hoc consultation to the Principal and faculty was provided again this year, focusing on maintaining a clinical orientation toward student concerns and conflict resolution.

SGA/Truman Middle College High School
BUDGET
FY' 22

Services provided by Masters Level Clinical Social Worker ($75.00 per hour x 23.80 hrs. per week x 42 weeks)	$75,000

SIGNATURES

Michelle Yoo, Principal, Truman Middle College Date

Susana Marotta, CEO, SGA Youth & Family Services Date

SGA/Truman Middle College High School
BUDGET
FY'22

Services provided by Masters Level Clinical Social Worker ($xx.00 per hour x 21 hrs. per week x 42 weeks)	$xx,xxx
Amount of Total Costs Covered by Truman	$xx,xxx
Percent of Total Costs Covered by Truman	xx%
Amount of Total Costs Covered by SGA	$xx,xxx
Percent of Total Costs Covered by SGA	xx%

SIGNATURES

Michelle Yoo Bremehr, Principal, Truman Middle College Date

Martha Guerrero, President, SGA Youth & Family Services Date

EXHIBIT A

SGA YOUTH & FAMILY SERVICES
School Counseling Program
Comparison of Traditional Counseling Groups
To Life Skills Groups

	Traditional Counseling	**Life Skills Groups**
Purposes:	To gain insight into motivation of dysfunctional behavior.	To learn skills to aid in personal development.
Sizes:	5 to 10 members	15 to 20 members
Duration:	Once a week, typically for the length of the year	Once a week for a limited time (8 weeks).
Assessment:	Individual screening interview required.	No individual screening.
Structure/Format:	Tendency is toward an interpretive, therapeutic format.	Tendency is toward an educational focus
	More emphasis on process	More emphasis on content
	More of an intrapsychic, looking inside focus.	More of interpersonal, looking outside focus.
	Clinical orientation	Didactic orientation
	Unstructured conversation facilitated by the clinical social worker.	Structured presentation of lecture, discussion, role-play, and/or visual led by CSW.
Confidentiality:	Necessary	Not necessary.
Membership:	Voluntary. Selected through screening.	Required as part of curriculum and by virtue of assignment to class.
Groupings:	Teen mothers, students exhibiting discipline and attendance problems, students living semi-independently, etc.	New students and/or students who need generic exposure to an issue or topic.
Awarded High School Credit:	No (Distortion of the therapeutic process).	Yes (facilitation of the Educational process).

EXHIBIT B

SUICIDE PREVENTION: OUT OF THE DARKNESS
SGA YOUTH & FAMILY SERVICES
Rich Horowitz, LCSW, ACSW
11 November 2020

"Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self--to the mediating intellect--as to verge close to being beyond description. It thus remains nearly incomprehensible to those who have not experienced it in its extreme mode, although the gloom, "the blues" which people go through occasionally and associate with the general hassle of everyday existence are of such prevalence that they do give many individuals a hint of the illness in its catastrophic form."

-William Styron, *Darkness Visible*, 1990, p.7

"It is often easier to account for a suicide by external causes like marital or work problems, physical illness, financial stress or trouble with the law than it is to attribute it to mental illness. Certainly, stress is important and often interacts dangerously with depression. But the most important risk factor for suicide is mental illness, especially depression or bipolar disorder (also known as manic-depressive illness). When depression is accompanied by alcohol or drug abuse, which it commonly is, the risk of suicide increases perilously."

-Kay Redfield Jamison, "To Know Suicide", *New York Times*, August 15, 2014.

TOP TEN FINDINGS:
SUICIDE PREVENTION RESEARCH*

**https://afsp.org/what-we-ve-learned-through-research*

1. Suicide is related to brain functions that affect decision-making and behavioral control, making it difficult for people to find positive solutions.

2. Limiting a person's access to methods of killing themselves dramatically decreases suicide rates in communities.

3. Ninety percent of people who die by suicide have an underlying — and potentially treatable — mental health condition.

4. Depression, bipolar disorder, and substance use are strongly linked to suicidal thinking and behavior.

5. Specific treatments used by mental health professionals — such as Cognitive Behavior Therapy-SP and Dialectical Behavior Therapy — have been proven to help people manage their suicidal ideation and behavior.

6. No one takes their life for a single reason. Life stresses combined with known risk factors, such as childhood trauma, substance use — or even chronic physical pain — can contribute to someone taking their life.

7. Asking someone directly if they're thinking about suicide won't "put the idea in their head" — most will be relieved someone starts a conversation.

8. Certain medications used to treat depression or stabilize mood have been proven to help people reduce suicidal thoughts and behavior.

9. If someone can get through the intense, and short, moment of active suicidal crisis, chances are they will not die by suicide.

10. Most people who survive a suicide attempt (85 to 95 percent) go on to engage in life.

I. FACTS ABOUT SUICIDE [1,2,3,4,5,6]

A. According to the most current data from the Centers for Disease Control and Prevention, there were 48, 344 suicides in 2018, evidence of a continuing rise. From 1999-2018 national rates have soared 35%.

1. Latest CDC report covering June 24-30, 2020 reveals that the percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7%) was significantly higher among respondents aged 18–24 years (25.5%) and minority racial/ethnic groups (Hispanic respondents [18.6%], non-Hispanic black [black] respondents [15.1%]).

2. The National Institutes of Health spent more money researching dietary supplements than suicide and suicide prevention.

3. Rates of death from heart disease and HIV have plunged but not suicide. The lack of research dollars reflects stigma.

B. Suicide is the tenth leading cause of death overall but second among Americans aged 15-34 and 4th leading cause of death for ages 35-54.

1. The suicide rate for males aged 15–19 years has risen by 31% from 2007-2015. Rates for females doubled from 2007 to 2015 (from 2.4 to 5.1 per 100,000 population). The rate in 2015 was the highest for females for the 1975–2015 period (CDC).

C. The 2015 Youth Risk Behaviors Survey showed that 8.6 percent of youth in grades 9-12 reported that they had made at least one suicide attempt in the past 12 months.

D. Upwards of 90% of people who die by suicide are suffering from one or more psychiatric disorders.

1. Often, however, these disorders had not been recognized, diagnosed, or adequately treated.

2. Although the latest CDC report states that more than half of suicides were among people with no diagnosed mental health condition, psychological autopsies show that

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[1] American Foundation for Suicide Prevention https://afsp.org/about-suicide/suicide-statistics/
[2] Center for Disease Control and Prevention https://www.cdc.gov/vitalsigns/pdf/vs-0618-suicide-H.pdf
[3] National Institute of Mental Health http://www.nimh.nih.gov/health/topics/suicide-prevention/
[4] https://www.nytimes.com/2018/06/08/health/suicide-spade-bordain-cdc.html
[5] The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf
[6] Increase in Suicide Mortality in the United States, 1999–2018 https://www.cdc.gov/nchs/products/databriefs/db362.htm

people had evidence of a mental health condition. They were simply never diagnosed, meaning they were not receiving the help they needed.

3. *The onset of most psychiatric disorders associated with suicide is late adolescence or early adulthood. The risk of suicide is much greater early on in the illness when someone is least likely to be diagnosed, least likely to be treated, and least likely to be compliant with medication.*

E. Suicide among males is 3.5 times higher than among females.

F. In 2017 there were more than twice as many suicides as homicides.

II. RISK FACTORS FOR SUICIDE

A. Mental health conditions

1. Depression
2. Bipolar (manic-depressive) disorder
3. Schizophrenia
4. Borderline or antisocial personality disorder
5. Conduct disorder
6. Psychotic disorders, or psychotic symptoms in the context of any disorder
7. Anxiety disorders
8. Substance abuse disorders
9. Serious or chronic health condition and/or pain

B. Environmental Factors

1. Stressful life events which may include a death, divorce, or job loss
2. Prolonged stress factors which may include harassment, bullying, relationship problems, and unemployment
3. Access to lethal means including firearms and drugs
    a. Half of all suicides result from guns
    b. Most often we hear about guns and homicides. However, according to the CDC's latest figures through 2017 approximately 60% of all gun-related deaths are suicides.
4. Exposure to another person's suicide, or to graphic or sensationalized accounts of suicide

C. Historical Factors

1. Previous suicide attempts
2. Family history of suicide attempts

Erika's Lighthouse
https://vimeo.com/282907828/d5e633e16c

III. RECOGNIZING WARNING SIGNS

A. Talk

If a person talks about:

1. Being a burden to others
2. Feeling trapped
3. Experiencing unbearable pain
4. Having no reason to live
5. Killing themselves

B. Behavior

Specific things to look out for include:

1. Increased use of alcohol or drugs

2. Looking for a way to kill themselves, such as searching online for materials or means
3. Acting recklessly
4. Withdrawing from activities
5. Isolating from family and friends
6. Sleeping too much or too little
7. Visiting or calling people to say goodbye
8. Giving away prized possessions
9. Aggression

C. Mood

People who are considering suicide often display one or more of the following moods:

1. Depression
2. Loss of interest
3. Rage
4. Irritability
5. Humiliation
6. Anxiety

D. Identify Persons at Risk and Arrange Appropriate Referrals

1. Take evidence of any of the above with great seriousness; never minimize concerns
2. Seek consultation

IV. PROTECTIVE FACTORS

A. Connectedness between Individuals

1. Greater social integration (prosocial friends, contact with trusted, caring adults, low levels of social isolation) serve as protective factors against suicidal thoughts and behaviors.
2. Restrict access to lethal means
3. Is Connectedness Ever Harmful?
    a. Youths' connectedness to negative peer groups may increase their risk for suicidal behavior

B. Connectedness of Individuals and Families to Community Organizations

1. Develop positive attachments to schools and faith-based organizations
2. Cultural and religious beliefs may discourage suicide and support self- preservation
3. Try to strengthen family connections

C. Connectedness among Community Organizations and Social Institutions

1. Establish formal relationships between schools and mental health providers

V. COMPREHENSIVE APPROACH TO PREVENTING SUICIDE

A. *ALGEE* – Mental Health First Aid

1. *Assess* for risk of suicide or harm
2. *Listen* nonjudgmentally
3. *Give* reassurance and information
4. *Encourage* appropriate professional help
5. *Encourage* self-help and other support strategies

B. Increasing Awareness

1. Primary risk factor for suicide is psychiatric illness
2. Depression is highly treatable

3. Reduce prejudice about mental illness

a. Stigma and lack of understanding are the main reasons discussion of mental illness remains a taboo. People suffering from psychiatric ailments fear others will think they are crazy or weak, or somehow a lesser person. Changing cultural norms is imperative. Education helps reduce stigma and save lives.

4. Preserve dignity, counter negative stereotypes, shame, and discrimination.

5. Engender hope

C. Role of Teachers

1. By virtue of the number of hours teachers spend with students, they are often the first to hear about a crisis.

2. Empathize with student and encourage that he or she seek support from social worker.

a. *Convey deep and genuine concern; treat with great seriousness.*

3. If student is unfamiliar with social worker or wary about seeking support, offer to escort him or her and introduce to staff.

4. See that student receives help.

5. Monitor our own reactions

a. Even working as a clinician for over thirty-five years grants me no immunity to deep psychological responses. We might doubt the potential threat or freeze over to protect ourselves from rising anxiety.

b. Share the concern with a colleague to check out the legitimacy of your perceptions.

Crisis Lines

- National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
  - In 2018 more than 2.2 million people called the Hotline. The F.C.C. is considering changing the number to 988.
- Northwestern Memorial Hospital 24 Hour Hotline: 312-926-8100

Additional Resources

- American Association of Suicidology
  http://www.suicidology.org/
  AAS advances suicidology as a science; encourages the development and application of strategies that reduce the incidence and prevalence of suicidal behaviors.

- American Foundation for Suicide Prevention
  http://www.afsp.org/
  The American Foundation for Suicide Prevention (AFSP**)** is the leader in the fight against suicide. It funds research, creates educational programs, advocates for public policy, and supports survivors of suicide loss.

- Erika's Lighthouse
  www.erikaslighthouse.org
  Excellent resource on teen depression

- Jamison, K. R. To know suicide. *The New York Times*. August 15, 2014. https://www.nytimes.com/2014/08/16/opinion/depression-can-be-treated-but-it-takes-competence.html

- Live Through This
  http://livethroughthis.org/
  Live Through This is a moving collection of portraits and stories of suicide attempt survivors, as told by those survivors.

- Suicide Awareness Voices of Education (SAVE)
  http://www.save.org/index.cfm
  The mission of SAVE is to prevent suicide through public awareness and education, reduce stigma, and serve as a resource to those touched by suicide.

- The Trevor Project
  http://www.thetrevorproject.org/
  The Trevor Project offers accredited life-saving, life-affirming programs and services to LGBTQ youth that create safe, accepting and inclusive environments over the phone, online and through text.

- World Suicide Prevention Day
  https://www.iasp.info/wspd/

LGBTQ YOUTH: IDENTITY FORMATION AND MEANINGS FOR SCHOOLS

Truman Middle College and SGA Youth & Family Services
Rich Horowitz, LCSW, ACSW
19 NOVEMBER 2020

I. The Paradox of LGBTQ Mental Health Concerns

A. The acceptance of same-sex relations has increased dramatically over the past forty years.

1. Thirty nations now recognize same-sex marriage. As the number of countries legalizing same-sex marriage rises, the age of coming out has fallen from twenty in the 1970s to fourteen in 2010.

2. Growing social acceptance has sharply lowered the age of coming out.

B. Social and Developmental Implications of Earlier Coming Out

1. LGBTQ youth today come out during psychosocial periods marked by strong peer influences heightening the risk of peer victimization.

2. The age of coming out now overlaps with a period of intense feelings about gender and sexuality including homophobia.

3. Even with increasing social acceptance, changes in developmental issues around the period of coming out intensify psychosocial pressures and imperil mental health for many LGBTQ youth.

C. LGBTQ youth report higher levels of emotional distress.

1. During the same years when mental health disorders commonly emerge, they are dealing with the added pressure of confusion around sexual identity.

2. According to the Trevor Project's 2020 National Survey, nearly half of LGBTQ youth reported engaging in self-harm in the past twelve months, including over 60% of transgender and nonbinary youth.

3. LGBT youth are 4 times more likely to attempt suicide, experience suicidal thoughts, and engage in self-harm, as compared to youths that are straight.

4. 29% of LGBTQ youth have experienced homelessness, been kicked out, or run away.

a. One-third of LGBTQ youth reported that they had been physically threatened or harmed in their lifetime due to their LGBTQ identity

5. An estimated 20-30% of LGBT individuals abuse substances, compared to about 9% of the general population. 25% of LGBT individuals abuse alcohol, compared to 5-10% of the general population.

6. 2.5 times more likely to experience depression, anxiety, and substance misuse.

7. Universal risk factors like family conflict and child maltreatment become even more prominent among LGBTQ youth.

a. Stigma and discrimination compound ordinary risk factors.

8. Social media breach personal boundaries and expose highly vulnerable youth to bullying.

II. Cyberbullying

A. Definition

- *An aggressive, intentional act carried out by a group or individual, using electronic forms of contact, repeatedly and over time against a victim who cannot easily defend him or herself.*

B. Prevalence

1. Large scale studies and reviews place the average annual cyber victimization rates between 14%–21%. According to the U.S. Department of Health and Human Services (CDC) 14.9% of high school students reported being cyberbullied in the last year.

2. The confluence of low adult supervision, the perception that cyberbullying will not be reported, low bystander intervention, and the lack of repercussions for such behavior are all major contributors to cyberbullying perpetration.

C. Perils

1. Targets of cyberbullying experience helplessness, psychological distress, as well as fear that there is no safe place online. It is then clear why cyberbullying is associated with long-term psychosocial dysfunction, above and beyond the effects of traditional bullying.

2. The most recent results of the Youth Behavior Risk Surveillance from the CDC indicate that females reported nearly twice as high cybervictimization as males (19.7% and 9.9% respectively).

3. Another study found that in a sample of undergraduates, females were more likely to be targeted with topics about sexual activity (e.g., nude photos, etc.), whereas men were more frequently cyberbullied about their skills/talents (e.g., intelligence) and sexual orientation.

4. Cyberbullying is associated with: anxiety, depression, suicidal ideation and suicide attempts, somatic complaints and compromised physical health, symptoms of post-traumatic stress disorder (PTSD), and academic difficulties.

D. Role of Educators and Schools

1. The way schools can work towards preventing cyberbullying, is to directly tackle the issue through the school's curriculum in age- appropriate fashion. The evidence is clear that social emotional learning is one of the core supports effective anti-bullying programs are founded on.

https://www.youtube.com/watch?v=haPXxFLQhJI (Interviewing LGBTQ High Schoolers)

III. Gender Dysphoria

A. Gender dysphoria is defined by the distress caused by the discrepancy between a person's body and their gender identity.

1. DSM 5 (2013) replaced gender identity disorder with gender dysphoria to make clear that the diagnosis pertains to distress and not identity.

2. The term is meant to distinguish between the condition of being transgender and symptoms that arise from distress over being transgender.

B. Transgender Individuals

1. Not all who identify as transgender have gender dysphoria at the level of distress that requires diagnostic treatment.

2. The process of transitioning

a. For some, transitioning may not involve any kind of surgical intervention; it might be enough to change their name or gender designation on identity documents and come out to friends and family, known as social transitions.

III. Social, Psychological, and Cultural Contexts

A. LGBTQ mental health must be understood in the context of other aspects of identity: gender, ethnic, cultural, and religious.

1. Only in 1973 in the revised edition of DSM–II did the American Psychiatric Association remove homosexuality from its list of mental disorders. Became known as sexual orientation disturbance.

2. With the publication of DSM-5 replacing Gender Identity Disorder with Gender Dysphoria, this recognized that a mismatch between birth gender and identity is not a sign of pathology.

B. Minority Stress Model and Disparities in Health

1. Social stigma

a. Youth living in neighborhoods with high concentration of LGBTQ hate crimes report greater likelihood of suicidal ideation than those living in areas with a lower concentration of such offenses.

2. Compromised interpersonal relationships

3. Internalization of stigma at the individual level

C. Coming out for adults is associated with positive adjustment.

1. Its meaning for adolescents is far more nuanced.

2. Increasingly early disclosure of sexual orientation is associated with greater victimization at school.

a. Yet hiding one's LGBT identity during adolescence is associated with depression.

3. However, coming out promotes greater social and emotional well-being in adulthood.

D. Respect Families' Beliefs

1. Maintain nonjudgmental stance while trying to lessen rejecting behaviors.

2. Educate families on value of supportive behaviors.

https://www.sprc.org/video/lgbtq (Culturally Competent Care)

IV. Culturally Competent Care

A. Critical need for support around the time of coming out.

B. At its heart, this involves representation of realities that may be remote from our own. Our responsibility is to suspend judgment and strive for acceptance and understanding.

C. Empathy requires a phenomenological approach where listeners immerse themselves in the experience of the other and try to "sense the client's private world as if it were [their] own, but without ever losing the 'as if' quality" (Carl Rogers).

a. We may have to step outside of our own frames of reference and look at the world from a radically altered perspective.

V. Institutional Supports

A. Family

1. Rejection from parents contributes to especially high homeless rate among LGBTQ youth.

2. Minority youth may experience added stressors.

a. Youth who feel they are a burden to important people in their lives experience higher rates of suicidal ideation.

B. Schools

1. Biased-based bullying has especially pernicious effects.

2. Preventing bullying and countering social rejection are critical concerns.

C. Communities

1. Youth living in neighborhoods with high concentrations of LGBTQ - motivated assault crimes experience higher levels of suicidal ideation.

VI. PROTECTIVE FACTORS

A. School structural strategies that provide affirming and protective environments

1. Creating a sense of belonging and reducing isolation are critical elements.

2. Broad availability to all students of information and resources on sexual orientation and gender identity.

3. LGBT- inclusive curriculums that introduce specific historical events, persons, and information about the LGBT community into student learning have been shown to improve students' sense of safety and feelings of acceptance and to reduce victimization in schools.

4. Empathy from teachers, staff, and administrators

5. Expressive writing may prove beneficial

6. Student-led groups like the Gay Straight Alliance are recommended

B. School individual approaches

1. Counseling

a. Helping adolescents talk about their LGBTQ identity

b. Helping them learn about their identity

c. Helping them recognize when it is safe and appropriate to make disclosures - all these measures reduce major risk factors and promote healthy adjustment.

2. When family supports break down, young adults will inevitably turn to schools where trusting relationships with faculty and staff fill the breach.

a. Everyone here plays a vital role in creating a safe environment where vulnerable youth can find the support to help them navigate critical life passages.

RESOURCES

Broadway Youth Center
Part of Howard Brown (see below). BYC serves ages 12-24 regardless of ability to pay.
4009 N. Broadway
773.935.3151

The Center on Halsted
3656 N. Halsted Street
773.472.6469
Center on Halsted is the Midwest's most comprehensive community center dedicated to advancing community and securing the health and well-being of the Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) people of Chicagoland. More than 1,000 community members visit the Center every day, located in the heart of Chicago's Lakeview Neighborhood.

Howard Brown Clinic
4025 N. Sheridan
773.388.1600

Howard Brown Health was founded in 1974 and is now one of the nation's largest lesbian, gay, bisexual, transgender, and queer (LGBTQ) organizations. The agency serves more than 27,000 adults and youth each year in its diverse health and social service delivery system focused around seven major programmatic divisions: primary medical care, behavioral health, research, HIV/STI prevention, youth services, elder services, and community initiatives.

Lurie Children's Hospital
Gender Development Program
225 E. Chicago Ave.
800.543.7362
Gender development services at Lurie Children's are outpatient services aimed at supporting the physical, mental and social health of patients and their families as youth progress through gender identity development. As specialists in pediatric and adolescent gender development, we recognize that when it comes to providing effective care "no one size fits all." Therefore, our goal is to keep our families most informed of their treatment options, supporting them with medical and behavioral health care along the way.

Lurie
North Side - 1440 N. Dayton
312.227.6800
Adolescent Medical and Behavioral Health Services
Gender development Program
Trans Mentor Program
First time patients ages 12-22 but will follow patients to 25.

PFLAG – Parents, Families, and Friends of Lesbians and Gays
https://www.pflag.org/
Their mission is to build on a foundation of loving families united with LGBTQ people and allies who support one another, and to educate ourselves and our communities to speak up as advocates until all hearts and minds respect, value and affirm LGBTQ people.

The Trevor Project
thetrevorproject.org
866.488.7386
The Trevor Project offers accredited life-saving, life-affirming programs and services to LGBTQ youth that create safe, accepting and inclusive environments over the phone, online and through text. The only national 24/7 crisis intervention and suicide prevention lifeline for LGBTQ young people under 25.

U.S. Transgender Survey (2015).
http://www.ustranssurvey.org/

WPATH – World Professional Association for Transgender Health
https://www.wpath.org/

DEFINITIONS*

Lurie Children's Hospital: Model Policy and Administrative Procedure

Understanding the terminology associated with gender identity and expression is important to providing a safe and supportive school environment for students. These definitions are provided not for the purpose of labeling students but rather to assist in understanding this Policy and the District's legal obligations.

Cisgender

Cisgender is a term used to describe people whose gender identity corresponds with their assigned sex at birth.

Gender Identity

Gender identity is a person's inner sense of being male or female, a combination of both, or neither, and is not dependent on the sex assigned at birth. All people have a gender identity, not just transgender people.

Gender Expression

Gender expression is an individual's characteristics and behaviors such as appearance, dress, mannerisms, speech patterns, and social interactions that are perceived as masculine or feminine.

Gender Expansive

(also called Gender Nonconforming, Gender Variant, or Gender Creative) Gender expansive is a term that refers to individuals whose gender expression does not follow social expectations or stereotypes based on their sex assigned at birth. It may (or may not) include a change in gender identity. For example, a person with sex assigned at birth as male could be: "I am a girl and I like to express femininity." Or "I am a boy and I like to express femininity."

Sex Assigned at Birth

Sex assigned at birth is often based solely on external genitalia but also includes internal reproductive structures, chromosomes, hormone levels, and secondary sex characteristics. This is typically the sex reflected on one's original birth certificate.

Sexual Orientation

Sexual orientation is a person's emotional and sexual attraction to other people based on the gender of the other person. Sexual orientation is not the same as gender identity. Not all transgender youth identify as gay, lesbian or bisexual, and not all gay, lesbian and bisexual youth display gender nonconforming characteristics.

Transgender

Transgender is a term that describes individuals whose gender identity is different from what is assumed based on their sex assigned at birth, and/or whose gender expression is different from the way males or females are stereotypically expected to look or behave. This term applies to identity but not necessarily body parts. This is an umbrella term for a variety of gender identities and expressions.

Transition

A way to describe the process(es) an individual may go through to change their gender expression and identity documents to match their internal gender identity. Transition can be social, emotional, and/or medical and is different for every individual. For most transgender students, the experience of

transition does not involve medical intervention but rather will be achieved through social transition, a process whereby they begin to live and identify with the gender consistent with their gender identity. There is no medical threshold, mental health diagnosis, or treatment requirement that a student must meet in order to have the student's gender identity recognized and respected by the District.

* https://www.luriechildrens.org/globalassets/media/pages/specialties--conditions/programs/gender-development/documents/model-policy-for-student-gender-support.pdf

EXHIBIT C

SGA Client Satisfaction Survey - English

1. SGA Client Satisfaction Survey

SGA Youth & Family Services constantly works to improve the quality of services for our clients.

You can assist the agency in this process by answering the following questions. DO NOT write your name on the survey. All the answers you give will be kept private - no one will know what you write. Please answer the questions truthfully based on what you believe.

Thank you for helping us provide the best programs.

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1. **Which SGA program(s) have you participated in? Please check all that apply.**

If you are unsure which program you are in, please ask your SGA worker

- ☐ Bridges to Pathways
- ☐ Brighton Park Youth Services
- ☐ Chicago Young Parents Program
- ☐ Chi-Works
- ☐ Core
- ☐ Counseling
- ☐ DFSS Early Head Start
- ☐ Early Advantages
- ☐ Healthy Start
- ☐ Higher Sights
- ☐ Intensive Youth Services
- ☐ JISC
- ☐ JISC-Rise
- ☐ One Summer Plus/Summer Jobs
- ☐ Ounce - Head Start/ Early Head Start
- ☐ P.A.S.S. - Partners Achieving Student Success
- ☐ P.O.A.H.
- ☐ Safe Passage
- ☐ SCOPES
- ☐ Stars of Health
- ☐ Street Level Scholars
- ☐ Wraparound

Other (please specify)

2. What is your gender?

- ◯ Male
- ◯ Female
- ◯ Other (please specify)

3. Do you consider yourself to be transgender?

- ◯ Yes
- ◯ No

4. What is your ethnicity?

◯ Hispanic/Latino

◯ Non-Hispanic/Latino

5. What is your race? (Please select all that apply.)

☐ Native American/Alaskan Native ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander

☐ Asian ☐ White/Caucasian

☐ Other (please specify)

6. Did you complete this survey for yourself?

◯ Yes, I completed this survey for myself.

◯ No, I am a parent/guardian filling this out for my child.

7. How old are you? (Or, if completing for a child/dependent, how old is your child/dependent?)

◯ 0-5 ◯ 13-17

◯ 12 ◯ and older

SGA INTRODUCTION

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8. Indicate how much you agree or disagree with the following questions:

	Strongly Disagree	Disagree	Agree	Strongly Agree
The SGA program and services were explained well.	◯	◯	◯	◯
My rights as a client were explained well to me.	◯	◯	◯	◯

SGA WORKER

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9. How many times have you seen your SGA worker?

One time Two times Three times Four times or more

10. How long have you worked with your SGA worker?

0-3 months 3-6 Months 6-9 Months 9-12 Months 1 or more years

11. Indicate how much you agree or disagree with the following questions:

	Strongly Disagree	Disagree	Agree	Strongly Agree
The SGA worker understood me and my life.				
The SGA worker was easy to meet with.				
My SGA worker helped me reach my goals.				
I was happy with the way the SGA worker treated (or treats) me.				
The SGA worker gave me helpful information.				

PERSONAL PROGRESS

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12. Indicate how much you agree or disagree with the following questions:

	Strongly Disagree	Disagree	Agree	Strongly Agree
I learned new ways to handle my problems because of my SGA worker.				
I have better relationships with other people because of SGA services.				
I have made progress because of SGA services.				

OVERALL

13. Indicate how much you agree or disagree with the following questions:

	Strongly Disagree	Disagree	Agree	Strongly Agree
The location (or place) of SGA services was good.	◯	◯	◯	◯
SGA delivered quality services.	◯	◯	◯	◯
I would recommend SGA services to others.	◯	◯	◯	◯

14. Overall, how do you feel about the SGA services you received?

- ◯ Unhappy
- ◯ Somewhat happy
- ◯ Happy
- ◯ Very happy

Please explain

15. Any additional comments?

YOUTH & FAMILY SERVICES

INDIVIDUAL SERVICE PLAN

Client Name: _____ **Date of Birth:** _____

Initiation Date*: _____ **Comprehensive Assessment Date**: _____

Reason for Referral (include description of symptoms): _____

_____

_____

_____

Client's Strengths, Capabilities, and Competencies (include factors that support resilience):

_____

_____

_____

_____

Long Term Goal # _____ **Date Established**: _____

Goal: _____

Short Term/Measurable Objectives:

1. _____ Target Date: _____

2. _____ Target Date: _____

3. _____ Target Date: _____

4. _____ Target Date: _____

Mode(s): ❑ Individual counseling ❑ Group Counseling ❑ Family Counseling ❑ Case Advocacy

Plan/Intervention: _____

_____

_____

Person responsible for completion of goal: _____

Long Term Goal # _____ **Date Established**: _____

Long Term Goal # _____ **Date Established**: _____

Goal: _____

Short Term/Measurable Objectives:

1._____ Target Date:_____

2._____ Target Date:_____

3._____ Target Date: _____

4._____ Target Date:_____

Mode(s): ❑ Individual counseling ❑ Group Counseling ❑ Family Counseling ❑ Case Advocacy

Plan/Intervention: _____

_____

Long Term Goal # _____ **Date Established**: _____

Goal: _____

Short Term/Measurable Objectives:

1._____ Target Date:_____

2._____ Target Date:_____

3._____ Target Date: _____

4._____ Target Date:_____

Mode(s): ❑ Individual counseling ❑ Group Counseling ❑ Family Counseling ❑ Case Advocacy

Plan/Intervention: _____

_____

_____

Person responsible for completion of goal:_____

_____ _____
Counselor's Signature (MHP, QMHP, LPHA, LCSW, LCPC) Date

_____ _____
Supervisor's Signature (QMHP, LPHA, LCSW, LCPC) Date

I have participated in developing and/or reviewed this Treatment Plan and consent to receive services in order to complete the identified goal(s). Staff has explained the treatment planning process and contents to my understanding.

_____ _____
Client** Date

_____ _____
Parent/Guardian Date

_____ _____
DCFS/State Guardian Designee*** Date

* Must be 30 days from completion of Assessment or prior expiration of current ISP
** Required if 12 years or older, if contra-indicated, note reason must be addressed
*** Required for Wards (note efforts to obtain)