

**City of Seattle, Department of Neighborhoods, Office for Education Division
Families and Education Levy
Attachment 2
Request for Program Information
Middle and High School Social, Emotional and Behavioral Support**

Organization Information:

Organization name: Sound Mental Health

Organization address: 1600 E. Olive Street, Seattle, WA 98122

Describe your legal status and, if applicable, state of incorporation (for example, Washington State non-profit corporation, Washington State partnership, sole proprietorship):

Washington State non-profit corporation

Application Components and Checklist (submit in this order)

- Cover Sheet
- Participants
- Strategies
- Results
- Financial Projections
- Budget Template (in Excel)

Contact Information:

Contact person: Susie Winston

(please print clearly)

Title: Director, Child and Family Services

Mailing address: 1600 E. Olive Street, Seattle, WA 98122

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Signature: *Susie Winston*

Date: 2/14/12

Sound Mental Health RFQ Response: Middle and High School Social, Emotional and Behavioral Support

Key People

1. SMH has had a collaborative working relationship with the Seattle School District since 1986 when we were contracted for services in the EBD classrooms. Since that time we have expanded our services throughout the district and are currently providing service to 11 elementary, 6 middle, 4 K-8 and 8 high schools. Our Child and Family staff is highly trained, Master (MA/MSW) level clinicians with many years of experience in school settings. All clinicians are Washington State Registered Counselors and many are licensed within their discipline (LICSW, LMHC) in addition to being a Child Mental Health Specialist (CMHS). Two of our school based clinicians are certified Ethnic Minority Mental Health Specialists (EMMHS): African American and Asian/Pacific Islander. Our clinicians have had extensive training and background in milieu treatment, facilitating specialty groups (social skills, anger management, grief and loss, anti-bullying/harassment and substance abuse), behavior management, safety and de-escalation, individual/family/group therapy, parenting skills /education, crisis intervention, case management and wraparound services.

The key SMH clinical staff who will deliver the proposed middle and high school social, emotional and behavioral support services are: David Lewis, MA, CMHS, Lead Clinician Nesholm Middle School Support Project (MSSP); Manoshi Vin, LICSW, CMHS; Bobby Gaon, MSW, CMHS, EMMHS; Melissa Morrissette, LICSW, CDP, CMHS; Julie Turcott, LMHC, CMHS; Laura Zucker, LICSW, CMHS; TK Brasted, PsyD, Supervisor/Coordinator, Child and Family Services; Eun Ku, LICSW, CMHS, EMMHS, Lead Clinician Child and Family Services.

The SMH middle school and high school clinicians are accustomed to using reading and math MAP scores, grades and attendance as indicators of progress/outcomes. Clinicians work closely with school staff. Additionally, clinicians assist students with planning for transition to high school or college and/or employment.

2. The project will be led by Terry Richardson, MS, LMHC, CMHS, Manager of Child and Family Services. Terry has had over 30 years of experience working with children, youth and families, 21 of those with Sound Mental Health. She has successfully supervised our Early Childhood Preschool Program which was partially funded through Seattle School District, 2 SMH ECEAP classrooms and currently manages our Nesholm Middle School Support Project. She is a member of the Readiness to Learn Consortium and the King County Metro Community Resource Team. For the past ten years, Terry has managed the School Based and Children's Community Support Programs which have recently merged into our current Child and Family Services program. SMH consistently receives positive feedback from the schools we serve. SMH clinical services are effective at reducing barriers to learning and enabling students to make academic gains.

Previous Experience

1. Sound Mental Health Child and Family Services (CFS) provides behavioral health services to multi-cultural students and families living in low income or poverty environments who have high risk, complex needs and multi-system involvement. CFS serves children and youth who are mentally ill, chemically dependent, developmentally disabled, deaf and hard of hearing, physically or sexually abused or neglected, and/or subject to domestic violence. Many are at risk to be homeless, hospitalized, in detention, or have multiple home placements which are barriers to their successful school experience. Many are failing classes, or at high risk to drop out. Most are well below grade level in reading and math (MAP scores). Many of these barriers result in poor attendance and missed learning opportunities/time away from the classroom due to absences, suspensions and exclusions. 2011 SMH demographics show the ethnic breakdown of our client population as: 20% African American; 9% multi-racial; 3% Asian/Pacific Islander, 2% Native American; and 53% Caucasian, including 19% Hispanic. Our clients include refugees and immigrants (non-English speakers).

2. SMH has provided services to over 4000 children and youth countywide in the past two years. Specifically, in 2009-11 our Middle School Support Program (MSSP) provided coordination of care to 779 students at 3 identified middles schools: Aki Kurose, Mercer and Denny International in the Seattle School District. The goal of MSSP is to provide onsite mental health experts, called Care Coordinators in Seattle Schools, to ensure that the mental health needs of students who are struggling academically are being addressed in concert with their academic needs. The intent of the MSSP is to address any social and emotional barriers that prevent students from being able to concentrate on academics in the classroom, assist students who present behavioral barriers to learning, contribute to plans that result in attendance of school on a consistent basis. By assessing and addressing social emotional needs of students, we have been able to help students address barriers that have prevented them from accessing education on a regular basis. MSSP students have demonstrated academic achievement reflected in grades and MAP reading and math scores. MSSP is shown to successfully addresses barriers to learning and promote academic success.

SMH Care Coordinators provide three Levels of Service: 1) MSSP Intensive: Provides comprehensive care management and wraparound services targeted to the hardest-to-serve young people who need coordinated and integrated services from multiple systems. The Care Coordinator facilitates the building of a Wraparound Team and a Care Plan with input from the student, his/her family, teachers, other providers and "natural" support givers such as friends, family, neighbors, and clergy. The Care Coordinator ensures ongoing coordination between the student, the school and the Care Team. 2) Screening/Assessment and Referral Services: The mid-level service is screening, brief assessment and referral of the student (and his/her family as appropriate) to behavioral health services either within the school or in the community. Screening and Referral is recommended when the problem faced by the student requires care within only one system. Once a referral has been made, the Care Coordinator facilitates the linkage between the student and the provider and coordinates with the student, the school, the family and with the provider. 3) Consultation and Crisis Support: SMH Care Coordinators serve as consultants on the school's Student Support Teams (or Care Teams, Student Intervention Teams, etc.) and in this capacity

are able to offer expertise regarding behavioral health concerns. Crisis Support is provided to assist staff during their response to immediate, acute problems experienced by students in the school setting. The Care Coordinator is available to consult, collaborate and support school personnel as incidents arise. Examples of situations needing Crisis Support include a fight between students, a student stricken by grief at the death of a family member, or a disciplinary problem with a student for whom such behavior is out of the ordinary.

Additionally, Care Coordinators utilize their clinical skills to provide group treatment. These groups may focus on anger management, coping skills training, social skills training, motivation and leadership training, and other issues experienced by these students. In addition to serving students in the middle schools, MSSP has also supports students with their transition high school. Care Coordinators facilitate individualized plans that will translate well into the high schools with the goal of capitalizing on the gains made while in middle school.

3. SMH funders and collaborative partners for school based services are listed below:

Funders

Nesholm Family Foundation - Laurel Nesholm 206-324-339
College Sparks Foundation - Rachel Clements 206-461-5480
Medina Foundation - Jennifer Teunon 206-652-8783
Norcliff Foundation - Arline Hefferline 206-682-4820

Schools

Aki Kurose M S - Mia Williams Principal; Jennifer Hodges Asst. Principal 206-252-7700
Denny International M S - Jeff Clark Principal; Patricia Rangel House Administrator 206-252-9000
Mercer Middle School - Susan Toth Principal; Katie Pearl, Asst. Principal 206-252-8000
Eckstein Middles School – Kim Whitworth Principal 206-252-5010
Hamilton M S -Heather Babbit Wellness Center (NeighborCare) 206-940-2582
Whitman Middle School - Cheryl Fraley School Counselor; 206-252-1202
Ballard HS -Paul Berry Teen Health Center (Swedish); 206-252-1149
Sealth HS - Tisha Satow, MH Therapist, Teen Health Center; 206-938-1360 x103
Franklin HS -Robin Fleming, Nurse Teen Health Center (Group Health)
rflaming@seattleschools.org
Garfield HS - Rosie Moore Mental Health Therapist Teen Health Center (Odessa Brown) rcmoore@seattleschools.org
Nathan Hale HS -Marion Howard School Counselor 206-252-3697
Ingraham HS -Elenora Von, Barbra Bush Teen Health Center (Public Health/Group Health) 206-205-0430
Roosevelt HS -Amy Schwentor Assistant Principa; Helen Weems Teen Health Center (NeighborCare) 206-527-8336
Nova- Anne Lung (NeighborCare) annel@neighborcare.org

Community Based Organizations

UW/ Seattle Children's Hospital Elizabeth McCauley 206-987-0000
NeighborCare Lisa Thocher 206-548-7470
Group Health Dori Guterson gutersound@ghc.org
Asian Counseling and Referral Services (ACRS) Ken Huey 206-695-6700

Atlantic Street Center Ralph Fragale 206-329-2050
Consejo Margaritz Gomez 206-461-4880
Navos Saul Krubali 206-661-1276
Powerful Voices Devon De Lena, Charys Bailey 206-860-2084
Safefutures Yao Chin 206-321-7012
Seattle Youth & Violence Initiative Marty Patu 206-436-1894, Richard Finely 206-218-7905, and Rick Maltby 206-948-4280
Treehouse Roland Pablo 206-267-5441
BRIDGE.Start at Denny Kathryn Murray 206-252-9000
Communities in Schools Denny- Tia Yarbrough 206-252-9000; Aki Dalisha Phillips 206-252-7753
Diplomas NOW-John's Hopkins Katrina Hunt 206-252-7700
City Year Nick Hernandez nhernandez11@cityyear.org
Casa Start Mohmed Abdi miabdi@seattleschools.org
College Success Program Anna Prada akprada@seattleschools.org

4. The students intended to be served have a variety of challenges and barriers to successful achievement in school. Many come from families with histories of poverty, drug/alcohol abuse, incarceration and violence. Some of the parents/guardians are unable to provide structure, supervision and consistency needed by youth to succeed in school. Some of the students get very little support to attend school as families struggle to meet basic needs. Many of the focus students live in neighborhoods where violence and gang activity dominate. Refugee and immigrant students have additional challenges trying to learn English, understand school expectations while navigating Western school/peer culture and the values and behaviors expected by their parents. Undocumented families lack funding for health care and social services. SMH utilizes interpreter services for non-English speaking clients.

SMH has ensured that clinicians are responsive to the many challenges faced by the families we serve. Child and Family clinicians have received training to provide culturally informed and appropriate services that respect the values and unique perspective of each individual and family. SMH strives to assist unfunded clients to access services whenever possible. These Levy dollars provide another opportunity for SMH to ensure access to services that will meet the mental health and behavioral needs of students without funding. SMH collaborates with all other child serving systems so that services are coordinated, effective and meet the identified goals of the client, while honoring the client voice and choice. SMH Child and Family Services has developed and implemented the Children's Domestic Violence Response Team, a collaborative program with the major domestic violence advocacy service provider's county wide to meet the needs of children, youth and families impacted by domestic violence. In 2011, this program served more than 500 individuals. SMH has supported this effective program through grant writing (Foundation Grants, Government Grants), that supports the participation of unfunded survivors and their children.

SMH Child and Family Services has prioritized the needs of schools and students since 1986, and over time has developed an expertise in the provision of school based mental health services in collaboration with SPS.

Tracking to Success

1. The Sound Mental Health (SMH) program described in the Previous Experience section, the Middle School Support Project (MSSP), was implemented in Seattle public middle schools in 2006. Since that time, various indicators have been tracked to evaluate program effectiveness. Behavioral rating scales have been used to monitor the mood and functional impairment of participating students. In the 2009-2010 school year, SMH also started formally tracking grades, credits earned, attendance, disciplinary actions, school attachment, school/activity engagement, goals, community connections, and life domains.

In the 2007-2008 and 2008-2009 school years, depression scores in participating students significantly decreased. Improvement in functioning was also observed during both school years. Statistics for the past two school years are not yet available due to an expansion in the evaluation period from one to two school years.

2. The MSSP care coordinators monitor various data points on The Source via the Seattle School District for the purpose treatment planning. The academic indicators used by care coordinators vary depending on the area of concern for a given student. However, quarterly MAP scores are tracked for all participating students.

Based on the review of MAP reading test for students who have had uninterrupted participation in MSSP from 2009-present, a mean improvement in percentile rank of 15% was observed. On the MAP math test, there was a mean improvement in percentile rank of 12%. There were a few outliers (students who demonstrated extraordinary improvement on the MAP test during this 2-year period) that have inflated the mean improvement in percentile rank. However, it must be noted that 93% of these MSSP participants improved their scores on MAP relative to other members of their grade-level cohort.

3. The MSSP care coordinators use various weekly data points on The Source to track treatment objectives. The specific indicators used by care coordinators vary depending on the area of concern for a given student. However, weekly grades are tracked for all participating students.

4. See Attachment A.

Woman and Minority Inclusion; Non-discrimination

If selected, SMH will not be subcontracting. Our plan is to utilize our current staff who understands how to work effectively with and in schools, hiring, as necessary, additional staff for Child and Family Services to replace staff needed for this project. SMH values diversity, and strives to hire persons of color and/or with diverse cultural experience. Our EEO Policy states: "SMH will comply with local, state, and federal laws, and executive orders in implementation of equal employment opportunity policies. Our Non-Discrimination Policy states: "In regard to matters affecting employment and application of these matters, SMH will provide equal opportunity and advancement to all individuals, regardless of age, sex, race, color, creed, religion, political ideology, national origin, ancestry, sexual orientation, marital status, physical or mental disabilities or sensory impairments. This policy applies to recruitment, hiring, training, promotion, demotion, transfer, layoff, termination, compensation, use of facilities and other agency practices." SMH advertises and recruits via internet and community publications.

Attachment A – Sample Data Report

PROGRAM OUTCOMES

Our chief objectives are for children to meet age-level expectation on WaKIDS, as well as on grade-level standards on state tests (math, reading, science, writing).

INDICATORS

The following indicators were used to track success on program outcomes:

- annual typical growth on reading MAP,
- annual typical growth on math MAP,
- fewer than 5 absences per semester,
- and sub-clinical scores on measures of depression and externalizing behavior problems.

DEMOGRAPHIC CHARACTERISTICS

During the 2012-2013 school year, a total of 30 students were enrolled in our care coordination and/or behavior health services. Of the enrolled students, 40% were female and 60% were male. Thirty percent were in the 6th grade, 37% were in the 7th grade, and 33% were in the 8th grade. Table 1 shows the breakdown of services received by these students.

TABLE 1
Children Served by SMH in 2012-2013

Service Type	Intensive Care Coordination	Behavioral Health	Onsite Crisis Services	Referral to other services
Number of students	19	11	13	3

RESULTS

Academic Indicators

The growth rate on the reading and math sections of the MAP test were tracked for the 30 students enrolled in our program. The mean RIT scores for the enrolled students on the fall reading MAP were below the national average across all three grade levels (Table 2). Most of the students in the program demonstrated a significant improvement on the reading MAP during the course of the 2012-2013 academic year, as demonstrated by an annual growth rate that far exceeded the national average and mean RIT scores that are on par with the national average for each respective grade (Table 3). Tables 2 and 3 also illustrates similar results on the math MAP.

TABLE 2
Descriptive Statistics for Fall MAP Across Grade Levels

	Reading MAP					Math Map			
	<i>n (%)</i>	<i>M</i>	<i>SD</i>	<i>Range</i>	<i>National Average</i>	<i>M</i>	<i>SD</i>	<i>Range</i>	<i>National Average</i>
Total	30	202	14.9	182-229	-	206	15.1	175-233	-
6 th grade	9 (30%)	204	15.9	182-219	211.6	206	16.1	175-233	218.3
7 th grade	11 (37%)	210	13.7	182-219	215.4	213	12.0	175-223	224.1
8 th grade	10 (33%)	209	15.0	193-229	219.0	214	10.6	195-233	229.3

TABLE 3
Descriptive Statistics for Annual Growth on MAP Across Grade Levels

	Reading MAP					Math MAP			
	<i>n (%)</i>	<i>M (T_S-T_F)</i>	<i>% M Growth</i>	<i>SD (Growth)</i>	<i>Typical Annual Growth</i>	<i>M (T_S-T_F)</i>	<i>% M Growth</i>	<i>SD (Growth)</i>	<i>Typical Annual Growth</i>
Total	30	10.00	4.9%	3.0%	-	11.00	5.0%	3.3%	-
6 th grade	9 (30%)	10.00	5.0%	3.2%	1.5%	10.89	5.4%	4.1%	2.5%
7 th grade	11 (37%)	7.63	3.7%	1.9%	1.2%	8.38	4.0%	1.7%	1.8%
8 th grade	10 (33%)	11.98	5.7%	3.1%	1.0%	12.09	5.6%	4.9%	1.5%

Behavioral and Emotional Indicators

Three indicators were used to measure the emotional and behavioral health of students enrolled in our program, the Moods and Feelings Questionnaire (MFQ), the Columbia Impairment Scale – Youth Version (CIS), and the number of school absences per semester. The Moods and Feelings Questionnaire (MFQ) is a 13-item self-report instrument that screens for symptoms of depression. On the MFQ, a score of 11 or higher indicates clinically elevated depression symptoms. Of the 30 students who completed a baseline MFQ, 50% scored 11 or higher. The MFQ was re-administered to the enrolled students after 6 months of treatment to determine whether there had been improvements in depression. Paired t-tests were conducted and it was found that the drop in depression scores reached statistical significance ($t=2.22$, $df=74$, $p=.029$).

The CIS is a 13-item self-report measure of functional impairment in several domains, including interpersonal relations, broad psychopathological domains, school functioning, and use of leisure time. Higher scores indicate greater impairment in functioning. At the start of services, 60% of the enrolled students rated themselves as having considerable functional impairment. The CIS was re-administered to the participants after 6 months of treatment. Paired t-tests were conducted and it was found that there was a statistically significant drop in the students' scores on the CIS, suggesting noteworthy improvements in functioning ($t=2.18$, $df=24$, $p=.032$).

School absenteeism for the enrolled students was assessed at the end of each semester across grades (Table 4). Consistent with research findings (Hansen, Sanders, Massaro et. al, 1998), age seemed to be a predictor

of absenteeism, with older students missing more days each semester. Also consistent with the findings from Hansen, Sanders, Massaro et. al, there appeared to be a correlation between absenteeism and impairment in interpersonal relations and use of leisure time. The students who showed the greatest improvements on the CIS also had a reduction in the number of school absences. During the second semester, most of the students achieved the objective of fewer than five absences.

TABLE 4
Descriptive Statistics for Absenteeism Across Grade Levels

	Semester 1				Semester 2		
	<i>n</i>	<i>M Absences</i>	<i>SD</i>	<i>Range</i>	<i>M Absences</i>	<i>SD</i>	<i>Range</i>
Total	30	4	2.29	1 - 9	3	1.65	1 - 6
Grade 6	9	2	1.30	1 - 5	2	0.87	1 - 3
Grade 7	11	4	2.34	1 - 8	3	1.78	1 - 6
Grade 8	10	5	2.31	1 - 9	3	1.77	1 - 6

CONCLUSIONS

During the 2012-2013 school year, significant improvement has been observed on all of the academic and behavioral indicators for the students enrolled in our program. Because a control group was not tracked, we cannot state with confidence the observed improvements were the direct effect of our program. However, there is anecdotal evidence to suggest that this program served as a catalyst for change to many of the participating students. For example, one student stated, “I felt really sad and tired all the time and you (care coordinator) helped me to feel better.” As this child’s depression improved so too did his attention and concentration. He also became more social, participated in more leisure time activities outside of the home, and was sick less often.