Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: May 19, 2022

Documents Pertaining to 5/26/22 Agenda items:

Public

Health, Housing & Community Service Department
Mental Health Commission

Berkeley/ Albany Mental Health Commission

Regular Meeting
Thursday, May 26, 2022

Time: 7:00 p.m. - 9:00 p.m. **Zoom meeting** https://us06web.zoom.us/j/83719253558

Public Advisory: Pursuant to Government Code Section 54953(e) and the state declared emergency, this meeting of the City Council will be conducted exclusively through teleconference and Zoom videoconference. The COVID-19 state of emergency continues to directly impact the ability of the members to meet safely in person and presents imminent risks to the health of attendees. Therefore, no physical meeting location will be available.

To access the meeting remotely: Join from a PC, Mac, and IPad, IPhone or Android device: Please use the URL: https://us06web.zoom.us/j/83719253558. If you do not wish for your name to appear on the screen, then use the drop-down menu and click on "rename" to rename yourself to be anonymous. To request to speak, use the "raise hand" icon by rolling over the bottom of the screen.

To Join by phone: Dial 1-669-900-9128 and enter the meeting ID 837 1925 3558. If you wish to comment during the public comment portion of the agenda, Press *9 and wait to be recognized by the Chair.

Please be mindful that the teleconference will be recorded, and all other rules of procedure and decorum will apply for Council meetings conducted by teleconference or videoconference.

All agenda items are for discussion and possible action

Public Comment Policy: *Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may also comment on any item listed on the agenda as the item is taken up. Members of the public may not speak more than once on any given item. The Chair may limit public comment to 3 minutes or less.*

AGENDA

7:00pm

1. **Roll Call**
2. **Preliminary Matters**
    a. Action Item: Approval of the May 26, 2022 agenda
    b. Public Comment
    c. Action Item: Approval of the April 28, 2022 minutes

Public

Health, Housing & Community Service Department
Mental Health Commission

3. **Public Program re: Student Mental Health & BUSD**

4. **Bridge to SCU and SCU Update– Dr. Lisa Warhuus**

5. **Selection Process for Mental Health Division Manager Update - Dr. Lisa Warhuus**

6. **Santa Rita Jail Subcommittee Report**
   a. Behavioral Health Diversion Intervention Report

7. **Site Visit Subcommittee Report**

8. **Mental Health Manager's Report**
   a. MHC Manager Report for May 2022
   b. MH Caseload Stats Final for April 2022
   c. BUSD Strengths and Needs Assessment
   d. Berkeley High School exec summary

9. **Mental Health Service Act (MHSA) FY23 Annual Update – Karen Klatt**
   a. Mental Health Service Act
   b. MHSA FY23 Annual Update Community Input Meeting

10. **Adjournment**

Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. **Please note: Email addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record.** If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary to the relevant board, commission or committee for further information. The Health, Housing and Community Services Department does not take a position as to the content.

Contact person: Jamie Works-Wright, Mental Health Commission Secretary (510) 981-7721 or Jworks-wright@cityofberkeley.info

Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. ***Please refrain from wearing scented products to this meeting. Attendees at trainings are reminded that other attendees may be***

Public

Health, Housing & Community Service Department
Mental Health Commission

sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs. *Thank you.*

SB 343 Disclaimer

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Adult Clinic at 2640 MLK Jr. Way, Berkeley, CA 9470

Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Drafted Minutes

7:00pm
Zoom Webinar

Regular Meeting
April 28, 2022

Members of the Public Present: Andrea Zeppa, Barb Atwell, Charles Clarke, Katrina Killian, Glenn Turner, Joe Okies, Mel Turner, Mary Lee-Smith, Rene Joy, Danielle Dedrick, Mary Fey Long Norris, Wendy Alfsen, Carole Marasovic, Stephanie Lewis, Francesca Tenenbaum Andrew Phelps
Staff Present: Jeff Buell, Lisa Warhuus, Steven Grolnic-McClurg, Fawn Downs, Jamie Works-Wright

1) **Call to Order at 7:07pm – No Quorum until 7:08**
   Commissioners Present: Tommy Escarcega (7:25), Margaret Fine, Monica Jones, Edward Opton (7:05), Andrea Prichett **Absent:** Terry Taplin

2) **Preliminary Matters**
   a. **Approval of the agenda April 28, 2022 Agenda**
   M/S/C (Fine, Prichett) Motion to approve the agenda
   PASSED
   Ayes: Fine, Jones, Opton, Prichett **Noes:** Escarcega; **Abstentions:** None; **Absent:** Taplin

   b. **Public Comment-** No Public Comments

   c. **Approval of the March 24, 2022 Minutes**
   M/S/C (Prichett, Jones) Move that we approve the minutes
   PASSED
   Ayes: Escarcega, Fine, Jones, Opton, Prichett **Noes:** None; **Abstentions:** None; **Absent:** Taplin

3) **Public Program on Exploring a Diversion Approach to People Experiencing Behavioral Health Crisis in Berkeley and Access of Crisis Services – Panelist**
   - Stephanie Lewis - Division Director Crisis Services Alameda County – mapping the crisis services system
   - Chief Joe Okies - Berkeley Police Department – reporting on 5150s

- Francesca Tenenbaum - Director of Patient's Rights Advocacy, Alameda County Mental Health Association
- Katrina Killian - Executive Director for Alameda County Network of Mental Health Clients – peer services

No Motion Made

4) Bridge to SCU & SCU Update– Dr. Lisa Warhuus

No Motion Made

5) Selection Process for Mental Health Division Manager Update- Dr. Lisa Warhuus

No Motion Made

6) Review and Vote on Application for the Mental Health Commission

a. Mary Lee Smith for Mental Health Commission

M/S/C (Fine, Jones) Make a motion to nominate Mary Lee Smith for the Mental Health Commission and send the nomination to the Berkeley City Council for approval as a Mental Health Commissioner.

PASSED

Ayes: Escarcega, Fine, Jones, Opton, Prichett **Noes:** None; **Abstentions:** None; **Absent:** Taplin

b. Glenn Turner for the Mental Health Commission

M/S/C (Fine, Prichett) Make a motion to nominate Glenn Turner for appointment to the Mental Health Commission and send the nomination to the Berkeley City Council for appointment.

PASSED

Ayes: Fine, Jones, Opton, Prichett **Noes:** None; **Abstentions:** Escarcega; **Absent:** Taplin

*Motion to extend the meeting by 10 minutes (8:59 PM)

M/S/C (Fine, Prichett)

PASSED

Ayes: Escarcega, Fine, Jones, Opton, Prichett **Noes:** None; **Abstentions:** None; **Absent:** Taplin

*Motion to extend the meeting by 10 minutes (9:10 PM)

M/S/C (Opton, Fine)

PASSED

Ayes: Fine, Jones, Opton, Prichett **Noes:** None; **Abstentions:** None; **Absent:** Escarcega, Taplin

7) May is Mental Health Month Proclamation

M/S/C (Fine, Opton) Motion to approve this letter so it an be sent to the Mayor and City Council for May is Mental Health Month.

PASSED

Ayes: Escarcega, Fine, Jones, Opton, Prichett **Noes:** None; **Abstentions:** None; **Absent:** Taplin

*****Motion to extend meeting by 5 min (9:20)

M/S/C (Opton, Fine)

PASSED

Ayes: Escarcega, Fine, Jones, Opton, Prichett **Noes:** None; **Abstentions:** None; **Absent:** Taplin

8) **Mental Health Manager's Report – Steven Grolnic-McClurg**
   a. MHC Manager Report April 2022
   b. MH Caseload Stats Final for March

   No Motion Made

9) **Mental Health Service Act (MHSA) FY23 Annual Update – Karen Klatt**
   a. Mental Health Service Act
   b. MHSA FY23 Annual Update Community Input Meeting

10) **Santa Rita Jail Subcommittee Report -** Did not get to item

11) **Site Visit Committee Report -** Did not get to item

12) **Adjournment – 9:25**

Minutes submitted by: _____
Jamie Works-Wright, Commission Secretary

Behavioral Health Diversion Interventions:

Moving from Individual Programs to a Systems-Wide Strategy

October 2019

INTRODUCTION

People who have mental illnesses and substance use disorders are overrepresented in the criminal justice system. Indeed, the prevalence of people in jails who have serious mental illnesses is often three to six times higher than that of the general public.[1] And for people who have serious mental illnesses and co-occurring mental health and substance use disorders, up to 50 percent have had criminal justice contact.[2] Often, these individuals cycle through local criminal justice systems, which are frequently not equipped to provide the costly treatment and support services needed by people who have behavioral health needs. This population's frequent contacts with the criminal justice system cause a strain on local resources and typically result in their increased chances of recidivism and behavior that can negatively impact the public's safety. These repeated contacts also often cause strain on a person's wellbeing and disrupt housing, jobs, and family stability as well as negatively impacting their physical and mental health.

To address these challenges, a growing number of communities are implementing behavioral health diversion programs as alternatives to conventional criminal justice case processing and incarceration, namely, by connecting people to the appropriate community-based treatment and support services outside of the criminal justice system.[3] However, implementation of these alternatives has largely been kept to individual, or one-off, recognizable programs that are often insufficient in meeting the needs of the community and reducing the over-representation of people who have behavioral health needs in the criminal justice system. To achieve the greatest impact and reduce the overall number of people who have behavioral health needs in the criminal justice system, communities must have a range of diversion programs and practices embedded within a comprehensive, coordinated strategy which offers behavioral health diversion interventions at every point in the criminal justice system[4] and fully leverages the community's resources.

While diversion may not be appropriate or possible for every person in the criminal justice system who has a behavioral health need, a strategic, systems-wide approach (which includes input from mental illness and substance use disorder treatment system leaders) will better define which interventions are best for a community and reduce the likelihood it is using inefficient programs and practices. This publication is intended to provide these local leaders with a systems-level conceptual framework for developing a continuum of behavioral health diversion interventions that span the community's criminal justice system—starting from first contact with law enforcement through incarceration.

DEVELOPING A CROSS-SYSTEMS BEHAVIORAL HEALTH DIVERSION STRATEGY

While the opportunities for behavioral health diversion look different in communities across the country, leaders are seeking opportunities to build bridges across systems to create community-wide strategies that have the greatest impact. In some places, the leadership comes from the courts, and in others, law enforcement or the jails are leading efforts. But from wherever they "sit," these leaders are learning that the overarching elements needed to create a holistic and effective diversion response strategy include the following key components:

1. Developing and engaging collaborative partnerships
2. Understanding the community's behavioral health needs
3. Identifying existing services and supports and gaps
4. Defining key measures and collecting data
5. Leveraging funding to prioritize interventions
6. Measuring and sustaining progress

[1] H. Steadman et al., "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60, no. 6 (2009): 761–765.

[2] J. F McGuire and R. A. Rosenheck, "Criminal history as a prognostic indicator in the treatment of homeless people with severe mental illness," *Psychiatric Services* 55, vol. 1 (2004): 55, 42–48.

[3] Hallie Fader-Towe and Fred C. Osher, *Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements* (New York: The Council of State Governments Justice Center, 2015), 7, https://csgjusticecenter.org/courts/publications/improving-responses-to-people-with-mental-illnesses-at-the-pretrial-stage-essential-elements/.

[4] Many communities use the Sequential Intercept Model (SIM), which is a conceptual model to guide community and systemwide responses to people with mental and substance use disorders in the criminal justice system. SIM focuses on six discrete points of potential intervention (also known as intercepts) in the criminal justice system at which a person who has behavioral health needs might be screened, assessed, and connected to treatment. These six points are (0) community services, (1) law enforcement, (2) initial detention/initial court hearings, (3) jails/courts, (4) reentry, and (5) community corrections. See Policy Research Associates, *The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders* (New York: Policy Research Associates, 2018), https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf.

BEHAVIORAL HEALTH DIVERSION TERMINOLOGY

While diversion, particularly behavioral health diversion, is becoming more common in the U.S. as an alternative to incarceration, there are not consistent, universally accepted terms and definitions that clarify who can be diverted, to what systems or services, and who can divert someone at various points in the criminal justice system. This lack of a shared language has led to wide variance among state "diversion" statutes[5] and local practices and often creates inconsistencies in criteria and the ways programs operate by jurisdiction. For the purposes of this publication, **behavioral health diversion** refers to adult jail diversion, whereby a person who has a behavioral health need may still have involvement with the criminal justice system (such as the courts) but spends little to no time in a jail facility and is instead connected to community-based treatment and support services either with or without court involvement or correctional supervision.[6]

OTHER COMMON BEHAVIORAL HEALTH DIVERSION DEFINITIONS INCLUDE:

Behavioral health diversion intervention: These programs and practices reduce or eliminate jail time for people who have behavioral health needs by connecting them to community-based treatment and support services. This term includes recognizable diversion programs such as mobile crisis teams and Law Enforcement Assisted Diversion (LEAD), as well as local practices that lead to a diversion-related outcome.

Pre-arrest diversion: Refers to diversion whereby a person who has initial contact with the criminal justice system (typically with law enforcement or first responders) is not arrested, but is instead connected to a behavioral health community provider or potentially given a civil citation.

Pre-booking diversion: Most commonly defined as programs and practices that can occur at any point in the criminal justice system before a person is booked into a facility and relies heavily on effective interactions between police and community mental health and substance use disorder treatment providers.[7]

Post-booking diversion: Most commonly refers to programs that are used to identify and divert people who have behavioral health needs after they have been booked into jail.[8] Post-booking diversion interventions are typically led by either the courts or jails.

Pretrial diversion: Pretrial diversion is a type of post-booking diversion. It is commonly defined as programs and practices that occur at any level or stage of justice supervision between law enforcement contact and a plea or other disposition of the criminal case. As a result, pretrial diversion may involve multiple agencies, including jail, pretrial release, prosecutors, defense counsel, and even probation departments that operate in a pretrial capacity.[9]

This publication delineates diversion opportunities as "pre-booking" or "post-booking" because different actors become involved once someone enters a correctional facility. Distinguishing the behavioral health diversion options into just these two categories also allows a clear line to be drawn when talking about the agencies within the system leading the implementation of a diversion intervention (see Figure 1). However, diversion opportunities are also often delineated by their place in the flow of the criminal case (e.g., pre-charge, pre-arraignment, pre-plea). While not a focus of this publication, consensus on which of these process points provide a ramp for diversion is critical.

---

[5] "Pretrial Diversion," National Conference of State Legislatures, accessed September 11, 2019, http://www.ncsl.org/research/civil-and-criminal-justice/pretrial-diversion.aspx.

[6] This definition is adapted from the definition given in Judges' Criminal Justice/Mental Health Leadership Initiative, *Judges' Guide to Mental Health Diversion: A Reference for Justice System Practitioners* (Delmar, NY: Policy Research Associates, CMHS National GAINS Center, 2010). While some interventions can occur post-conviction (through reduced jail time or supervision for treatment compliance), this definition of diversion does not consider those interventions as diversion, but instead as reentry practices. Traditional reentry practices are an important piece of the criminal justice process; however, they are not considered diversion interventions.

[7] CMHS National GAINS Center, *Practical Advice on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center* (Delmar, NY: Policy Research Associates, CMHS National GAINS Center, 2007).

[8] Ibid.

[9] The Center for Health and Justice at Treatment Alternatives for Safe Communitiies (TASC), *No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives* (Chicago: The Center for Health and Justice at TASC, 2013).

UNDERSTANDING THE COMMUNITY'S BEHAVIORAL HEALTH NEEDS

To develop a systems-wide strategy for a continuum of behavioral health diversion interventions, local leaders must identify the people who have behavioral health needs in the criminal justice system, how they flow through the criminal justice system, and the gaps in community-based treatment and support services for this population. Identifying these needs and gaps can be accomplished by conducting comprehensive process analyses and inventorying any existing services and supports for people who have behavioral health needs. Local leaders should also consider engaging stakeholders in both the criminal justice and behavioral health systems, as well as people who have lived experiences, in discussions and efforts such as collecting baseline data on programs and practices geared to people who have behavioral health needs in the criminal justice system.[10]

Additional data collected from law enforcement, pretrial services, courts, jail facilities, health providers, and housing continuums of care can be used to analyze the number of people who have mental illnesses, substance use disorders, and co-occurring illnesses and how this population moves through the system. This type of data analysis can reveal potential areas where one or more diversion interventions are needed as part of an overarching strategy. For example, an analysis of data may reveal that too many people with low level offenses but who have significant behavioral health needs are being booked into the jail. In this instance, local leaders may consider implementing a pre-booking diversion intervention that connects this population to community-based mental health and substance use disorder services as part of their systems-wide strategy.

Often, leaders realize the need for a more comprehensive strategy when they determine that individual programs are not efficiently meeting the needs of their community. When this occurs, it is critical to have data and information from both criminal justice and behavioral health systems so these leaders can begin to rethink coordination across the multiple systems. In fact, while a comprehensive systems-wide diversion strategy would ideally begin before any programs or practices are implemented, communities that have already implemented individual diversion programs (such as a co-responder model or a mental health court) without a formal diversion strategy in place still have plenty of opportunities to build upon these programs to develop their strategy. In these instances, local leaders should conduct a gap analysis to examine the existing diversion intervention(s), assess what needs are not being met by these interventions based on data and information collected, and determine where any additional diversion interventions can be implemented.

When leaders have a clear understanding of the community's needs and gaps in treatment and services, they are better positioned to develop a systems-wide diversion strategy that includes diversion interventions at multiple points in the criminal justice system. This process can help a jurisdiction ensure resources are aligned correctly to maximize intended goals, both through sustaining successful interventions and filling gaps.

OPPORTUNITIES FOR BEHAVIORAL HEALTH DIVERSION

Like many systems, a local community's criminal justice system is a set of connected parts consisting of different agencies. Each of these agencies (i.e., law enforcement, courts, pretrial services, and jails) has opportunities to implement behavioral health diversion interventions at their respective points in the criminal justice system. Too often, however, these interventions operate as stand-alone programs in isolation of one another, and are not implemented in coordination with the interventions that can occur in other parts of the system. As a result, many communities find that these individual interventions—while effective for the people they reach—do not produce the desired results of reducing the overall number of people who have behavioral health needs in their criminal justice system.

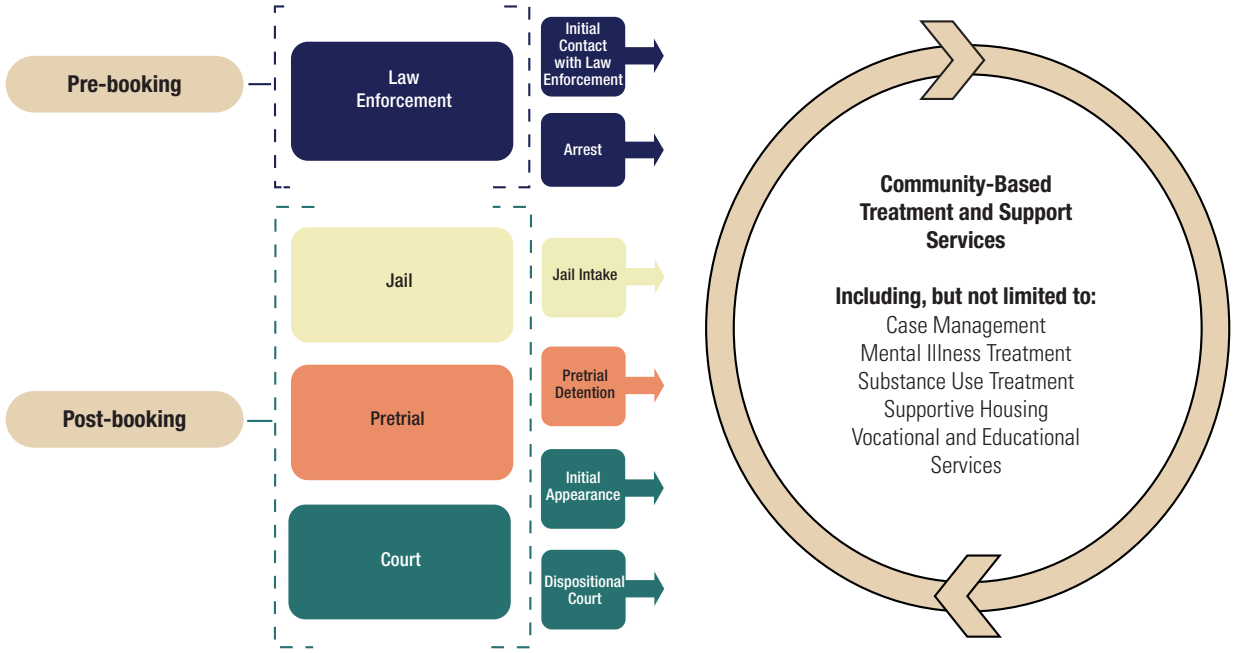
When this occurs, leaders should conduct an analysis of the behavioral health and criminal justice systems to help identify which agencies have the resources and best opportunities to implement coordinated behavioral health diversion interventions and engage new stakeholders from the different agencies to think through the communities' goals for behavioral health

[10] Risë Haneberg et al., *Reducing the Number of People with Mental Illnesses in Jails* (New York: The Council of State Governments Justice Center, 2017), https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf; and "The Stepping Up Initiative," https://stepuptogether.org.

diversion. This analysis, in combination with information gathered about the people who have behavioral health needs in their criminal justice system and the gaps in community-based treatment and support services, can reveal which behavioral health diversion opportunities a community should prioritize and invest funding in.

Figure 1 shows the potential behavioral health diversion interventions within a community's criminal justice system that can be used to connect people to community-based treatment and support services, organized around the specific agencies that would best lead the implementation of a diversion intervention. These opportunities range from interventions that operate prior to arrest and booking by law enforcement to those that provide alternatives to incarceration at adjudication or sentencing. Categorized by which opportunities fall under the pre-booking and post-booking diversion classifications, the larger boxes indicate which agencies can lead implementation of the behavioral health diversion interventions, while the smaller boxes to the right describe key points in the criminal justice process where a behavioral health diversion intervention could be implemented based off the agency with the best opportunity to do so. Once implemented, these interventions should all have a similar end result: the person connected to community-based treatment and support services.[11]

FIGURE 1. BEHAVIORAL HEALTH DIVERSION OPPORTUNITIES WITHIN A LOCAL CRIMINAL JUSTICE SYSTEM LEADING TO COMMUNITY-BASED TREATMENT AND SUPPORT SERVICES



This agency-specific framework helps local leaders determine which agencies will best lead their agreed upon behavioral health diversion interventions and how those agencies can collaborate to develop the systems-wide strategy, reducing the silos that often occur when interventions are implemented without community-wide coordination. By using this framework, agencies can have a better understanding of what behavioral health diversion interventions are possible. Communities can also determine what types of interventions best address their needs and where they should focus their interventions to create diversion opportunities across the criminal justice system. A systems mapping exercise, such as Sequential Intercept Mapping (derived from SIM), can be used to identify the agencies responsible for each process point and subsequent identification of a diversion intervention. Once local leaders have an understanding of the needs of their identified population, the diversion interventions already implemented, and the capacity of community-based services organizations, they can begin to explore behavioral health diversion interventions that would provide the level of treatment and supervision needed by this population.

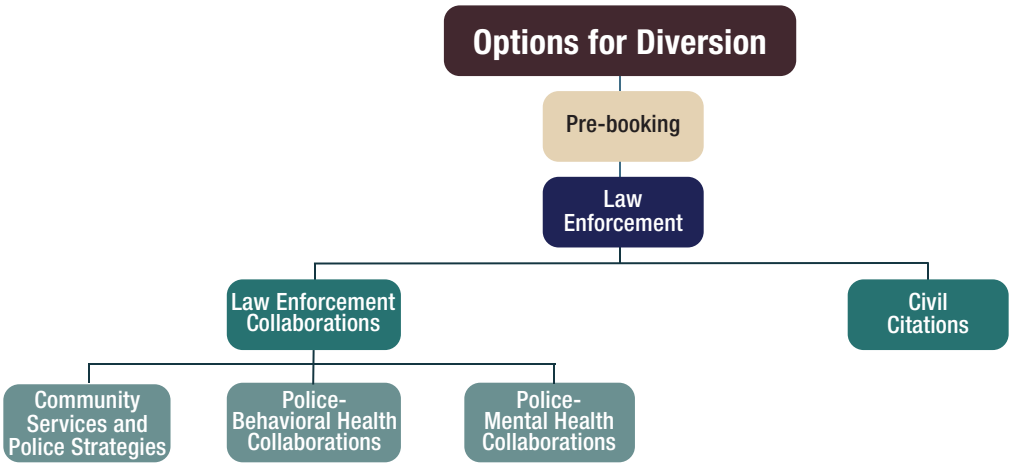
[11] Figure 1 highlights the agencies typically associated with each key process point in the criminal justice system of a given jurisdiction, but it is important to note that the agency responsible for each process point varies across jurisdictions. It also indicates examples of community-based treatment and support services that people should be connected to once they are diverted from the criminal justice system. Many communities have begun using Collaborative Comprehensive Case Plans to faciliate these efforts as part of a systems-wide strategy. See, "Collaborative Comprehensive Case Plans: Addressing Criminogenic Risk and Behaviorial Health Needs," The Council of State Governments Justice Center, accessed September 13, 2019, https://csgjusticecenter.org/nrrc/collaborative-comprehensive-case-plans/.

Pre-booking Diversion Interventions

Although there are key points in the criminal justice process to divert people after they have been booked into jail, diverting people at the pre-booking stage typically results in limited or no jail time or justice involvement for an individual. Therefore, communities should consider investing in behavioral health diversion interventions at the pre-booking point in the criminal justice system if their data analysis reveals the needs of their identified population are best addressed through programs and practices that intervene early in the criminal justice process. If it is determined that a significant proportion of the population with behavioral health needs is arrested or convicted for low level offenses, for example, a pre-booking diversion intervention would allow people to be connected to community-based treatment and support services rather than booked into a jail facility. Pre-booking diversion interventions can reduce burdens on the booking and jail staff by diverting people prior to being booked into a jail, reducing the number of people who have behavioral health needs from entering a jail facility. These interventions can also reduce individual barriers to recovery. For people who have mental illnesses, jail time often means a disruption to community-based treatment, as well as any community supports, such as benefits enrollment, housing, and employment.[12]

Figure 2 illustrates the types of opportunities for pre-booking diversion interventions law enforcement agencies can implement. These interventions are often focused on law enforcement collaborations with community providers in the behavioral health system that have more knowledge and resources to treat people who have behavioral health needs.[13]

FIGURE 2. LAW ENFORCEMENT OPTIONS FOR IMPLEMENTING PRE-BOOKING DIVERSION INTERVENTIONS[14]



Post-booking Diversion Interventions

After an individual has been booked into jail, there are still numerous opportunities for diversion through the efforts of the jail, pretrial services, or the courts. Communities should consider investing in post-booking diversion interventions, if it is determined that existing treatment and service gaps are best addressed by the courts, jail facilities, or pretrial services. For example, a jurisdiction may determine that the people who have behavioral health needs in their community have longer lengths of stay in a jail facility or their criminal charges are largely predicated on their behavioral health need. Examples of post-booking diversion interventions can include a reduction in charges or case dismissal pending completion of a behavioral health diversion program. While these interventions will not reduce the number of jail bookings, they can significantly impact an individual's length of stay, as well as help avert the consequences of a criminal conviction.

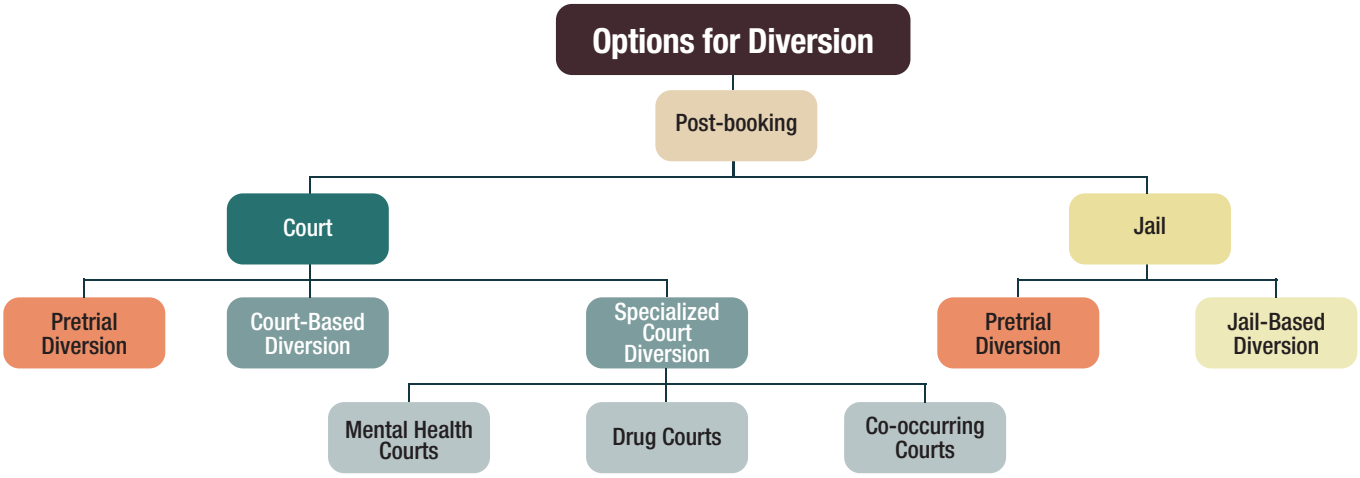
[12] Hallie Fader-Towe and Fred Osher, *Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements*, 9, https://csgjusticecenter.org/courts/publications/improving-responses-to-people-with-mental-illnesses-at-the-pretrial-stage-essential-elements/.

[13] The Council of State Governments Justice Center, *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs* (New York: The Council of State Governments Justice Center, 2019), https://csgjusticecenter.org/wp-content/uploads/2019/04/Police-Mental-Health-Collaborations-Framework.pdf.

[14] Figure 2 uses categorizations to describe various collaborative efforts led or joined by law enforcement agencies across the country. "Community Services and Police Strategies" includes diversion interventions where a person is diverted to crisis services; "police-behavioral health collaborations" refers to diversion interventions where connecting people with substance use disorders or concerns to treatment is the primary focus; and "police-mental health collaborations" refers to diversion interventions where connecting people with mental health needs to treatment is the primary focus.

For these interventions, prosecutors, defense counsel, pretrial services staff, jail staff, judges or others working in the courts may help to identify people who meet eligibility criteria for diversion. Figure 3 illustrates some common post-booking diversion options based on the criminal justice agencies and partners that can best implement those programs and practices.

FIGURE 3. COURT AND JAIL OPTIONS FOR IMPLEMENTING POST-BOOKING DIVERSION INTERVENTIONS[15]



DEVELOPING A SYSTEMS-WIDE STRATEGY

Local leaders can begin developing a systems-wide strategy by engaging criminal justice and community partners in efforts to identify their behavioral health needs and gaps in services and determining the pre- and post-booking interventions that work best for them. They should use this information to inform the development of a systems-wide behavioral health diversion strategy based on what behavioral health needs they want to prioritize and which agencies are best positioned to lead and collaborate on implementing the behavioral health diversion interventions. To develop that strategy, leaders must also determine where they should focus their behavioral health diversion interventions within the various points in the criminal justice system.

The use of data, system mapping, and analysis of flow of people through a local criminal justice system can help to identify points in the criminal justice system where one or more behavioral health diversion interventions should be implemented. In addition to identifying areas to implement new programs and practices, local leaders should also examine and assess the performance of any existing efforts within the criminal justice and behavioral health systems. Combining both these efforts will help leaders develop a systems-wide strategy that includes multiple points in the criminal justice system where agencies have the ability to identify people who have behavioral health needs as well as divert them to the community-based providers that can provide the needed treatment and support services.

A thoughtful systems-wide behavioral health diversion strategy that builds a continuum of behavioral health diversion interventions into the criminal justice system will maximize the number of interventions available, ensure that the interventions offered meet the needs of the community, and more effectively reroute the appropriate people from conventional case processing and incarceration into the community-based treatment and support services that better serve their needs.

[15] Although pretrial diversion is included as an intervention that can be led by either the courts or the local jail, it is often a stand-alone agency run by community supervision or a branch within the courts. The inclusion of pretrial diversion on both sides of Figure 3 reflects the variety of pretrial services administrative locations in communities. Additionally, under "specialized court diversion," it is worth noting that these programs are all pre-plea and may have a variety of program names depending on the jurisdiction. While drug courts, mental health courts, and co-occurring courts are among the most common types of specialized court diversion, jurisdictions are constantly innovating in this area, and there may be other specialized court diversions available that would be appropriate (e.g., homelessness court, opioid court, etc.).

Justice Center
THE COUNCIL OF STATE GOVERNMENTS

This project was supported by Grant No. 2016-MU-BX-K003, awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART). Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Mental Health Commission
From: Lisa Warhuus, Director, Health, Housing and Community Services
Date: May 16, 2022
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for April, 2021.

Information Requested by MHC

The MHC Chair requested the following information:

Data from the BHC Health Center:

21-22 School Year (Jul 21-Apr 22)
# of Referrals: 485
Unduplicated # of Referrals: 359
# of clinical services (intake/therapy): ~1,440

- ~890 Health Center
- ~550 Medi-Cal
- 6 groups conducted in April to support the BHS Community after the student suicide (# of participants not tallied)

4.0 FTE – MH Clinical Supervisor and 3 Behavioral Health Clinician IIs

- 1 BHC II began on August '21
- 1 BHC II began on October '21
- 1 BHC II was on parental leave from Aug-Dec '21
- No Graduate-Level Trainees due to above-mentioned staff transitions

Health Center Updates for 2021-2022 School year:

In the 21-22 school year, the BHS Health Center supervisor onboarded two new clinicians (see above) and had another who was on parental leave from Aug-Dec 2021, which impacted the capacity of the team to provide mental health services during the first semester of school. Even with the staffing challenges, during this school year the team has been able to return to pre-pandemic levels with the number of students served in the clinic. This is partly due to a new resource, JotForm, which allows students, staff, and parents to make electronic mental health referrals to the HC, through any computer, smart phone, or tablet. With the shelter in place/remote learning for the past two years, the team has not provided the usual array of

groups on campus due to limited spaces that complied with the COVID restrictions (social distancing, sufficient air circulation, etc.) The plan is to re-engage with this service modality beginning Fall 2022. The team has also not been able to host graduate trainees due to the need to manage the foot print in the health center and the unknowns related to students returning to in person learning. In spite of these challenges, the MH team continues to be an accessible resource on campus that supports the health/well-being of the BHC community through drop-in, crisis support, and planned mental health services.

COB funded mental health programs for BUSD:

Mental Health Peer Education Program (MEET): ***After original agreement BUSD has declined to implement this program.***

The MEET program implements a mental health curriculum for 9th graders and an internship program for a cohort of high school students in an effort to increase student awareness of common mental health difficulties, resources, and healthy coping and intervention skills. Through this program students are trained by a BUSD clinician to conduct class presentations covering common mental health disorders, on and off campus resources, as well as basic coping and intervention skills. The goal of this program is to bring about improved mental health for Berkeley High School students. The MEET program funding may also be used, after the MEET specific requirements are satisfied, to support coordination of mental health services within Berkeley High School.

Dynamic Mindfulness (DMind) Program

Dynamic Mindfulness (DMind) is an evidence-based trauma-informed program that will be implemented in each BUSD middle school and high schools. Validated by independent researchers as a transformative program for teaching children and youth, skills for optimal stress resilience and healing from trauma, the DMind program integrates mindful action, breathing, and centering. DMind can be delivered as intervention that can be implemented in the classroom in 5-15minute sessions, three to five times a week, or combined with other interventions, support and services offered at each school. This program has proven to be successful with vulnerable students who are exhibiting signs of trauma/PTSD from Adverse Childhood Experiences (ACEs), and/or disengagement from school, chronic absences, and significant behavioral challenges, including emotion regulation, impulse control, and anger management. DMind also enables teacher well-being, which has been shown to enhance student learning. The program components will include in-class and after-school DMind sessions for students, student peer leadership development, training and coaching of school staff, and program evaluation. The goal of this program is to increase the mental health of students using mindfulness as a skill to identify emotions, express feelings, and cope with negative emotions. Contracts over the amount of ten thousand dollars require approval of BUSD Board of Education.

Supportive Schools Program (Elementary Schools)

Early Intervention Behavioral Health Services will be provided at 11/11 (100%) of BUSD elementary schools. $10,000 will be allocated to each elementary school to provide early intervention services as defined by MHSA. This amount is supplemented using various funding streams in order to offer more robust behavioral support services. BUSD sub-contracts with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) are agencies with which BUSD subcontracts to provide

services at BUSD elementary schools. Agency and district staff providers lead social skills groups, early intervention social and emotional support, playground social skills, "check in / check out," individual counseling, and support for parents and guardians from diverse backgrounds.

To leverage this City investment, BUSD also hires and assigns school counselors to elementary schools to provide behavioral support services. District personnel coordinate services and participate in Coordination of Services (COST) team meetings. In addition, BUSD funds two teachers on special assignment with focus on equity and school climate, Positive Behavior Intervention and Support (PBIS) 1,0 FTE and Multi-Tiered Systems of Support (MTSS), 1.0 FTE. special education program supervisors, support services for students who are foster youth and homeless in the BUSD Homeless Outreach Program for Education (Berkeley HOPE), classified staff in the Office of Equity and Family Engagement (OFEE), and a coordinator responsible for professional development of certificated staff. The BUSD Student Services Department provides professional development and training related to serving students and families who are legally homeless, in foster care, and students in families facing stressors and histories of trauma. With priority and focus on equity, school-based providers link parents and guardians with resources at the school, within the school district, and in the community.

African American Success Project

The African American Success Project (AASP) was first implemented in FY19 in four Berkeley Unified School District Schools (King, Longfellow, Willard and Berkeley High School). Closely aligned with the work of Berkeley's 2020 Vision, the AASP works with African American youth and their families to actively engage students in the classroom and school life while creating a pathway for their long-term success. The project implements a three-pronged approach that includes case management and mentorship (which are individualized and tailored to meet each student's needs), community building, and family engagement. Through this approach a case manager engages and works with each student on school success planning. This work includes establishing student check-ins, family connections, teacher and staff collaborations, advocacy, and community building sessions. The project supports students who have disproportionately faced barriers in Berkeley public schools to promote an individual's learning, mental, and socioemotional well-being.

MHSSA Grant:

The City of Berkeley has secured Mental Health Student Services Act (MHSSA) funding ($2.5 million over 4 years) from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to address pressing needs within the Berkeley Unified School District (BUSD) related to student mental health and wellness. Initial planning conversations between District and school leadership and the Berkeley Mental Health Division (MHD) have resulted in the identification of three priority areas for MHSSA funding:

1. Dedicated staff to facilitate relationship building and service coordination across MHD and BUSD,
2. Services to address BUSD's most pressing mental health needs through increased availability of on-campus mental health treatment, navigation support for parents/caregivers, and training for teachers and school staff related to student mental health and wellness, and
3. A comprehensive assessment and strategic planning process to inform BUSD's long-term approach to student mental health.

There is an urgent need for dedicated staff to facilitate relationship building and service coordination across MHD and BUSD. The very real need for this coordination was evident in the initial planning conversations for this grant. In several instances, BUSD staff expressed a need for services and resources that they were unaware are already available through MHD. To this end, BUSD will utilize MHSSA funding to hire a full-time (1.0 full-time equivalent) Mental Health Coordinator employed by BUSD who will oversee all grant activities and actively work to strengthen collaboration and coordination between BUSD, MHD, and other key mental health system stakeholders such as community-based organizations (CBOs) and private insurers.

While increased availability of on-campus mental health treatment, navigation support for parents/caregivers, and training for teachers and school staff related to student mental health and wellness are long-standing needs within BUSD, these needs have intensified greatly as a result of the COVID-19 pandemic and resulting shelter-in-place restrictions. Berkeley school leaders at the elementary, middle, and high-school level have all noted decreased emotional regulation and increased anxiety, social conflict, and behavioral issues within their student bodies. Leadership at all levels have also noted increases in the number of students requiring residential treatment for severe mental health concerns, as well as increases in the prevalence of eating disorders and self-harm behaviors. Although all BUSD schools provide some access to counseling, demand routinely outpaces counselor availability, and in many cases, counselors must balance addressing student mental health needs with responsibilities related to academic counseling. To this end, MHD and BUSD may utilize MHSSA funding to bolster on-campus mental health treatment. This could include contracting with one or more CBOs or expanding existing CBO contracts to provide additional individual and group treatment at a variety of school sites. This could also include adding additional mental health staff to specific school sites to provide individual and group counseling. Additionally, BUSD may explore implementing universal mental health screening for BUSD students to support the identification of mental health needs and to inform the mix of services available to students, the support available to parents/caregivers, and the training available to teachers and school staff.

In initial grant planning conversations, school leaders at the elementary, middle, and high-school level also noted that many parents/caregivers are either unaware of the mental health resources available, do not know how to access those resources, or struggle navigating the process for obtaining access. These barriers are further complicated by the very real stressors parents themselves have experienced due to the pandemic, including increased burden of caregiving, transitioning to a remote work environment, job losses, and grief associated with the loss of loved ones. To address this need, MHD and BUSD may utilize MHSSA funding to add staff at the district or school-site level who can support parents in identifying and accessing a variety of counseling options, including insurance-based as well as MHD and other Mental Health Plan services. School leaders at all levels have also noted the challenges teachers and other school staff face as they navigate the increased mental health needs of students returning to an in-person learning environment. To better equip teachers and school staff to address these needs, BUSD may utilize MHSSA funding to provide training in one or more of the following: Mental Health First Aid for Youth, Trauma-Informed Care, and/or any other specific behavioral health models of care.

Finally, Berkeley recognizes that, although MHSSA funding will provide crucial resources to address some of the most pressing student mental health concerns, there is a real need for a robust plan that will: 1) ensure the sustainability of staffing and programming instituted through grant funding, and 2) guide the long-term work of creating a comprehensive system of student mental health support that is well-aligned to student needs, leverages the strengths and resources of both BUSD and MHD, and ensures meaningful collaboration and coordination

across BUSD, MHD, and other mental health stakeholders. Berkeley intends to address this need by utilizing MHSSA funding to undertake a comprehensive assessment and strategic planning process during the first year of program operations that will inform BUSD's approach to student mental health throughout and well beyond the life of the grant. This assessment will build off of two previous mental health needs assessments conducted by Alameda County (a funder of the BHS Health Center) in partnership with BUSD that focused on mental health systems needs at the K-8 schools and at Berkeley High School, and will also include an updated community engagement process to make sure that the impacts of the pandemic, current political and social context, and needs of the current student body and staff are addressed.

Reports from the Center for Healthy Schools and Communities – attached

Berkeley Mental Health Caseload Statistics
for April 2022

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2022 (July '21-June '22) Demographics as of April 2022
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	4 Clinicians 1 Team Lead	57	$5,596	72 Clients Black or African-American: 35 Hispanic or Latino: 4 Other/Unknown: 2 White: 31 Male: 40 Female: 25 Missing Gender ID: 4 Prefer Not to Answer Gen ID: 2 Multiple Gender ID: 1 Heterosexual: 51 Missing Sex Orient: 12 Bisexual: 2 Gay: 2 Multiple Sex Orient: 2 Lesbian: 1 Prefer Not to Answer Sex Orient: 2
Adult FSP Psychiatry (April Stats)	1-100	.75 FTE	48		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,037,600		
Homeless Full-Service Partnership (HFSP) (Highest level outpatient clinical case management and treatment)	1-8 for clinical staff	4 Clinicians, 1 Team Lead	31	$5,294	31 Clients API: 2 Black or African-American: 17 Hispanic or Latino:2 Other/Unknown: 1 White: 9 Male: 21 Female: 8 Missing Gender ID: 1 Hetrosexual:24 Missing Sex Orient: 4 Bisexual: 1

					Multiple Sex Orient: 1
HFPS Psychiatry (April Stats)	1-100	.2 FTE	28		
HFSP FY22 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			TBD		
Comprehensive Community Treatment (CCT) (High level outpatient clinical case management and treatment)	1-20	8 Clinicians 1 Manager	169	$2,244	195 Clients American Indian: 3 API: 14 Black or African-American: 75 Hispanic or Latino: 11 Other/Unknown: 12 White: 80 Male: 97 Female: 92 Female to Male: 1 Non-Conforming Gender ID: 1 Other Gender ID: 1 Queer Gender ID: 0 Prefer Not To Answer Gender ID: 1 Missing Gender ID: 1 Heterosexual: 151 Bisexual: 18 Gay: 6 Lesbian: 5 Multiple Sexual Orient: 2 Queer Sexual Orient: 2 Other Sexual Orient: 1 Prefer Not To Answer Sex Orient: 2 Missing Sexual Orient: 18
CCT Psychiatry (April Stats)	1-200	1 FTE	134		
CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,617,010		
Focus on Independence Team (FIT) (Lower level of care, only for individuals previously on FSP or CCT)	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Clinical Supervisor, I Licensed Clinician, 1 CHW Sp./ Non-Degreed Clinical	94	$1,106	104 Clients API: 8 Black or African American: 42 Hispanic or Latino: 1 Other/Unknown: 2 White: 50

					Male: 62 Female: 39 Other Gender ID: 1 Missing Gender ID: 2 Heterosexual: 87 Multiple Sexual Orient: 1 Gay: 1 Questioning: 1 Prefer Not to Answer Sexual Orien: 2 Missing Sexual Orient: 12
FIT Psychiatry (April Stats)	1-200	.5	86		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$900,451		

Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2022 (July '21-June '22) Demographics as of May 2022
Children's Full-Service Partnership (CFSP)	1-8	.5 Clinical	5	$6,696	13 Clients American Indian: 1 API: 2 Black or African-American: 5 Hispanic or Latino: 2 Other/Unknown: 1 White: 2 Male: 6 Female: 4 Non-Conforming Gender ID: 1 Missing Gender ID: 2 Heterosexual: 7 Gay: 1 Other Sexual Orient: 1 Questioning Sexual Orient: 1 Missing Sexual Orient: 3
CFSP Psychiatry (April Stats)	1-100	0	3		
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	2 Clinical	66	$1,982	82 Clients American Indian: 2 API: 5 Black or African-American: 32 Hispanic or Latino: 21 Other/Unknown: 2 White: 20 Male: 33 Female: 31 Non-Conforming Gender ID: 2 Multiple Gender ID: 2 Other Gender ID: 1 Female to Male: 1

					Missing Gender ID: 12 Heterosexual: 28 Gay: 5 Bisexual: 3 Multiple Sexual Orient: 3 Other Sexual Orent: 2 Queer Sexual Orient: 1 Questioning Sexual Orient: 1 Prefer Not To Answer: 1 Missing Sexual Orient: 38
ERMHS/EPSDT Psychiatry (April Stats)	1-100	0	8		
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	3.5 Clinical	Drop-in: 47 Externally referred: 26 Ongoing tx: 52 Groups: 6/6		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$396,106		

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Calendar Year 2021 (Jan '22-Dec '22) Demographics – From Mobile Crisis Incident Log (through April 2022)
Mobile Crisis (MCT)	N/A	2 Clinician filled at this time	• 111 Incidents • 17 5150 Evals • 4 5150 Evals leading to involuntary transport	• 77 Incidents: Location - Phone • 23 Incidents: Location - Field • 2 Incidents: Location - Home	226 Clients API: 14 Black or African-American: 50 Hispanic or Latino: 6 Other/Unknown: 99 White: 57 Male: 110 Female: 104 Transgender: 2 Unknown: 10
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$771,623		
Transitional Outreach Team (TOT)	N/A	.5 Licensed Clinician, (TOT and CAT have been recently merged)	4 Incidents	N/A	12 Clients API: 2 Black or African-American: 5 Hispanic or Latino: 1 Other/Unknown: 1 White: 3 Male: 4 Female: 8 Transgender: 0 Unknown: 0
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available))			$272,323		
Community Assessment Team (CAT)	N/A	1 Team Lead, .5 Clinician, 2 Non-Degreed Clinical	167 Incidents	N/A	182 Clients API: 10 Black or African-American: 42 Hispanic or Latino: 7 Other/Unknown: 82 White: 41 Male: 82 Female: 70

					Transgender: 1 Unknown: 6
CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available))			$735,075		

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.
In demographics, other/unknown is used both when a client indicates that they are multi-racial and when demographic info is not known.

*Average System Costs come from Yellowfin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

Berkeley High School
Health Needs Assessment

August 30, 2017
A publication of the Center for Healthy Schools and Communities
Alameda County Health Care Services Agency

Prepared by:
School Health Services Evaluation Team
UCSF Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco
And the Alameda County Center for Healthy Schools and Communities

UCSF
University of California
San Francisco

CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES
ALAMEDA COUNTY HEALTH CARE SERVICES

Berkeley High School Health Needs Assessment Executive Summary

In the fall of 2016, with staffing support from HCSA Center for Healthy Schools and Communities (CHSC), Berkeley High School and the University of California San Francisco (UCSF) partnered to gather data on the access and delivery of both behavioral health school health center services at Berkeley High. A Needs Assessment Steering Committee was established, tasked with conducting a comprehensive assessment of the school's health and wellness systems and supports. Consisting of 13 stakeholders from the school community; the committee met 4 times over the course of the assessment to provide input on data collection and develop recommendations to improve health and wellness supports.

The needs assessment used guiding questions drawn from the core components of the CHSC's School-Based Behavioral Health (SBBH) Model[1] as well as access to and quality of school based health services for high school students. The CHSC SBBH model looks at 6 key areas: *Ongoing Assessment, Cultural Responsiveness, Three Tiers of Support, District Capacity, Coordination Practices* and *Whole School Responsibility*. Additional guiding questions were developed for the focus groups and interviews to gauge access, coordination and integration between the Berkeley High Health Center and Berkeley High. The Berkeley High Health Center evaluation conducted by UCSF and the CHSC was also utilized as a resource. Recommendations based on the findings were developed to improve identified issues.

Primary data collection for the needs assessment was conducted with students, parents, school staff, and other key stakeholders representing BUSD, Berkeley High School and the Berkeley High School Based Health Center. Four focus groups were conducted including 3 with students (n=34 students) and one with the Steering Committee. Additionally, surveys were administered to students, staff and families. In total, 886 student (9th and 11 grade), 108 staff and 178 parent/guardian surveys were completed. Lastly, 8 key stakeholder interviews were conducted with providers, staff, and site and district administrators. To provide context, secondary data from the California Healthy Kids Survey (CHKS) and School-Based Health Center evaluation was also analyzed.

The following is a summary of key findings, followed by recommendations and next steps. The purpose of this document is for the district, key partners and stakeholders to use it as a tool to help shape and implement improvements to the health and wellness system to ensure that all students have access to the supports they need to learn and thrive.

Key Findings

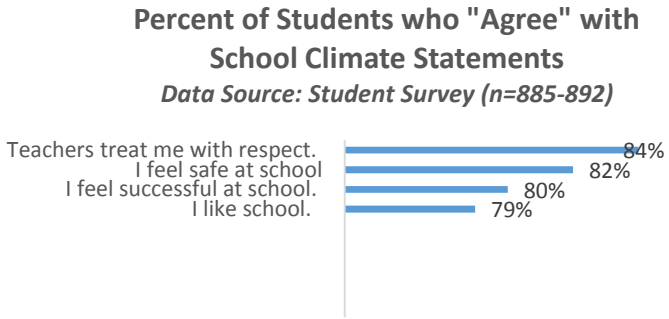
Strengths

1. **Dedicated and committed staff providing critical mental health supports:**
   The quality and commitment of staff and providers supporting students was widely viewed as strength of the health and wellness system. Outside mental health providers were described as providing high quality intensive and early intervention services. In addition, it was noted that some

[1] For a more detailed description of the SBBHI model, see *Alameda County School- Based Behavioral Health Model: Creating Nurturing School Environments* at the CHSC's School Health Works website: www.achealthyschools.org/schoolhealthworks

staff without mental health training made efforts to fill the gaps in services by offering students support groups a safe space to de-stress. Informal methods of providing support are widely practiced by academic counselors, SROs (School Resource Officers), SSOs (School Security Officers), and teachers. This all hands on deck approach was seen as both admirable and a reflection of the enormous need for additional social-emotional supports for students.

2. **Efforts are underway to improve the school climate and build a more supportive community for students and families:**
Some efforts to build cultural sensitivity amongst staff and restorative practices are taking place on campus. A team of staff is dedicated to building community by training other staff around issues of diversity and cultural responsiveness. The vast majority of *Student Survey* respondents felt positively about the school climate, in particular how they are treated and how they feel at school.



3. **School Based Health Center providing critical services to Berkeley High students:**
Many staff and students view the Berkeley High Health Center as a valuable resource. 1,350 students were seen at the Berkeley High Health Center during the 2015-16 school year, 67% of which returned for at least one subsequent visit. 93% of surveyed students that used the SBHC during the 15-16 school year reported that the health center helped them to get services they wouldn't otherwise get and most reported positive impacts on academic indicators and health behaviors. In addition, many stakeholders reported positive views of the services that the health center provides, such as health education and reproductive health. The health center director's collaborative efforts were highlighted as a strength, as well as the historical role of the health center in supporting the mental health needs of students.

Areas of Growth/Improvement

1. **Lack of district leadership and investment in developing a comprehensive Health and Wellness strategy for Berkeley High:**
Stakeholders reported "frustration" and discontent with the lack of involvement of district leadership with respect to health and wellness at Berkeley High. It was noted that there has been a historical disconnect between the health and wellness needs of students on the Berkeley High campus and the broader district-wide health and wellness strategy. This "disconnect" was reflected in the lack of consistent participation on the part of district and site leadership throughout the assessment process. This lack of engagement led to challenges with data collection and overall skepticism on the part of key stakeholders about whether the assessment recommendations would be taken seriously by the district. There is currently no one at the district level responsible for overseeing the health and wellness work at Berkeley High. The limited district engagement as well as lack of alignment between leadership and the City of Berkeley around the goals for the health center has led to insufficient resources and limited capacity to implement a sustainable health and wellness plan.

2. **Behavioral Health services tend to be heavily focused on intensive intervention and crisis response**
   While existing providers offer high quality supports to students, services tend to focus on intensive interventions to fewer, higher need students. Many stakeholders explained that a small portion of students with challenging behavior (about 10-15 students) absorb most of support staffs' time and resources, leaving little support available for students that are struggling but not acting out. Key stakeholders noted a recent dramatic increase in the number of students with depression and anxiety, and cases that reach a crisis level. Many stakeholders reported that the behavioral health support services are provided in a reactive manner – addressing one crisis to the next.

3. **Limited Coordination between the School Based Health Center and High School around health and wellness**
   Stakeholders reported general integration and coordination challenges between the SBHC and the larger school community. Confusion about confidentiality (HIPAA/FERPA) and processes for following up on referrals, as well as mistrust and lack of understanding about the role of the SBHC were among the top concerns. Although there are some coordination efforts taking place on campus, such as monthly meetings between the OCI and Special Education with the SBHC staff, and a Student Intervention Team (often referred to as a COST or Coordination of Services Team) stakeholders viewed these efforts as insufficient to meet the needs of the larger school community.

4. **Students do not feel that the School Based Health Center meets their needs**
   There was broad agreement from stakeholders across the board that students and families are unclear about what services are available at the SBHC and/or how to access these supports. *Focus Groups* students cited several reasons for not feeling "comfortable" using the SBHC including: concern about confidentiality and mandated reporting, counselors not being "relatable" (lack of counselors of color or from shared backgrounds), staff turn-over (i.e. interns who provide services for one school year only), front office staff not welcoming. Students also reported that they are hesitant to use the SBHC because often teachers do not allow students to leave class for an appointment or "ask too many questions," indicating a need for improved education for staff around protocols for students' accessing the Health Center services.

5. **Student and Staff perceive significant racial tensions**
   Many *Focus Group* participants reported feeling unsupported by staff when it came to issues of racism and discrimination and felt that "teachers don't call out racism like they should." According to the "Closing the Achievement Gap" module of the *California Healthy Kids Survey (CHKS)*, 34% of 9th grade and 38% of 11th grade students feel that there is *a lot* of tension between different cultures, races, or ethnicities (see chart below). Staff perception about racial tensions on campus was similar with fifty-eight percent of *School Staff Survey* respondents reporting that "a lot" of students were affected by racism.

Fairness and Respect for Diversity *(Data Source: California Healthy Kids Survey) (agree or strongly agree)*	**Grade 9 (n=528)**	**Grade 11 (n=459)**
There is a lot of tension in this school between different cultures, races, or ethnicities.	34%	38%
All students are treated fairly when they break school rules.	28%	27%
I have been disrespected or mistreated by an adult at this school because of my race, ethnicity, or culture.	16%	17%

Recommendations

Based on the needs assessment findings, we are making the following recommendations:

Recommendation 1: Build District leadership to develop and oversee the implementation of a BHS health and wellness strategy.

1. Identify district and site leads to drive health and wellness strategy and be accountable for implementation.

2. Establish Berkeley High and Wellness/Mental Health Committee that is **co-lead by BHS and BUSD district administration** with representatives from the City of Berkeley and School Health Center. Develop an operating structure for the committee, clarify purpose and develop shared vision around health and wellness for BHS students and identify core strategies.

3. Fund a full-time Berkeley High School Health and Wellness coordinator (like the district behavioral health consultant) to build capacity and coordinate supports across Berkeley High and between BHS and the SBHC. The coordinator will work with site administration to "hold the work" and drive the implementation strategy.

4. Develop financial sustainability plan to increase health and wellness supports, prioritizing funding for services identified in the needs assessment (i.e. individual and group counseling for depression and anxiety, training and professional development for staff around cultural responsiveness) and securing long term funding for critical support positions such as the Dean of attendance and academic counselors.

Recommendation 2: Build relational trust among stakeholders and health and wellness providers that result in improved coordination of care for youth and their families.

1. Conduct outreach to youth and their families on a regular basis to increase understanding of the continuum of services available at BHS, including the SBHC and how to access these services (i.e. culturally and linguistically appropriate materials, assemblies, resource fairs)

2. Create more “welcoming” Health Center environment (i.e. improved signage, diverse and “relatable” staffing)

3. Create youth leadership, peer mentorship opportunities and service learning projects so that students will feel more engaged in their school community and develop important skills (i.e. student panel or advisory committee)

4. Build capacity of staff to understand the impact of behavioral health on learning so that the entire school community can effectively support students health and wellness needs (i.e. ongoing trainings for staff, analyze capacity of existing staff to provide additional supports)

Recommendation 3: Strengthen Coordination systems to improve service delivery and increase access to health and wellness supports for students.

1. Develop and implement communication plan between the School Based Health Center and Berkeley High staff that includes:
    a. Establish monthly service team meetings with BHS support staff (including Special Education) and SBHC staff, convened by the Health and Wellness Coordinator and a BH administrator to more effectively serve the students.
    b. Update LOA between school/district and SBHC every year to set health and wellness priorities and clarify expectations around service delivery, confidentiality, and communication protocols.
    c. SBHC staff present at all-staff meeting so teachers are aware of how to refer students

2. Create structures to improve collaboration and communication among staff and partners, including non-clinical partners like teachers and classified staff
    a. Establish Crisis Response Team with identified lead and increase partnerships with outside agencies to provide additional crisis support services
    b. Revise existing Crisis Response Protocols and include crisis response "flow chart."

3. Strengthen existing **Response to Intervention team** by aligning with district guidelines, strengthening protocols, utilizing data and designating site administrator to attend weekly RTI meetings and set expectations for provider/staff/ SBHC staff attendance.

Recommendation 4: Improve school climate through a comprehensive Tier 1 strategy that builds cultures of wellness and healing, is aligned with the district, trauma informed, and culturally relevant.

1. Task Health and Wellness Committee to develop a phased implementation strategy:
    a. Year one: Health and Wellness committee considers existing work (i.e. such as Restorative Practices, Professional Development Teams), explores options for expansion and growth, and prioritizes various options, and identifies a comprehensive Tier 1 strategy that builds on the work already taking place
    b. Year two: Health and Wellness committee develops training plan for school staff and providers and leads roll out.
    c. Year three: Larger school-wide implementation and evaluation of strategy

2. Create "culture and climate committee" (comprised of staff and students) to develop and implement a comprehensive strategy for **addressing racial tensions on campus and improving cultural sensitivity amongst staff**. Hire an outside consultant to help implement and oversee the strategy and ensure that it is integrated into larger school climate and health and wellness plan.

Next Steps

With the needs assessment findings in mind, recommended next steps for Berkeley High School and partners include:

1. **District and site leadership should jointly develop an action plan** that is based on the assessment recommendations. Creating an action plan will help set the stage for successful implementation of the health and wellness strategy and create a structure of accountability and ownership. The plan should consist of: an overall implementation timeline; clear, measurable goals, objectives and activities that can be accomplished in a specific timeframe and; an identified point person or point people responsible for implementing each step.

2. **Develop and implement a communications strategy** to share the action steps that will be taken as a result of this assessment. Communication would address issues of: *what* action will be taken, *why* such action is critical, and *how* students, adults, and the high school will be better off as a result.

3. **Identify district and site administrative leads** to co-convene Berkeley High Health and Wellness team. This team should meet monthly and include district and site administrators, and representatives from the City of Berkeley and School Health Center. The purpose of this team is to develop and drive the health and wellness strategy for BHS (see Recommendation 1).

Berkeley Public Schools
Behavioral Health Needs Assessment

Understanding the Behavioral Health Needs, Strengths, and Gaps in Berkeley's Elementary and Middle Schools

May 2015

A publication of Berkeley Unified School District
and the Alameda County Center for Healthy Schools and Communities

Prepared by:
Jamie Keehan, U.C. Berkeley School of Social Welfare
Hanna Melnick, U.C. Berkeley Goldman School of Public Policy

Berkeley PUBLIC SCHOOLS
Berkeley Unified School District

CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES
ALAMEDA COUNTY HEALTH CARE SERVICES

Table of Contents

Executive Summary

In Spring 2015, Berkeley Unified School District (BUSD) partnered with the Alameda County Center for Healthy Schools and Communities (CHSC) to conduct a strengths and needs assessment of the district's behavioral health systems and services. The purpose of the assessment was to get an overview of BUSD's behavioral health supports and identify areas for growth. In this process, recommendations were developed on how to use existing resources and other funding streams to improve the behavioral health of Berkeley's students.

A set of guiding questions, based on the six core components and the foundational elements of the CHSC's School-Based Behavioral Health (SBBH) Model, informed our data gathering strategy and helped us to identify the strengths and areas of improvement in the behavioral health system. Primary data sources included focus groups with Response to Intervention (RTI) teams at each elementary and middle school in the district, district specialists, and students. Interviews were also conducted with parents, teachers, district and county leadership, and outside service providers. Counseling satisfaction surveys were also collected from middle school students. Secondary data sources included the California Healthy Kids Survey and Medi-Cal billing data from the County and outside providers.

The assessment identified several key strengths and challenges in the district. These findings are organized by the CHSC SBBH core components: *Three Tiers of Support, Coordination Strategies, School-wide Responsibility, District Capacity, Cultural Responsiveness, and Ongoing Assessment.* Examples of strengths include established RTI teams meeting regularly at every school, widespread recognition of the impact of trauma on children's learning and behavior, and strong practices at certain schools around student leadership and family engagement. Some of the challenges include a lack of district-wide coordination of services, a lack of clarity regarding services offered by outside providers in schools, and waiting lists of students in need of counseling.

Based on the assessment findings, the following changes are recommended:

1. Hire a district behavioral health Services and Positive Discipline Coordinator to hold the BUSD's vision of behavioral health and increase capacity throughout the district.
2. Provide district-wide recommendations for mental health practices to support the implementation of effective practices at all sites.
3. Clarify expectations for RTI and PBS Teams to facilitate effective interdisciplinary collaboration and student support.
4. Establish clear expectations for outside providers through MOUs to ensure that providers and the district know what services should be provided.
5. Implement a tracking and accountability plan across the district to establish a clear picture of the services being provided and bring attention to areas that need support.
6. Build capacity of staff to understand the impact of behavioral health so that the entire school community can effectively support students.

7. Initiate intern programs at all sites to increase counseling and capacity in a low-cost way.
8. Develop district-wide best practices for family engagement so that these critical members of students' support teams feel welcome and involved.
9. Establish a district-wide protocol for behavioral health crises so that all adults in the school have clarity on how to keep students safe in emergency situations.
10. Increase transparency in behavioral health funding and service provision to support schools' informed decision-making.
11. Partner with Alameda County Center for Healthy Schools and Communities to share resources that support the creation of district-wide behavioral health systems.
12. Increase behavioral health staff time in order to ensure that all students receive the services and supports they need.

Introduction

In its 2014 Local Control Accountability Plan (LCAP), Berkeley Unified School District identified the mental health of its students as a top priority. Many stakeholders – from community members to teachers to students – believe that their schools should be doing more to promote the health and wellness of students. Why?

There is a growing movement nation-wide that recognizes the effect of behavioral health struggles on young people's long-term health and educational outcomes. In the course of a year, about 20% of young people in the U.S. experience symptoms of a behavioral health problem.[1] One study shows that almost 30% of youth reported feeling so sad or hopeless every day for at least two weeks that they stopped participating in some of their normal activities.[2] There is also an increased recognition of the prevalence of traumatic childhood experiences and their impact on children's physical and mental health as well as their academic outcomes.[3] Of the estimated one in eight children who experience severe levels of trauma, 51% are diagnosed with a learning or behavioral health disorder, compared to just 3% of those who report no traumatic experiences. Children who have experienced trauma are more likely to be expelled from school[4] and are more likely to have adverse health outcomes that lead to everything from alcoholism to diabetes.[5] According to leading work in the field, cohesive and effective behavioral health supports in schools are one way of improving outcomes for students who have experienced trauma.[6]

In BUSD there is also a growing concern about the racial and income disparities in students' behavioral health. School connectedness, for example, is considered a "critical factor in promoting academic achievement and preventing risk behaviors" according to the California Department of Education. Having a caring adult in school makes a big difference in student success. Yet on the "school connectedness" measure in 2014's California Healthy Kids Survey, only 37% of BUSD's African American and 56% of Latino 7th grade students felt connected at school, compared to 72% of white students.[7] This may partially explain why absenteeism for these groups was significantly higher. In 2012-13, Latino students where chronically absent at 2.5 times the rate of whites, and the rate for African Americans was over 4.7 times as high. Suspension rates in the district also disproportionately affect minority students.

One way of addressing these disparities is by providing the behavioral health supports that all students need. These supports include mental health counselors who build relationships with high-need students; fostering collaboration between school staff to keep young people who are absent from "falling through the cracks"; and creating a culturally responsive school climate. In building these supports, BUSD will take an important step in ensuring that students from all backgrounds have a safe and supportive place to learn.

---

[1] Shaffer et al., 1996.
[2] Centers for Disease Control and Prevention, 2007.
[3] Kaiser Permanente, 1998.
[4] Wolpow et al. 2011
[5] Tough, 2012, pp. 9-11 and 17. "High levels of trauma" is defined as having experienced 4 or more Adverse Childhood Experiences (ACES) out of 9 possible factors.
[6] Massachusetts Advocates for Children, 2005.
[7] The data is similar for elementary schools, where 8% of students scored "Low" on indicators of meaningful participation in school.

The Needs Assessment

Understanding the current needs and strengths of students and those who support them is critical to creating a behavioral health system that promotes social-emotional and academic success. An assessment can help identify priorities not only for programs and services, but also for the behavioral health infrastructure needed at the school and district levels.

In 2005, district-level staff in BUSD led a needs assessment of mental health systems and identified key issues such as a lack of coordination of care and school-based prevention systems. The findings of this assessment led to significant changes across the district, including the implementation of Positive Behavior Intervention and Support (PBIS), the utilization of Response to Intervention (RTI) teams at every school site, and eventually the enactment of the Mental Health Services Act, in which the City of Berkeley gives $5,000 per year to each BUSD elementary school.

Despite this progress, some of the issues that were identified continue to permeate the system. The school district identified two problems in particular that motivated the current assessment. First, they were concerned that students' behavioral health needs were not being met at all sites. While some schools appeared well equipped to support student wellness, they felt that others were not. Second, district staff were concerned that mental health services were not being provided according to evidence-based practices. Since there is a lack of a unified, central strategy for how mental health would be addressed, they wanted to learn what practices sites were using and see if there was room for growth.

This assessment is only the first step in establishing a strategy for ongoing assessment and continuous improvement of behavioral health supports. From here, we hope that key partners and stakeholders will help shape and implement improvements to the behavioral health system.

Center for Healthy Schools and Communities

The Alameda County Center for Healthy Schools and Communities (CHSC) worked in collaboration with BUSD to complete the following assessment. For almost two decades, the CHSC has partnered with schools districts, community-based providers, youth and families, and policymakers to develop school health initiatives that eliminate health and education disparities and support the whole child. The CHSC, through its School-Based Behavioral Health (SBBH) Initiative, invests over $25 million annually in behavioral health systems in all 18 Alameda County school districts and at over 170 schools. Through these partnerships and investments, the SBBH Initiative expands universal access to behavioral health supports. It also builds the capacity of schools and districts to promote social-emotional development and learning.

The CHSC defines a "school-based behavioral health system" *as the infrastructure, programs, and relationships within a school and district that promote the healthy development of all students and address barriers to learning.* The SBBH model identifies six core components of an effective SBBH system, which are supported by a set of foundational elements common to all activities of the CHSC.

The CHSC School-Based Behavioral Health System Model is as follows:

The SBBH Core Components
Three Tiers of Support that includes universal prevention and promotion of positive school climate, early intervention for students with behavioral health challenges, and intensive intervention services
Coordination Strategies at the district-level and at individual school sites to ensure resources are accessible, effective, and allocated where they are needed most
School-Wide Responsibility whereby everyone within a school, from teacher to parents to students to providers, play a role in supporting the social-emotional health of all students
District Capacity which supports the implementation, ongoing assessment, and sustainability of the SBBH system
Cultural Responsiveness that honors the culture of students, family, and community, and results in supports and services tailored to the unique needs of those served
Ongoing Assessment to understand the needs and strengths of students and those who support them, and that results in action

In addition to the core components, the SBBH model relies upon a set of foundational elements, developed by the CHSC, that are essential for the growth, impact, and long-term stability of school heath and community school initiatives. These foundational elements are the backbone upon which behavioral health supports in schools and districts are built and enhanced. The Foundational Elements are:

- Transformative Leadership
- Capacity Building
- Dynamic Partnerships
- Equity Lens
- Quality Practice
- Results Focus
- Smart Financing

Together, the core components and foundational elements make up a comprehensive system that can support the success of students and their schools, and that can endure the inevitable transitions within schools, districts and partner agencies.

Methodology

For this assessment, a set of guiding questions, based on the six core components and the foundational elements of the SBBH model, informed our data gathering strategy and helped us to identify the strengths and areas of improvement in the behavioral health system. We used a variety of methods to collect data to map the existing services and system infrastructure, as well as identify assets and gaps across the core components (e.g. access, quality, barriers, unmet needs, cultural responsiveness).

We began the needs assessment with an analysis of the existing data, such as that collected in the LCAP and California Healthy Kids Survey. We also read through relevant previous assessments.[8] From there, we conducted focus groups, interviews, and surveys with key stakeholders to drill down into issues that had emerged. A brief description of this process follows.

In addition to data collection, we met monthly with the Mental Health Subcommittee at the district, which was convened in 2014. We discussed findings and recommendations with its members and received valuable feedback and information. We hope that the subcommittee will continue to meet in the upcoming year and help oversee any changes that are implemented to the behavioral health system.

Interviews and focus groups

We conducted focus groups at all 13 elementary and middle schools at the district. Most of these focus groups were centered on the Response to Intervention (RTI) team. RTI teams are interdisciplinary groups at each school that decide how best to support students academically and behaviorally, similar to Coordination of Services Teams (COST) in many school districts. At each school, this team consists of the principal, the RTI teacher, and other core members such as mental health counselors or family engagement coordinators.

We also conducted focus groups with a team of middle school leadership students, two groups of elementary students, district psychologists, and behaviorists. Individual interviews were completed with teachers, parents, members of outside provider agencies, and leaders in the district and the county. For a full list of participants and sample interview questions, please see the appendix.

[8] These included the 2005 Needs Assessment conducted for the district, the 2007 Schools Mental Health Partnership Strategic Plan, and the 2007-8 Universal Learning Support System Process Evaluation Report.

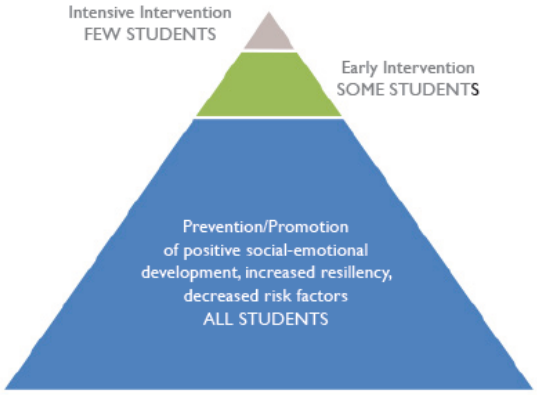
Findings

Below is a summary of our findings. The information is organized using the framework of CHSC's Core Components.

1. Three Tiers of Supports

The Response to Intervention model divides student needs into three groups. Tier 1 needs are best addressed through preventative programs that focus on positive social-emotional development. Tier 2 needs are more serious and need more individual attention through targeted early interventions. Tier 3 needs, exhibited by only a small fraction of students, require intensive intervention. In this section, we look at what services currently exist in BUSD across the three tiers of support, their state of implementation, and areas where additional support may be needed.

Diagram 1: The Response to Intervention Pyramid



Tier 1: Creating a Positive School Environment

Tier 1 supports in BUSD include Positive Behavioral Interventions & Supports (PBIS), which BUSD rolled out in 2004. PBIS is currently in place at all elementary and middle schools. It is intended to cultivate positive school climate and preempt severe behaviors that require higher levels of support. Recently PBIS was supplemented district-wide by use of "Toolbox", an evidence-based social-emotional learning curriculum that focuses on teaching students the "tools" fundamental to creating a caring and cohesive community. Toolbox was spoken of positively by all groups of stakeholders.

During the initial implementation of PBIS, Positive Behavioral Support (PBS) teams were established at all sites to oversee and support school climate programs. Conversations with RTI teams indicate that they may not be fully implemented at all schools. The frequency with which PBS teams meet varies widely, and not all schools conduct routine evaluations of school climate. Some stakeholders mentioned that it is difficult to maintain these programs with fidelity, as new programs take up more time and attention.

Restorative Justice (RJ) was another school climate initiative mentioned at many sites. Schools using RJ practices take incidents that might otherwise result in punishment and create opportunities for students to become aware of the impact of their behavior and take steps towards making things right. While stakeholders expressed great interest in the program, they were dissatisfied with the number of trainings and lack of ongoing support. Most schools use RJ practices primarily for positive discipline and conflict resolution as opposed to community building, which is a core component of the practice.

Staff at nearly every school in the district identified trauma as a primary concern in the lives of many of their students. They perceived this trauma as stemming from factors including family and community violence, and noted that it affects behavior both inside and outside the classroom. Many school staff members indicated that district-level trainings and presentations at staff meetings had been useful in helping them understand trauma. This understanding is an important step toward creating trauma-informed environments within schools, an important part of Tier 1.

A general concern was that the bulk of Tier 1 interventions were the responsibility of individual teachers in their classrooms, without significant support from behavioral health professionals. As will be discussed later, certain factors (such as time and billing) make it difficult for behavioral health support staff to do preventative, school climate work.

Tier 2: Early Intervention

One of the strongest Tier 2 interventions being implemented at most sites was student support groups. Most schools run groups for students, with social skills lessons and support for pre-pubescent girls, LGBTQ students, etc. Mental health counselors most frequently ran these groups. In schools that had both a mental health counselor and interns, interns ran more groups. The mental health counselors also reported being able to provide early intervention services for students with an urgent need such as a change in family circumstance, before having them go through the RTI process. This early intervention work was cited as a strength.

Schools that relied upon a Medi-Cal-funded mental health counselor, however, reported not being able to run as many groups as they would like. As part of their county contract, Medi-Cal funded providers are required to run groups. It is unclear why they are not following this mandate.

Tier 3: Intensive Intervention

Tier 3 programs vary significantly by school site. The following sections describe the differences in funding and service provision across the district.

Variation in Provider Models. Counseling services are provided by different community based organizations across the district. It is up to schools to decide what provider they work with. Most relationships with providers were initiated by principals many years ago, and have not been revisited.[9] The table below shows the various providers and their service model.

[9] Only one school has changed providers in the last few years. Two others recently added a district-hired mental health counselor to supplement their interns from Berkeley Mental Health.

Table 1: Behavioral Health Service Providers in Elementary Schools

Provider	# Schools	Model
Bay Area Community Resources	5	Each school has 1 full- or part-time mental health counselor who splits time between clients with and without Medi-Cal coverage.
Berkeley Mental Health	3*	Each school has 1-2 interns supervised off-site. 2 sites supplement with 1-2 days of a district-hired mental health counselor.
Child Therapy Institute	2	One school has 3 part-time mental health counselors. Another has one case manager for 2 less experienced mental health counselors.
Lifelong Mental Health	1	One full-time mental health counselor oversees 6 interns.

Our overarching finding was that most stakeholders feel there is a need for increased counseling services. At least 5 schools have a counseling waitlist. At most schools, mental health counselors only focus on intensive interventions, rather than school-based climate work or early intervention for Tier 2 students.

Due to different service models and funding levels, there is great variation in the number of on-site counseling hours provided at each school. The graph below shows the percentage of school hours that a mental health counselor is on-site, broken down by the counselor's primary funding source for that time. The majority of schools have one or more part-time mental health counselors. Rosa Parks, Cragmont, and Longfellow are the only schools that have one counselor working five days a week full-time. One school, Emerson, does not have a mental health counselor at all. Funding for counseling is only weakly correlated with school size and demographics.

Chart 1: Mental Health Counselor Time by School (Elementary Schools)

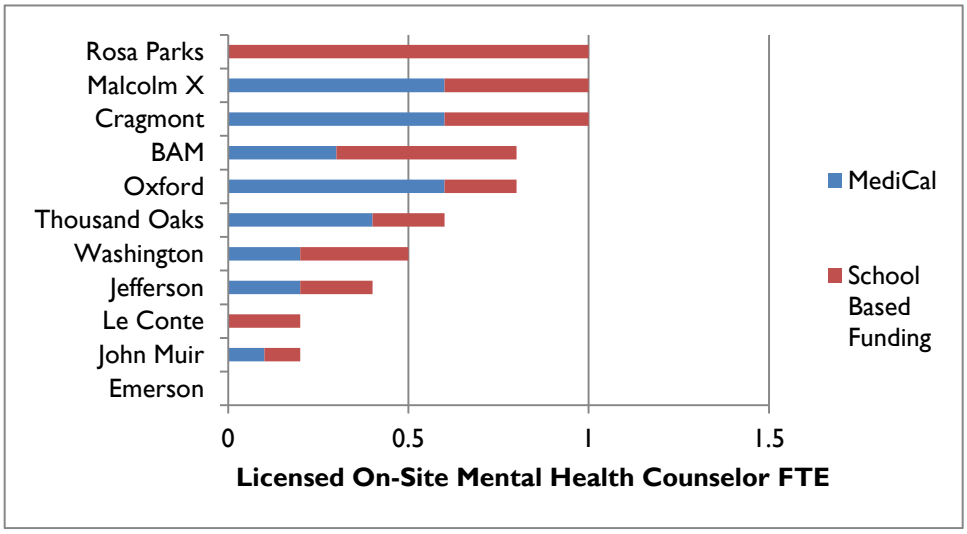
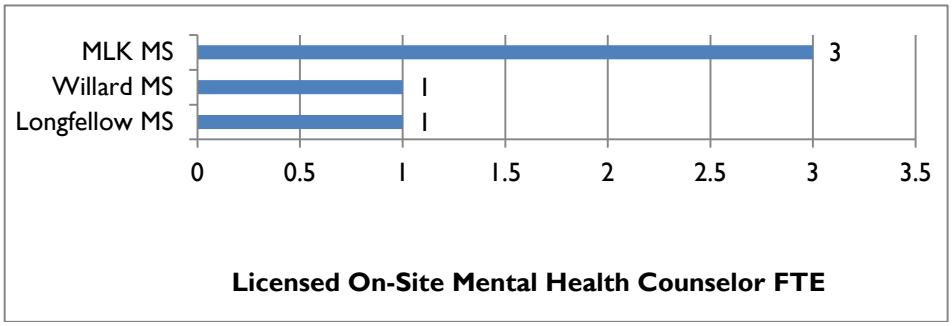


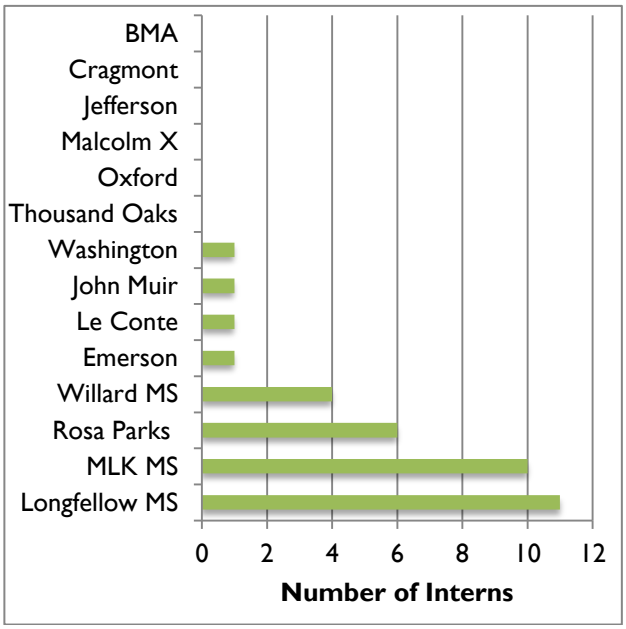
Chart 2: Mental Health Counselor Time by School (Middle Schools)*



*Note: MLK has more counselors in part because it has about twice as many students.

Interns can be a low-cost resource for many schools to provide group and individual counseling services to students. Of the eleven elementary schools, five have interns, with one school relying exclusively on its intern. All three middle schools have interns, although the number varies (see chart). The interns are mostly first year MSW and MFT students, who typically leave after one school year. At Longfellow and King Middle schools, several interns are post-Masters and continue more than one year until they have completed the necessary 3000 hours for licensure. This helps to provide continuity of care on these sites. Intern supervision is provided on-site at only two schools.[10] Five sites do not have any interns, and rely on counselors alone.[11]The quality of the services provided by interns varies significantly according to the different structure of their training, supervision, and evaluation. Interns with some providers collaborate effectively with staff and families to provide quality and evidence-based services, while staff at other schools say that the interns are disconnected from the community. There is concern these interns provide less effective services.

Chart 3: Number of Interns by School



[10] Interns supervised off-site are supervised by Berkeley Mental Health and Child Therapy Institute.

[11] Four of the sites without interns are run by BACR and one is run by Child Therapy Institute.

Variation in Funding. Tier 3 services vary greatly by school in part because of funding. Besides a small amount of base funding from the district, sites pay for counseling services through Medi-Cal, PTA, and School Governance Council (SGC) funds. The amount of school-based funding varies by site, as does the extent to which counselors are leveraging Medi-Cal.

Table 2: Funding for Counseling Services

Source	Amount
City of Berkeley*	$5,000[12]
District (LCAP)*	$5,000[13]
School Governance Council	$0 - $40,000
County (Medi-Cal)	$13,470 - $50,870
PTA Funds	Unknown

*Uniform amount for all elementary schools.

Clinical interns and licensed mental health counselors are both allowed to bill the county for services such as counseling through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). They may only bill EPSDT when students are on Medi-Cal, California's state insurance program for low-income legal residents. Roughly 41% of students in BUSD are low income, and therefore may qualify for Medi-Cal.[14]

One significant difference between the sites is how much they bill to EPSDT. From the data available, it appears that the amount a provider bills is not directly correlated with the number of Medi-Cal students on site. However it is difficult to know how much providers are billing because they do not need to report this data broken down by school site.[15] Furthermore there is no published data regarding what services are being provided with these funds.

Another huge difference across sites is the amount of outside funding they have for behavioral health services. A few sites dedicate significant School Governance Council (SGC) and PTA funds to behavioral health, which allows them to afford mental health counselors who can spend more time on group therapy, teacher and staff consultation, and work with non-Medi-Cal students. On the other hand, one school has no outside funding, and relies exclusively on Medi-Cal and its small amount of district money.

Educationally Related Mental Health Services (ERMHS). Another important aspect of Tier 2 and Tier 3 intervention for some students is ERMHS – mental health services provided to qualifying students who are enrolled in Special Education. ERMHS services include individual

[12] This money is intended for coordination of services, rather than direct service provision.

[13] This amount is projected in the LCAP to increase to $10,000 in 2015-16.

[14] "Low income" is measured by students receiving Free or Reduced Priced Lunch. Data comes from CDE for the 2013-14 school year. Not all of these students are Medi-Cal eligible.

[15] One provider, BACR, does provide this information to the county. Another, Berkeley Mental Health, only provides information on the total amount they bill across sites.

and group counseling. ERMHS differ from the counseling for students in General Education in that schools are required to provide them and the services are funded differently.[16]

Staff at all sites report that the process of securing ERMHS for a student is lengthy and bureaucratic. There is a lack of clarity at the school level as to who qualifies for services, how these services are accessed, and how they are funded. Many members of RTI teams, for example, did not know who their ERMHS provider was.

Until recently, provision of ERMHS was restricted to a few county-authorized providers. Due to recent changes, however there is more flexibility for the school-based mental health counselor to provide these services to some students.[17] This may present an opportunity for greater continuity of care, with a single school based behavioral health provider serving all students at a school.

2. Coordination Strategies

RTI teams meet weekly at all schools, and at elementary schools are led by an RTI coordinator. The RTI coordinator is a teacher on special assignment who is funded for 1-2 days of coordination per week.[18] These coordinators are tasked with coordinating intensive student cases for both academic and behavioral referrals, providing coaching to teachers, and, in many cases, providing interventions with students.

A concern expressed by RTI teams was that there has been little training for RTI coordinators. The district was unable to fill a part-time RTI District Coordinator position for the 2014-15 school year, so few district-wide meetings have been held. Some schools have still managed to maintain what we consider to be strong RTI practices, while others have struggled. For example, many teams are not reviewing student-level data systematically or recording interventions, key stakeholders such as the mental health counselor are not always present in meetings, the referral process can be informal or haphazard, and the RTI team is not always involved in school climate initiatives.

Physical health services are also notably absent at the elementary schools, with only one nurse for the entire district. The district nurse and Public Health coordinator note that when students are referred for physical ailments such as chronic asthma or headaches, other mental and behavioral health concerns often come up in the ensuing discussions with the students and their families. However, physical health staff lack the time to attend RTI meetings to discuss these concerns and have few resources to which they can direct families and students.

[16] The majority of the funding is from the County, although there is a 5% district match.

[17] Effective April 2015, these services can now be provided by authorized school-based providers to a maxium of two students per site. Memorandum from Children's Specialized Services to Special Education Departments, April 1, 2015. Subject: "Criteria Based Resource for ERMHS Students Eligible for Outpatient Services on School Sites."

[18] FTE depends on school size. Funding comes from LCAP Supplemental and Concentration Funds.

3. School-Wide Responsibility

It is important for all members of a school community to understand their role in supporting students. In BUSD, school climate initiatives such as "Toolbox" provide students, teachers, and administrators with a common language to discuss issues of student wellness. RTI teams meet to ensure that stakeholders work together to provide students with the support that they need, and staff who do not attend team meetings generally understand the referral process and how to get students further help. Additionally, a number of parents refer their students to the RTI team (although is unclear how many parents are aware of the formal referral process). The PBS teams that meet regularly at some schools also provide an opportunity to engage a wide range of stakeholders in Tier 1 behavioral health strategies.

An additional way of increasing school-wide responsibility is to have mental health counselors consult with other school stakeholders on behavioral health strategies. Many focus groups in BUSD stated that this is not happening because their counselors and interns are not fully integrated into the school community. Teachers do not regularly approach them when students struggle in the classroom. At a few schools, teachers were not aware there was a mental health counselor.

Mental health counselors and interns say that they have limited time to consult with families and staff, especially with the pressure to put in more billable hours and given the time Medi-Cal paperwork takes. All parties agreed that it would be beneficial to have more time for consultation, so that the work counselors were doing in groups or individually with students could be extended to the classroom and home. Mental health counselors were involved in designing behavioral interventions at RTI meetings at only a few sites. Their contributions were considered valuable by the rest of the team.

4. District Capacity

When asked in what ways they feel supported by the district, the first thing that most school staff referred to was training. The district has made a push to train staff district-wide both on Equity and PBIS.

Additionally, BUSD has formed a Mental Health Subcommittee made up of individuals involved with behavioral health across the district. This committee has met to share information and strategize about how to improve supports district-wide, and has been an important source of support for the current assessment.

Despite these strengths, there do appear to be distinct gaps in district-level infrastructure. Each school has created its own behavioral health system according to its own resources or sense of best practices. While to a certain extent this is necessary given that every school has its unique needs and climate, some principals expressed dissatisfaction with having to create these systems when they themselves were not trained extensively in behavioral health, and without knowing current best practices or even what other schools were doing. District staff expressed their frustration with not having a "unified vision of behavioral health" across the district to help create more cohesive support systems, including the use of evidence-based practices district-wide.

The second most cited district supports were behaviorists and district psychologists. The district has six behaviorists that are hired by the Special Education department to provide support in implementing Tier I programs, consultation for staff, and direct student behavioral health support. They are primarily meant to support students in Special Education, but they may also support the general student population. Behaviorists are stationed at the district office work with 2-3 schools each. The district also hires school psychologists, who focus mainly on assessment for Individual Education Plans (IEPs). School psychologists also work with 2-3 schools each.

A number of schools indicated that they were grateful for the support they received from these specialists in times of student crisis. Some also described useful trainings that the behaviorists led at their school. However, most of these schools also stated that the specialists did not have enough time to fully share their expertise with the rest of the school community. It was unclear to many RTI teams what the exact role of these specialists is, and how they can be called upon for support and follow-up. These concerns were confirmed by many of the specialists themselves. Despite a recent decrease in the number of schools served by each school psychologist, many expressed that it was still difficult to find time to build relationships with school communities, provide consultation, and be present at team meetings.

5. Cultural Responsiveness

In 2014-15 BUSD provided 3-day "cultural competency academies" for all schools to address the concerns with academic and behavioral disparities across racial and ethnic lines. The district also tried to focus on equity in trainings on other topics, such as "Culturally Sensitive PBIS." However, most sites requested more training on cultural responsiveness. In particular, staff mentioned wanting follow-up training or discussion on the equity trainings that they had participated in earlier in the year. In addition to trainings, many schools also track how the school is serving students of color by breaking down discipline and achievement data according to race and ethnicity during RTI and PBS team meetings.

There have also been recent attempts to reach out to parents and to make schools more welcoming for parents of color. This past school year, BUSD began funding part-time family engagement liaisons for all elementary schools. These liaisons generally work 1-2 days per week. Some, but not all, participate actively in RTI meetings, where students with the most intensive needs are discussed. They are frequently integrated into Tier I services such as Welcoming Schools or promoting Toolbox strategies for social-emotional growth. They have also helped to support English Learner Advisory Committees (ELACs) run by parents.

Despite these efforts, there are significant discrepancies across schools in family engagement, especially for parents of color. Many behavioral health staff members cited this as an area that their school needs to address. Schools vary widely in the number of parent activities, leadership or outreach positions created for parents, and groups specifically for parents of color that they offer.

An additional finding is that while some schools still have the "equity teams" that were rolled out across the district, others have stopped meeting or meet very infrequently. These teams

were created to focus on how schools can become a more healthy and supportive environment for students of color. There do not appear to be standardized practices for how these teams operate.

6. Ongoing Assessment

All RTI teams have at least an informal process for following up on student referrals and monitoring progress. The most common method is to have a conversation with teachers after six weeks of suggested interventions. Some schools cite using universal screening tools at the start of each school year, in which they look at progress indicators for each student systematically. These practices help staff identify students for early intervention before concerns arise.

Some schools also are beginning to standardize the way their mental health services are evaluated. One provider (BACR) recently began using the Child and Adolescent Health Needs and Strengths Assessment (CANS), an individualized, interactive assessment tool that monitors student progress over time and can be used to help evaluate service effectiveness. By 2015-16, most Alameda County SBBH providers will be using this program.

Many schools do not routinely evaluate the efficacy of their student supports, however. Some providers used to conduct student evaluations, but they discontinued this practice because the data was not considered robust (students tend to give the highest marks to all counselors). Only one middle school conducts routine evaluations.

There is also a lack of data at the school and district level regarding basic service provision. The district does not have information on how many students are being served by outside providers, what services they are receiving, and from whom. In addition, there is no clear data about how many students are waitlisted for services. This lack of data made it hard to gauge the level of need for this assessment. As for RTI team data, most schools did not have this information collected systematically, nor do most track demographic information.

Recommendations

After reviewing the data collected, we recommend the following actions. These actions will help BUSD to establish the core components of effective school-based behavioral health. Many of the recommendations have little or no direct cost, but will help build capacity and infrastructure. Other recommendations having to do with staffing, such as hiring a district coordinator or increasing behavioral health staff time at sites, do come with significant costs. However, we consider these staff members to be essential for schools' behavioral health.

Recommended Actions
1. Hire a district behavioral health Services and Positive Discipline Coordinator
2. Provide district-wide recommendations for mental health practices i
3. Clarify expectations for RTI and PBS Teams
4. Establish clear expectations for outside providers
5. Implement a tracking and accountability plan across the district
6. Build capacity of staff to understand the impact of behavioral health
7. Initiate intern programs at all sites
8. Develop district-wide best practices for family engagement
9. Establish a district-wide protocol for behavioral health crises
10. Increase transparency in behavioral health funding and service provision
11. Partner with Alameda County Center for Healthy Schools and Communities
12. Increase behavioral health staff time Option 1: District hires a full-time mental health counselor at each site Option 2: Increase funding for outside mental health providers Option 3: Share one Medi-Cal and one non-Medi-Cal mental health counselor between two schools Option 4: Increase funding for RTI teachers Option 5: Clearly define the roles of behaviorists and psychologists

1. Hire a district Behavioral Health Services and Positive Discipline Coordinator

Creating and sustaining effective behavioral health systems in a district requires significant effort, vision, and management. We therefore recommend that BUSD hire a staff person who will be responsible for overseeing behavioral health throughout the district, especially in the face of inevitable changes in staff and leadership.

The Behavioral Health Services and Positive Discipline Coordinator would help to put CHSC's seven "core components" of district engagement in place, including ongoing assessment, capacity building, school climate initiatives, and partnership building for increased sustainability. The coordinator's role would include responsibilities such as managing positive discipline practices like Restorative Justice, partnering with local service providers, managing grants and funding to make sure that resources are leveraged effectively, keeping the district up to date with research-informed practices, evaluating service quality and effectiveness, and providing support to schools. This coordination would be time consuming, and thus would be best to be full-time or combined with a complementary role. The coordinator would manage a point person from each site, such as the RTI coordinator or mental health counselor. This person would also have the opportunity to partner with CHSC, which would allow him or her to attend quarterly consultation meetings with other district leads and access resources.

2. Provide district-wide recommendations for mental health practices

Having district-wide recommendations for behavioral health practices is one way of helping all schools ensure that they are providing the supports their students need. Many schools in the district are already engaging in positive practices that support their students' behavioral health. However, there are significant differences in the extent that these are established and carried out, and some school administrators have expressed that they feel that they are "re-inventing the wheel" trying to create behavioral health structures and services at their schools without district-wide guidance and support around best practices.

The mental health subcommittee might make these recommendations with input from schools. If hired, the District Behavioral Health and Positive Discipline Coordinator should facilitate this process. Practices would be chosen based on their effectiveness in supporting students and promoting equity, and should include programs from all three tiers. For example, Tier 1 interventions might include Toolbox and components of PBIS; Tier 2 interventions might include check-in check-out and group counseling; and Tier 3 interventions might specify best practices for individual counseling and crisis management. This plan may also contain a list of school-wide practices such as Restorative Justice and Trauma-Informed practice, with recommendations for the frequency of related training. The district should be prepared to support schools in implementing and funding each of these recommendations.

3. Clarify expectations for RTI and PBS Teams

Coordination of care teams that focus on the needs of individual students are a vital component of positive behavioral health systems. Each middle and elementary school in BUSD currently has an RTI team, but there is a lack of clarity on the most effective practices for these meetings.

To support schools in ensuring quality coordination of care, the district should provide specific RTI recommendations related to behavioral health and provide related training for RTI coordinators. Recommendations may involve meeting format, frequency, participants, and topics for discussion. They may reflect best practices set forth in documents about inter-disciplinary support team meetings produced by BUSD (*BUSD Response to Instruction and Intervention*, 2012) and CHSC (*Coordination of Services Team Toolkit,* 2015). Primary recommendations from these works include:

1. Regularly scheduled meetings with a standing agenda
2. Interdisciplinary collaboration around service delivery, with participation likely including school leadership, members of Special and General Education, behavioral health professionals, family engagement coordinators, and other appropriate stakeholders
3. Data-informed decision-making and progress tracking, including data from universal screening, benchmark data, diagnostic assessment and/or specific classroom observations, and equity audit
4. Development of a universal intake and assessment process across the district, including an effective referral system (potentially simplified by e-mail referral submission process)
5. Focus on all three levels of the RTI pyramid and collaboration with PBS teams on school climate work

Schools might also be asked to submit information about the students they are supporting in RTI meetings to the district coordinator, so that the district is informed about recurring behavioral health issues that arise for students and is able to provide support.

PBS teams may meet with less frequency than RTI teams but should also be regularly scheduled. While they should still include school leadership, RTI coordinators and behavioral health leads, they may also include other members of the school community who might not be as involved in Tier 2 or 3 interventions (students, administrative support staff, cafeteria workers, etc). This team will focus exclusively on Tier 1. The team should look at school-wide data to help inform school climate goals and methods of achieving those goals.

4. Establish clear expectations for outside providers

There are significant differences in the services offered by mental health providers in the district. While not all schools need to receive the same array of services, there are some services that should clearly be provided at all sites. For example, all schools should have at least one mental health counselor on site during the week. It also makes sense for all schools to make use of interns when possible.

It became clear while conducting interviews that there may be a lack of understanding as to what services are desired by schools and the district and what the providers are able to offer.

The district should therefore define clear expectations for what it wants from outside providers, keeping in mind the core components of school-based behavioral health. These expectations might not only include district-wide procedures that have proven effective (such as teacher consultation, conducting group therapy, providing crisis response, etc.), but also that providers participate in monthly or quarterly meetings with district staff regarding services. The district should then come up with a Memorandum of Understanding with each provider outlining these expectations. Site agreements between schools and providers could be created to address site-specific needs.

5. Implement a tracking and accountability plan across the district

As BUSD works to sustain and grow its behavioral health systems and services, it is important that the district be data-driven in its decision-making so that it makes changes based on real need. Currently, the district only collects some basic data from schools, such as that included in the LCAP parent and student survey, the number of suspensions and absences, etc. To give a better picture of their services and growth areas, schools should be asked to report certain data yearly or semiannually, such as their caseload, number and type of referrals, provider information, etc. School mental health counselors may be requested to report how many students they see in individual therapy and groups each quarter, whether these students have IEPs or 504s, and how long these students have been receiving services. They might also be encouraged to disaggregate this information by race/ethnicity, and language proficiency. The district behavioral health coordinator or the Mental Health Subcommittee could partner with schools to determine areas of growth and create an action plan when gaps emerge.

6. Build capacity of staff to support students' behavioral health

It is important for all adults within a school to have a common framework for understanding behavioral health and know how they fit into their school's structure. Many teachers and administrators stated that they feel that school-wide work such as PBIS and building a trauma-informed climate are important, but that they did not have the support to incorporate it fully into their classrooms.

Our first recommendation for building this capacity is to focus on consultation: all behavioral health staff should have consulting with teachers and other staff as part of their job description, so that they serve as an active behavioral health resource.
The second recommendation is to increase and improve training. Trainings and/or discussions of PBIS, trauma-informed practices, and equity should be integrated more regularly into the district's schedule, so that practices around these centrally important themes become routine. In schools where Restorative Justice is being implemented, more training should also be provided. In all areas there needs to be a greater focus on follow-up. The district or school could provide refreshers on school-wide practices at staff meetings and create peer support systems for staff to encourage one another's continued growth. This is happening in many schools already, but not district-wide.

7. Initiate intern programs at all sites

Interns can be a cost-effective way of providing behavioral health supports to students. We recommend that the district help schools without internship programs in building this infrastructure. If the district successfully establishes a behavioral health staff member at each school (see Recommendation 12), this person would be able to supervise the school's interns. The district should support quality programs by making sure that interns are trained by licensed behavioral health staff, prioritizing communications with parents, providing teacher consultation, and attending district trainings related to behavioral health.

8. Develop district-wide best practices for family engagement

Families are vital to students' learning, and connections between families and the school are essential. BUSD can build on some of its schools' strengths in family engagement to develop district-wide best practices. These may include guidelines and supports for active parent advisory committees, having at least two school community events per semester that parents are encouraged to attend, and expecting mental health providers (including interns) to attempt to contact their clients' guardian(s) at least once a month. There should also be recommendations regarding how to tap into parent resources, for example partnering with parents to coordinate events or conduct outreach to other parents. These guidelines could be developed by the district Family Engagement Coordinator in conjunction with the family engagement liaisons, the Mental Health Subcommittee, and the district's Behavioral Health Services and Positive Behavior coordinator.

9. Establish a district-wide protocol for behavioral health crises

Even with the best behavioral health supports, crises may arise in which students need more intensive services. Currently, schools within the district respond to these crises in a variety of ways, with varying degrees of involvement for both parents and outside resources such as the Mobile Crisis Team and police. Teachers express that they are not always well informed about how to respond at these times. In order to ensure that all staff know what steps to take to maintain safety during a behavioral health crisis, the district should develop a consistent protocol across schools and ensure that school staff are thoroughly trained in that protocol. This might be modeled on CHCS's comprehensive crisis response manual.

10. Increase transparency in behavioral health funding and service provision

One concern that arose in conversation with multiple stakeholders is that funding for behavioral health supports comes from multiple sources, and many sites do not know if they are leveraging all available resources. The district, through the behavioral health coordinator, could help build transparency in the following ways. First, it could share information regarding outside providers' pricing structures, so that sites are making informed decisions about the providers they choose. Second, it could share information about how much each site spends

on behavioral health services from their SGC and PTA funds, and on what services, since school leadership teams would benefit from knowing the service mix at other sites. Third, the district could look into collecting more specific data about how much EPSDT (Medi-Cal) is billed at all sites. As explained in the findings, not all providers break their EPSDT bills down by school, nor do they provide estimates for how many students are potentially eligible for services at these schools. A comparison of this information would help schools see whether there is an opportunity to leverage more EPSDT funding. Finally, the district coordinator and the Special Education department should consider doing some outreach to RTI teams to clarify the ERMHS process: who qualifies, how these services are provided and funded, and who should provide them.

11. Partner with Alameda County Center for Healthy Schools and Communities

As stated previously, CHSC has extensive experience in helping to create and support behavioral health systems and services in school districts throughout Alameda County, and has helped to establish the SBBH core components in other districts. BUSD may choose to partner with CHSC in order to consult and share resources, from MOU drafts for providers to Medi-Cal data to crisis procedure protocols. CHSC may also be able to support with developing the job description for various mental health employees, sample expectations for RTI/Coordination of Services Teams, and developing expectations for providers, as well as providing training and support for the Behavioral Health Services and Positive Discipline Coordinator.

12. Increase staff time for school-based mental health providers

The main finding of this assessment was that schools want one person who is consistently available to provide behavioral health services and coordination on-site. This mental health counselor should be able to serve students regardless of whether they qualify for Medi-Cal. He or she should also be able to communicate with other staff and parents about these students' needs, build capacity through supervising interns, and support school climate initiatives. Because most counselors do not currently have the time or flexibility to attend to these responsibilities, we recommend that the district increase funding for mental health counselors. The following staffing options would each address this need. Options 1-3 are alternative ways to increase mental health counseling time and are mutually exclusive. Options 4-5 – increasing RTI teachers' FTE and clearly defining the role of the psychologists and behaviorists – should be considered if mental health counseling time is not increased.

The options listed first are those that we believe would have the greatest potential impact. They are also the most costly. If the district is not independently able to fund the proposed staff increases, one possibility is having School Governance Counsels (SGCs) and Parent Teacher Associations (PTAs) provide matching funds. The district could provide a certain amount of funding (e.g. 50% of the cost of a counselor) if the SGC or PTA provide the rest of the funding. This would give schools that do not currently spend much of their SGC money on behavioral health a greater incentive to do so.

Option 1: District hires a full-time mental health counselor at each site

Having a district-funded mental health counselor is the preference of most schools. It is also the option with the highest cost. A district-hired mental health counselor would be able to see any student at a school, whether or not the student has Medi-Cal or qualifies for Special Education. If hired full time, the counselor could also do family outreach and manage coordination of care for students with behavioral health issues. This counselor would also be able to observe and consult with teachers more often than counselors are currently able to, since their non-billable time is limited. A district staff person would offer greater continuity from year to year than staff from an outside agency, since the district tends to have less turn-over than outside hires. This person would also be more accountable to the district than someone hired from outside.

Each of the elementary schools would benefit from more unrestricted counseling time. Each of the three middle schools already have a full time mental health counselor, but more mental health staff time should be considered for these sites as well, since they are much larger and student needs tend to be more acute in middle school.

The main concern with a district-hired mental health counselor is that this person would not be able to bill EPSDT (Medi-Cal). EPSDT funding makes up the majority of most schools' billing, so moving to a district-hired mental health counselor would greatly increase costs. However, since EPSDT billing takes up a great deal of some counselors' time, the district counselor would have much more time for other work.

Option 2: Increase funding for outside mental health providers

Increasing funding for outside mental health providers would increase the flexibility of mental health staff currently operating in schools. One problem with the current staffing arrangement is that most mental health counselors need to prioritize Medi-Cal students, who pay their bills. If the district paid for a greater part of their salary, it would allow staff to offer more individual and group therapy to non-Medi-Cal students, take a greater role in coordination of care, and consult more with teachers and families.

For most schools, increasing funding for outside providers would be the simplest solution, so long as those staff members are able to increase their FTE. Schools that currently share a single mental health counselor would need to add a staff member. Only one school does not have at least a part-time licensed mental health counselor, and would need to initiate a new contract. This option would allow the district to continue billing EPSDT, but would also require new funds, because the mental health counselor would now spend more time on non-billable work.

Option 3: Share one Medi-Cal and one non-Medi-Cal mental health counselor between two schools

In this option, two partner schools would share a district-hired mental health counselor and a mental health counselor from an outside provider who could bill EPSDT. The two counselors would split their time between the two schools. The outside provider would see mostly Medi-Cal students and the district mental health counselor would see non-Medi-

Cal students and perform other duties. These staff members might both attend weekly RTI meetings, but split other responsibilities such as IEP meetings. The district-hired staff person would act as the point person for the district coordinator.

This option might be preferable to Option 2, increasing district funding for outside providers, if having multiple funding sources for a single position proves too logistically challenging for accountability purposes. The tradeoff is that in splitting their time between two schools, the counselors would have less time to get to know each school's students, families, and staff members.

Option 4: Increase funding for RTI teachers

If mental health counseling time is not increased, a less costly option for addressing some of the concerns expressed in the findings would be to increase the FTE of schools' current RTI teachers (they are currently in this role for 8-16 hours per week). This would allow schools to spend more time on service coordination, teacher consultation, and family outreach through this point person. If this option is pursued, the RTI teachers' job description should be refined to include expectations for their newly expanded role.

Increasing the RTI coordination time would improve care coordination, but would not address concerns such as counseling waitlists, mental health counselors' ability to serve non-Medi-Cal students, or counselors' ability to consult with teachers or parents.

Option 5: Clearly define the roles of behaviorists and psychologists

There was almost unanimous agreement among behaviorists, school psychologists and school staff that the district specialists should have more time to engage with schools and share their expertise. The first step to achieving this may be for Special Education and Student Services to work together to make sure that job descriptions for both roles are clarified. These roles should include consultation with staff and attendance at certain collaborative meetings. Descriptions of the roles should be shared with school sites and provide clarity on the specialists' ability to work with students outside of Special Education.

One possible scenario would be to have the behaviorists staffed at school sites rather than the district office, with each behaviorist responsible for two schools. This would allow them to get to know students, families, and school staff better. If the behaviorists were staffed at schools, they might be able attend to the responsibilities of the district mental health counselor suggested in Staffing Option #3: Share One Medi-Cal and One Non-Medi-Cal mental health counselor between two schools.

We also recommend that school psychologists spend more time on consultation with teachers and families beyond the formation of IEPs. One way to do this would be to incorporate them routinely in RTI meetings. Psychologists" testing caseload should be kept at a level that allows them to spend a certain number of hours in consultation.

Next Steps

As explained in the introduction, this needs assessment is only the beginning of BUSD's work in moving its behavioral health system forward. In the coming months, the Mental Health Subcommittee should identify priorities for the district. Part of this process will be presenting material to district leadership and the school board to make sure that key stakeholders recognize the importance of this work. Another important next step will be disseminating the findings of this study to school and community members and other stakeholders.

To start, we recommend that the district prioritize the following actions:

1. Hire a Behavioral Health Systems and Positive Discipline Coordinator. This person can help oversee the work that will be done in all of the recommended areas.
2. Partner with the Center for Healthy Schools and Communities. It will take time and capacity-building to implement all of these changes. CHSC can provide useful resources to facilitate the start of the coordinator's work.
3. Continue with regular Mental Health Subcommittee meetings. The subcommittee should begin developing some of the guidelines suggested in our recommendations, such as an MOU for outside providers, expectations for RTI teams, and guidelines for district-wide behavioral health practices.

The district and subcommittee members are clearly committed to the goal of creating effective behavioral health systems and services that support all BUSD students. We look forward to seeing them make this goal a reality.

Appendix A:
Focus Groups and Interviews Conducted

Focus groups

- District behaviorists (6 participants)
- School psychologists (6 participants)
- Students (3 groups with 5-15 students each)
- RTI teams (at each of the 11 elementary and 3 middle schools)
    - Principals and RTI coordinators (all schools)
    - Family Engagement Liaisons (# schools)
    - Mental health counselors (# schools)
- Parents (2 group meetings to share findings and receive feedback)

Interviews

- Teachers (7 interviews)
- Parents (3 interviews)
- Community Based Mental Health Directors (Bay Area Community Resources, Berkeley Mental Health, and Child Therapy Institute)
- School-based mental health counselors
- BUSD Director of Student Services
- BUSD Directors of Special Education
- BUSD Coordinator of PBIS
- Alameda County Center for Healthy Schools and Communities
- Coordinators of San Leandro's Behavioral Health Needs Assessment

Appendix B: Additional Data Sources

1. California Healthy Kids Survey (2013-14 and 2011-12 surveys of elementary and middle school students)
2. Student Satisfaction Survey (adapted from the CHSC Client satisfaction survey) administered by providers at 2 middle schools
3. Medi-Cal billing data from the County and outside providers
4. SGC Reports

Appendix C:
Sample Interview Questions

Interview Questions for RTI Teams

1. How long have each of you been in your current role?
2. What are the most pressing behavioral health needs facing students in the school? How are those needs being addressed?
3. Of the three tiers of services you described in your survey response, what do you see as your school's primary strengths? What do you see as needing improvement?
4. Are there any mental health service providers you work with in the community? How are they integrated into the school community?
5. Is there an identified lead person who coordinates supports related to student wellness? What does that person do?
6. When do you meet to discuss individual students, and how often? Who attends these meetings?
7. How are students referred to services? How are staff and families informed about this process?
8. Is there a system in place to follow up on referrals? How is it working?
9. How does the school assess the effectiveness of its behavioral health services?
10. How does the school involve families in the behavioral health supports and services it offers?
11. In what ways do students engage with creating a positive school community? What additional resources or opportunities could increase student engagement?
12. How does district staff help to support school-based programs?
13. If your school were allotted another $10K each year, what would you invest in?

Works Cited

Adelman, H. a. (2010). *Mental Health in Schools: Engaging Learners, Preventing Problems, and Improving Schools.* Thousand Oaks, CA: Corwin.

Alameda County Center for Healthy Schools and Communities. (2013). *San Leandro Behavioral Health Needs Assessment.* San Leandro Public Schools and Alameda County CHSC, San Leandro.

Center for Healthy Schools and Communities. (Forthcoming). *School-Based Behavioral Health Assessment.* San Leandro: Center for Healthy Schools and Communities.

Centers for Disease Control and Prevention. Youth Risk Behavior Survey, 2007.

Copeland, W.E., G. Keeler, A. Angold, E.J. Costell (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, *64* (5), 577-584.

Dryfoos, J. (1990). *Adolescents at Risk: Prevalance and Incidence.* New York: Oxford University Press .

Dryfoos, J. (2007). *Evaluation of Community Schools.* Carnegie Foundation.

Kaiser Permanente (1998). The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction. *American Journal of Preventive Medicine*, *14*, 245–258.

Makeoff, D. (2004). *Group Work with Adolescents: Principals and Practice.* New York: Guilford Press.

Massachusetts Advocates for Children (2005). Helping Traumatized Children Learn. http://www.bvsde.paho.org/bvsacd/cd41/learn2.pdf

National Institute for Mental Health. (2015). *National Institute for Mental Health*. Retrieved Jamuary 26, 2015 from Chldren and Adolescent Mental Health: http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml.

Picus, L., & J. Wattenbarger. (1996). *Where does the money go? : resource allocation in elementary and secondary schools.* Thousand Oaks, CA: Corwin.

Poston, W. (2011). *School budgeting for hard times : confronting cutbacks and critics.* Thousand Oaks, CA: Corwin.

Rathvon, N. (2008). *Effective School Interventions* (Second ed.). New York: The Guilford Press.

Schear, T. and L. Warhuus (2007). *Schools Mental Health Partnership Strategic Plan.* Berkeley Mental Health Initiative, Berkeley.

Shaffer, D., P. Fisher, M.K. Dulcan, M. Davies, J. Piacentini, M.E. Schwab-Stone, et al. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptibility, prevalence rates, and performance in the MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 865-877.

Star-Witortt, K. T. (2008). *Universal Learning Support System: 2007-8 Process Evaluation Report.* Berkeley: Berkeley Mental Health Initiaitive .

Tough, P. (2012). *How Children Succeed: Grit, Curiosity, and the Hidden Power of Character.* New York: Houghton Mifflin Harcourt.

UCLA Center for Mental Health in Schools, Program and Policy Analysis. (2015). *Center for Mental Health in Schools*. Retrieved January 26, 2015 from 2015 National Initiative for Transforming Learning Supports: http://smhp.psych.ucla.edu/.

Wolpow, R., Johnson, M., Hertel, R., Kincaid, S. (2011). The Heart of Learning and Teaching: Compassion, Resiliency, and Success. http://k12.wa.us/CompassionateSchools/pubdocs/TheHeartofLearningandTeaching.pdf

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, May 11, 2022 11:20 AM
To: Works-Wright, Jamie
Subject: FW: Understanding Grief and the Grieving Process - Community Workshop - Thursday, May 12th
Attachments: Grief & Loss Community Webinar - 2022 (1).pdf

Internal

Please see flyer.

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: White, Barbara Ann
Sent: Wednesday, May 11, 2022 10:33 AM
To: All Mental Health <AllMentalHealth@cityofberkeley.info>
Subject: Understanding Grief and the Grieving Process - Community Workshop - Thursday, May 12th

FLYER ATTACHED - FREE COMMUNITY WEBINAR

Understanding Grief and the Grieving Process

THURSDAY, MAY 12, 2022 5:00 pm - 7:00 pm

Every family — every person — will at some point have to deal with the pain of losing a loved one. Grief is universal. Yet, it's something we don't like to talk about.

REGISTRATION LINK:
https://us02web.zoom.us/webinar/register/WN_6DJGd28UQoqYsWFZp7CLpg

Join Jaymie Byron, MFT of the non-profit organization, Kara, as she discusses how to meet and accept the painful feelings of grief — both yours and others. Learn about what it means to grieve and how you can be a companion to someone who's grieving. Often, we want to take away the pain, but a more helpful approach is to be willing to enter into another person's grief and difficult feelings.

WE WILL DISCUSS:
- The fundamentals of grief & mourning
- How to bust some of the myths around grief
- How to best support someone who is grieving using a concept called "companion grief" and "How families can support young children with grief"

Barbara Ann White, **MA**

Training and Diversity & Multicultural Coordinator

City of Berkeley Mental Health

3282 Adeline Street

Berkeley, CA 94703

510-981-7646 (Office)

510-833-0843 (Cell)

bawhite@cityofberkeley.info

#RacismIsAPublicHealthCrisis

FREE COMMUNITY WEBINAR

Understanding Grief and the Grieving Process

THURSDAY, MAY 12, 2022

5:00 pm - 7:00 pm

Every family — every person — will at some point have to deal with the pain of losing a loved one. Grief is universal. Yet, it's something we don't like to talk about.

REGISTRATION LINK:
https://us02web.zoom.us/webinar/register/WN_6DJGd28UQoqYsWFZp7CLpg

Join Jaymie Byron, MFT of the non-profit organization, Kara, as she discusses how to meet and accept the painful feelings of grief — both yours and others. Learn about what it means to grieve and how you can be a companion to someone who's grieving. Often, we want to take away the pain, but a more helpful approach is to be willing to enter into another person's grief and difficult feelings.

WE WILL DISCUSS:

- The fundamentals of grief & mourning
- How to bust some of the myths around grief
- How to best support someone who is grieving using a concept called "companion grief" and "How families can support young children with grief"

ABOUT OUR EXPERT:

Jaymie Byron, LMFT is the Director of Community Outreach and Education for Kara. Her work at Kara over the past 7 years has been focused on supporting those in the initial wake of grief. Jaymie manages and maintains the crisis response team for Kara that supports schools, organizations, first responders, and large families in the wake of crisis. Within her capacity at Kara, Jaymie has extensive experience working directly with clients impacted by and processing the death of a significant relationship. Jaymie has an MA in counseling psychology from the University of San Francisco and a BA from UC Santa Barbara in Economics and Global Studies. Prior to her work at Kara, Jaymie served in the United States Peace Corp from 2010-2012 in the Dominican Republic.

HOSTED BY:

CITY OF BERKELEY

Mental Health Division

HEALTHY BLACK FAMILIES, INC.

Sisters Together Empowering Peers (STEP)

Kara
Grief Support for Children, Teens, Families & Adults

For information contact: bawhite@cityofberkeley.info or step@healthyblackfamiliesinc.org

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, May 9, 2022 3:14 PM
To: Works-Wright, Jamie
Subject: FW: Regional Election - 2022-24 CALBHB/C - Please share with MH/BH Board/Commission Members

Please see email below

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: CAL BHBC <cal@calbhbc.com>
Sent: Thursday, May 5, 2022 2:06 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Regional Election - 2022-24 CALBHB/C - Please share with MH/BH Board/Commission Members

California Association of Local Behavioral Health Boards and Commissions

All current CA local mental/behavioral health board and commission members are invited to cast votes in the CALBHB/C Governing Board Election for their region. Due to the number of open positions and the number of candidates, this year's election is a *formality.*

Bay Area Ballot Link: https://forms.gle/TrrVaifyKkwZGwtTA

www.calbhbc.org Newsletter Resources

CA Association of Local Behavioral Health Boards & Commissions (CALBHB/C) supports the work of California's 59 local mental and behavioral health boards and commissions.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, May 4, 2022 9:46 AM
To: Works-Wright, Jamie
Subject: FW: MHSA Community Input Meetings
Attachments: MHSA FY23 Flier Annual Update Community Input Meetings copy 2.pdf

Hello Commissioner,

Please see the message below and the flyer

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Klatt, Karen
Sent: Wednesday, May 4, 2022 9:23 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: MHSA Community Input Meetings

Hi Jamie,

Can you please forward this email to the Commissioners?

Thanks much!

Karen

Greetings MH Commissioners!

Attached you will find a revised flier with information on five upcoming MHSA Community Input Meetings that will be held on the Zoom platform. I have added three evening meetings. The Community Input Meetings are being held to provide information and obtain input on current and proposed services in the MHSA FY23 Annual Update. The meeting information is also outlined below:

Meeting Dates/Information
Thursday, May 5: 11:00am-12:30pm
Tuesday, May 10: 1:00pm-2:30pm
Wednesday, May 11: 6:00pm-7:30pm
Thursday, May 12: 6:00pm-7:30pm
Monday, May 16: 6:00pm-7:30pm

Join Zoom Meetings at: https://us06web.zoom.us/j/8446733966?pwd=OGp3Tm5LQTc5TGdhb2tYWllKcDVhdz09
Or call into Zoom Meetings: 1 (669) 90-6833
Meeting ID: 844-673-3966
Password: 081337

Please share widely with anyone who you feel would be interested in providing input into this process!

Thanks much,

Karen

Karen Klatt, M.Ed.

MHSA Coordinator

City of Berkeley, Mental Health Division

1521 University Ave., Berkeley CA 94703

(510) 981-7644 – Office

(510) 849-7541 – Cell

KKlatt@cityofberkeley.info

JOIN A COMMUNITY ZOOM MEETING TO LEARN ABOUT, AND INFORM, CITY OF BERKELEY MENTAL HEALTH SERVICES ACT (MHSA) FUNDING AND SERVICES!

MHSA LEGISLATION PLACES A 1% TAX ON PERSONAL INCOMES ABOVE $1 MILLION DOLLARS. FUNDS ARE DISTRIBUTED TO MENTAL HEALTH JURSIDICTIONS BASED ON THE POPULATION IN A GIVEN AREA. ANNUAL FUNDING IS LOCALLY PROVIDED IN THE FOLLOWING AREAS:

COMMUNITY SERVICES & SUPPORTS (CSS): PROVIDES TREATMENT SERVICES AND SUPPORTS FOR SEVERELY MENTALLY ILL ADULTS AND SERIOUSLY EMOTIONALLY DISTURBED CHILDREN.

PREVENTION & EARLY INTERVENTION (PEI): FOR STRATEGIES TO RECOGNIZE EARLY SIGNS OF MENTAL ILLNESS; TO IMPROVE EARLY ACCESS TO SERVICES AND PROGRAMS; AND TO PREVENT MENTAL ILLNESS FROM BECOMING SEVERE AND DISABLING.

INNOVATIONS (INN): FOR SHORT-TERM PILOT PROJECTS TO INCREASE NEW LEARNING IN THE MENTAL HEALTH FIELD.

MEETINGS ARE BEING CONDUCTED TO ELICIT COMMUNITY INPUT ON THE PROPOSED MHSA FY22/23 ANNUAL UPDATE FUNDS, AND ON NEW IDEAS AND STRATEGIES TO ADDRESS MENTAL HEALTH NEEDS IN BERKELEY.

Meeting Dates/Information:

Thursday May 5: 11:00am -12:30pm
Tuesday, May 10: 1:00pm-2:30pm
Wednesday, May 11: 6:00pm-7:30pm
Thursday, May 12: 6:00pm-7:30pm
Monday, May 16: 6:00pm-7:30pm

Join Zoom Meetings at:
https://us06web.zoom.us/j/8446733966?pwd=OGp3Tm5LQTc5TGdhb2tYWllKcDVhdz09
Or call into Zoom Meetings:
1 (669) 900-6833
Meeting ID: 844-673-3966
Password: 081337

*If you are calling into the meeting and would like a copy of the PowerPoint Presentation that will be shown, please contact Karen Klatt.

For more Information contact:
Karen Klatt (510) 849 -7541
KKlatt@cityofberkeley.info

**To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services Specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date.