



CONTRA COSTA
MENTAL HEALTH
COMMISSION

1220 Morello Ave., Suite 100
Martinez, CA 94553

Ph (925) 957-2619

Fax (925) 957-5156

cchealth.org/mentalhealth/mhc

Executive Committee

Tuesday, November 26, 2019 ♦ 3:30-5:00pm

At: 1220 Morello Avenue, Suite 100 Conference Room, Martinez, CA

- I. Call to order/Introductions**
- II. Public comments**
- III. Commissioner comments**
- IV. Chair announcements**
- V. APPROVE minutes from September 24, 2019 meeting**
- VI. DISCUSS status of the nominating process and the 2020 slate with Warren Hayes or Alexander Ayzenberg**
- VII. CREATE work plan for completing the 2019 CA Behavioral Health Planning Council Data Notebook presented by Barbara Serwin**
- VIII. CREATE work plan for completing the 2019 MHC Annual Report presented by Barbara Serwin**
- IX. REVIEW MHC Commissioner orientation and training curriculum with Warren Hayes or Alexander Ayzenberg**
- X. SHARE information on the newly resurrected Behavioral Health Care Partnership presented by Barbara Serwin**
- XI. Adjourn**



The Contra Costa County Mental Health Commission is appointed by the Board of Supervisors to advise them on all matters related to the county's mental health system, in accordance with mandates set forth in the California State Welfare & Institutions Code, Sections 5604 (a)(1)-5605.5. Any comments or recommendations made by the Mental Health Commission or its individual members do not represent the official position of the county or any of its officers. The Commission is pleased to make special accommodations, if needed, please call ahead at (925) 957-2619 to arrange.

Mental Health Commission Annual Report 2018

Submitted by Chair, Barbara Serwin

Theme

The theme of 2018 was integration and collaboration between the Mental Health Commission (MHC) and Behavioral Health Services (BHS), following two years of intensive conflict, negotiation and problem solving. From the MHC perspective, this theme has ultimately led to a much closer-knit and trusting working relationship, while still respecting the MHC's role as a mandatory and objective observer of Contra Costa County's system of care and advisor to the Board of Supervisors (BOS) on matters related to mental health in our county.

Below are key examples of the current integrations between the MHC and BHS:

- The collaborative MHC retreat (see description below)
- Monthly report outs at Commission meetings by Acting Director Dr. Mathew White
- Steady attendance by Anna Roth, Director of Health Services and/or her team members, Erika Jennsen and Duffy Newman
- Monthly meetings between the MHC Chair and Vice Chair and the BHS Director and leadership team
- Assignment of BHS resources one hundred percent committed to supporting the MHC in the way of our new Executive Assistant, Sarah Kennard, and the new role of MHC Liason, filled by Warren Hayes, who is part of the BHS Leadership Team and provides a deep history and knowledge of current BHS and MHSA activities.

2018 MHC Retreat

The 2018 MHC retreat introduced a new concept of a collaborative and interactive learning event based on close involvement of BHS and Health Services. The theme of the retreat was "Communication, Collaboration, and Trust". It had the goal of integrating Behavioral Health Services staff with the Commission and developing more trust and more understanding of each other's positions and roles and responsibilities. The event was attended by members of the Health Services leadership team and the BHS leadership team and a broad range of BHS staff.

Responded to BOS Family and Human Services (FHS) Committee Referrals 115 and 116 Reports and Grand Jury Report No. 1703

At the end of 2017 the Commission reported to the BOS FHS Committee regarding responses to the MHC White Paper and BHS Grand Jury Report response. This discussion resulted in the FHS Committee, chaired by Supervisors John Gioia from District I and Supervisor Candace Andersen from District II, requesting an ongoing six-month updates from BHS services on the issues put forth in the White Paper and Grand Jury Report.

Between the end of 2017 and April 2018, the MHC and BHS engaged in ongoing working meetings regarding problem-solving potential solutions for the relating to the challenges that the BHS was facing. In late Spring of 2018, the MHC and BHS gave a joint update to the FHS

Committee that reported on our further developing collaborative working relationship, progress made by BHS and plans for further improvements. The report ended with the joint recommendation that updates to the BOS FHS Committee were no longer necessary from the BHS point-of-view, pending consistent, ongoing internal dialog between the MHC and BHS, which the FHS Committee accepted.

Continued Advocacy for Increase Number of Psychiatrists and Decreased Wait Times

The Commission continued to direct much attention to advocating for an increase in the number of psychiatrists and a decrease in wait times at county clinics. The Commission pressed for consistent progress reports from BHS, which were provided. The Commission also worked jointly with BHS to report on this area to the BOS FHS.

Continued Tracking on the West County Mental Health Detention Expansion

The Commission continued to track on efforts to expand West County Mental Health Detention. We heard updates from Assistant Sheriff Schuler and Captain Tom Chalk and participated in the series of *Detention Rapid Improvement Events* sponsored by Health Services.

Advocating For a Mandatory PES Evaluation in Cases of Violent Consumer Behavior

Throughout the year, the Commission advocated for requiring a medical evaluation at PES of consumers who pose harm (immediate or potential) to themselves or others at the scene of a call for an involuntary hospitalization (5150). We sought to find the best avenue to influence the policy of the Sheriff's department and the countywide police force towards this policy. Our current strategy is to work with the director of the county Crisis Intervention Team, Chief Brian Bothran, to potentially train officers on this approach.

Participation in Rapid Improvements Events

One of the most exciting efforts that the MHC learned from and participated in was the Rapid Improvement Events moderated by Erika Jenssen, Assistant to Health Services Director of Contra Costa County and Chris Farnitano, Health Officer of the county. The MHC gained a general overview of the value and workings of RIE's and participated as part of the leadership that gave feedback to the RIE teams each day of their week-long events and attended some of the tours of facilities related to the RIE's. The RIE's that the MHC participated in were:

- The Value Stream Mapping process for Detention Mental Health
- Detention RIE events
- Value Stream Map for BHS
- Redesigning the First Visit RIE
- Standardizing Screening and Scheduling RIE

Varied Discussion Topics and Updates

- ECAMH registered nurses addressed Patient Safety concerns and the lack of protection for mental health professionals with respect to the current mental health crisis in our community, Therese Becker, AMFT
- Community Connect Program which aims to connect consumers and families to community services, Emily Parmenter, Program Manager
- Discussed BHS efforts relating to housing for the seriously mentally ill, led by Dr. Jan Coboleda-Kegler, Program Chief for Adults and Aging Adults
- Discussed Network Adequacy Standards, which is a review of a mandatory analysis of the distribution of mental health services in our system of care compared to the metrics of comparably-sized counties in California, Mathew Luu, Deputy Director of BHS
- Learned more about the new BHS Adult Mobile Crisis Response Team, which aims to reduce suicides and PES hospitalizations, de-escalate crises, and initiate 5150s as needed, Mobile Crisis Team
- Learned more about the Child and Youth Mobile Response Team, which aims to minimize police involvement or hospitalization during incidents of crisis, Seneca Family of Agencies
- Updated on the San Pablo building for the West County clinic, by Contra Costa Health Services Planning and Evaluation Staff, West County Behavioral Health Center

Advocacy for Children’s Residential and Tay Residential Programs

The Commission continued to consistently advocate for children’s and Tay residential programs. We discussed a new BHS proposal for a children’s program with Warren Hayes (now on the back burner for good reasons) and the new Tay program moving forward in the Oak Grove county property.

Review of the Mental Health Services Act (MHSA) Activities and Budget

The MHC reviewed the MHSA activities and budget on multiple occasions as presented by Warren Hayes, MHSA Program Manager. In addition to hearing multiple updates, the Commission hosted the Public Hearing on the MHSA Three Year Plan update.

Change in By-laws

The Commission updated its bylaw regarding attendance and the formation of a quorum. At the committee level we now permit the Chair or Vice Chair to represent absent Commissioners, thereby permitting a quorum to be more easily formed. This in turn increased the capacity of work by the Committees.

Implemented Motion Track

The Commission implemented a “Motion Tracker” to record in one place motions made at the Commission and Committee levels, thereby, at a glance being able to see which motions have been executed, which haven’t, who is responsible for leading the efforts of incomplete motions, etc. This tool enables the Commission to track on progress and move along completion of its commitments.

Formed Ad Hoc Data Committee

The Commission formed an ad hoc Data Committee to illicit the informational needs of the Commission. This was in response to efforts by BHS to provide standardized reporting on key benchmarks of BHS system of care performance. Defining our own informational needs has been a thoughtful, and rewarding process. This important endeavor is led internally by Commissioner Joe Metro and externally by the BHS driver of the data and reporting definition effort, Warren Hayes.

Interaction With CALBHC

The MHC learned more about statewide mental health issues, training, resources, etc. tracked by the CALBHC/C from Theresa Comstock the CALBHC/C President. The MHC Chair also attended the CALBHC/C Bay Area April regional meeting and participated in a call with other statewide MHC chairs regarding challenges and lessons learned in other counties. The urgent issue of disaster planning was called out, a topic that the MHC will study more in 2019 for our county.

Membership Update

- *Current Number of Commissioners:* 11 of 16 (5 open seats)
- *Current Commissioners:* Barbara Serwin, District II, Diane Burgis, County Supervisor District III, Geri Stern, District I, Diana Makeover, District II, John Kincaid, District II, Douglas Dunn, District III, Tasha Kamegai-Karadi, District IV, Sam Yoshioka, District IV, Leslie May, District V, Joe Metro, District V, Gina Swirsding, District I
- *Changes in Membership:*
 - Duane Chapman, District I, who sadly passed away in December, after two years acting as Chair and strong advocacy for West County
 - Lauren Rettagliata, District II, who advocated tirelessly for housing for the seriously mentally ill, was co-author of the *White Paper* and major contributor to working with BHS to improve our system of care
 - Meghan Cullen, District V, Patrick Field, District III, Michael Ward, District V
 - Julie Neward, District III (pending formal de-commissioning)
- *Challenges in Recruitment:* Supervisor Burgis stated it well that for Supervisors, it is difficult to fill vacancies, specifically when there are certain requirements attached to them. This translated to as many as five open vacancies on the Commission at any given time, reducing capacity for representation of our community and for conducting the work of the Commission.

Committee Reports

Annual Report 2018 Justice Systems Committee

- Participated in and/or observed the following advisory body meetings that help set and or implement the strategies of justice for adults and juveniles with mental illness in our County:
 - Community Corrections Partnership CCP (Quarterly)
 - Community Advisory Board CAB (Monthly- advisory to CCP)
 - Continuum of Care (Quarterly)
 - Council on Homelessness (Monthly)
 - Juvenile Justice (Monthly and meets in conflict with the MHC)
 - Assisted Outpatient Treatment. (Quarterly)
- Partnered with Behavioral Health and Detention by participating in or observing the feedback of Rapid Improvement/Value Stream Mapping Events, impacting the receipt of treatment and care of those in Detention or upon their release.
- Received information from Behavioral Health, Detention, Juvenile Justice and Office of Reentry and Justice to be informed about current operations as well as new programs funded through Prop 47 and AB109, including Antioch's diversion program and reentry programs to connect individuals with programs and services upon reentry to avert future involvement in the criminal justice system. We also received information about our CORE Teams, MHET program, the Adult Crisis Response Team, Children's Crisis Response Teams, and Assisted Outpatient Treatment (AOT) program.
- Took the first step to begin identifying areas of interest for a Detention/Office of Reentry and Justice, Data Dashboard, from the perspective of the Mental Health Commission.
- Advocated for fully implementing and funding the Office of Reentry and Justice with a letter of support to the Board of Supervisors.
- Tour of Juvenile Hall to more fully understand the integration of mental health treatment, continuing education, and safe and nurturing environment while incarcerated.

Quality of Care Committee 2018 Annual Report

- Continued to review consumer advocacy and grievance procedures of Behavioral Health. Learned about some of the practices used by CCRMC in an effort to look for ways to learn from other successful systems. Advocated for the improvement of the problem resolution process and resources used at PES and 4C with the goal of bringing them more into alignment with those of the rest of CCRMC. Proposal to conduct a customer satisfaction survey and/or talk directly to consumer and family to measure satisfaction with the Behavioral Health Services problem resolution process.
- Facilitated discussion of how Behavioral Health Services could improve its process of evaluating and tracking at-risk consumers and eliminate delays in the availability and delivery of patient care.
- Continued to advocate for the development of a Crisis Inpatient/Residential Treatment Facility for Children and Young Adults, reviewing plans for a new feasibility analysis by Behavioral Health Services in 2019.
- Reviewed how Behavioral Health Services monitors the performance of CBO's operating board and care facilities, including augmented board and care facilities and services, when problems are identified through the annual (or triennial?) review process. Proposed the creation of a tool for monitoring and ensuring resolution of problems identified through the review process. This tool will be an extension to the tool developed by the MHC to review MHSA projects.
- Participated in the development of a BHS "data dashboard" information model and report through discussion of the information needs of the committee.
- Reviewed the 2017 EQRO Report on behalf of the Commission
- Continued to track on quality of care information at PES.

MHSA-Finance Committee 2018 Annual Report

- ***Fiscal and Program Reviews***

- January-June Meetings: Warren Hayes, MHSA Program Chief
Mr. Hayes and MHSA staff kept the committee up-to-date on the schedule and outcome of Fiscal and Program Reviews of all 86 MHSA funded programs in the county. Major corrective action needed in several of the reviews (such as Hope House and COFY) were noted and discussed. Mr. Hayes apprised the Committee of how and when the required corrective actions had been taken and completed. Members of this Committee, as well as the Quality of Care Committee, the Mental Health Commission, and Community stakeholders will follow up to make sure how and when these corrective actions are completed. Depending on the nature of the Fiscal and Program Review Findings, the Commission will, if necessary, recommend contract provider changes to Contra Costa Behavioral Health Services BHS. The Commission will also promptly follow up on demonstrated deficiencies that arise between these reviews and with other non-MHSA programs overseen by BHS.

Housing

- July, August, and December meetings: Warren Hayes, MHSA Program Chief
 - Mr. Hayes kept the committee apprised of developments regarding funding housing opportunities for the most severely mentally ill among us, especially the \$1.73M returned by the state and the \$2.1M available in non-competitive funding provided by the new No Place Like Home (NPLH) initiative passed by voters in November, 2018. He has also let us know of the successive NPLH bidding opportunities “coming down the pike” in the next several years.
 - We had a discussion with Pat Godley, CEO of Mental Health Services regarding the Behavioral Health Budgeting Process and 2018 budget.
- September Meeting:
 - The Committee hosted presentations by the Adults and Older Adults Division Chief, Dr. Jan-Cobelada-Keglar, Psy.D. and the Alcohol and Other Drugs (AOD) Program Director, Fatima Matal Sol, LCSW.
 - Both Program Chiefs gave a detailed overview of their respective departments’ budgets and how they are developed. Dr. Cobelada-Keglar gave the latest updates on new programs, especially the Adult Mobil Crisis Response Team (MCRT) and how it fits into the adult system continuum of care. Ms. Matal Sol gave a very comprehensive overview of the AOD budget process and how her department operates (10% county staff, 90% CBO staff). She also explained how the 1115 Drug Med-Cal Waiver (Whole Person Care) program is helping to greatly expand the integration of both AOD and mental health services throughout the county. Both persons answered in-depth questions posed by Committee members and other stakeholders.

- October Meeting: Children and Adolescents: Gerold Loenicker, LMFT, Program Chief
 - Mr. Loenicker gave a very comprehensive presentation of how children and adolescent budgets are developed. He also delved into the background behind the major expansion of the in-person SENECA Mobil Response Team hours, 7AM-11:30 PM M-F, and 9 AM-7 PM Saturday and Sunday, as well as 24/7 phone availability. SENECA serves the highest acute children and adolescents in this county. He also discussed the expanded school programs, especially in East County, that involve new CBO service providers. He also answered the in-depth questions posed by Committee members and other stakeholders.

CONTRA COSTA COUNTY: DATA NOTEBOOK 2019

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS



*Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions*

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

Acknowledgements: Most of the trauma-informed care information and data presented in the following pages was drawn from several online sources for the purpose of public education. These sources included: www.cdc.gov, www.samhsa.gov, www.kidsdata.org, Center for Youth Wellness, and research studies of Vincent Felitti, M.D., Robert Anda, M.D. and associates (1998).

Table of Contents

County Data Page.....	5
Introduction: Purpose and Goals of the 2019 Data Notebook.....	6
Standard Yearly Data and Questions for Counties and Local Advisory Boards.....	7
• Rationale for these Monitoring these Data and Questions.....	7
• Adult Residential Care Facilities	7
• Homelessness: Your County’s Programs and Services.....	9
• Child Welfare Services: Foster Children in Certain Types of Congregate Care...11	
Background and Context: Trauma-Informed Care across the Life Span.....	13
• What is Trauma and How Common is It?.....	13
• Multiple, Complex, or Cascading Traumatic Events.....	14
• ACEs: Early Studies Linked Health Effects to Childhood Trauma.....	15
• Recent California Data Confirm Link of early Trauma to Health Outcomes.....	17
• Focus on Trauma in Children and Adolescents.....	19
• Prevalence of ACEs in California’s Children.....	20
• What Resilience?.....	21
• Trauma-Informed Care: The Basics.....	22
• Trauma-informed Programs Developed for Children and Families	23
• Conclusion.....	24
Trauma: Focus Topic Discussion Questions for Boards/ Commissions.....	25
Informational Appendices: I, II, III.....	27
Questionnaire: How Did Your Board complete this Data Notebook?	31
Reminder: Where to submit your Data Notebook before October 15, 2019	32

This page intentionally left blank.

Contra Costa County

Population (2018): 1,145,876

Total Medi-Cal Eligible Beneficiaries (FY 2016-17): 303,126

Total Specialty Mental Health Service (SMHS) Recipients: (FY 2016-17): 15,284

Children and Youth, SMHS

	FY 16-17		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	5,987	126,065	4.7%
Children 0-2	88	17,856	0.5%
Children 3-5	487	18,452	2.6%
Children 6-11	1,875	38,310	4.9%
Children 12-17	2,689	35,571	7.6%
Youth 18-20	848	15,876	5.3%
Alaskan Native or American Indian	24	254	9.4%
Asian or Pacific Islander	210	11,206	1.9%
Black	1,258	17,744	7.1%
Hispanic	2,487	54,495	4.6%
White	1,109	17,617	6.3%
Other	451	17,534	2.6%
Unknown	448	7,215	6.2%
Female	2,922	61,953	4.7%
Male	3,065	64,112	4.8%

Adults and Older Adults, SMHS

	FY 16-17		
	Adults and Older Adults with 1 or more SMHS Visits	Certified Eligible Adults and Older Adults	Penetration Rate
All	9,297	177,061	5.3%
Adults 21-44	4,700	92,999	5.1%
Adults 45-64	3,861	55,903	6.9%
Adults 65+	736	28,159	2.6%
Alaskan Native or American Indian	62	647	9.6%
Asian or Pacific Islander	602	26,732	2.3%
Black	1,943	27,566	7.0%
Hispanic	1,348	42,204	3.2%
White	3,308	44,198	7.5%
Other	973	23,567	4.1%
Unknown	1,061	12,147	8.7%
Female	5,266	100,557	5.2%
Male	4,031	76,504	5.3%

Introduction: Purpose and Goals: What is the Data Notebook?

The Data Notebook is a structured format to review information and report on each county's behavioral health services. Recent practice has focused on different parts of the public behavioral health system each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for specific age groups of adults or children and youth.

Local behavioral health boards/commissions are required to review performance outcomes data for services in their county and to report their findings to the California Behavioral Health Planning Council (CBHPC). To provide structure for the report and to make the reporting easier, each year we create a Data Notebook for local behavioral health boards to complete and submit to the CBHPC. Both statewide and county-specific data are provided for review. The discussion questions seek input from the local boards and their departments. These responses are analyzed by Council staff to create a yearly report to inform policy makers, stakeholders and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates¹ to review performance data for their county mental health services and report on performance every year,
- To serve as an educational resource on behavioral health data for local boards,
- To obtain opinion and thoughts of local board members on specific topics,
- To identify unmet needs and make recommendations.

The 2019 Data Notebook focus topic is an examination of behavioral health services and needs from a perspective of "Trauma-informed principles of care across the lifespan." Understanding the role of childhood trauma reveals the urgent need for trauma-informed practices in all parts of the public behavioral health system.

This year the focus topic will comprise only part of the Data Notebook. We also have developed a section with standard data and related questions which will be addressed each year to help us detect any trends. Monitoring these trends will assist in identification of unmet needs or gaps in services, which may occur due to changes in the population, resources available, or public policy (i.e., eligibility criteria).

The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing responses for the Data Notebook. This is an opportunity for the local boards and their county behavioral health departments to work together to identify the most important issues in their community. This work

¹ W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

informs county and state leadership about local behavioral health programs, needs, and services. This information is used in the Council's advocacy to the legislature and for input to the state mental health block grant application to SAMHSA².

Note that there are two sets of Discussion Questions. The first group are the standard yearly data questions. The second group, the Focus Topic Questions, are at the end of the Data Notebook, following the presentation on Trauma-informed Care.

Standard Yearly Data and Questions for Counties and Local Advisory Boards

In recent years, major improvements in data availability now permit local boards and other stakeholders to consult extensive Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services and substance use treatment. Related data are analyzed for yearly evaluations of county programs that are reported at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data can be found in the 'MHSA Transparency Tool' presented on the MHSOAC website.

However, members of the Planning Council would like to examine some county-level data that are not readily available online and for which there is no other accessible public source. The items of interest include data that are collected by the counties because they need to know how much they are spending in these service categories and for how many clients. Collecting this information will fill one gap in what is known about services that might be needed or provided in the course of a fiscal year (FY). And may help identify unmet needs in services.

Standard Annual Questions for the Data Notebook

Please answer these questions using information for fiscal year (FY) 2017-2018 or the most recent fiscal year for which you have data. Not all counties have readily available data for some of the questions. If so, please enter N/A for 'data not available.' Please note that a second group of Discussion Questions follows the Focus Topic, at the end of this Data Notebook.

Adult Residential Care Facilities

There is little publicly available data on the website of the Community Care Licensing at the CA Department of Social Services. This lack of information makes it difficult to determine how many of the licensed Adult Residential Care Facilities operate with

² SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For more information and reports, see www.SAMHSA.gov.

services that would meet the needs of adults with chronic and/or serious mental illness (SMI), (and are willing to accept clients with SMI), compared to other adults such as those with physical disabilities, or who are developmentally disabled. There is a bill (AB 1766) before the legislature that would authorize and require the collection of data from licensed operators of adult residential facilities regarding how many residents have SMI, or whether these facilities have the services these clients would need to support their recovery or transition to other housing. The Planning Council supports this bill.

The Planning Council would like to understand what type of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)³ available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs.

There are 181 licensed Adult Residential Care Facilities (ARF) in Contra Costa county, according to the list provided on the CA Department of Social Services website.⁴

- 1) For how many individuals did your county pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last FY? _____
- 2) What is the total number of ARF bed-days paid for these individuals, during the last FY? _____
- 3) Unmet needs: how many individuals served by your county need this type of housing but currently are not living in an ARF? _____
- 4) Does your county have any 'Institutions for Mental Disease' (IMD)?
___No. ___Yes. If yes, how many IMDs? _____
- 5) For how many individual clients did your county pay the costs for an IMD stay (either in or out of your county), during the last FY?
In-county: _____ Out-of-county: _____
- 6) What is the total number of IMD bed-days paid for these individuals by your county during the same time period? _____

³ Institution for Mental Diseases (IMD) List https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

⁴ Link at CDSS: <https://secure.dss.ca.gov/CareFacilitySearch/Search/AdultResidentialAndDaycare>

Homelessness: Your County's Programs and Services

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at risk of becoming homeless, or need assistance to transition to stable housing after a hospitalization or crisis residential stay. Within the last few years, the problem of homelessness has increased significantly, not only for those with SMI, but for large numbers of adults and children lacking resources for stable housing (for many different reasons). This increase has occurred in spite of greater resources allocated by public agencies to the problems of homelessness and affordable housing.

Studies indicate that approximately 1 in 3 individuals who are homeless also have serious mental illness and/or a substance use disorder. The Council does not endorse the idea that homelessness is caused by mental illness nor that the public behavioral health system is responsible to fix homelessness, financially or otherwise, but we know that recovery happens when an individual has a safe, stable place to live so we are interested in what types of things counties are doing. And because this issue is so complex and will not be resolved in the near future, the Council is planning to continue to track and report on the myriad of programs and supports the counties offer to assist individuals who are homeless and have serious mental illness and/or a substance use disorder and who would benefit from such programs.

Current news articles highlighted a recent surge in homelessness numbers in some counties and cities, based on analysis of data from "Point-in-Time" (PIT) counts taken in January of each year, including 2019, 2018, and 2017. From those numbers, local officials found the percent increases from 2017 to 2018, and from 2018 to 2019, to be quite startling, as outlined in New York Times articles in April⁵ and June,⁶ 2019.

The table on the next page shows the January, 2018 'Point in Time Count' for the number of homeless in your county (or federally designated Continuum of Care, 'CoC') from the website at www.hud.gov. (For more information, see URL link in the footnote).⁷

Table: Summary of Number of Homeless Persons in each Household Type, 'CoC' Region CA-505 (Includes Contra Costa County)

⁵ www.NYTimes.com, April 10, 2019. California Today: How Large is the Bay Area's Homeless Population?

⁶ www.NYTimes.com, June 5, 2019. California Today: Homeless Populations Are Surging. Here's Why.

⁷ Your county data may be grouped with other counties, depending on the assigned group for federal "Continuum of Care" (CoC) designation. Example: data for the **CoC CA-516** includes Shasta, Siskiyou, Sierra, Lassen, Plumas, Del Norte, and Modoc Counties. The annual HUD "Point-in-Time" counts of homeless persons for all California counties are at:

https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=2018&filter_Scope=CoC&filter_State=CA&filter_CoC=&program+Coc&group=PopSub.

SUMMARY of PERSONS in each TYPE of HOUSEHOLD	SHELTERED: in Emergency Shelter	SHELTERED: In Transitional Housing	UNSHELTERED	<u>TOTAL</u>
Persons in Households without any Children	419	104	1,432	1,955
Persons in Households with at least one adult ≥ 18 and at least one child < 18	133	41	105	279
Persons in Households ⁸ with <u>only</u> Children < 18	0	0	0	0
Total Homeless Persons	552	145	1,537	2,234

7) During the most recent FY (2017-2018), what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?

- a. Emergency shelter
- b. Temporary housing
- c. Transitional housing
- d. Housing/Motel vouchers
- e. Supportive housing
- f. Safe parking lots
- g. Rapid re-housing
- h. Adult residential care patch/subsidy
- i. Other, please specify: _____

8) **Optional:** If your county (or CoC) has data for 2019, please enter that total number here: Point-in-time Count = _____ persons. If you compare that number to the total for 2018, you may determine the percent increase in homeless persons over one year: _____%. This number may provide some indication of how much worse the problem is getting, and how quickly that change is taking place.

Child Welfare Services: Foster Children in Certain Types of Congregate Care

⁸ Data definition: Persons in Households with only Children < 18 includes unaccompanied child or youth, parenting youth < 18 who have one or more children, or may include sibling groups < 18 years of age.

About 60,000 children, under the age of 18, in California are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receives foster children; however, a small number of the children necessitate a higher level of care and are placed in a Group Home.

California has had a long standing goal of moving away from the use of long term group homes, also known as congregate care, and are increasing youth placement in family settings. Assembly Bill 403, California's Child Welfare Continuum of Care Reform, provided timelines and requirements to reform the foster care system including the reduction in reliance on congregate care as a long-term placement setting, AB 403 narrowly redefines the purpose of group care. Group homes are to be transitioned into a new facility type, Short-Term Residential Treatment Program (STRTP), which will provide short-term, specialized, and intensive treatment and will be used only for children whose needs cannot be safely met initially in a family setting.

A STRTP is a residential facility that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children. STRTPs are required to provide trauma-informed and culturally relevant core services, which include: specialty mental health services (SMHS); transition services; education, physical, behavioral, and extracurricular supports; transition to adulthood services; permanency support services; and Indian child services.

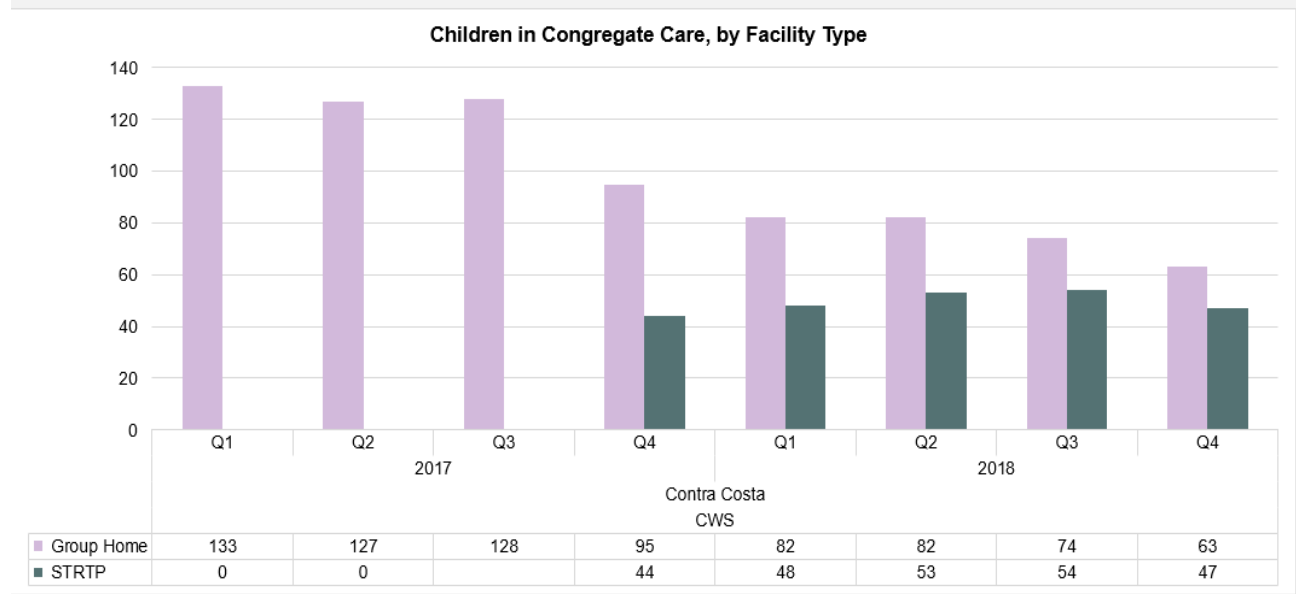
All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for any children in foster care who are not yet able to be placed in a family setting or who are in a family setting and experience a crisis which requires short-term intensive treatment.

The following chart displays the count of children age 0-17 years in your county who were in a group home compared to a count of the children age 0-17 years who were in an STRTP at some time during that quarter. Note that it does not display point-in-time counts of children in a group home or STRTP on a particular day in the quarter. This measure looks at all children who were in a group home placement at some time during the quarter and all children who were in an STRTP placement at some time during the quarter as two separate populations. If a child was placed in one type of congregate care home but then was moved to a different type of facility during the quarter, then that child was counted once in each population group. These children are part of an extremely vulnerable population and the Council will be tracking them over the next several years.

Please examine the data below. If there were no children in a given category during that quarter, then a zero was entered. Blanks in the table mean that data were suppressed due to small numbers (<11 cases). Thus, some small population counties may have only, or mostly, blanks, indicating that “some” children were in those groups but not enough to safely depict.

Your county: **Contra Costa County**

How does the number of children in a Group Home during the quarter compare to the number of children in an STRTP during the quarter?



9) Do you think your county is doing enough to serve the children/youth in group care? Yes_____ No_____

If not, what is your recommendation? Please list or describe briefly (in 30 words or less).

Many counties do not yet have STRTPs and are having to place children/youth in another county. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

10) Has your county received any children from another county? Yes _____ No_____. If yes, how many? _____

11) Has your county placed any children into another county?

Yes ____ No ____ . If yes, how many? ____

Background and Context: Trauma-informed Care across the Life Span

One goal of our 2019 Data Notebook is to examine behavioral health services and needs from the perspective of “Trauma-informed principles of care across the lifespan.” Our choice of this focus topic recognizes that childhood adversity and trauma contribute profoundly to an individual’s lifelong mental and physical health outcomes, and in turn, to the well-being of our families and communities.

What is Trauma and How Common is It?⁹

- Experiences that cause ‘intense physical and psychological stress reactions.’
- Events that are physically and emotionally harmful or threatening and that cause lasting damage to a person’s physical, social, emotional, or spiritual well-being.’
- Many individuals report a single traumatic event, but ‘others--especially those seeking mental health or substance abuse services--have been exposed to multiple or chronic traumatic events.’

Why focus on trauma? Trauma is more prevalent in our society than many realize. In the U.S. general population, one survey (NSARC, 2012)¹⁰ found that 72% of adults reported witnessing a trauma, 31% experienced trauma due to injury, and one-sixth (17%) had experienced serious psychological trauma. Potential sources of trauma include natural disasters, accidents, interpersonal violence (domestic violence, rape, mass casualty events), and severe childhood maltreatment. (See Appendix I.) Some may experience post-traumatic stress disorder in the course of their work in military service, or as first-responders, providers of emergency healthcare or trauma therapy.

Regardless of cause, screening for psychological trauma is an essential first step to treatment, and can be performed with standard methods targeted specifically for adults, or for children and youth (See Appendix II for methods). Screening is now deemed so important that the state of California has designated specific funding for trauma screenings of all children and adults with full-scope Med-Cal (FY 2019-20).

Multiple, Complex, or Cascading Traumatic Events¹¹

⁹ SAMHSA, Treatment Improvement Protocol (TIP) 57.

¹⁰ NSARC: National Epidemiological Survey on Alcohol and Related Conditions, 2012.

¹¹ SAMHSA, TIP 57, page 47.

- California is prone to multiple large-scale catastrophes, including fires, floods, landslides, droughts, and earthquakes.
- The primary trauma can lead to secondary losses of home, school, work, and neighborhood relationships, in a cascading sequence of loss and displacement.
- CA residents may experience consecutive and/or simultaneous natural disasters, in a pattern without time for healing from one event before another occurs.
- The mobility of our population can result in a lack of supportive relationships or resources. This lack compounds the vulnerability to trauma and delays recovery.
- Finally, when faced with new disasters, adults who experienced early life 'adverse childhood experiences' (ACEs) may find it much more challenging to recover and be resilient in the face of new trauma.

The concept of multiple or complex trauma is particularly important in the discussion of childhood trauma, because children may experience repeated traumatic events, multiple types of trauma, or chronic circumstances of profound neglect or deep poverty. Substantial research indicates that severe trauma, early in life, has the potential to create a level of stress that is toxic to the developing brains of young children.

The implementation of basic trauma-informed practices can help organizations provide more sensitive, respectful, and effective health care and to avoid triggers of emotional distress. Therefore, this report will include some trauma-informed practices. Briefly, ***trauma-informed care*** involves a model of care intended to promote healing and reduce risk for re-traumatization. Avoiding re-traumatization largely depends on how individuals and organizations interact with the traumatized person from initial point of contact and throughout diagnosis, screening, and the provision of care.

Next, having acknowledged the larger issues of human trauma, this Data Notebook will focus primarily on the effects of childhood trauma because of the greatly increased risks for mental illness, substance use disorders, and other social and health/medical outcomes. Knowledge about the origins and consequences of childhood trauma may yield information about how to reduce its incidence, causes, and consequences.

ACEs: Early Studies Linked Health Effects to Childhood Trauma

Several types of childhood trauma, hardship, and adversity are studied by researchers. Many of these studies build on the foundation laid by Dr. Vincent Felitti of Kaiser Permanente in San Diego and Dr. Robert Anda of the Center for Disease Control and Prevention (1998).¹² They collected data from over 17,000 adult patients of Kaiser Permanente in the San Diego area.

These researchers found that a specific subset of traumatic childhood experiences were highly correlated with later life physical and mental health problems. They defined these traumatic experiences as “adverse childhood experiences (ACEs).” This research was the largest epidemiological study of its kind ever done to examine the health and social effects of ACEs over the lifespan. They further developed a way to categorize and determine scores for ACEs that showed a relationship to later outcomes.

There are three major categories of defined ACEs: abuse, neglect, and household dysfunction. Within these three categories are ten types of ACEs, as follows.

- Abuse: includes physical, emotional and sexual abuse
- Neglect: includes physical and emotional neglect
- Household Dysfunction: includes having a family member with: serious mental illness, substance abuse disorder, or who is incarcerated, or experiencing domestic violence, or divorce.

These adverse events were used for the basis of the “ACEs Score.” The ACE Score for each individual is determined by answering 10 questions regarding events experienced in their life prior to the age of 18 years.

In this original ‘Adverse Childhood Experiences Study’ (1998), the majority of participants were white (74.8%), middle class, had health insurance, and had achieved a college-level education (75.2%) or more. Almost two-thirds (63.9%) had experienced at least one adverse childhood experience. One in eight people (12.5%) had four or more ACEs. Clearly, for the middle class population in this study, the percentages of people who had experienced at least one or more ACE may seem surprisingly high. But these experiences were remarkably common.

The ACE Study also found that ACEs are highly interrelated – where there is one ACE, there are likely others. So, it didn’t make sense to study one category of adversity at a time. It made more sense to study the accumulation of ACEs– so the scientists made a

¹² The definitive early study of Felitti, Anda, et al.; Vincent J. Felitti, et al., Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. American Journal of Preventative Medicine, 245 (1998).

simple score. Each type of ACE adds to the total ACE Score – from experiencing zero ACEs to experiencing all ten ACEs. ACE scores in the study ranged from 0 to 10. So even if a person experienced several different experiences of physical abuse, say spanking or kicking or blows to the head, this is counted as one ACE, that of physical abuse. The separate examples or events physical abuse do not yield any kind of cumulative score, and this was an arbitrary choice made by the researchers to find some kind of way to analyze what could otherwise be a complex data set.

Remarkably, the data showed a strong dose-response relationship between ACEs and poor health and life outcomes. As the number of ACEs increased, the risk of negative health outcomes also increased. Later studies discovered that the life expectancy of a person with six or more ACEs is 20 years shorter than for someone with zero ACEs.

These results led to a new way of thinking about the connection between childhood and adult health. They found that ACE scores directly correlated with the population health. The data showed that, compared to those with zero ACEs, individuals with ACE scores of 4 or more were likely to have exhibited these high-risk behaviors:

- more than twice as likely to be smokers,
- 7 times more likely to alcoholic,
- 10 times more likely to have injected street drugs, and
- 12 times more likely to have attempted suicide.

In addition, ACEs increased the risk for serious health conditions. The data showed that, compared to those with zero ACEs, individuals with 4 or more ACEs were:

- 2.4 times as likely to have a stroke,
- 2.2 times as likely to have ischemic heart disease,
- 1.9 times as likely to have cancer, and
- 1.6 times as likely to have diabetes.

Those were very serious outcomes documented in that largely white, middle-class San Diego area population studied by Drs. Felitti and Anda. Those findings raised important questions about the effect of early life experiences on lifelong health.

But what are the results when those early studies are compared to more recent data¹³ about the economically diverse populations of the state of California as a whole? Key differences were that significant numbers of our residents lived in poverty, lacked health insurance, had poor access to healthcare, and worse outcomes.

¹³ These statewide data findings (following pages) were derived from four years of statewide data from 27,745 adults that was collected by the annual California Behavioral Risk Factor Surveillance Survey data [BRFSS, 2008-2013]. These data were reported by the Center for Youth Wellness, using analyses by the Public Health Institute.

Recent California Data Confirm Link of early Trauma to Health Outcomes

Recent statewide data (2008-2013) show that the prevalence of ACEs is relatively consistent across race and ethnic groups in the state. However, high numbers of ACEs do correlate with a person's poverty, lack of education and/or unemployment. When compared to someone with no ACEs, data show that a person with **4 or more ACEs** is:

- 21% more likely to be below 250 percent of the Federal Poverty Level (FPL),
- 27% more likely to have less than a college degree,
- 39% more likely to be unemployed,
- 50% more likely to lack health insurance (and more likely to delay seeking care).

Using this recent statewide data, what percentage of California adults recalled one or more ACEs from their childhood, regardless of household type? The data below show that 45% had 1-3 ACEs, and almost 16% (or one-sixth) had 4 or more ACEs.

California	Percent		
	Households with Children	Households without Children	All Households
0 ACEs	36.8%	40.8%	39.0%
1-3 ACEs	46.7%	43.9%	45.1%
4 or More ACEs	16.5%	15.3%	15.9%

TABLE: Adult Retrospective Data (2008-2013), from www.kidsdata.org¹⁴

What is the prevalence of ACEs for adults in your county?

Contra Costa County	Percent		
	Households with Children	Households without Children	All Households
0 ACEs	35.8%	45.6%	41.6%
1-3 ACEs	44.2%	42.5%	43.2%
4 or More ACEs	20.0%	11.9%	15.2%

¹⁴Your county data may be found at: <https://www.kidsdata.org/>.

Adult retrospective data are shown above. “Retrospective surveys,” are those in which adults were asked about their life experiences prior to age 18, for example. Take note of the average percent taken from adults in all households (regardless of whether the adult resides in a household with, or without, any children). (LNE means data are suppressed due to a ‘low number event.’)

In some counties, over 75% of residents have at least one ACE. Even in counties with the lowest prevalence of ACEs, 50% had one or more adverse experiences in childhood. If the statewide numbers are very different from your county data, you may wish to explore potential contributing factors. Contributory factors could include poverty, unemployment, lack of education, high rates of child maltreatment or substance abuse, among other possible reasons. However, causes might not be readily identifiable.

Furthermore, the ranking of which ACEs were most common varies among adults in different counties. However, based on statewide data for adults, the most common ACE is emotional abuse. The most common ACEs among California adults are reported as follows (Behavioral Risk Factor Surveillance Survey data, 2008-2013):

- Emotional or verbal abuse: 34.9%
- Parental separation or divorce: 26.7%
- Substance abuse by household member: 26.1%
- Physical abuse: 19.9%
- Witness to domestic violence: 17.5%
- Household member with mental illness: 15.0%
- Sexual abuse: 11.4%
- Physical or emotional neglect: 9.3%
- Incarcerated household member: 6.6%.

ACEs affect every community in California, urban and rural, “regardless of geography, race, income, or education.” A marked percentage of adults has experienced four or more ACEs, a score that confirms a strong correlation with serious health conditions. Some health outcomes include increased lifetime risks for asthma, arthritis, and any cardiovascular disease. Specifically, adults in California¹⁵ with 4 or more ACEs are:

- 2.4 times as likely to have chronic obstructive pulmonary disease (COPD),
- 1.9 times as likely to have asthma
- 1.7 times as likely to have kidney disease, and
- 1.6 times as likely to have a stroke.

¹⁵ These data are from BRFSS and CDC statewide data collection in California during the years 2008-2013. The numbers are similar, but not identical, to the findings from the early studies (1998) of Drs. Felitti and Anda on San Diego area patients of Kaiser Permanente, which were cited earlier in this report.

Most importantly, behavioral health challenges in adulthood have a long association with ACEs. In California, when compared to a person with no ACEs, the data show that a person who has experienced four or more ACEs is:

- 5.1 times as likely to have depression,
- 4.7 times as likely to seek help from a mental health professional,
- 4.2 times as likely to be diagnosed with Alzheimer’s disease or dementia,
- 3.2 times as likely to engage in binge drinking,
- 2.5 – 3.0 times as likely to have mental, physical, or emotional conditions that cause difficulty in concentrating, remembering, or making decisions.

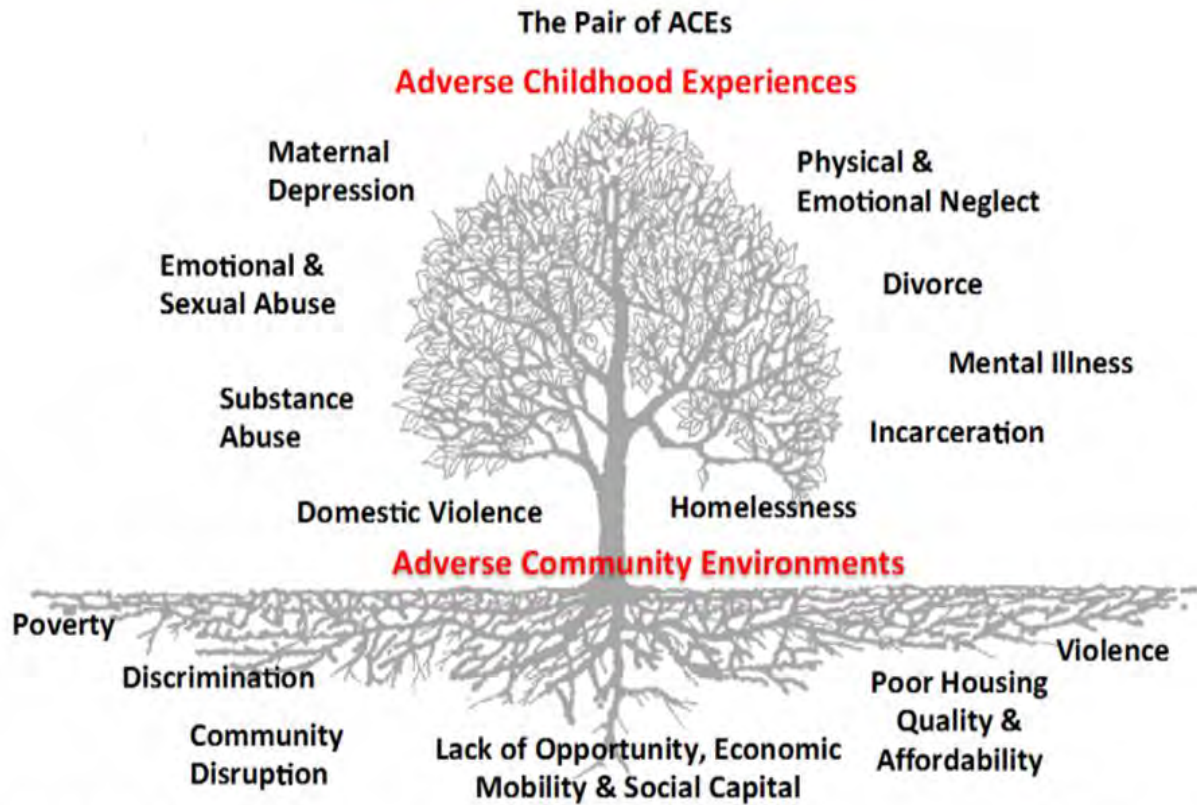
Taken together, the findings of these studies strengthen our understanding that ACEs are common, and that ACEs have a strong cumulative impact on the risk of common physical and mental health problems. The results of these adult retrospective studies, where adults were asked about their experiences prior to age 18, help us to recognize the consequences of childhood trauma, and highlight the urgency of providing early screening and treatment for trauma, at every stage of a person’s life.

There is a large variety of treatments commonly utilized for adults who have experienced trauma, and there are more therapeutic approaches being developed all the time. Depending on whether a history of trauma occurs with other clinically important issues, different types of therapy may be adapted or combined to meet the individual’s current needs.

Focus on Trauma in Children and Adolescents

The ACEs Neurodevelopmental Model proposed that ACEs disrupt early brain development, which in turn leads to social, emotional, and cognitive adaptations that can then lead to the risk factors for major causes of disease, disability, social problems, and early death. Since the time of the original ACE Study, breakthrough research in developmental neuroscience showed that the hypothesis of the ACE Study is biologically sound, i.e., that the developing brain is affected by toxic stress. These studies are important because what is predictable is preventable. Preventing ACEs and their intergenerational transmission is the greatest opportunity for improving the health and well-being of our population.

Abundant data demonstrates that trauma in children and youth are linked to a variety of adverse outcomes in behavioral health, physical health and negative life outcomes. Key factors include the larger community environment and the effects of parental hardship, poverty, violence and a general lack of resources. Those resources and needed supports may not be present in a child’s family life. Many researchers and clinicians have found that adverse community environments are fertile ground for adverse childhood experiences (ACEs). (See illustration below).



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. *Academic Pediatrics*. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Prevalence of ACEs in California's Children¹⁶

Compared to the retrospective adult data described earlier, we want to examine what the data show for how common are ACEs in today's children? This type of data¹⁷ is collected from questions asked of a parent about their children's experience of hardships that correspond to 'ACEs'. These 2016 data show that an estimated 16.4% of California children had experienced two or more adverse experiences.

Your county:

Contra Costa County: 14.7% of children have experienced two or more adverse experiences.

¹⁶ <https://www.kidsdata.org>

¹⁷ National Survey of Children's Health, 2016, Data Source: [Population Reference Bureau](#), analysis of data from the [National Survey of Children's Health](#) and the [American Community Survey](#) (Mar. 2018).

The county data are similar to those indicating that approximately one-sixth of **California** children (or 16.4%) have experienced two or more hardships (or ACEs). These findings further support the need to implement trauma-informed care in every school or agency or healthcare provider that touches the lives of children.

In particular, foster youth experience many stressors, many emotional losses, and are challenged to constantly make new adaptations to sudden changes in placements, often with corresponding changes in their assigned school. Foster youth are a vulnerable group that receive specific attention in county departments of child welfare and behavioral health. There are now legal requirements for early and prompt screenings and referral to address identified mental health needs. Foster youth are a key demographic in need of trauma-informed care as they interact with multiple agencies.

What is Resilience?¹⁸

“Resilience is an adaptive response to hardship, and can mitigate the effects of adverse childhood experience. It is a process of adapting well in the face of adversity, trauma, threats, or other significant sources of stress.”

“Resilience involves a combination of internal and external factors. Internally, it involves behaviors, thoughts, and actions that anyone can learn and develop. Resilience is strengthened by having safe, stable, nurturing relationships and environments within and outside the family.”

Resilience is most simply described as a quality linked to recovery and the ability to heal and adapt. Research data can be obtained from mothers who were asked about their child’s behaviors when confronting a challenge or stressful experience: “Is your child usually able to stay calm and in control when faced with a challenge?” And the answer is either yes or no.

The estimated percentage of children in **California** (2016) who are ‘resilient’ (using that definition¹⁹) is 52.4%. Examples of county data range from 50.8% to 53.2%. Data²⁰ for the largest 40 counties can be found at KidsData.org.

¹⁸ Definitions and descriptions from background research material provided at www.KidsData.org.

¹⁹ Definition: Estimated percentage of children ages 6-17 who are calm and in control when facing a challenge (e.g., in 2016, an estimated 52.4% of California children ages 6-17 were resilient). Data Source: [Population Reference Bureau](#), data from the [National Survey of Children’s Health](#) and the [American Community Survey](#) (Mar. 2018).

²⁰ You may examine the data tables at the following source. <https://www.kidsdata.org/topic/1928/resilience-nsch/table#fmt=2450&loc=2,127,331,171,345,357,324,369,362,360,337,364,356,217,328,354,320,339,334,365,343,367,344,366,368,265,349,361,4,273,59,370,326,341,338,350,342,359,363,340,335&tf=88>.

Your data for Contra Costa County: show that 51.6% of children are 'resilient;' that is, they stay calm and in control when faced with a challenge (as reported by parent).

Trauma-Informed Care: The Basics

Trauma-informed care describes a variety of approaches that acknowledge the impact of trauma. Programs and organizations that use a trauma-informed approach may not necessarily treat the consequences of trauma directly, but instead train their staff to interact effectively with participants who have been affected. Approaches include supporting participants' natural coping skills and the use of appropriate behavior management techniques. The desired outcomes are to help young people develop resilience and the ability to deal with difficulties. These methods are increasingly used in systems and settings that involve young people and their families.

Schools are a frontline for meeting children and youth with trauma, in that chronic or acute home stressors may lead to problems in attention, behavior, or actions. There are excellent programs that change a school's focus from discipline to a trauma-informed approach, with one goal being to help children find their own inner calm or strength. The results of implementing such programs have dramatically reduced the number student suspensions in those schools.

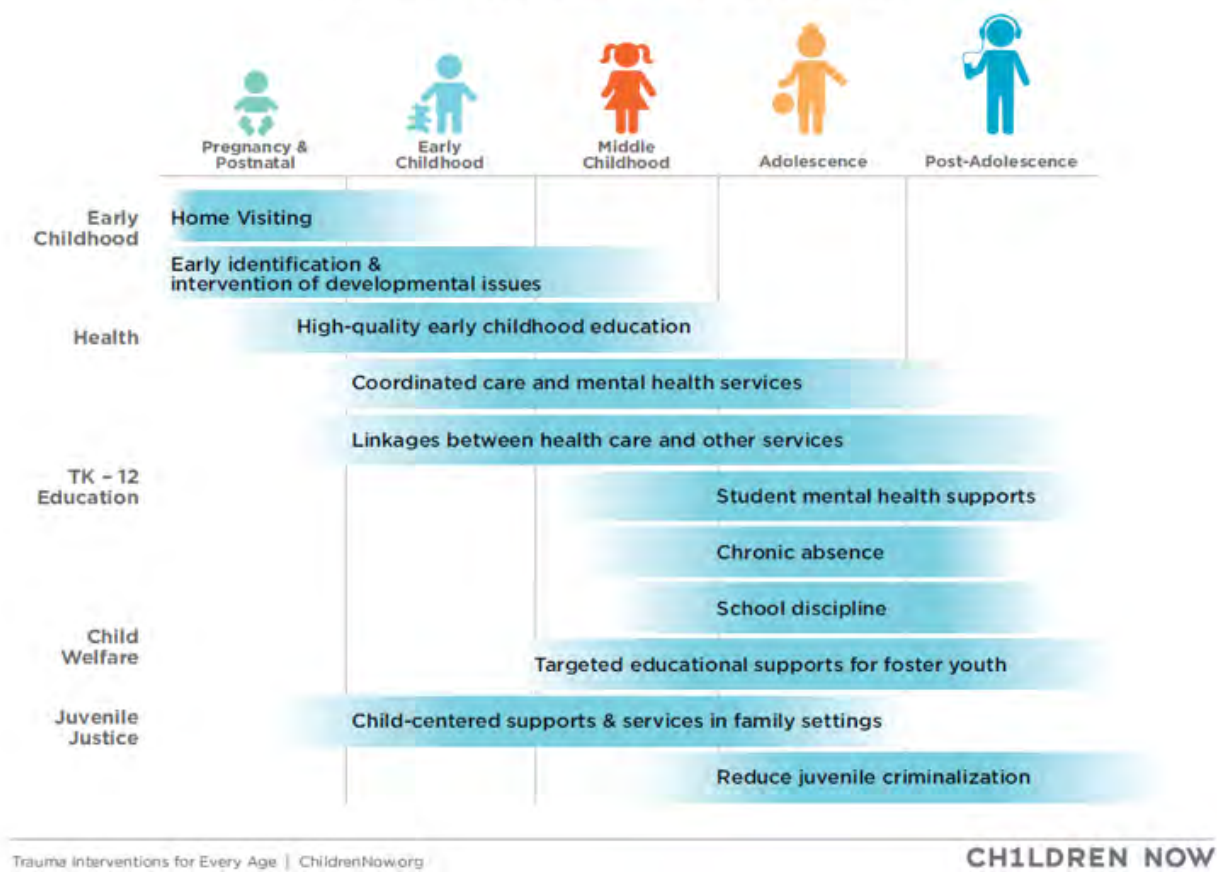
An example of one very important trauma-informed approach that interfaces between the school and first-responders is the FOCUS model, where 'FOCUS' stands for 'Focusing on Children Under Stress.' Most communities refer to the program as 'Handle With Care.' This is a program brought into being to respond when a child is witness or a victim of traumatic events in a child's home or neighborhood. First responders notify the school that the child is under stress and needs a 'focus on the child and handle them with care' approach.²¹

Trauma-informed Programs Developed for Children and Families

One of the most important things to address in discussions of trauma and childhood adversity is to ask: what are some of the positive, prevention-oriented, or problem-solving ways that we can address these issues? Different categories for trauma-related interventions for children have been designed for every stage of growth and development, as shown in the following figure.

²¹ <http://www.focuscalifornia.org>

Trauma Interventions for Every Age



The next table lists specific programs developed for children and families. These examples are evidence-based practices rooted in the principles of trauma-informed care. These programs are common in California and it is important to publicize those that are found in your community. Often, parents may not be aware of the resources available to help them learn about parenting skills and strategies.

Evidence-Based Practices for Children and Families: Some Examples

40 Developmental Assets: are a set of skills, experiences, relationships and behaviors that enable young people to develop into thriving adults. The Search Institute developed many training materials focused on these ‘40 Developmental Assets.’

Strengthening Families has a framework that is based on engaging families, programs and communities in building five protective factors:

- Parental resilience.
- Social connections.

- Knowledge of parenting and child development.
- Concrete support in times of need.
- Social and emotional competence of children.

Help Me Grow is a new program that will give parents the opportunity to complete a developmental assessment of their child and provide support and resources for their child if any problems are identified.

Triple P is a multi-level program for children and teenagers that provides parents with training on assertive discipline and child development.

First 5 California and the First 5 county organizations provide leadership and funding for necessary programs specific to children pre-natal to 5 years of age and their families. Since 1998, First 5 CA has worked to improve the lives of children and families with the vision that California's children will receive the best possible start in life and thrive.

In conclusion, trauma-informed care promotes resilience and health for families, communities, and public health. Resilience, in a broader sense, originates from buffers in communities and families to protect individuals from the accumulation of toxic stress due to ACEs and other types of trauma. The long-term goal is to instill trauma-informed principles of care in all systems, i.e., healthcare, social services, schools, child welfare/juvenile justice and criminal justice. Cross-system collaboration is important because many persons with serious mental illness and/or substance use disorders are served by multiple systems. For many, the experience of early trauma plays a causative, contributory, or aggravating role in their present difficulties.

Trauma-informed care: Discussion questions for local boards/commissions.

12) Has your behavioral health board/commission received information or training on trauma-informed practices and/or the need for such?

____ Yes ____ No

If yes, what type of information/training was it? Please state or list briefly:

_____.

13) Is your county currently implementing trauma-informed practices for youth? ____ Yes ____ No

For adults: ____ Yes ____ No

If yes, what evidence-based practices for trauma-informed care are being used in your county? Please state or list briefly: _____.

14) Are you aware of service areas in your county that are not using trauma-informed practices that should be doing so? ____ Yes ____ No

If yes, please identify those service areas briefly below.

____ Schools

____ First responders

____ Child Welfare Services

____ Juvenile Detention Facilities

____ Jail (Adults)

____ Other criminal justice system services, please specify: _____.

____ Un-served or underserved cultural groups, please specify: _____.

____ Other, Please specify: _____.

15) If you recommend the expansion of trauma-informed practices in your county for youth and/or adults, what are your top three priorities for services (or programs) for each age group?

Priorities for Children/Youth services, please state or list briefly:

1. _____

2. _____

3. _____

Priorities for Adult services, please state or list briefly:

1. _____

2. _____

3. _____

Priorities for Older Adult services, please state or list briefly:

1. _____

2. _____

3. _____

Appendix I. Types of Trauma. (per SAMHSA).²²

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado Lightning strike Wildfire Avalanche Physical ailment or disease Fallen tree Earthquake Dust storm Volcanic eruption Blizzard Hurricane Cyclone Typhoon Meteorite Flood Tsunami Epidemic Famine Landslide or fallen boulder	Train derailment Roofing fall Structural collapse Mountaineering accident Aircraft crash Car accident due to malfunction Mine collapse or fire Radiation leak Crane collapse Gas explosion Electrocutation Machinery-related accident Oil spill Maritime accident Accidental gun shooting Sports-related death	Arson Terrorism Sexual assault and abuse Homicides or suicides Mob violence or rioting Physical abuse and neglect Stabbing or shooting Warfare Domestic violence Poisoned water supply Human trafficking School violence Torture Home invasion Bank robbery Genocide Medical or food tampering

²² www.samhsa.gov, Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP) 57.

Appendix II.

Examples of Trauma Screening tools²³ designed for specific age/ developmental groups:

Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment

Trauma

Key question: Did the client experience a trauma?

Examples of measures: Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

Note: A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

Acute Stress Disorder (ASD) and PTSD

Key question: Does the client meet criteria for ASD or PTSD?

Examples of measures: Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

Note: A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

Other Trauma-Related Symptoms

Key question: Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

Examples of measures: Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 1996b); Modified PTSD Symptom Scale (Falsetti et al., 1993).

Note: These measures can be helpful for clinical purposes and for outcome assessment because they gauge *levels* of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

Other Trauma-Related Diagnoses

Key question: Does the client have other disorders related to trauma? These include mood disorders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

Examples of measures: Mental Health Screening Form III (Carroll & McGinley, 2001); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSM-IV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

Note: For complex symptoms and diagnoses such as dissociation and dissociative disorders, interviews are recommended. Look for measures that incorporate DSM-5 criteria.

Sources: Antony et al., 2001; Najavits, 2004.

²³ www.samhsa.gov, SAMHSA: Treatment Improvement Protocol (TIP) 57.

QUESTIONNAIRE: How Did Your Board Complete the Data Notebook?

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, behavioral health boards or commissions, etc. Signature lines indicate review and approval to submit your Data Notebook.

(a) What process was used to complete this Data Notebook? Please check all that apply.

MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

MH Board completed majority of the Data Notebook

County staff and/or Director completed majority of the Data Notebook

Data Notebook placed on Agenda and discussed at Board meeting

MH Board work group or temporary ad hoc committee worked on it

MH Board partnered with county staff or director

MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

Other; please describe: _____.

(b) Does your Board have designated staff to support your activities?

Yes No

If yes, please provide their job classification _____

(c) What is the best method for contacting this staff member or board liaison?

Name and County: _____

Email _____

Phone # _____

Signature: _____

Other (optional): _____

(d) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: _____

Email: _____

Phone # _____

Signature: _____

REMINDER: Please submit this Data Notebook by October 15, 2019.

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. As always, we welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.ca.gov .

For information, you may contact the email address above, or telephone:

(916) 327-6560

Or, you may contact us by postal mail to:

Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413
Sacramento, CA 95899-7413

