



**An Ecological Model of Care  
for Healing Victims through School-Based Mental Health Centers:  
An Implementation Guide for the VOCA Program at Austin ISD with Vida Clinic**

By Children's Optimal Health  
For Austin Independent School District  
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## Executive Summary

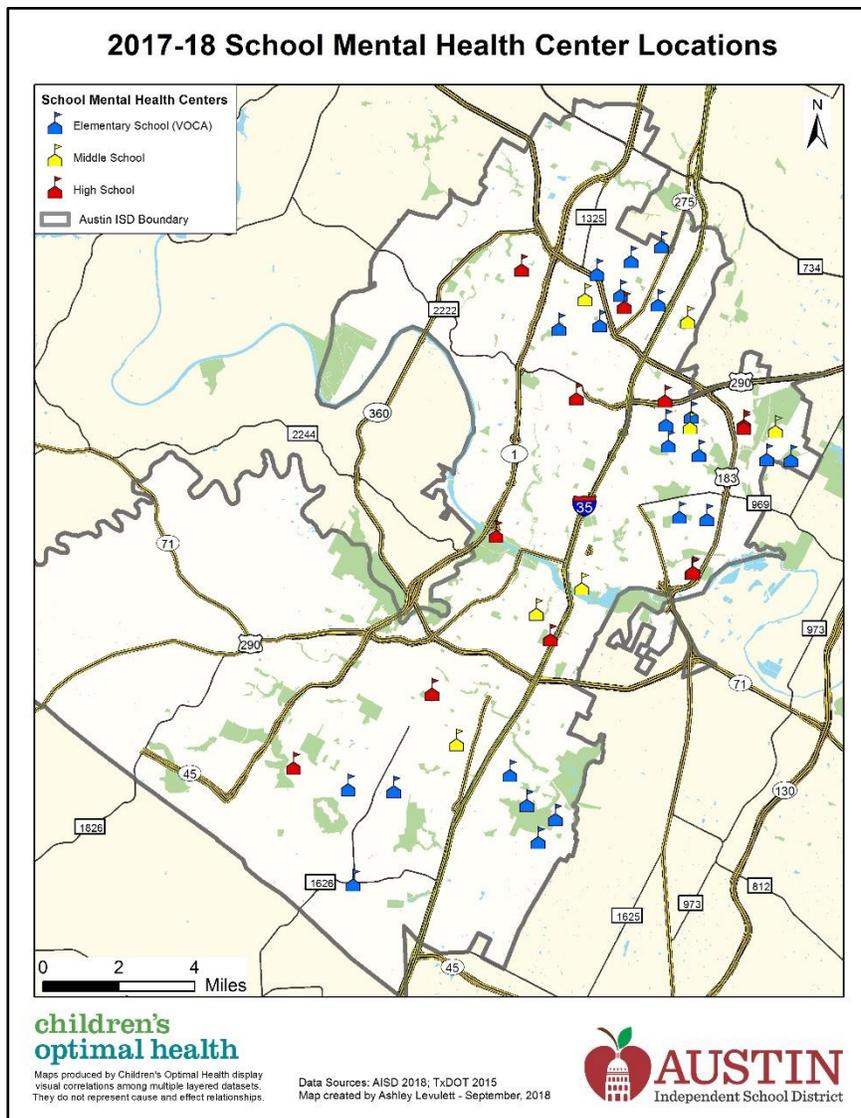
The experience of trauma and its effects cuts across all demographics including children, adults, cultural background, and income level. The effects of trauma can be lifelong and life-limiting. Health science is revealing how trauma impacts brain development, particularly when experienced in childhood, and how it is related to poor educational and health outcomes. Improving the capacity of children and youth to heal from trauma can similarly have life-lasting and multi-generational effects. Doing so within a school environment increases access to care, places the context of care within a normalizing environment, and offers the opportunity to most directly impact critical outcomes for children and youth: their school performance in terms of attendance, behavior and academic performance.

Not all trauma is the result of victimization. For example, severe weather events can result in trauma. However, under the federal Victims of Crime Act (VOCA), grant funds can provide access to school based clinical mental health services and treatment for individuals that have experienced primary (direct) or secondary (indirect) victimization. Victimization includes:

### VOCA Categories of Victimization

Arson	Kidnapping Custodial
Assault	Kidnapping Non- Custodial
Bullying (verbal, physical, cyber)	Mass Violence (Domestic/International)
Burglary	Other Vehicular Victim (hit and run)
Child Physical Abuse & Neglect	Robbery
Child Sexual Abuse/Assault	Secondary Victim of Adult Physical
Domestic/Family Violence	Secondary Victim of Adult Sexual Assault
DUI/DWI	Secondary Victim of Adult Sexually Abused as a Child
Elder Abuse/Neglect	Stalking/Harassment
Hate Crime (racial, religious, gender, sexual orientation, etc.)	Survivor of Homicide/Murder
Human Trafficking/ Labor	Teen Dating Victimization
Human Trafficking/ Sex	Terrorism
ID Theft/Fraud/ Financial Crime	Violation of a Court Order

Austin ISD has been documenting the need for, and effects of providing school mental health centers. The district currently operates 42 School Mental Health Centers (SMHCs). The centers are located throughout the district to provide services to a diverse array of students across the city. Austin ISD was the first school district in the state of Texas to apply for and receive funding under the VOCA grant to operate some of the centers. The VOCA grant currently funds 24 centers on elementary campuses. An additional 18 SMHCs are operating on secondary campuses, through multiple community partnerships and a portfolio of funding sources which have evolved over time.



The VOCA grant provides a potentially significant source of external funds for supporting the delivery of mental health services to students. This implementation guide covers the steps taken by Austin ISD during its first year of implementation to apply for and receive the funds, conduct the Request for Proposal process, contract with vendors, create FERPA and HIPAA-compliant parent/guardian consents for referral to the centers, as well as consents to treat, and Data Sharing Agreements which enabled monitoring of student outcomes and program evaluation. Initial results are pointing to increased attendance, fewer negative behaviors, and improving academic performance. A separate Quick Start Guide is provided in addition to the full implementation report and findings.

## Introduction

### Purpose of this Manual

The purpose of this manual is to assist other Texas school districts who are interested in providing school based mental health services. The implementation guide is intended to build capacity and support district preparedness to pursue VOCA funding. It provides guidance in understanding the VOCA grant cycle and application process, as well as reporting requirements. Additionally, it is intended to serve as a pragmatic guide for implementation. Feedback from campus and district staff, as well as from the mental health provider, including lessons learned during the first year are incorporated into the implementation study. The ecological model of treatment within a trauma-informed framework is presented. Using this ecological model, treatment has included not only students but their family members and school staff.

### Childhood Trauma and School Performance: A Literature Review

The prevalence of trauma in the US was estimated by Saunders and Adams (2014) through a review of five empirical studies that used samples of youth between the ages of 0-17. This research collectively indicates that approximately two out of three students in the US are likely to have experienced at least one or more traumatic events by age 17. Although most children show remarkable resilience when faced with a traumatic event, or even several events, some children may show significant impairments, including social-emotional difficulties and significant barriers to learning (Burke, Hellman, Scott, Weems & Carrion, 2011; Copeland, Keeler, Angold, & Costello, 2007; McLaughlin et al., 2013).

Socioemotional functioning, including affect regulation and interpersonal relationship management, play a critical role in both learning and classroom performance. Youth who are exposed to complex trauma often fail to meet socioemotional developmental competencies on par with their same-aged peers and are more likely to respond to stressful situations with limited or underdeveloped coping strategies, such as aggression, dissociation, and avoidance (Kinniburgh, Blaustein, & Spinnazola, 2005). These developmental delays can lead to problems in cultivating healthy relationships. Masten and Coatsworth (1998) contend that the ability to self-regulate emotions is a key predictor of academic and social success. Disruptions in the ability to modulate emotions are among the most prevalent features among children with complex, chronic trauma (Toth & Cicchetti, 1998). Difficulty with regulating emotions can contribute to debilitating problems in and out of the classroom, including impaired ability to interpret emotional content, chronic distrust in interpersonal relationships, and lack of a cohesive sense of self (Brenner & Salovey, 1997).

In order to cope with feelings of vulnerability, or triggering of their trauma, many youth may adopt maladaptive strategies to cope. The research literature has consistently linked various types of both acute and chronic trauma exposure with higher levels of aggression, defiant and disruptive behavior, hyperactivity, impulsivity, sexual promiscuity, sleep dysfunction, and substance abuse and dependence (Armsworth & Holaday, 1993; Bronstein & Montgomery, 2011; Brown, 2003; De Bellis & Thomas, 2003; De Bellis & Zisk, 2014; Dimitry, 2012; Gilbert et al., 2009; Joshi & O'Donnell, 2003; Nooner et al., 2012; Lubit, Rovine, DeFrancisci, & Eth, 2003; Overstreet & Mathews, 2011; Paolucci & Genuis, 2001; Saunders, 2003; Shaw, 2003; Wang, Chan, & Ho, 2013). Withdrawal is also a significant concern for traumatized youth at school. For example, the chronic experience of vulnerability may inhibit a child's engagement in both academic and social conversation in the classroom (Pynoos et al., 1996). Some children who present as behaviorally withdrawn may dissociate, which can be difficult to detect for educators who are untrained in the effects of trauma on youth.

Teachers play an important role in shaping children's experience in school. Beyond the role of teaching academic skills, teachers are responsible for helping students to regulate behavior, communication, and contact with peers (Doll, 1996; Pianta, 1999). Once children enter school, relationships with non-parental adults, specifically child-teacher relationships, become increasingly important to classroom adjustment (Birch & Ladd, 1997; Greenberg, Speltz, & DeKlyen, 1993; Howes, Hamilton, & Matheson, 1994). Data from a large national survey show that, even in adolescence, relationships with teachers are one of the single most common resources for children and may be a protective factor against risk for a range of negative outcomes (Resnick et al., 1997). Thus, from both teachers' and children's perspectives, the emotional connection between adults and children in schools is an important factor in children's school performance.

### **The Attachment, Regulation, and Competency (ARC) Framework**

The Attachment, Regulation, and Competency (ARC) framework is based on theory and research in the attachment, trauma, and developmental theories literature (Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2005; Kinniburgh, Blaustein, & Spinazzola, 2005). Interventions developed out of this framework emphasize the attachment system as a foundation on which to base clinical intervention. Trauma literature consistently points to an important relationship between trauma and attachment. Secure attachment in childhood is linked to several beneficial developmental outcomes (Ontai & Thompson, 2008; Rice, 1990), whereas disrupted attachment is associated with negative outcomes which impact areas of neurobiological, psychological, and social functioning (Fernandez, 2008; Wakschlag & Hans, 1999; Schneider, Atkinson, & Tardif, 2001; Schuengel, Oosterman, & Sterkenburg, 2009). The development of the ARC framework for trauma-informed care (TIC) intervention was informed by the available research evidence and clinical expertise in defining the core components of complex childhood trauma, thereby qualifying it as an evidence based practice as defined by the American Psychological Association task force on evidence-based practice (Levant, 2005), and is recognized as such by Substance Abuse and Mental Health Administration (SAMHSA).

The ARC framework conceptualizes trauma across three domains: (a) attachment (e.g., building consistent relationships with caregivers and emotional attunement skills), (b) self-regulation (defined as affect/emotion identification, expression and modulation) and (c) competency (e.g. executive functioning, self-development, and identity). School-based interventions can be framed by each of the core domains within the ARC theory, making the ARC framework ideal for developing, implementing, evaluating, and sustaining TIC interventions in schools.

- The **attachment** domain of the ARC framework describes the child's system of caretakers, which can include parents, extended relatives, school personnel, and clinicians. The attachment system is a foundational component in a child's developmental process.
- The **self-regulation** component describes a child's ability to identify, moderate, and express their internal experience. Difficulties with self-regulation is a consequence of exposure to complex traumatic stress, which compromises a child's ability to use coping resources (Alink, Cicchetti, Kim, & Rogosch, 2009). In the absence of a healthy attachment figure or system, a child who lacks self-regulation skills cannot benefit from a source of external regulation, which can lead to emotional disconnection or the use of maladaptive coping skills.
- **Competency** is the third domain of the ARC framework. It describes a youth's ability to develop age-appropriate, developmental competencies. Children with complex trauma histories can experience delays in several domains of biopsychosocial development (Perfect et al., 2015).

## An Ecological Model of Care

### Educating the Whole Child with a Three-tiered Approach in Austin ISD

Within the Austin Independent School District (AISD), student well-being is considered within a philosophy of educating the *whole* child. **The four components to the whole child approach** are: coordinated school health, creative learning strategies, social and emotional learning, and culturally responsive strategies. Aligning with the district's whole child approach, AISD's Coordinated School Health program incorporates the tenets of the Centers for Disease Control and Prevention (CDC) [Whole School, Whole Community, Whole Child \(WSCC\)](#) model, a cross-sector comprehensive and collaborative approach to improving learning and health as represented by the Association for Supervision and Curriculum Development (ASCD):



- Each student enters school healthy and learns about and practices a healthy lifestyle.
- Each student learns in an environment that is physically and emotionally safe for students and adults.
- Each student is actively engaged in learning and is connected to the school and broader community.
- Each student has access to personalized learning and is supported by qualified, caring adults.
- Each student is challenged academically and prepared for success in college or further study and for employment and participation in a global environment (ASCD, 2018).

**The whole child approach is employed through a multi-tiered system of supports (MTSS) through the Child Study System.** Services include prevention, instruction and intervention for academics, attendance and behavior. At the base of the system, the *universal level* is provided for all students. Here, the provision and effectiveness monitoring of core instruction and behavioral supports occurs. A research-based social-emotional learning curriculum forms a key aspect of prevention at this level and is used across all AISD campuses. The tier 1 universal level is anticipated to meet the needs of 80-85% of students without further intervention.

Among the Tier 1 components are the following:

#### **Cultural Proficiency and Inclusiveness (CP&I):**

An understanding that an adult's personal culture, background, and experiences impact their students' learning and social emotional development. Austin ISD's Cultural Proficiency and Inclusiveness work seeks to provide ongoing, meaningful professional learning opportunities for staff to engage in critical self-reflection regarding their interaction with

students and their families in a manner that considers the diverse needs of all.

**Positive Behavioral Interventions and Support (PBIS):** A broad range of systemic and individualized strategies with emphasis on proactive interventions for promoting, teaching, reinforcing, and monitoring positive student behaviors by all adults on campus while preventing problem behavior with all

students.

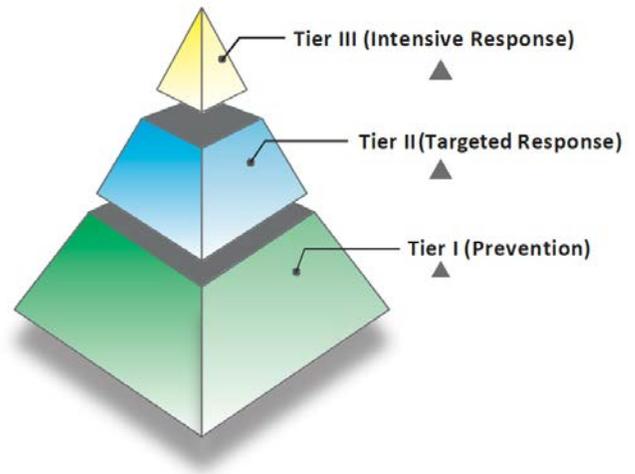
**Restorative Practices:** A continuum of responsive practices available to a campus to focus on developing a campus culture and climate that supports the needs of each individual student and their family.

**Social and Emotional Learning (SEL):** A fundamental research-driven approach where students learn critical life skills such as recognizing and managing emotions, solving problems effectively, and establishing positive relationships through explicit instruction and adult-modeling. Austin ISD is moving into the next stage of implementation that includes a deep integration of Social Emotional Learning into core teaching and learning in every classroom, maximizing implementation on every campus, and ensuring seamless delivery systems of intervention and support.

**Trust-Based Relational Interventions (TBRI):** A trauma-informed intervention designed to meet the

needs of children who have experienced abuse, neglect, and/or trauma and students who are not responding to the learning environment.

### A Multi-tiered System of Supports



Progress monitoring and measuring response to intervention (RTI) is used throughout the system. For students whose progress in academics, attendance or behavior is insufficient, **targeted services are provided through evidence-based tier 2 supports which incorporate the concepts of attachment, self-regulation and competency.** Tier 2 supports are team based and can address academic, behavior or attendance issues. Goals, interventions, and progress are documented in the electronic Child Study Team (eCST) system, an advanced case management system developed by and used throughout the district. Parents are notified of the supports being used. Progress is tracked and reviewed by the team on at least a 6-9-week period with adjustments made in accord with the findings for the student. Tier 2 supports may involve community partnerships such as with mentoring programs, tutoring, Communities in Schools, or other engaging after school programs. They can involve linkage to mental/behavioral health services or wrap around services for the families, perhaps mediated by Family Resource Centers.

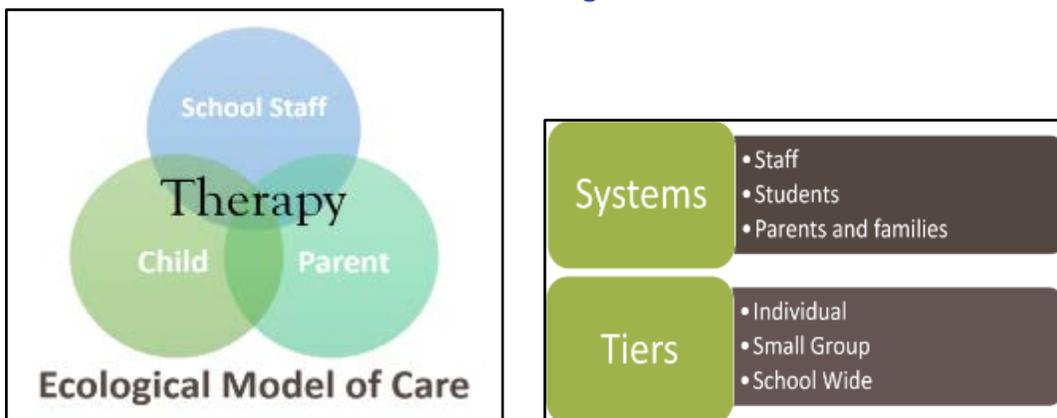
For students with complex needs, there are no simple solutions. These students may need the intensive services of tier 3. Such students are found across all demographic variables, all neighborhoods and all campuses within the district. However, students who have experienced the challenges of poverty, loss, or live in areas where crime is more prevalent may be more vulnerable to negative impacts on school performance, attendance or behavior. For these students it is important to understand and address the root causes of decreased performance. **We do not ask “What is wrong with this student?” but rather, “What is going on with this student?”** Less intensive supports have likely been provided, with inadequate results prior to a tier 3 intervention. The School Mental Health Centers (SMHCs) constitute a tier 3 support. Because not all students who meet the definition of

a victim of crime exhibit intractable deficits in academics, attendance or behavior, they may access the intensive services of the SMHCs without prior tiered school interventions. Since the SMHCs exist within an ecological framework, adult victims of crime including parents/caretakers and campus staff also have access to SMHC services.

**SMHCs are one component of student assistance within the district infrastructure.**

AISD Student and Family Support Services At-A-Glance				
SEL and Multi-Tiered Systems of Support		Health Services	Special Ed & 504 Services	School, Family, and Community Education
Child Study System MTSS Coaches	SEL Specialists	 Coordinated School Health Services	Protected Accommodations	Communities in Schools (CIS)
Guidance & Counseling	SEL Parent Coach		Licensed Specialist in School Psychologists (LSSP)	Cap City Kids: Social Work Interns
Licensed Mental Health Professionals (LMHP)	SEL Mindfulness Coach		Social Behavior Skills (SBS)	Project HELP
Crisis Coordination & Response	Cultural Proficiency & Inclusiveness		Social Communication and Resource Services (SCORES)	Parenting Programs
Behavior Counselors	• Restorative Practices		Family Resource Centers	Parent Support Specialists
Learning Support Services	• No Place For Hate		School Health Advisory Committee	After School Programs
TBRI/TIC/NME				Special Ed Mental Health Professionals
Graduation Coaches			Family and School Support Team	Homebound Virtual School Programs

### School Mental Health Centers in an Ecological Model of Care



The Ecological Model of Care, which is an evidence-based framework, focuses on students, school staff and families. Each of these three “systems” becomes the target of intervention at three interconnected

“tiers”: individual, small group and school wide. This approach addresses the needs of the whole child by focusing on the many interconnections between children, families, schools and communities through the lens of trauma informed care and the attachment, regulation, and competency model. Using the concepts of attachment, regulation and competency in the ARC framework, goals for students are to: 1) develop healthy relationships with caregivers including the parent/guardian and teachers, 2) receive support in learning to self-regulate in expressing thoughts and feelings, and 3) develop competence in interpersonal relationships and in academics.

The environment is trauma-informed when the program, organization or system:

- **Realizes** the widespread impact of trauma and understands potential paths for recovery;
- **Recognizes** the signs and symptoms of trauma in clients, families, staff and others involved with the system;
- **Responds** by fully integrating knowledge about trauma into policies, procedures and practices; and
- Seeks to actively **resist re-traumatization**

The six key principles of trauma-informed practice are: providing safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice; and sensitivity to cultural, historical and gender issues (SAMHSA, 2014). SAMHSA provides guidance for implementing a trauma informed approach across ten different domains.

## Student Mental Health and School Safety

In the wake of the Santa Fe school shooting in Texas, addressing school violence and its devastating impact on schools, communities, and the country at large has become an urgent matter. At the same time, openly talking about mental health and academic performance and outcomes are not mutually exclusive. While there are numerous barriers that may stand in the way of addressing mental health needs of individuals who are most at risk of committing aggressive offenses, Austin ISD, through school based mental health services in partnership with clinical mental health providers, is committed to breaking through these barriers.

Austin ISD, in partnership with Vida Clinic's work through our School Mental Health Centers, shows promising potential in addressing school violence because our school mental health work effectively intervenes on key emotional and behavioral issues that could lead to serious violent acts if left unresolved. The data and research in collaboration with Vida Clinic compares students to themselves before and after treatment. The results have shown substantial reductions in aggressive offenses and suspensions following therapeutic treatment.

## Implementation Guide

### The Victims of Crime Act (VOCA) Program in Texas

The federal Victims of Crime Act of 1984 (VOCA) as amended, 42 U.S.C. 10601 authorizes the Office for Victims of Crime (OVC) to provide an annual formula grant from the Crime Victims Fund to each State and eligible territory for the purpose of providing assistance to victims of crime. All awards are subject to the availability of appropriated federal funds and any modifications or additional requirements that may be imposed by law (Office of Justice Programs, 2018). A brief history of victims of crime legislation is available through West's Encyclopedia of American Law (West's Encyclopedia of American Law, edition 2 (2008), 2018).

In Texas, information on the application for VOCA-funded services is available through the Criminal Justice Division (CJD) of the Office of the Governor, which provides a funding announcement ([General Victim Assistance-Direct Services Program](#)), or via contact at [eGrants@gov.texas.gov](mailto:eGrants@gov.texas.gov) or (512) 463-1919. The purpose of the program is to provide services and assistance directly to victims of crime to speed their recovery and aid them through the criminal justice process. In 2017 it was anticipated the state of Texas would receive up to \$130 million. Funding availability for states is subject to changes in the federal budgetary process and/or amendments to VOCA.

All applications must be for projects that provide direct services to victims in one of the following categories: victims of child abuse and neglect, victims of family violence, victims of sexual assault, victims of human trafficking, or victims of other types of violent crime. Victims may be the direct (primary) or indirect (secondary) victim of a crime. The period of award is no more than 12 months for a first-time award, and no more than 24 months for continuation projects.

The minimum grant allowed under the Texas VOCA program is \$10,000 with no limit on the amount of funding an applicant can request. However, applicants are strongly cautioned to only apply for the funding they can responsibly expend in the grant period. CJD tracks expenditure rates throughout the life of the grant and may take action to avoid large de-obligations at the end of grant periods. Cost-effectiveness is a significant factor in selection, and regional councils of governments are authorized to request changes to the amount to fit within regional priorities and funding allocations (Office of the Governor of Texas, Criminal Justice Division, 2017).

Austin ISD was the first school district in the state of Texas to apply for and secure funds under the VOCA grant program. Grantees must provide matching funds equal to 20% of the total project cost. The match requirement can be met through cash or in-kind contributions. For Austin ISD this match is being made through in-kind contributions of staff time to the VOCA initiative, such as counselors and campus administrators, who are essential to the successful implementation of the program but are not directly funded through the grant because they are district employees. Careful tracking of that in-kind time and effort is a part of the monitoring process implemented by Austin ISD.

### The Application Process

Applications may be submitted by state agencies; units of local government; hospital districts; nonprofit corporations with an active charter number from the Texas Secretary of State; Native American tribes;

universities; colleges; community supervision and corrections departments; councils of governments that offer direct services to victims of crime; hospital and emergency medical facilities that offer crisis counseling, support groups; or other types of victims services; and faith-based organizations that provide direct services to victims of crime. Faith-based organizations must be tax-exempt nonprofit entities as certified by the Internal Revenue Service.

The funding announcement is released by the Governor's Office in December with applications due the following February. Award notifications are made by September. The earliest start date for awardees is October 1, with the latest start date being December 1 for a funding cycle. Applicants must have a demonstrated record of providing effective victim services. In rare cases where services are critically needed, CJD may award funds to entities that have not yet demonstrated a record of providing services, if they can demonstrate that (1) 25 percent of their financial support comes from non-federal sources (to demonstrate financial stability); and (2) the entity is already operational at the time of application.

### Critical Precursor: Administrative Support

Key informant interviews, participatory observation and staff surveys in Austin ISD were conducted as a part of this implementation study. Findings are covered more extensively in the evaluation section of this report, but one clear finding on which there was consensus is that **the effort to establish and sustain SMHCs is not likely to be successful without significant support across the district**. A campus or a few dedicated nurses, counselors or other school staff are not likely to succeed without clear support from administrative officials at both the campus and district level. If these are not evident at the time a district is considering applying for VOCA funds, it is recommended that efforts to build that support across key individuals, roles, departments, and community sectors proceed prior to applying for funds. Campus or District Advisory Councils or School Health Advisory Councils may be useful mechanisms for developing such support.

Campus level administrative support is crucial to successful implementation. If the principal's commitment to SMHC success is not clearly evident the initiative will not succeed. A campus should not be targeted for SMHC implementation if the principal is not serving as a champion for the idea. That leadership role is essential for helping reduce stigma around the topic of mental health, helping others recognize that students, families and staff all need to be mentally healthy to perform well, and addressing the logistics of setting up a campus-based clinic.

While campus leadership is essential, no less important is the support from district administration, including both the Superintendent and the School Board. When interviewed for this study, Dr. Paul Cruz, Superintendent for Austin ISD reflected on his experience learning to approach student behavior and discipline issues from a trauma-informed perspective:

This has been a learning for me as a Superintendent. This is my 32nd year in education, and I started in the days of desegregation, in the days when court ordered busing had stopped, actually working in urban here when busing was still going on. This to me is an exciting learning for how to work with kids and how to work with institutions that serve kids in a much better way (Cruz, 2018).

Commenting on the value of school board support, Dr. Cruz stated **“Fortunately, I have a board that agrees with me.”** The board is also seeing the benefits in aggregate reports. “They know the need at their campuses, but you get a different perspective when you see the [district-wide] aggregate data and what's happening to our kids over time, how they are improving” (Cruz, 2018). This is an important consideration. Students with complex needs may have lower academic performance than their peers, contributing to reduced campus performance metrics on standardized tests, even though the student is showing key behavioral improvements in attendance and discipline. The capacity to track and trend improvements in student behavior creates the anticipation that academic performance will improve over time as attendance and discipline improve. This can establish a more tolerant atmosphere for such students by campus administrators who are held accountable for standardized test scores.

## Compliance and Reporting Requirements for VOCA

### District Fiscal and Technical Capacity

Reporting requirements for the VOCA grant are significant. Quarterly reports corresponding to the state of Texas’ fiscal quarters are required. Maintaining the fiscal systems and having the technical capacity to track and report on students and other victims treated through the SMHCs is essential. The Austin ISD has developed a case management system (eCST) which tracks students receiving tier 2 and tier 3 interventions as well as outcomes in student performance (attendance, academics and behavior). The district has also contracted with its mental health service provider to generate and report in aggregate the victim services, categories of victimization and some outcomes. The vendor tracks services at a person level but reports aggregate findings to maintain HIPAA privacy protections. VOCA reporting requirements are addressed below.

Financial and Progress Reports: At the end of each quarter of the state fiscal year during the grant period, grantees will be required to submit a financial status report via eGrants and quarterly progress reports via <https://cjd.tamu.edu/> in the format required by CJD. Applicants must contact the criminal justice planner at their regional Council of Governments for additional local requirements that may apply, potentially including required workshops and prioritization meetings. To find contact information for your local COG, visit the Texas Association of Regional Councils website at <http://txregionalcouncil.org/>.

VOCA requires that applicants must be culturally competent when providing services to victims. Victim service providers must have the ability to blend cultural knowledge and sensitivity with victim restoration skills for a more effective and culturally appropriate recovery process. Applicants must agree to comply with all federal and state rules and regulations for program income and agree to report all program income that is generated as a result of the project's activities. All recipients of funding may be required to participate in a victim services assessment during their grant period, as directed by CJD. Grantees must comply with all standard CJD requirements.

Immigration and Customs Enforcement Requests: An application requirement pertaining to full compliance with Department of Homeland Security detainer requests applies to all municipal or county governments that operates a subdivision or department that detains individuals after arrest for a criminal violation. Full text of this certification can be found on the Narrative tab of each application or

at [http://gov.texas.gov/cjd/dhs\\_detainerrequest](http://gov.texas.gov/cjd/dhs_detainerrequest). All applicants must select one of four options in their eGrants application to be considered for funding under this announcement (Office of the Governor of Texas, Criminal Justice Division, 2017).

## Establishing Elementary School Mental Health Centers

### Overview

For Austin ISD, professional development around the whole child and a trauma-informed care model, implementation of a social emotional learning curriculum on all campuses, and training in mental health first aid all served as important precursors to the VOCA grant application. These efforts conveyed that district leadership values the mental/emotional/behavioral components of personal well-being, and that they affect the capacity to learn. Another important precursor to expanding SMHCs to elementary schools via VOCA was the student outcome data for attendance, behavior and academics for students receiving SMHC services at the secondary level. That data demonstrates the efficacy of the approach. Elementary campus principals were requesting SMHCs for their campuses. The VOCA grant provided an opportunity to fund the elementary SMHCs. Preparation for establishing a mental health center on elementary campuses occurred prior to submission of the grant, with periodic updates on the grant status as the new school year opened.

### Three-tiered Model of Care and an Ecosystems Approach

As previously described in the section on the Whole Child and a Three-tiered Approach, Austin ISD SMHCs are not typically the first point of contact or intervention for a distressed student, unless a crisis is involved. They are an intensive tier 3 intervention within a multi-tiered system of supports and are built on a platform that emphasizes prevention and social emotional learning, with intermediate targeted supports that include an array of community partnerships.

Austin ISD's VOCA-funded Vida Clinics implement therapeutic interventions within a district-wide effort to develop trauma-informed school environments. That effort is ongoing and includes significant professional development for staff. Using an ecological framework, not only is the identified student able to access services, but so are family members and school staff. School staff receive support and coaching in their professional roles including the management of challenging behavior within a trauma-informed framework. School staff may also access the centers to address their own histories of victimization as needed.

### *Preparation for Implementation: Communication within the District*

Our experience has reiterated that communication from central administration through campus leadership and across departments is essential in creating a team-wide commitment to establishing the clinics. That communication begins prior to the grant application process. It proceeds throughout implementation, maturation of the clinics on campus and planning for sustainability over time.

### *Prior Staff Development*

The development of VOCA-funded Vida Clinics was not the first attempt to systematically address student mental health needs in the school setting. Earlier efforts have helped establish a school climate that embraces the mental, emotional and behavioral needs as part of the whole student and their

successful learning. Austin ISD has made an extensive commitment to social emotional learning (SEL), implementing a research-based curriculum across all grades and all 130 campuses. This is a universal level intervention for all students and fundamental to the whole child approach. The Child Study Teams (CSTs) are interdisciplinary teams on each campus that convene to address student issues in academics, behavior, and attendance. For students needing targeted (tier 2) or intensive (tier 3) services, interventions and associated progress monitoring occurs through the electronic case management system known as e-CST. Ongoing efforts exist to provide staff development related to mental, emotional and behavioral health. This has included training in mental health first aid for teachers.

### *Leveraging Prior Experience and Partnerships*

This manual is intended to share our experience with other districts contemplating the use of school based mental health centers in order to reduce their time and effort to successfully establish such centers. To that end, Austin ISD and Vida Clinic are sharing processes, forms, experiences and lessons learned. A critical factor in the successful implementation of the VOCA-funded Vida Clinics has been the prior experience of Austin ISD and community partners in establishing school mental health centers in middle and high schools. The experience of implementing the VOCA-funded clinics is built upon and informed by prior efforts establishing SMHCs at middle and high schools, and the outcomes achieved in those clinics.

Austin can be perceived as having many resources not available in other Texas communities, especially in rural areas. However, the processes of reaching out, examining the research, learning where local resources are, being creative in forming partnerships, and maintaining communication with existing and potential partners to better meet the mental health needs of students can happen in any community. Austin ISD has leveraged its array of community partnerships, such as those with Integral Care, the local Mental Health Authority, the National Alliance for the Mentally Ill (NAMI), and a collective impact group of social service and behavioral health providers called Kids Living Well. Monthly meetings with the latter group enable communication between district officials and community partners.

### *From Grant Award to Vendor Contracting*

For Austin ISD, the official notice of grant award occurred in mid-October 2017 with an effective grant start date of October 1, 2017. Although the district was as prepared as possible to receive the award, it took approximately six months to establish clinics and initiate services. Most of the VOCA clinics were established in March 2018. Logistically, this was a very rapid implementation, possible only because there was significant experience on which to draw in establishing the clinics. Governmental procurement regulations require that no Requests for Proposals can be posted until a notification is received. A school board vote was required before any vendor could be contracted. This process took until December 18, 2017. Work with the campuses could not proceed until after the winter holidays. The first student mental health encounter at a VOCA-funded Vida Clinic occurred on February 7, 2018, reflecting a very rapid roll-out, which was only possible due to the high degree of readiness.

An anticipatory timeline for prospective use by districts is as follows:

1. Approval of grant. Time: 6-8 months after submission (in the following school year)
2. Write and publish RFP. Time: 1-2 months
3. Accept Proposals. Time: 2 weeks - 2 months depending on district rules

4. Evaluate Proposals. Time: 2 weeks - 2 months depending on district rules
5. Board approval of Proposal: Time: 2 weeks - 4 months depending on district rules
6. Notify Contract Awardee: Time: 1 day - 1 month depending on district rules
7. Execute Service Agreement with Contractor: Time: 2 weeks - 4 months depending on district rules
8. Establish legal forms and processes for Contractor and employees. Time: 2 weeks - 12 months
9. Contractor begins rollout. 1 - 24 months depending on district and contractor variables such as allocating space, hiring staff, etc

Clearly, district rules and the capacity to meet VOCA timelines can impact the viability of VOCA funds for school mental health services. This implementation guide is intended to build capacity and support district preparedness to pursue this funding avenue. Several forms, practices and lessons learned are shared for that purpose.

### *Creating the Request for Proposals*

A key lesson learned has been the value of specificity in the language used in the Request for Proposals (RFP), and in contracting. Sample RFP language is provided in the Appendices. Without clarity in the RFP it may be difficult to assess whether a respondent is offering psychotherapy by trained and licensed professionals, or social support services. Expectations of compliance with both FERPA and HIPAA should be specified. The VOCA-funded Vida Clinics are providing individual, family and group psychotherapy with experienced licensed professionals. They also support school staff in understanding and responding to student behavior within a trauma-informed framework by providing classroom observation and teacher coaching. Clinic staff work closely with school teams to create the ecological model of care for the campus. Disruptive behavior is not ignored, it is dealt with using strategies that address considerations of attachment, self-regulation and competency development. For teachers this may mean learning what might trigger a reaction in a traumatized student and creating opportunities for students to re-regulate themselves in a safe environment. The language of the RFP and the contract together help to define the scope of services.

Clinic staff must be knowledgeable of how to work with school systems at the campus and district level. Clinicians may be unfamiliar with necessary school systems and strictures, such as wearing badges and signing in at the main office, using hall passes or the need for an adult to accompany a child in the hallway, school schedules, use of bathroom facilities, or communication protocols needed to maintain a safe and well-functioning school environment. Training is needed for clinicians, as well as support in understanding why such systems are in place. Failure to recognize this need, and to include it in the language of RFPs or contracts can lead to misunderstandings and conflict between school and clinical staff that can undermine the success of the system.

Schools measure student progress. There is an expectation of ongoing progress monitoring for students served, and outcomes achieved. This should be addressed in the RFP and contract. It is important that respondents be specific regarding the qualifications, experience and training of clinical staff, their staffing model, specific tools and metrics to be included in monitoring and evaluation, anticipated outcomes to be achieved, and fiscal management.

### *Defining the District's Relationship with an External Mental Health Provider*

Once the mental health provider has been selected, the next steps focus on defining the business relationship with the partner. The services agreement (or contract) scope of work must specify the services to be provided by the mental health provider, where they will be provided, when (will services be available when school is not in session?), and under what conditions. Contributions of the district should be identified, such as the provision of space commensurate with a therapeutic environment, any furniture or supplies, and access to campus resources should be identified. Will the therapist be a member of an interdisciplinary campus team to address student needs? Will school staff be contributing time and effort to the SMHC? Are there expectations that the provider will also be responsible for training school staff? Will they be part of the school team? What is the role of the provider in addressing classroom behavior management? These aspects should be discussed, clarified and codified in the contract.

The processes for making and receiving referrals, data tracking and reporting should be clarified and written. Both HIPAA and FERPA considerations apply. Austin ISD and Vida Clinic have shared their processes in this document. These can be adapted to meet local needs. Staff need to be trained in these processes and methods of review and oversight established.

The need to measure and understand the health and school outcomes achieved for persons receiving mental health services is a reasonable expectation, but again compliance with HIPAA and FERPA are considerations. Depending on district norms, an External Research Agreement may be required, as well as a Data Sharing Agreement. If student level school data is to be shared with the provider, parent/guardian consent is needed. Similarly, if health data is to be shared with the schools, a HIPAA-compliant consent, and possibly authorization will be needed. The Austin ISD consent forms, which have been legally vetted for our purposes, are shared in the appendix. If data entry, tracking, analysis, and reporting are expected of the provider, this needs to be made explicit by the ISD since there are significant budget implications for these activities.

### *Logistics of Establishing Successful School Mental Health Centers*

#### *Early Campus Engagement and Participation*

Efforts to inform campus administrators began before the VOCA grant application was submitted. Principals were informed that the grant opportunity was being pursued as an opportunity to expand the successful SMHC concept from the secondary to elementary schools. Principals were able to provide input through feedback to the grant writing team. Principals were aware that the grant was submitted in the spring semester prior to the award year. Austin ISD administrators determined early on to focus the grant on elementary schools in 3 vertical teams where student needs were higher and overall school performance more challenging to achieve than for the district overall.

At the beginning of the 2017 school year, principals were aware that if funded, the SMHCs would be implemented during the school year. Space considerations were discussed in advance of the award notice. According to Tracy Spinner, Austin ISD Director of Health Services, "Anytime we had an update from the governor's office regarding where we were in the process itself we provided communication back to them. We didn't want anybody surprised or find it something they couldn't accommodate" (Spinner, 2018).

Principals were immediately informed when the grant was awarded in October, however central administrative processes including procurement compliance, the development of Requests for Proposals, vendor selection, and the need for Board approval meant that active development of the centers did not occur until the spring semester. Implementation during a school year was challenging for administrators, particularly on over-enrolled campuses, due to the need to reassign space. However, efforts to maintain communication with campuses in advance of implementation helped to smooth the transition.

Following vendor selection and contracting, implementation occurred within a matter of 6-8 weeks across all 22 sites. Members of the Child Study Teams, teachers and other staff had been informed that centers were being established. Marketing materials were developed by the mental health provider in concert with the district and made available to campuses to facilitate communication with families. Clinical teams met with campus administrators, counselors and teachers to train on the trauma-informed, ecological model of care. Clinical staff became members of campus teams. School staff were trained in the referral process. The role of the referral coordinator was defined as the person responsible for obtaining parental consent to refer to the clinic. Policies and procedures to ensure client privacy and confidentiality in compliance with both FERPA and HIPAA were reviewed with school and clinic staff.

### *Space*

The need for adequate private, secure, accessible and welcoming space for a therapeutic environment has proved perhaps the greatest logistical challenge in the school setting. Fortunately, the mental health contractor is experienced in the provision of school-based mental health services and creative in adapting to the school environment. Similarly, with good communication between campuses, central district administration and the provider, space needs could be negotiated. On campuses that were under-enrolled finding adequate space was not as great a challenge as it was for those campuses whose enrollment exceeded built capacity. However even for those crowded campuses, clinical and school staff worked together successfully to locate the needed space.



Among the considerations in assigning space, a few patterns have emerged:

- The clinical staffing model calls for 1.5 FTE clinicians per campus. If two clinicians are seeing clients at the same time, two compliant spaces are needed.
- Some campuses have been designed with an 'open concept', having fewer walls or separate spaces. Finding private space on these has been particularly challenging. Some soft design techniques have been used to adapt the space, such as use of wall hangings and room dividers and the use of white noise machines to help muffle conversations. On one campus the clinic location was moved from a space near older students to one next to a Pre-K class where children were less cognizant of the clinic operations. This was augmented with the use of white noise machines.
- Another consideration has been whether the clinic should be within the school building or in an available portable. Discussions have varied by campus and both solutions have been used.
- Based on the ecological model, the SMHCs are available not just for the identified students, but for their parents and caretakers. School staff may also be victims of crime and can receive services personally, not just supports related to classroom management. On some campuses it is perceived that portables are more accessible and more private for adults. Easy access to bathrooms in the portables is also identified as a benefit.
- An additional issue related to access has been that the SMHCs operate year-round, while school buildings close for summer break. Managing building access requires planning, and in some cases has required clinics to be relocated over the summer. Access to clinics in portables is more readily managed during the summer.

### *Budget*

Funding of SMHCs could be a priority for districts seeking new ways to improve campus safety, attendance and academic performance. The budgeted start-up cost for a single campus clinic is \$200,000. Funds support staffing by licensed professionals, furniture, toys/manipulatives and items to create an inviting atmosphere. Funding is also needed to support use of assessment tools, data entry and analysis. Since serving the entire campus population is vital, the service provider needs to ensure that the cost of service is never a barrier to receiving treatment. VOCA clients are not charged for services.

### *Training, Processes and Roles*

#### *Training School District and Clinical Staff*

Training is required for school staff as well as for clinic staff working in the schools. Training incorporates awareness of the ecological model of care; the importance of protecting privacy and confidentiality, and the processes and mechanisms in place to do so, and to comply with FERPA and HIPAA. Through training, school staff are informed that the ecological model of care incorporates group and individual classroom supports and coaching for teachers, as well as access to clinic services for school staff. Persons who are victims of crime including parents, caretakers and school staff as well as students and their siblings can be served through the clinics. Persons who seek services but do not meet the federal definition of victim receive assistance from Vida Clinic in accessing services through other means.

#### *Training School District Staff*

In addition to addressing the ecological model of care and creating a trauma-informed school environment, training for school district staff emphasizes the referral process and the need to maintain

not just FERPA compliance, but HIPAA compliance for those receiving mental health services. This means that once a referral from the school to the clinic is complete, only limited information is shared with the school on an individual, and that is dependent upon parent consent. While the school-based referral process is key, it is also possible for a student, family, caretaker or staff person to self-refer to the clinic without the knowledge of school personnel. These multiple mechanisms for referral are addressed in the established workflows.

Beyond formal training for school staff, the clinic providers are available for campus team meetings and participate in Child Study Team meetings when a specific student is being discussed (with parent consent). While the full-time therapist predominantly provides individual, group and family therapy, the role of the halftime therapist is to participate in campus meetings, provide classroom support for management of challenging student behavior within a trauma-informed framework, and support campus understanding of the model of care. The halftime therapists also maintain a smaller case load. All campuses have access to bilingual (English and Spanish) therapists. An emerging need has been for services in Arabic or Farsi, and a skilled therapist has been identified. Additional translation services are available.

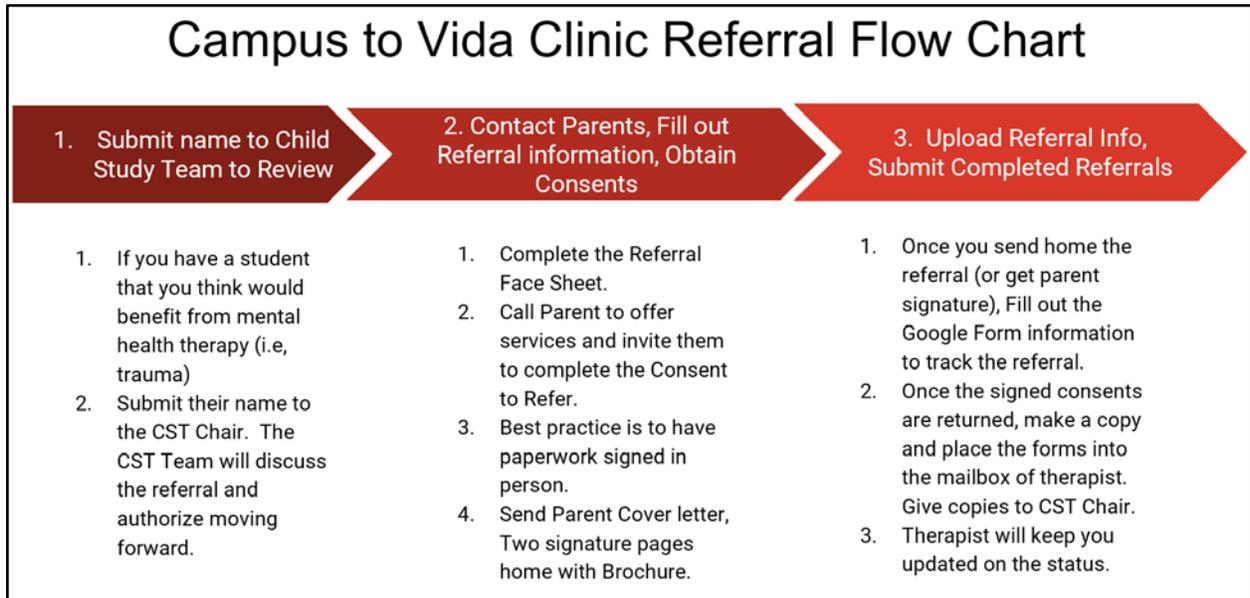
#### Training Clinical Providers

Training for clinicians is focused on orientation to work within a school environment. All clinicians are experienced, licensed therapists (Psychologists, LPCs, LCSWs). However, providing clinical care in a school setting is a new experience for some of them. Staff are trained in both FERPA and HIPAA compliance, school schedules, campus systems for entering and leaving the building, requirements for accompanying students, and the need to avoid pulling students out during core instructional periods. Clinical staff are also oriented to the campus physical and school team environment; district and campus safety protocols such as the use of badges and sign-in procedures for visitors; and to working with other campus personnel such as counselors, nurses and parent support specialists, administrators and school resource officers.

#### Workflow and the Consent Process

Austin ISD and the mental health provider, Vida Clinic, are able to draw on prior experience and lessons learned in establishing SMHCs at the middle and high schools before endeavoring to do so for elementary campuses under the VOCA grant. Workflows and processes have needed to be adapted but had already been tested in the school environment, making adaptations easier. Although families and staff can self-refer for clinic services, the more typical pattern is the referral of a child through the school. The campus multi-disciplinary Child Study Team is key to this process, described in the chart below. A teacher or other staff person initiates the referral to the Child Study Team. That team reviews and assigns a team member to work with the Referral Coordinator to provide follow up on the referral with the parent. **This initial referral seeks the parent's consent to release information from the school record to enable the student to be referred to the clinic, and to allow the clinician to monitor the child's school progress.** This approach maintains FERPA compliance. Without this consent the school cannot refer the student to the VOCA-funded Vida Clinic, though a family may self-refer. **Once the consent to refer is signed, the school can make the referral to the clinic. The mental health provider then obtains its own HIPAA-compliant consents for treatment.** Patients must sign a consent for

treatment form to engage in therapy services. For children, the consent form for treatment is signed by the legal guardian.



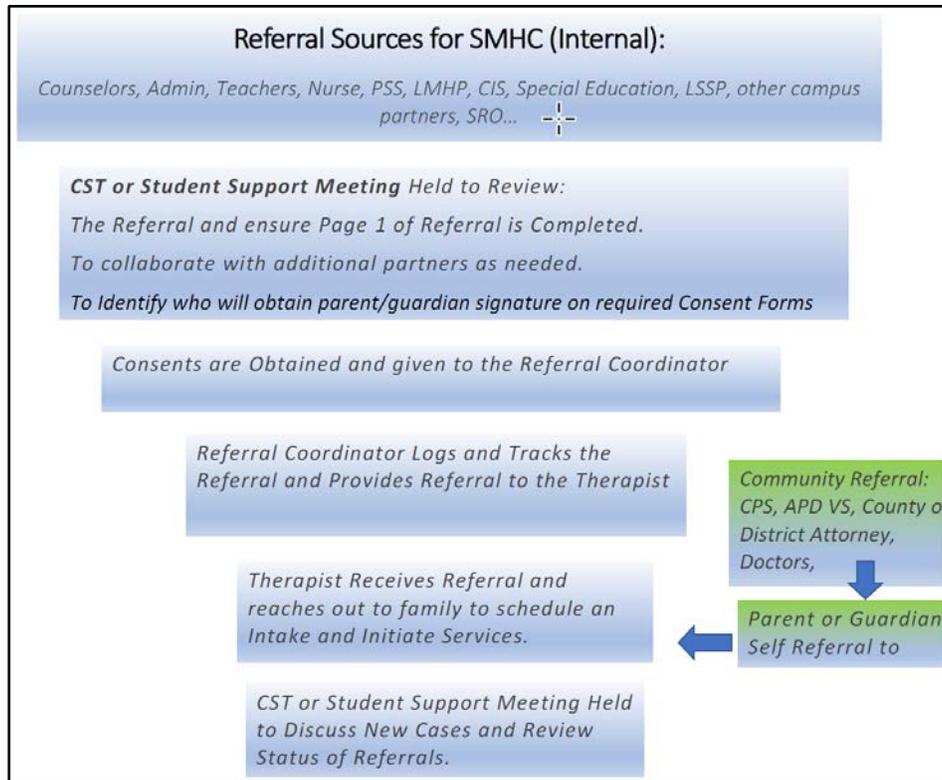
#### Referral Coordinator Position

The Referral Coordinator is an assigned role for a single identified campus staff person who is also a member of the Child Study Team. That person serves as the formal point of contact between the school and the mental health provider, managing paperwork for school-initiated referrals to the clinic prior to a student receiving service. The role is essential to maintaining FERPA compliance. If parent consent cannot be obtained no referral to the clinic can be completed and the student cannot be served.

The Referral Coordinator completes the referral face sheet, documents the referral on the tracking form, contacts the parent to offer services and to invite them to complete the consent for a release of information to the clinic, and updates the Child Study Team on the progress of the referral. It is *not* the Referral Coordinator’s role to be solely responsible for parent outreach, nor is it their role to determine whether a referral is appropriate. Those responsibilities are shared with the Child Study Team. If a parent is reluctant or unresponsive the team will discuss what campus member may have a supportive relationship with the parent to provide the outreach. Multiple attempts are made to engage the parent to complete the referral consent to the clinic. A best practice is to meet in person with the parent to explain the services available and obtain the written consent. The referral consent process includes a cover letter, a brochure and signed releases. These forms are included in the Appendix to this manual.

#### Managing the Consent Process

Though referral to the clinic typically occurs through the school, it is not the only way a referral can occur. Alternative mechanisms for referral can be through self-referral or from the community, such as Child Protective Services, the Austin Police Department Victim Services, District Attorney or from a medical provider. The flow chart indicates how these other mechanisms interact with the SMHC.



Once the referral from the school to the mental health provider is completed, the relationship between the clinician and the client can proceed. The mental health provider requires a separate consent process to provide treatment under HIPAA regulations.

School based therapy then proceeds. The clinician provides individual and family therapy. She also seeks to build a support team for the student, including the parent and campus personnel. The SMHCs use methods which are evidence-based, trauma-informed, culturally appropriate and inclusive; person-centered, confidential and easily accessed. Therapy includes ongoing sessions as needed. These may include individual, parent and family sessions, group sessions and crisis response services. The SMHCs remain open during school breaks. With parental consent, the therapist is able to participate in Child Study Team meetings on behalf of the student and to monitor student progress in school.

**Sample Forms**

Several forms are used to facilitate the workflows and to insure appropriate consents and authorizations have been received. Samples of the following forms are available in the Appendices:

- Campus Referral to Clinic Form
- Parent/Guardian Consent to Refer Student to SMHC
- Parent/Guardian Consent to Share Student Data with SMHC Provider

# Evaluation of the Austin ISD School Mental Health Centers

## Overview

The VOCA grant requires an evaluation component. For the Austin ISD VOCA grant, evaluation includes both an implementation study and a study of student outcomes. Sharing the practices, processes and forms used by Austin ISD as part of a manual for use by other districts that might consider using VOCA funds to address student mental health needs constitute the tier 2 evaluation requirement under the VOCA grant for AISD. The implementation study and the review of student outcomes follow.

A challenge for both implementation and evaluation was the distinction between the Texas fiscal year and either the school year or district fiscal year. Grant writing occurred during the 2016-17 school year. Principals were engaged in that process but decisions around campus staffing and space allocation had to be made at the beginning of the 2017-18 school year, before any award notification regarding the VOCA grant was made.

The VOCA grant requires that new grantees initiate implementation between October 1 and December 1 of the award year. For the school district this meant following district administrative processes compliant with procurement regulations and policies. Public posting of the RFP, proposal submission, review and vendor selection all occurred on a compressed time schedule. School Board approval of the contract occurred in December, but with the winter holidays, it was not until late January 2018 before vendor contracts were completed.

We couldn't actually award the contract to a vendor until after Board approval on December 18<sup>th</sup>, 2017. By that point, the first quarter of the award year had passed, and we were running months behind. That was purely out of our control, and the Governor's Office was really great at working with us, they completely understood . . . Any district that receives VOCA funds is going to have the same challenge, we all have to comply with Texas procurement laws. You can't act preemptively or post an RFP without an award notice (Spinner, 2018).

Although the Governor's Office was understanding of the timing challenges, scaling up to open clinics on 22 campuses and provide therapeutic care before the end of the school year was challenging and likely would not have been feasible if the district and its contractor had not already been experienced with the processes of establishing school mental health centers. The model, processes and forms had to be adapted for the VOCA grant, but they did not need to be newly developed. It is in that spirit of sharing that the processes, forms, insights and lessons learned are shared in this report to facilitate the experience for other interested school districts.

## Implementation Study

### Methods

The methods used for the implementation study include a combination of key informant interviews, observational notes, participation in planning/team focus groups, review of documents developed for the VOCA initiative, and a survey of campus counselors and administrators. In addition to these, the *Attitudes Relating to Trauma Informed Care* ([ARTIC](#)) provided a standardized measure of the level of

implementation of a trauma-informed school environment. The short form is easily administered. Used over time, it can provide an understanding of how a campus system is progressing in creating and maintaining an understanding and supportive school environment for those who have experienced trauma, and integrating the management of challenging classroom behaviors within a trauma-informed framework. Key informant interviews were conducted with central district administrators including the Superintendent, as well as principals and key clinical staff. Principals and counselors across all 22 campuses were surveyed regarding the implementation. Teacher input was gathered through the ARTIC. In addition to these, observational notes, meeting participation and the review of documents have informed writing and been integrated throughout this document.

## Findings

One key question to explore was how families served across the 22 campuses were similar and how they differed. Although the population overall was predominantly economically disadvantaged students and families of minority ethnicity, there were significant differences across campuses in terms of demographics as well as the variety of needs, intensity and types of victimization identified.

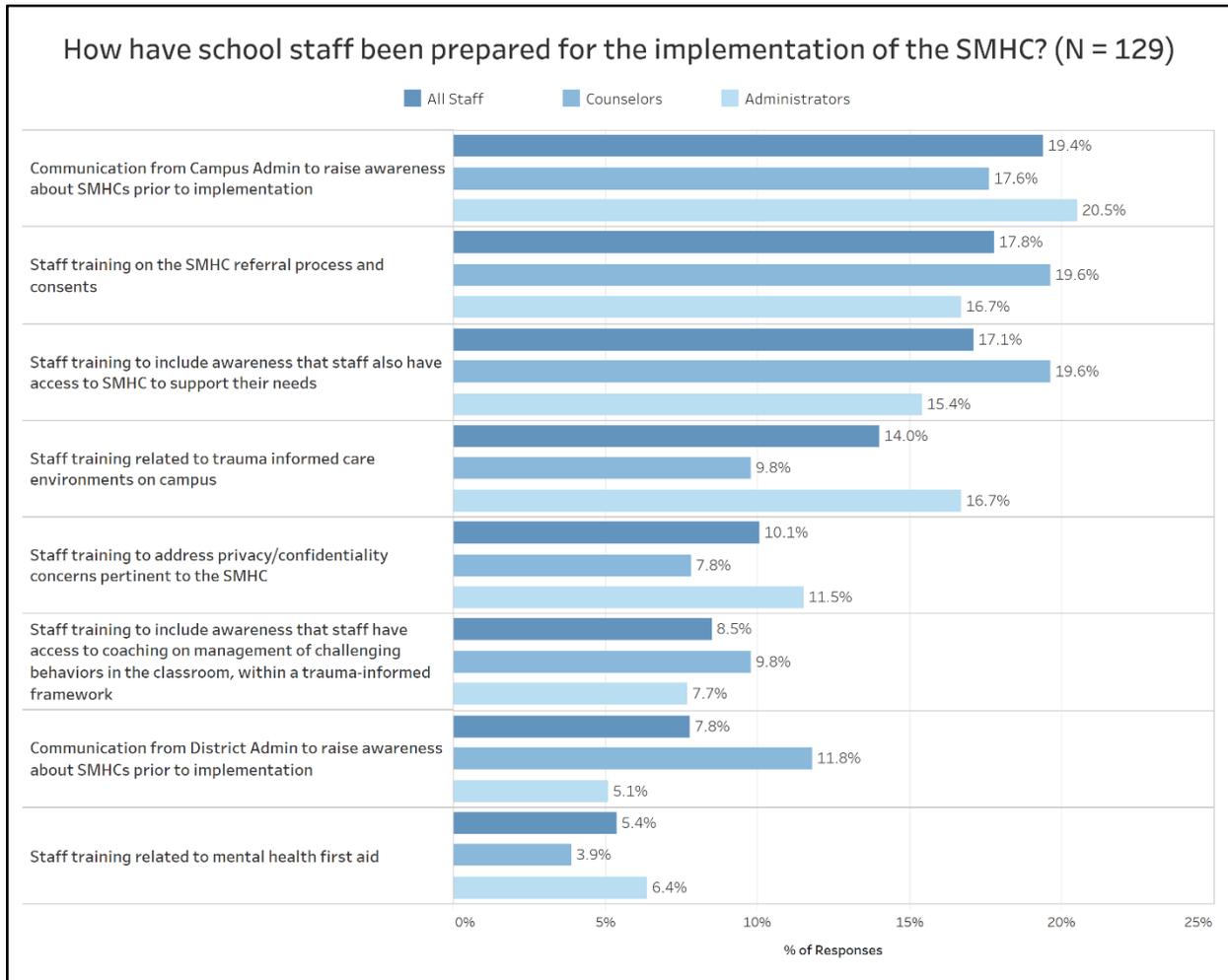
We see such a wide range of victimization from bullying, trauma, adverse childhood experiences all the way to sexual assault, homicide, violence in the home, parent incarceration, fear, immigration issues. There is such a wide variety of need that each center is helping to address, and each center is addressing different needs (Spinner, 2018).

For most campuses the SMHCs were set up and staffed beginning in March 2018. This meant that functionally, families were served mostly during the months of April and May during VOCA grant year one, though services did continue through the summer. **The most unexpected finding was the sheer number of persons seeking services who met the federal definition of victim.** By the end of June 2018, 1600 children and adults were seeking care. **“Certainly, what we have found is that we underestimated the need.”** (Spinner, 2018). This may speak to the value of locating accessible mental health services in locations, such as schools, that families naturally interact with. Services are provided at no cost to families, further increasing access.

**Another unanticipated finding was the extent of the need for clinical assessment, diagnosis and treatment services to be provided in a variety of languages.** All VOCA clinics have English and Spanish speaking staff. Vida Clinic expanded language services with a clinician fluent in Farsi who also spoke Arabic. At least 6 rare languages, including American Sign Language, were accommodated using contracted translation services. Providing services in multiple languages emphasizes the need for culturally competent care. Vida Clinic staff continue to seek professional development and work with local members of different ethnic communities to better understand how best to provide that care. Meeting the need for multi-lingual services became a larger budget consideration for the service provider than initially anticipated.

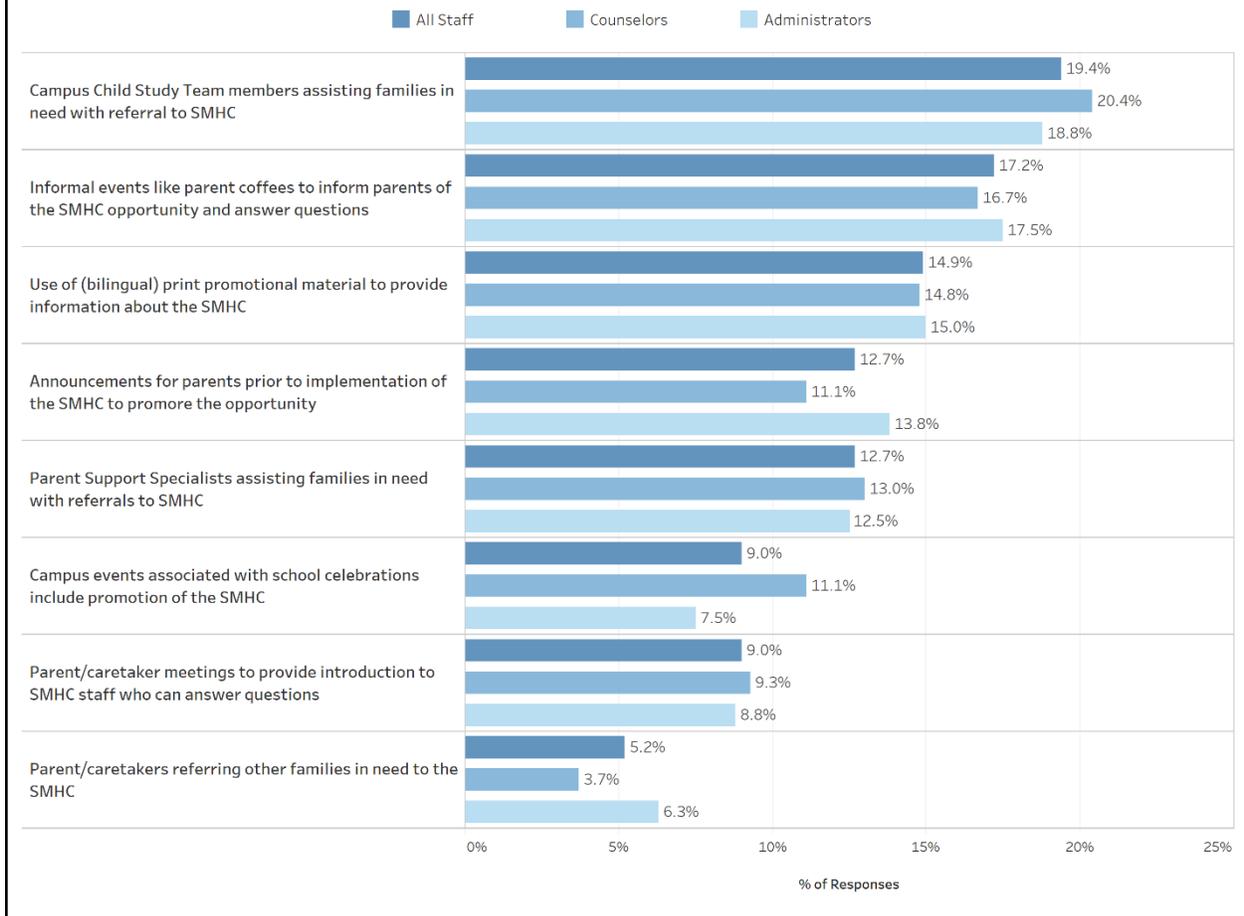
Following the end of the 2017-18 school year 60 principals, assistant principals and counselors across all 22 VOCA campuses were surveyed regarding the implementation process and early outcomes. A total of

37 surveys were returned (61%). Results of the campus survey are summarized below. For the first three questions presented below, the set of response options was based on information gathered during interviews and participant observation in meetings. Results are ordered based on the frequency of the responses received from campus staff. For all questions, respondents could provide additional comments.

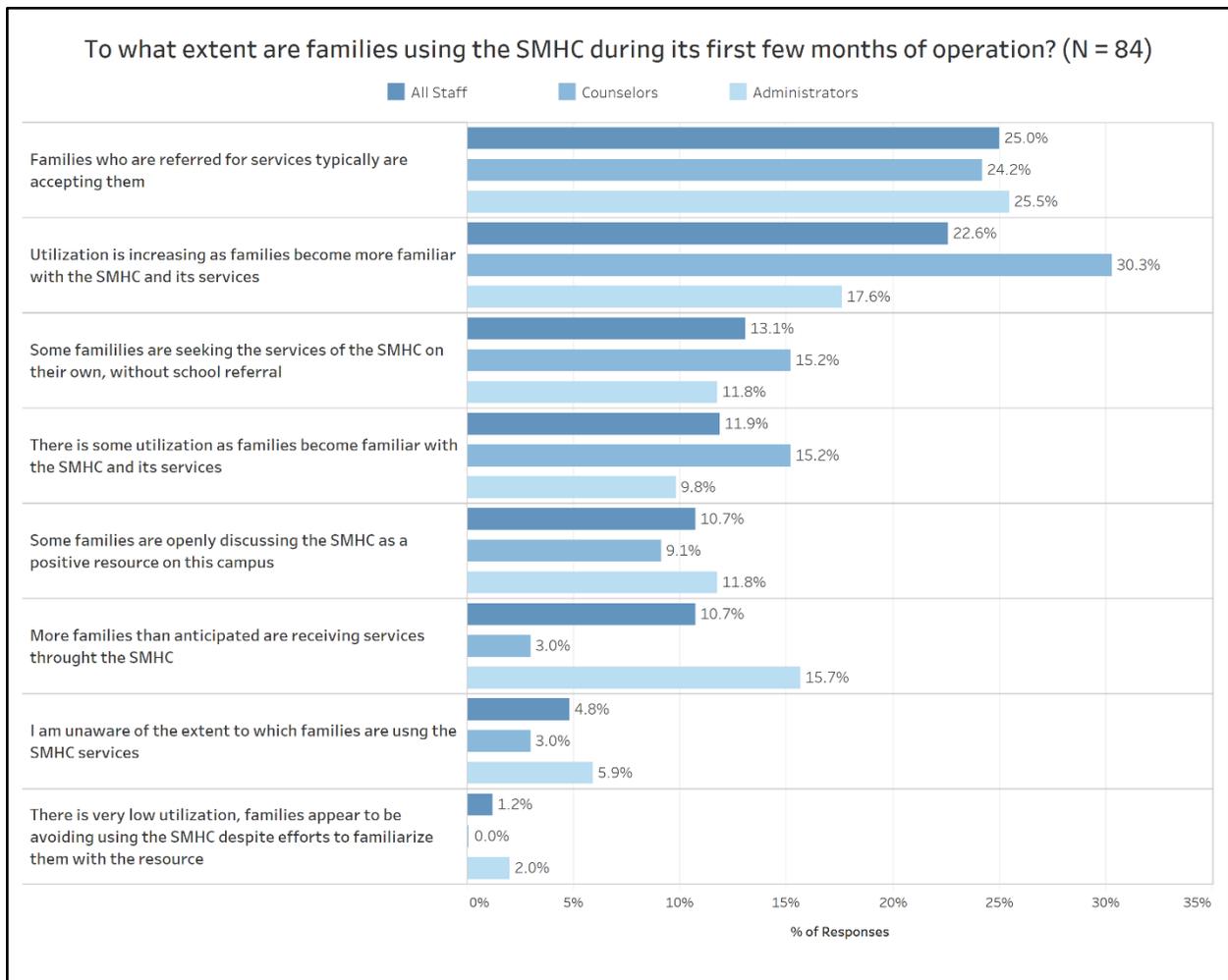


Responses reflect that several efforts were used to ensure that staff were prepared for implementation of the SMHCs. All the efforts to prepare campuses that had been identified through interviews and in meetings were endorsed by respondents, with varying levels of acknowledgment. It is likely that the combination of multiple efforts aided in the perception (below) that there were not many disruptions during implementation. The efforts identified for preparing campus staff prior to implementation can also be instructive for other communities considering establishment of SMHCs.

## How have parents/caretakers been prepared for the SMHC? (N = 134)



Like the efforts to prepare campus staff for implementation, it is apparent that campuses used multiple approaches to inform parents about the SMHCs. Given the early implementation phase, it was surprising to find some endorsement that parents are referring other families in need to the SMHCs, an indicator that the centers are being valued early on and there is a sense of trust. Comments from respondents included that teachers and counselors were also assisting families in need with referrals to the SMHC. The multiple efforts used to create awareness and perception of the SMHCs as a positive resource can also guide other campus communities in their preparation for implementation.



Given the very brief time frame for serving families prior to the end of the school year, it is particularly interesting that almost no one identified low utilization by families. This is consistent with the quantitative data on the numbers of persons seen. Concerns about stigma around mental health needs and the labeling of the centers as School Mental Health Centers seem to have been overcome with efforts to raise awareness and frame the SMHCs as a positive resource for the campus communities. High utilization could also be an indicator of the lack of access families have had prior to the opening of the centers.

It was quite heartening to find that typically families who are referred for services are accepting them, and surprising, given the newness of the SMHCs, that campus staff were observing families seeking services on their own and openly discussing the SMHCs as a helpful resource. Clearly efforts to build relationships between center staff, campus staff and families are resulting in trusting relationships and a sense of safety around seeking help to cope with the impacts of victimization.

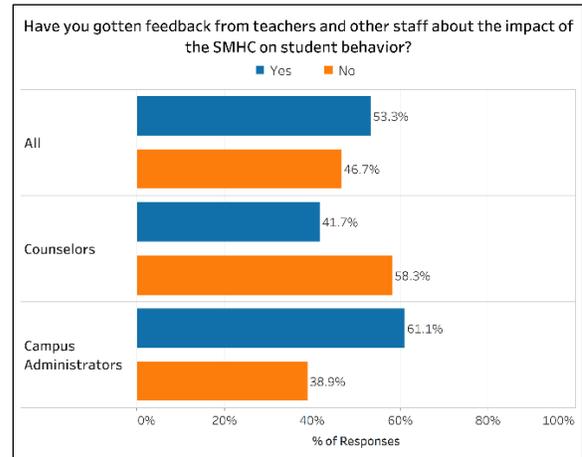
The difference in perception between counselors and campus administrators to the statement that ‘more families than anticipated are receiving services through the SMHC’ is interesting. This may speak to relatively heightened awareness by counselors to the level of need for family mental health support.



Services in more than 6 rare languages, including American Sign Language, were facilitated through contracted translation services. The need for services in multiple languages heightens awareness for the ongoing need to develop deepened cultural awareness and competency.

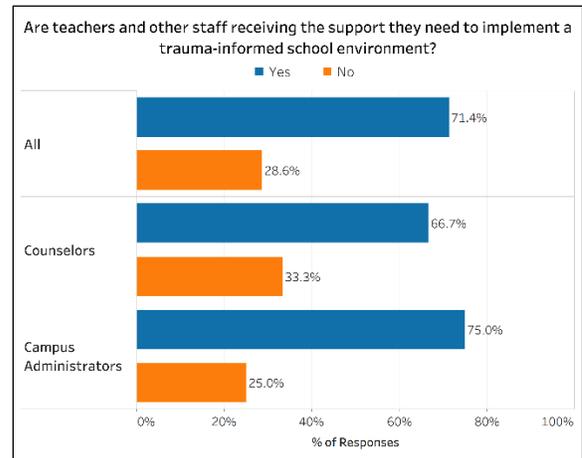
When asked whether they had gotten feedback from teachers and other staff about the impact of the SMHC on student behavior the survey results were more mixed quantitatively, but the comments revealed that there were no negative findings. Three staff commented that it was still new. Other comments indicated feedback was positive, very positive, or something similar. One stated “Teachers love the support”, while another “Parents are thankful for the assistance”. Finally, one commented “There has been incredible feedback from parents, students and staff

regarding the powerful impact it is having on social emotional [and] academics”.

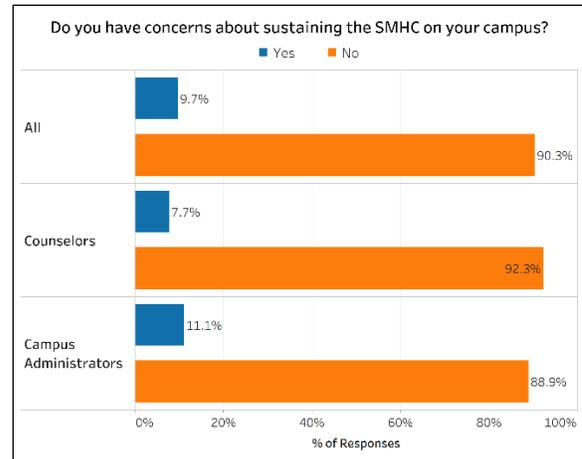


Respondents were asked whether teachers and staff were getting the support they needed to implement a trauma-informed school environment. Two thirds of counselors and three fourths of campus administrators identified that they were getting the needed support.

Of the comments received, nearly all indicated there was support, but that more was needed. Some comments indicated that teachers in particular needed additional support, including professional development. The SMHCs are available for staff use as well as student families. One comment noted “The therapists were located in the office area and it was not a large space. Some teachers may have felt uncomfortable. However now the therapists are located in the portable and we are hoping that more teachers and staff will access the resource.”



Finally, a question about sustainability was asked. Results were surprising to the evaluator, given the context that the Austin school district was in the midst of struggling to find resources to maintain existing SMHCs at the secondary level beyond the life of their DSRIP funding source, despite a proven model with strong student outcomes across behavior, attendance and academics



### *School Staff Stress and Attitudes Relating to Trauma Informed Care*

The Vida Clinics are working to create a standardized process for assessing staff stress levels and attitudes related to trauma-informed care. Standardizing the process and using periodic measures will enable clinicians and Austin ISD to adapt their interventions to campus needs over time. For teachers and other school staff, the evaluation tool for the implementation study is the Attitudes Relating to Trauma Informed Care (ARTIC). The tool was designed specifically for use in school settings. It is a psychometrically tested objective measure of the extent to which a person or system is trauma-informed. It is easily administered, can be used with all school staff, and is not terribly expensive. Used once or twice per year the tool can provide a gauge of how a system is progressing towards trauma-informed practice.

During the spring semester, 401 staff members were surveyed using the ARTIC-10, a ten-question short form version of the instrument, and the Perceived Stress Scale (PSS). Analysis of the ARTIC is based on a 7-point scale where higher scores indicate attitudes favorable to trauma-informed care. The median score across all school campus was 5.2. The median was selected as the appropriate metric to correct for skewing of scores. Annual measures will help monitor the level of implementation and maintenance of a trauma-informed school environment. Understanding the perceived stress of school staff continues to be explored. Teachers reported low levels of stress on the PSS. In human services it is not uncommon for the identification of need to increase as interventions to address the need are implemented. The possibility is anticipated that with persistent implementation of SMHCs and the ecological model, teacher perceived stress may actually increase, a result of stronger helping relationships to address the stress, rather than an increase in stress related to the presence of SMHCs. The work to understand and address staff needs continues.

## Outcomes Study

### Methods

Demographic, mental health diagnosis and victim category data was collected for all adults and children served in the VOCA-funded Vida Clinics. Summary information is provided to describe the population served. Student outcomes tracked for evaluation include attendance, behavior, and academic

performance measures. Students who received services were compared to those who were referred to the clinic but did not enroll in services.

### Impact of Implementation Timing on Evaluation

The evaluation plan is to monitor student outcomes across each 9-week grading period for elementary students. Because Austin ISD’s VOCA-funded Vida Clinics were not able to begin serving students until the latter half of the spring semester, student outcomes were measured only during the last 9-week grading period. As a consequence, although the plan is to track changes over time for students served, only a single data point is available for the year one implementation study.

### Description of Adults and Children Served

A critical component of the Austin ISD VOCA-funded Vida Clinics is that, in establishing an ecological approach to trauma-informed care, students, parents/caregivers/family members of the students, and school staff are eligible to use the services. The three most common diagnoses for child and adult patients in the clinics were trauma and stressor-related problems, depressive disorders, and anxiety disorders. A complete listing of diagnoses categories is provided below.

<b>Child and Adult Diagnoses (organized from most to least common)*</b>
Trauma and Stressor-Related Problems
Depressive Disorders
Anxiety Disorders
Adjustment Disorders
Neurodevelopmental Disorders
Disruptive, Impulse-Control and Conduct Problems
Obsessive Compulsive and Related Disorders
Elimination Disorders (children only)
Sleep-Wake Disorders
Bipolar and Related Disorders (adults only)
Substance-Related Disorders (adults only)

\*NOTE: Diagnosis data provided by Seek Institute

Most adult patients were between the ages of 25 to 59 years old. The VOCA-funded Vida Clinics serve a diverse array of adult community members including individuals who are deaf/hard of hearing, have disabilities (cognitive/physical/mental), are homeless, are veterans, identify as LGBTQ, have limited English proficiency, and/or are refugees/immigrants. Additional demographic information about the adult patients treated through the VOCA-funded Vida Clinics in Austin ISD is available in Table 1. School staff victims attended one or more in-person sessions.

**Table 1. Adult patient demographics\***

	<b>n(%) n=1036</b>
<b>Age</b>	
18-24	4.5%
25-59	91.1%
60 and older	4.3%

<b>Role at School</b>	
Parents/caregivers/family members	43.7%
Staff member	56.3%
<b>Gender</b>	
Male	13.0%
Female	87.0%
<b>Race/Ethnicity</b>	
Black/African American	10.2%
Hispanic/Latino	53.0%
Other races/ethnicities	4.0%
Not Reported	4.7%
White/Caucasian	28.1%

*\*Note: Adult patient demographic data was provided by Seek Institute  
Other races/ethnicities include adults reporting their race/ethnicity as American-Indian/Alaskan Native, Asian, Middle Eastern, and multiple races.*

Students referred and seen by the VOCA-funded Vida Clinics had anywhere between one session and 34 sessions with a staff clinician. The median number of sessions attended was seven.<sup>1</sup> A student must have received a minimum of two sessions to be included in the treatment group. In total, 569 students were referred to the VOCA-funded Vida Clinics in the second semester. Of these students, 78% received two or more sessions and are being defined as receiving treatment. **This large percentage of students receiving treatment is a testament to the effectiveness of the VOCA-funded Vida Clinics’ referral system at engaging students and parents to receive treatment.** A diverse array of students was served by AISD’s VOCA-funded Vida Clinics including students who were economically disadvantaged, English language learners, and students in special education. Table 2 provides demographic information on the students who received treatment from the VOCA-funded Vida Clinics and students referred for services, but who did not enroll.

**Table 2. Student demographics**

	Treatment Group n=442	Referred for services But did not enroll n=127
<b>Grade</b>		
PK	7.0%	9.5%
KG	12.0%	10.2%
01	11.8%	12.6%
02	11.1%	13.4%
03	19.7%	13.4%
04	22.2%	23.6%
05 and above	15.8%	17.3%
<b>Gender</b>		
Male	61.1%	59.1%
Female	38.9%	40.9%
<b>Race/Ethnicity</b>		
American Indian/Alaskan	0.2%	0.0%

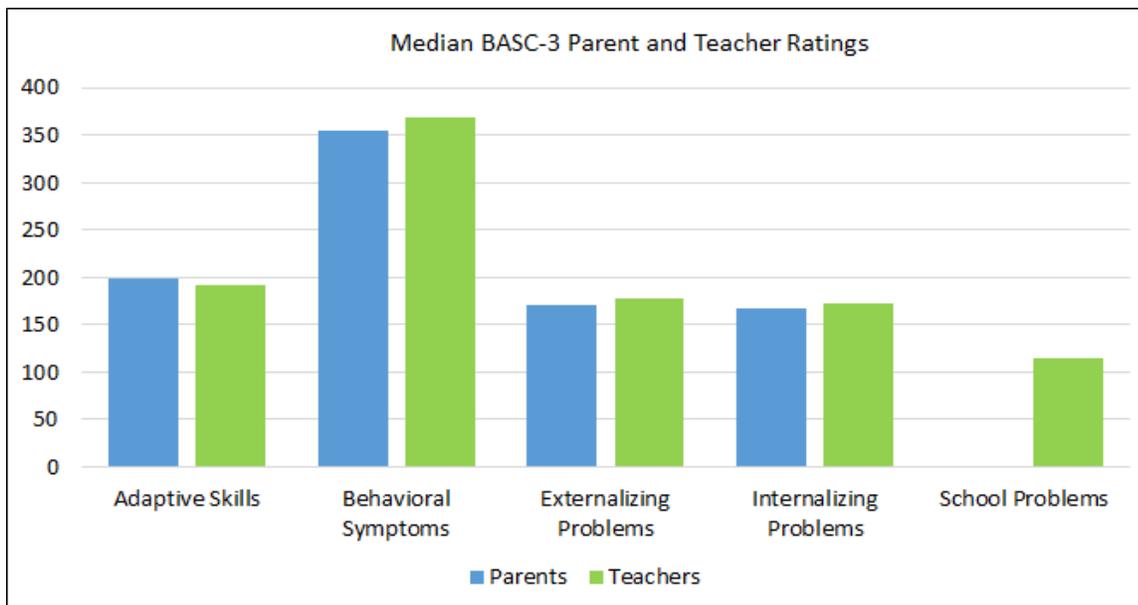
<sup>1</sup> Note: Data related to the number of sessions a patient had was provided by Seek Institute

Native, not of Hispanic origin		
Asian, not of Hispanic origin	0.0%	0.0%
Black, not of Hispanic origin	14.5%	24.4%
Hispanic	75.1%	63.8%
Native Hawaiian or Other Pacific Islander, not of Hispanic origin		
Other	1.8%	5.5%
White, not of Hispanic origin	8.6%	6.3%

*Note: Austin ISD's Standard Aggregate Reports for Student Service Providers was used to obtain aggregate data on the patient identification numbers provided by Seek Institute. Other races/ethnicities includes students reporting their race/ethnicity as American Indian/Alaskan Native or two or more races.*

### Initial Student Mental Health Outcomes

The Behavioral Assessment System for Children (BASC-3) was completed by 233 teachers and 157 parents of students referred and seen by the VOCA-funded Vida Clinics in order to provide in-depth information about students' emotional and behavioral functioning at the time they enrolled in services. Figure 2 depicts teacher and parent initial ratings of student functioning for the following behavioral categories: adaptive skills, behavioral symptoms, externalizing problems, internalizing problems, and school problems (only teachers rated students for school problems). The figure demonstrates that teachers and parents report that students are experiencing substantial issues in a variety of areas at the time that they enroll for services. Furthermore, parents and teachers tended to agree on particular areas of need that students demonstrate.



### Initial Student School-related Outcomes

To better understand the school performance of students participating in therapy services, school data was gathered using Austin ISD's Standard Aggregate Reports for Student Service Providers (SAR-SSP). This web-based tool allows service providers to directly access aggregate data (i.e., summary data for

multiple individuals) about students participating in their programs. The SAR-SSP allows for a comparison cohort based on selected demographic variables. For this study students who were referred for services at the VOCA-funded Vida Clinics, but did not enroll for therapy services were used as a comparison group.

Data on the VOCA-funded Vida Clinics was captured for the final 9-week grading period. Academic performance was captured for students in the treatment group who participated in 2 or more therapy sessions during the 9-week grading period, and for students who were referred for services but did not enroll. Treatment Group students had better performance on STAAR tests, fewer aggressive behavior offenses at school and fewer suspensions than the comparison (Referred but did not enroll) group. While these initial findings are promising, further evaluation is needed to determine whether the differences between these groups are based on chance alone or if the differences are attributed to the treatment. (See Table 3):

**Table 3. Student academic performance and discipline**

	<b>Treatment Group n=442</b>	<b>Referred for services but did not enroll n=127</b>
<b>Attendance</b>	93.8%	93.7%
<b>STAAR*</b>		
Reading	62.3%	59.1%
Math	67.5%	62.1%
Writing	44.7%	43.3%
Social Studies	65.7%	61.9%
<b>Discipline</b>		
Students disciplined for aggressive behavior offenses	4.8%	6.3%
Students Suspended (Home, ISS, or Long-Term ISS)	0.9%	1.6%
Students Removed or Expelled (Removal to DAEP or JJAEP)	0.0%	0.0%

*Note: AISD's Standard Aggregate Reports for Student Service Providers was used to obtain aggregate data on the patient identification numbers provided by Seek Institute. The number of students tested varied for reading, math, writing, and social studies.*

### Program Strengths

Although only one grading period was available for measuring the outcomes of Austin ISD's VOCA-funded Vida Clinics, the program has already exhibited multiple strengths. First and foremost was the capacity to scale and implement clinics on 22 campuses simultaneously. Implementation was well planned and executed, as reflected by interviews and staff surveys. A very innovative model for addressing victimization has been well received by parents, children and school staff. The demand for services, more than 1600 persons seeking care met VOCA criteria in just the first couple of months, and

the ability to meet that demand with services in a timely and responsive manner, speak highly of Vida Clinic and their model of services. They have been able to scale and respond even though the need far exceeded what was anticipated. With these strong early findings, we have good reason to anticipate that with continued evaluation student mental health, attendance, behavior and academic outcomes will reflect the value of an ecological approach to treating victims of crime in a school setting.

## Lessons Learned

The implementation of the SMHCs on elementary campuses has resulted in several lessons learned during the first year. They are summarized below:

1. Challenges associated with the timing of the grant and the need to meet state/federal reporting requirements can be anticipated. Communication within districts and with key community partners can create a sense of readiness that can facilitate implementation. Sample forms and language are provided to assist other districts in creating their documents.
2. The demand for services was greatly under-estimated. Having an experienced provider who was knowledgeable of district and campus practices was essential to the capacity to respond in a timely manner. The kind of need and types of victimization varied by campus/neighborhood. The capacity to customize services to meet the requirements of the local community is critical. Another issue was the variety of languages spoken and related cultural sensitivity necessary to effectively respond to the need. Developing cultural competence is an ongoing area for professional development. The extensive use of contracted interpreter services has had a budgetary impact.
3. The identification and prioritization of appropriate private, accessible space for the delivery of mental health services on campus has been a challenge, especially for campuses with high enrollments where space is at a premium. Despite the challenge, campus administrators and staff have valued the services and found solutions for the challenges working in concert with therapists.
4. The capacity to track and evaluate outcomes is crucial to understanding the impact of services individually and in aggregate. This has implications for the budget. The ARTIC is a useful and not expensive tool for monitoring the implementation of an ecological framework addressing attachment, regulation and competency in a trauma-informed school setting. Evaluation should look at more than simply school data on attendance, behavior, and academics. The Strengths and Difficulties Questionnaire (Goodman, 2018) is a validated tool that is free and available in multiple languages, with parent and teacher forms. It can be used to monitor student mental/emotional/behavioral changes if used over time. The BASC-3 provides more comprehensive mental health information, but its cost has presented challenges. For younger child victims, the Ages and Stages Questionnaire (ASQ) can provide periodic developmental screening information which can be instructive therapeutically, and potentially help improve school readiness for the youngest victims of crime. Cost must be considered for the ASQ.
5. Administrative support and leadership are necessary from the campus level through central administration, the Superintendent and School Board to effectively implement the ecological model. If that support is not evident, efforts to develop it should precede engaging in establishing a VOCA program. Implementing a trauma-informed school environment requires professional development and support for campus staff. That environment is essential to the

successful implementation of School Mental Health Centers, including VOCA-funded centers that address victimization.

## Conclusion

While the Austin ISD VOCA-funded Vida Clinics have only been open for one semester, hundreds of students, parents/caregivers/family members of the students, and school staff are receiving treatment. Most of the students in the treatment group are meeting STAAR standards for reading, math, and social studies. In addition, only a small number of students in the treatment group are receiving disciplinary action. To ascertain whether the initial results obtained are due to chance or are related to the mental health intervention, continued tracking and evaluation of services and outcomes is needed. Students can be compared to themselves over time. A comparison group of similar students who are not receiving the treatment will also help define the benefits of the program.

## Supplement: Findings from Vida Clinic High School Mental Health Centers

Because the implementation period for the VOCA-funded Vida Clinics was too brief to determine whether outcomes in elementary students are statistically significant, findings emerging from the longer-term work of Vida Clinic with high school students are summarized. **The high school clinics were not funded through the VOCA grant, and students were not required to meet the definition of a victim of crime. However, collectively they do point to the potential of an ecological model of treatment to achieve a significant impact on student outcomes.** High school students who received treatment in school year 2017-18 were compared by Seek Institute to a cohort of students who did not receive treatment. They were matched for gender, grade in school, economic status, ethnicity and special education status. Compared to the cohort, students receiving treatment were found to have better attendance, better academic performance, fewer expulsions and fewer suspensions. Each of these findings were found to be statistically significant. Students in treatment were also compared to themselves over time regarding emotional functioning. They demonstrated clinically and statistically significant improvements in emotional functioning in multiple areas, and a trend toward reduced substance use and aggression in school.

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## Resources

### Videos

[Adverse Childhood Experiences and Child Development](#) (Dr. Nadine Burke Harris TED talk, 16 minutes)

[Head Start Trauma Smart](#) (PBS News, 6 minutes)

[Introduction to Trauma-Informed Practices in Education](#) (Madison Public Schools, 11 minutes)

# Appendices

## Parent/Guardian Documents

### Campus Referral to Clinic Form

#### ISD ELEMENTARY SCHOOL MENTAL HEALTH CENTER (SMHC) REFERRAL FOR STUDENT SERVICES

*NOTE: SMHC referral form is to be completed by ISD staff. It is not to be sent home to the parent/guardian. The 2 consent forms (consent to refer and data sharing) require parent signatures. The referral coordinator will submit the signed consent forms and referral form to the SMHC therapist.*

Date Referral Received: \_\_\_\_\_ Date Staffed by Campus CST: \_\_\_\_\_

Referral Completed by: \_\_\_\_\_ Campus: \_\_\_\_\_

Referral Contact (phone/e-mail): \_\_\_\_\_

Referral Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Referral Coordinator Phone Number: \_\_\_\_\_

Student's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Student ID #: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Administrator: \_\_\_\_\_ Counselor: \_\_\_\_\_

Does student receive Special Education services?  Yes  No  504 Accommodations

Special Classifications:  Deaf/Hard of hearing  Refugee/Immigrant  Homeless  Limited English Proficiency  
 LGBTQ  Disabilities (Cognitive/Physical/Mental)  Other \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Female  Male  Other

Race/Ethnicity:  Hispanic/Latino  White Non-Latino/Caucasian  Asian  American Indian/Alaska Native  
 Black/African American  MENA (Middle East/North Africa)  Pacific Islander  Other  
 Not Reported by Client  Not Tracked by Agency

Parent/Legal Guardian Name: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Does family/student have health insurance? \*  Yes \_\_\_\_\_  No  Unknown

Services/Programs in which the student is currently enrolled? \_\_\_\_\_

\* Insurance WILL NOT be billed.

**ISD ELEMENTARY SCHOOL MENTAL HEALTH CENTER (SMHC)  
REFERRAL FOR STUDENT SERVICES**

*Please indicate which of the following relate to the student's overall health and/or history. Identify as many as applicable; Leave blank if unknown.*

**Behavioral/Social Emotional/Physical:**

- Symptoms of depression
- Symptoms of anxiety
- Self-injurious behavior
- Current or history of suicidal ideation
- Grief/Loss
- Explosive behavior
- Family disruptions
- Attention problems (home and/or school)
- Sexual identity/gender issues
- Sudden/increase high risk behaviors
- Irregular/extreme eating behaviors
- Substance use/abuse/experimentation
- Toileting Regression (Encopresis/Enuresis)

- Night Terrors
- Chronic health issues
- Pregnancy
- Other \_\_\_\_\_

**School Related Information:**

- Failing 2 or more core classes
- At least one discipline referral
- At least one disciplinary removal
- Attendance issues (5+ in semester)
- At least one Stay Away Agreement
- Other \_\_\_\_\_

*Please indicate which of the following crimes have affected the student – either as a primary victim of crime (Primary VC\*), or as a secondary victim of crime (Secondary VC\*), by placing a check mark in the appropriate box. Identify as many as possible.*

	Primary VC	Secondary VC		Primary VC	Secondary VC		Primary VC	Secondary VC
Child Physical Abuse & Neglect			Kidnapping Non-Custodial			Mass Violence (Domestic/International)		
Child Sexual Abuse/Assault			Human Trafficking/Labor			Terrorism		
Domestic/Family Violence			Human Trafficking/Sex			Survivor of Homicide/Murder		
Teen Dating Victimization			DUI/DWI			Elder Abuse/Neglect		
Stalking/Harassment			Other Vehicular Victim (hit and run)			Secondary Victim of Adult Physical Assault		
Violation of a Court Order			Burglary			Secondary Victim of Adult Sexual Assault		
Bullying (verbal, physical, cyber)			Robbery			Secondary Victim of Adult Sexually Abused as a Child		
Hate Crime (racial, religious, gender, sexual orient., etc)			Arson			Other:		
Kidnapping Custodial			ID Theft/Fraud/Financial Crime			Other:		

*\*Primary VC= Person referred is directly victimized. Secondary VC= Person referred is a family member, significant other, community member, or other person impacted indirectly by the crime.*

**Additional Information:**

# Parent/Guardian Consent to Refer Student to School Mental Health Center

## ISD ELEMENTARY SCHOOL MENTAL HEALTH CENTER (SMHC) REFERRAL FOR STUDENT SERVICES

### CONSENT TO REFER STUDENT FOR SERVICES

*The agreement below is to be signed by the youth's parent/legal guardian. The signature indicates the parent/legal guardian's consent to be contacted by a School Mental Health Center provider and allows for communication between the referring entity and the provider.*

I \_\_\_\_\_, agree to allow \_\_\_\_\_ <INSERT> ISD \_\_\_\_\_ to provide information to and receive information from the School Mental Health Center provider regarding my child, \_\_\_\_\_, and family. I am further consenting to be contacted by the School Mental Health Center provider so I can be provided additional information regarding how this program can serve my child and family.

\_\_\_\_\_  
Parent/Legal guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Preferred telephone number

\_\_\_\_\_  
E-mail (optional – for office use only)

### CONSENTIMIENTO PARA REFERIR AL ESTUDIANTE POR SERVICIOS

*El padre de familia o custodio legal tiene que firmar el acuerdo a continuación. Al firmar, el padre o custodio indica que está de acuerdo en que el proveedor del Centro de la Salud Mental Escolar se comunique con él y permite la comunicación entre la entidad remitente y el proveedor.*

Yo, \_\_\_\_\_, estoy de acuerdo en permitir que \_\_\_\_\_ ISD \_\_\_\_\_ dé información sobre mi familia y mi hijo, \_\_\_\_\_, al proveedor del Centro de la Salud Mental Escolar y la reciba de este. Además, doy mi consentimiento para que el proveedor del Centro de la Salud Mental Escolar se comunique conmigo para darme información adicional sobre la forma en que este programa puede ayudar a mi hijo y a mi familia.

\_\_\_\_\_  
Firma del padre de familia o custodio legal

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Número de teléfono preferido

\_\_\_\_\_  
Correo electrónico (opcional)

# Parent/Guardian Consent to Share Student Data with SMHC Provider

## ISD ELEMENTARY SCHOOL MENTAL HEALTH CENTER (SMHC) REFERRAL FOR STUDENT SERVICES

### CONSENT TO STUDENT DATA SHARING

**ISD Partner/Provider Organization Name:** SMHC

**Student ID:** \_\_\_\_\_

(Note: If unknown, SMHC can obtain student ID from ISD's central office)

**Student Name:** \_\_\_\_\_

**Campus Name:** \_\_\_\_\_

**Grade Level:** \_\_\_\_\_

SMHC requests your permission for ongoing access to data about your student from ISD.

SMHC will collect the data for the duration of your student's participation in the SMHC

SMHC will be granted permission to view your student's data in ISD's electronic data system.

The following specific data will be viewed by the authorized SMHC staff:

- **Demographics** – 11-digit TEA identification number, date of birth, age, gender, ethnicity, grade level, ISD enrollment dates, and types of services received, English Language Learner (ELL) flag and retained flag.
- **Attendance** (current and previous school year) – days enrolled, date absent, absence reason and dates tardy.
- **Grades** (current and previous school year) – teacher's names, courses, grades, teacher comments, personal development scores, missing assignments, HS graduation date, HS endorsement track, credits attempted (HS only), credits earned (HS only), class rank (HS only) and cumulative GPA (HS only).
- **Discipline** (for all the years enrolled in ISD) – dates, reasons, actions and incident location.
- **Standardized Test Scores** – District, State and National standardized tests (For example – STAAR, American College Testing (ACT) etc.)
- **Interventions and Services** as documented by ISD staff.

In addition, SMHC will be able to generate group reports of all participants' average attendance, discipline and academic achievement.

ISD and SMHC will share information about your student's attendance in the program.

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I understand that data access will be granted to the authorized SMHC staff. Each authorized staff member is responsible for maintaining the confidentiality of their login and password and may not share access with any other individual.

I understand this data will be used to provide individualized services to my student. Data may also be used, as approved, for the purpose of service tracking, grant reporting and/or program evaluation. No identifying data about my student will be published or distributed to third parties. Any reporting will be done in aggregate.

I understand my consent is optional and I may choose to withdraw permission at any time.

I understand sharing my student's data with SMHC is not a requirement to participate in SMHC's programs.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Parent/Guardian's Printed Name

\_\_\_\_\_  
Date

ISD ELEMENTARY SCHOOL MENTAL HEALTH CENTER (SMHC)  
REFERRAL FOR STUDENT SERVICES

CONSENT TO STUDENT DATA SHARING

ISD Partner/Provider Organization Name: SMHC

Identificación del estudiante: \_\_\_\_\_

(Nota: Si no lo sabe, SMHC puede obtenerlo en las oficinas centrales del ISD)

Nombre del estudiante: \_\_\_\_\_

Nombre de la escuela: \_\_\_\_\_

Grado: \_\_\_\_\_

SMHC solicita su consentimiento para tener acceso continuo a la información del ISD de su hijo. SMHC recopilará la información durante el tiempo que su hijo esté participando en el SMHC.

SMHC tendrá autorización para ver la información de su hijo en el sistema electrónico de datos del ISD. Personal autorizado de SMHC Programa podrá ver la siguiente información específica:

- **Datos demográficos** – número de identificación de 11 dígitos de la TEA, fecha de nacimiento, edad, género, origen étnico, grado escolar, fechas de matrícula en el ISD, tipos de servicios recibidos, clasificación como aprendiz del idioma inglés (ELL) y clasificación como retenido.
- **Asistencia** (actual y del año escolar anterior) – días en que el estudiante ha estado matriculado en la escuela, fecha de las ausencias, motivo de las ausencias y fecha de los retrasos.
- **Calificaciones** (actuales y del año escolar anterior) - nombres de los maestros, cursos, grados, comentarios de los maestros, puntaje relacionado con el desarrollo personal, tareas no entregadas, fecha de graduación de la preparatoria, trayectoria de especialización en la preparatoria, materias/créditos cursados y no obtenidos (solo preparatoria), créditos obtenidos (solo preparatoria), rango
- **Disciplina** (durante todos los años que el estudiante haya estado matriculado en el ISD) – fechas, motivos, medidas adoptadas y lugar del incidente.
- **Puntaje en las pruebas estandarizadas** – pruebas estandarizadas a nivel de distrito, estatal y nacional (por ejemplo – STAAR, American College Testing (ACT) etc.)
- **Intervenciones y servicios** – tal como esta documentado por el personal del ISD.

Además, SMHC podrá generar informes grupales de la asistencia promedio, disciplina y logro académico de todos los participantes. El ISD y SMHC compartirán información de la asistencia de su hijo al programa.

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Entiendo que se permitirá el acceso a la información al personal autorizado de SMHC. El personal autorizado es responsable de mantener la confidencialidad de su clave de acceso y contraseña y no puede compartirla con ninguna otra persona.

Entiendo que esta información será utilizada para proporcionar servicios individualizados a mi hijo. La información también será utilizada, conforme sea aprobado, con la finalidad de dar seguimiento de los servicios que recibe, informe sobre subvenciones y/o evaluación del programa. No se publicará o distribuirá a terceras personas información que identifique a su hijo. Todos los informes se harán en conjunto.

Entiendo que mi consentimiento es opcional y que lo puedo retirar en cualquier momento.

Entiendo que compartir la información de mi hijo con SMHC no es un requisito para participar en los programas de SMHC.

Firma del padre/madre o tutor legal \_\_\_\_\_

Nombre escrito en letra de molde del padre/madre o tutor legal \_\_\_\_\_

Fecha \_\_\_\_\_

## School District Documents

### Request for Proposals Sample Language

## Request for Proposals (RFP) for School Mental Health Centers

### Selected Sample Language

#### INTRODUCTION

The Independent School District (herein after referred to as “ISD” or the “District”) is seeking proposals from firms (herein after referred to as “Proposer”) qualified and experienced in providing and delivering school based mental health treatment and therapeutic services. The ISD seeks to fund mental health centers on campuses which are compliant with ISD Student Welfare, Wellness and Health Services (FFAE) policy. The District may select one or multiple providers to deliver full-time campus-based services.

The goals of the campus based mental health centers will include:

Provide direct mental health services to students and families identified as victims and referred by parents, staff, and individuals seeking mental health therapy. Victims are defined by one of the following categories:

- Child abuse and neglect;
- Family violence;
- Sexual assault;
- Human trafficking;
- Other types of violent crime.

Utilize the ISD School Mental Health Center (SMHC) tested referral forms and processes that comply with the Family Educational Rights and Privacy Act (FERPA) protecting students’ educational records and Health Insurance Portability and Accountability Act (HIPAA) protecting confidentiality and security of healthcare information. The referral process will allow individuals to refer student victims for evaluation. When students are referred for evaluation, the therapist will confirm it’s an appropriate referral, the therapist will contact parents to get consent and to ascertain whether other members of the household are also impacted by the crime and should also be evaluated for services.

Evaluation of the program will include:

- Summary of therapeutic outcomes using a well validated, standardized tool (i.e.; Behavior Assessment for Children, BASC).
- Summary of the child’s school related outcomes (comparison of students’ attendance rates, disciplinary records pre/post treatment, and academic performance).
- Summary of the projects training on teachers, school counselors, police officers, parents, and service providers.
- Interviews with stakeholders (parents, teachers, school counselors, police).

#### PROGRAM OVERVIEW / BACKGROUND

The funding for this expansion is from the Office of the Governor, Criminal Justice Division under the Victims of Crime Act of 1984 (VOCA) to provide direct mental health therapy for children and families who face barriers in accessing and using victim services, and includes populations underserved because of geographic location, religion, sexual orientation, gender identity, racial and ethnic populations, and

populations underserved due to special needs (such as language barriers, disabilities, alienage status, or age).

The treatment model is based in the following evidence-based orientations: Cognitive Behavioral Therapy, Trauma Informed Care, and Motivational Interviewing. All services are carried out in the form of individual, group, and family therapy sessions. Students are referred for SMHC services by the student, staff, campus Child Study Team, or parent/ guardian. Parent/Guardian consent is required in order for a student to receive services. SMHC services do not interfere with any other services the student may be receiving. All services provided at the elementary SMHCs are grant funded services at no charge to victims of crime. Providers are prohibited from billing Crime Victims Compensation, private insurance, Medicaid, or Medicare for services provided using VOCA funds. SMHCs are overseen by ISD Department of Comprehensive Health.

Our proposal, based on evidence-based framework for victims of complex trauma, ARC Model (Attachment, Regulation, Competency), requires cross system collaboration (home, school, treatment providers, child). Licensed counseling services will be provided for victims within their own schools. The on-site therapists will bring adults familiar with their case (educators, police, service providers, etc.) into consultation on the child's case, so that victims do not encounter additional impediments when they return to class, school environment, and home. Family members in need will also be eligible to receive services at school. This model emphasizes whole child development through phases that emphasize 1) development of healthy attachments (connections) with caregivers (teachers, parents) 2) support with self-regulation (expressing thoughts and feelings appropriately and effectively), 3) development of child competency (academic, interpersonal). The onsite SMHCs are open when the traditional school schedule is on holiday or summer vacation.

This competitive solicitation is a *Request for Proposals* (RFP) advertised under Texas Education Code 44.031 in the newspaper and the ISD web site.

Submit inquiries via email to the contact person listed on the cover page by the deadline specified in the schedule below. In the subject line of the email, type "Questions" and the solicitation number:<INSERT>

#### TERM OF AGREEMENT

The agreement(s) resulting from this solicitation will be in effect for an initial term of one (1) year from the date of award by the Board of Trustees, or such date established by the agreement. The parties by mutual consent may renew the agreement for up to four (4) additional one (1) year periods. In addition, the District reserves the right to extend the contract for an additional sixty (60) days beyond the final expiration date if necessary, to ensure no lapse in service.

The agreement(s) that may result from this proposal may contain different terms and conditions than the generic sample Service Agreement contained in this RFP.

#### SCOPE OF SERVICE AND PERFORMANCE REQUIREMENTS

The following describes the service and performance requirements that the selected vendors will be required to meet. Failure to address or to fully describe capabilities to accomplish all elements of this section will result in a loss of evaluation points.

Proposer will:

- Utilize the ISD School Mental Health Center referral form and process to obtain referrals on campus through teachers, campus staff, campus Child Study Team, parents/guardians, school counselors, police and resource officers, and external partner agencies (i.e.; Family Protective Services, police/sheriff officers, service providers such as Communities in Schools, SAFE, and other providing supports to students and families).
- Initiate interaction with school staff, community partners, and police about the referral process.
- Provide direct mental health services on campus to referred victims with appropriate parental consent.
- Provide direct mental health services on campus to siblings and family members of the student if identified they are also victims of crime.
- Ongoing case consultation will be conducted with staff, community partners, parents/guardians, and police to ensure that a supportive environment exists for the recovering victim.
- Have the ability to blend cultural knowledge and sensitivity with victim restoration skills for a more effective and culturally appropriate recovery process.
- Serve identified students with minimum interruption of the academic day to include scheduling meetings with students that do not interfere with core academic subjects unless court mandated, included in the Individual Education Plan, or approved by the Principal. Use before and after school time whenever possible.
- Not charge families for services; however, therapists will ascertain what the family's insurance status is, and if needed, provide linkage and referral as appropriate to intensive level services at other, medically appropriate, sites. Therapists will keep a record of insurance status so we can understand how many uninsured children and families are impacted.
- Provide a budget that stays within the budget identified (\$200,000 per campus).
- Provide full mal-practice coverage on employees assigned to serve ISD students.
- Collaborate with ISD to provide FERPA/HIPPA compliant evaluation on progress of students served.
- Collaborate with ISD staff to develop a model that can be sustained.
- Adhere to ISD systems and policies:
  - facility use agreements, including security procedures required as on all ISD campuses.
  - alignment of student services with the ISD Learning Support Services Child Study Team system.
  - coordinate services with the ISD Assistant Director of Comprehensive Health Services and/or designee.
- comply with policy Student Welfare, Wellness and Health Services (FFAE Legal). (<http://www.tasb.org/policy/pol/private/227901/pol.cfm>)
- With continued oversight of the ISD Assistant Director of Comprehensive Health Services and direct supervision of the project coordinator, Mental Health Specialist, regular reviews will be scheduled with the projects independent evaluator to monitor the progress on the evaluation and make sure the evaluator has access to needed data and stakeholders.

**COMPETITIVE SELECTION, EVALUATION, NEGOTIATIONS AND AWARD**

This is a NEGOTIATED procurement and as such, award will not necessarily be made to the Proposer submitting the lowest priced proposal. Award will be made to multiple firms that submit the best responsive proposal satisfying ISD’s requirements, price and other factors considered. ISD will evaluate each Vendor’s proposal in accordance to the Texas Education Purchasing Code 44.031.

The committee evaluating the proposals submitted in response to this RFP may require any or all vendors to clarify or elaborate on their proposal as well as to provide a presentation. Upon completion of oral presentations or discussions, vendors may be requested to revise any or all portions of their proposals. ISD reserves the right to add, remove, modify or establish additional evaluation points for each criterion. If the District determines that additional evaluation steps are required to determine the best value, the District reserves the right to consider any or all of the following additional criteria; Proposer’s experience, references and record for responsibility, or any other relevant factor that the District deems necessary to determine best value.

ISD reserves the right to make an award without discussion with any Proposer, after proposal responses are received. Proposer responses should therefore be submitted on the most favorable terms. The District may also request the Proposers to submit a Best and Final Offer for consideration. In making that determination which proposal responses are deemed acceptable and may be reviewed further, the District shall consider the following criteria during the evaluation process:

<b>Max Points</b>	<b>Proposal Scoring Criteria</b>	
<b>25</b>	Proposed Plan	The adequacy and completeness of the plan offered addressing the Scope of Services and Performance Requirements.
<b>30</b>	Proposer’s Capabilities	The demonstrated ability to provide services, including references.
<b>30</b>	Management Reporting and Data Capabilities	The ability of the Contractor to process information management requirements of the District and partners.
<b>15</b>	Financial Proposal	All fees associated with providing the services required.



SMHC Therapist Role Summary

<p style="text-align: center;"><b>Elementary School Mental Health Centers School-Based Therapist Role</b></p>		
Without Parent/Guardian Consent:	With Parent/Guardian Consent:	Generally, NEVER able to...
<ul style="list-style-type: none"> <li>• Meet with student and parents for a clinical consultation, schedule appt</li> <li>• Consult with staff about possible referrals</li> <li>• Provide short info sessions to staff about services</li> <li>• Provide support during major crisis as a result of a crime in coordination with the school.</li> </ul>	<ul style="list-style-type: none"> <li>• Contact parent/guardian of completed referrals to schedule intake</li> <li>• Provide ongoing individual &amp; family therapy</li> <li>• Share <b>consented</b> client information between school staff and other providers</li> <li>• Participate in student ARD/ CST/ problem solving meetings</li> <li>• Assist a client/family during mental health crisis (including drop-in if available)</li> <li>• Home and community-based services</li> </ul>	<ul style="list-style-type: none"> <li>• Provide short term or crisis counseling to students who are NOT on their caseload (HIPAA Violation)</li> <li>• Provide intervention to suicidal students without notifying the school</li> <li>• Participate in staffing students who are not already on caseload during CST meetings (FERPA violation)</li> <li>• Contact a referral before the Consent to Refer form has been signed (HIPAA/FERPA violation)</li> <li>• Transport students</li> <li>• Sign or use ISD Suicide Protocol documents</li> <li>• Perform lunch duty, hallway monitoring, etc.</li> <li>• Accept payment for services</li> </ul>

# School District Staff VOCA In-Kind Match Time Tracking Forms

Sample Excel form. The form is completed monthly by Assistant Principals, Counselors, Health Services Director and Grant Coordinator. Cash match is calculated monthly per staff person, based on time/activity and salary, then summed across staff.

ENTER NAME		Days of the Month																																										
ENTER CAMPUS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	TOTAL HOURS	Month	Year	Work Days in Month	Work Hours in Month	Percentage							
<b>Time and Activity Report</b>																																						0.00						
Activity																																							0.00					
Child Study Team Staffing																																							0.00					
Crisis Response/Safety Planning																																							0.00					
Parent Phone Call																																							0.00					
Teacher/Classroom Behavioral Consultation																																							0.00					
Staff Training																																							0.00					
Meeting or Referral with Community Agency																																							0.00					
Referral to CPS/Police Department																																							0.00					
Classroom Observation																																							0.00					
Documentation																																							0.00					
Miscellaneous																																							0.00					
Short Term Individual/Group Counseling																																							0.00					
Classroom Guidance																																							0.00					
<b>TOTAL HOURS</b>		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	Sep	2018	19	152	0%		