CONTRA COSTA
MENTAL HEALTH COMMISSION

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MENTAL HEALTH
COMMISSION
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Executive Committee

Tuesday, January 28, 2020 ◊ 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 November 26, 2019 meeting

VI. DISCUSS proposals to change Commission's Bylaws:

a. **To require that every Commissioner must participate in one standing non-elected committee**
b. **To state that a Commissioner who is absent from four regularly scheduled Commission meetings in any consecutive twelve month period (as opposed to calendar year) shall be deemed to have resigned from the Commission**
c. **To make Committee attendance mandatory and subject to the same attendance requirements as Commission meetings (current rule or point b. above)**

VII. DISCUSS how trauma informed care is implemented throughout County Behavioral Health Services (deep dive topic for Data Notebook) with invited Dr. Suzanne Tavano, Dr. Matthew P. White, Dr. Jan Cobaleda-Kegler, Gerold Loenicker, and Warren Hayes

VIII. DISCUSS general Commission goals for 2020

IX. DISCUSS MHC meeting locations for April and May 2020

X. DISCUSS a proposal to jointly host a Commission/Board meeting(s) with other county Commissions or Boards that have intersecting concerns with mental illness

XI. Adjourn

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).

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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 mandates[1] 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 SAMHSA[2].

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 April[5] 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	**TOTAL**
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 only 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.

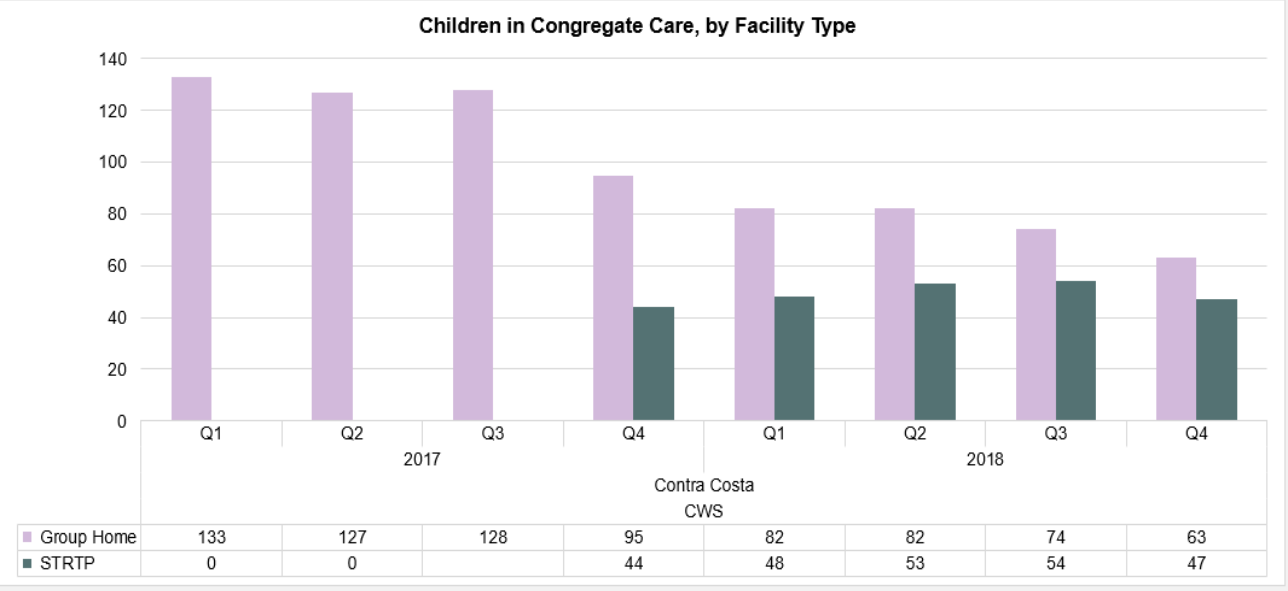
All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for any children in foster care who are not yet 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 <u>not</u> 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 <u>two separate populations</u>. 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?



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018
Group Home	133	127	128	95	82	82	74	63
STRTP	0	0		44	48	53	54	47

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 Events[11]

[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 data[13] 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		
Number of ACEs	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.org[14]

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

Contra Costa County	Percent		
Number of ACEs	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%

[14]Your 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 California[15] with 4 or more ACEs are:

- 2.4 times as like 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.

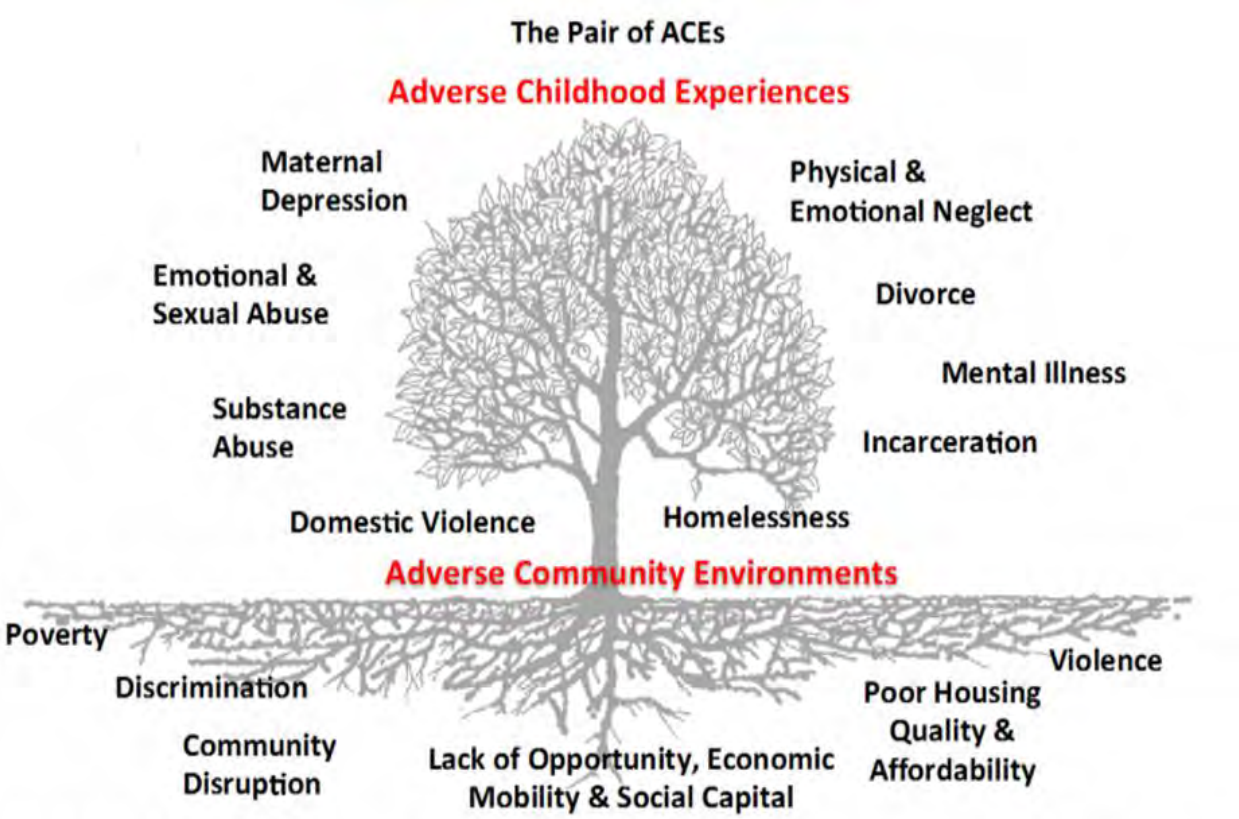
Taken together, the findings of these studies strengthen our understanding that ACEs are common, and that ACES have a strong cumulative impact on the risk of common physical and mental health problems. The results of these adult retrospective studies, where adults were asked about their experiences prior 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 Children[16]

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 data[17] 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 definition[19]) is 52.4%. Examples of county data range from 50.8% to 53.2%. Data [20] for the largest 40 counties can be found at KidsData.org.

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[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.

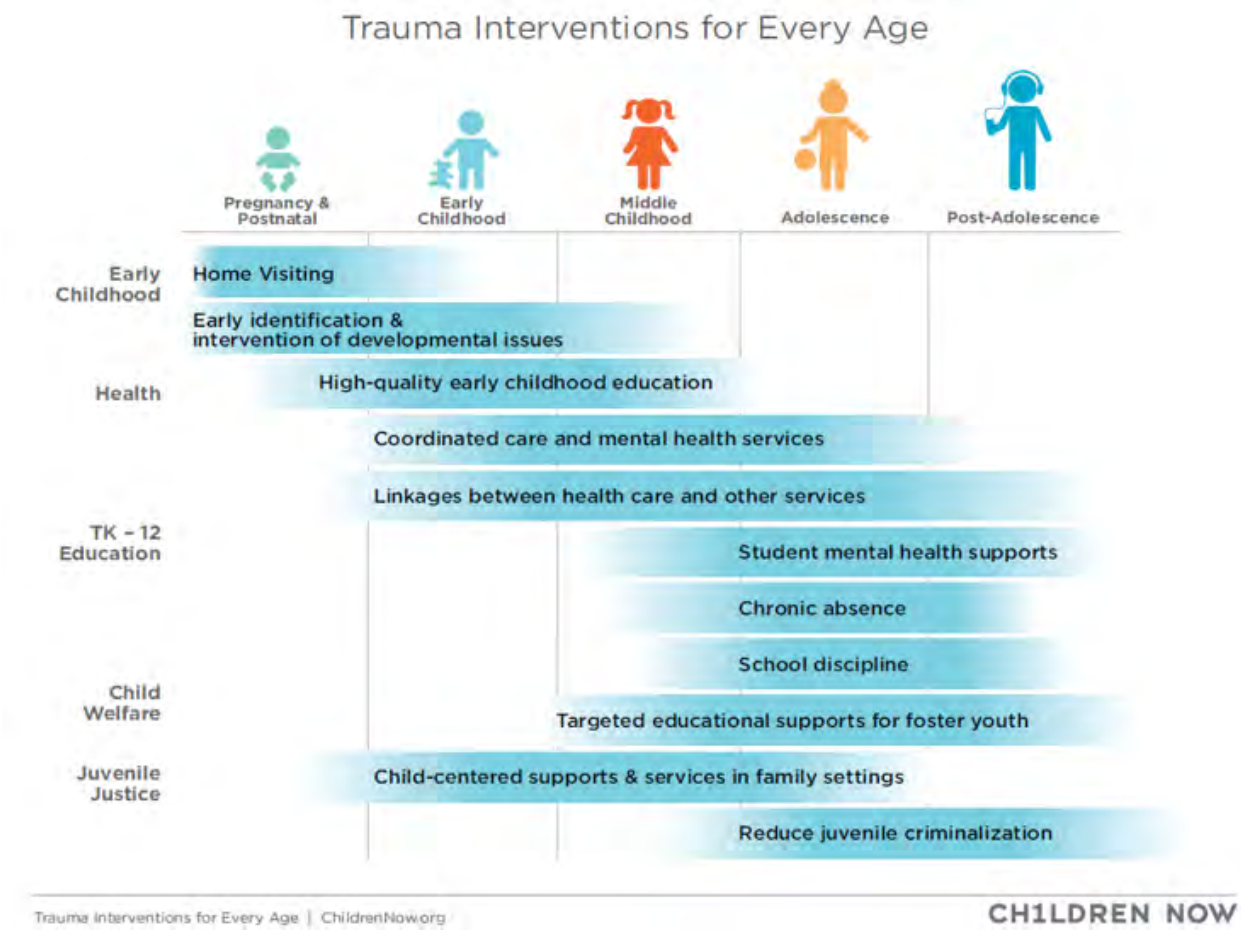
Schools are a frontline for meeting children and youth with trauma, in that chronic or acute home stressors may lead to problems in attention, behavior, or actions. There are excellent programs that change a school's focus from discipline to a trauma-informed approach, with one goal being to help children 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



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

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

Appendix II.

Examples of Trauma Screening tools[23] 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.

QUESTIONAIRE: 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

California Behavioral Health Planning Council
Advocacy • Evaluation • Inclusion

CONTRA COSTA COUNTY
MENTAL HEALTH COMMISSION

BYLAWS

Approved and Adopted:
November 20, 1997

Last Amended and Approved by the Board of Supervisors:
April 17, 2018

Contra Costa County
Mental Health Commission Bylaws

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ARTICLE I
NAME OF ORGANIZATION

SECTION 1. NAME OF ORGANIZATION

1.1 Name

The name of the organization shall be the "Contra Costa County Mental Health Commission."

ARTICLE II
DEFINITIONS

SECTION 1. DEFINITIONS

1.1 The following definitions shall apply to the Contra Costa County Mental Health Commission Bylaws:

a) Better Government Ordinance means the Contra Costa County Ordinance regarding open meetings and public records, commencing with the Contra Costa County Code §25-2.202

b) Board means the Contra Costa County Board of Supervisors

c) Brown Act means the Ralph M. Brown Act of 1974, commencing with section 54950 of the California Government Code

d) Commission means the Contra Costa County Mental Health Commission

e) Commissioner means a member of the Commission

f) Consumer means a person who is receiving or has received mental health services

g) Consumer Representative means a Consumer who is a member of the Commission

h) County means Contra Costa County

i) Family Member means a parent, spouse, registered domestic partner, sibling, or adult child of a consumer

j) Mental Health Director means the person serving as the director of the Contra Costa County Mental Health Department

k) Mental Health Department means the Contra Costa County Mental Health Department

l) Supervisor means a member of the Contra Costa County Board of Supervisors

ARTICLE III
GENERAL PROVISIONS

SECTION 1. AUTHORITY

I .I Establishment

The Contra Costa County Mental Health Commission ("Commission" hereinafter) was established by order of the Contra Costa County Board of Supervisors on June 22, I993, pursuant to the Bronzan McCorquodale Act, Stats. 1992, c. 1374 (AB. 14) to serve in an advisory capacity to the Board of Supervisors.

SECTION 2. MANDATED ROLES AND RESPONSIBILITIES

2.I Mandates

a) Pursuant to Welfare and Institutions Code Section 5604.2 (a) and (b), as it may be amended from time to time, the Commission shall do all of the following:

I) Review and evaluate the County's mental health needs, services, facilities, and special problems.

2) Review any County agreements entered into pursuant to Section 5650 of the Welfare & Institutions Code.
3) Advise the Board of Supervisors and the Mental Health Director as to any aspect of the County's mental health program.
4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
5) Submit an annual report to the Board of Supervisors on the needs and performance of the county's mental health system.
6) Review and make recommendations on applicants for the appointment of a Mental Health Director. The Commission shall be included in the selection process prior to the vote of the Board of Supervisors.
7) Review and comment on the County's performance outcome data and communicate its findings to the California Mental Health Planning Council.
8) Assess the impact of the realignment of services from the state to the county, on services delivered to clients in this County.
9) Perform those additional duties as may be directed by the Board of Supervisors.

b) Pursuant to Section 5848 (b) and (c) of the Welfare & Institutions Code:
1) The Commission shall conduct a public hearing on the draft three-year program and expenditure plan, and annual updates at the close of the required 30-day comment period and review the adopted plan or update and make recommendations to the County Mental Health Director for revisions.

ARTICLE IV
MEMBERSHIP

SECTION 1. MEMBERSHIP

1.1 Composition

a) The Commission shall consist of fifteen (15) members appointed by the Board of Supervisors, plus one member of the Board of Supervisors and an alternate assigned to be a representative to the Commission. Each member of the Board of Supervisors shall have three (3) members representing his or her district. The specific seat to be assigned to each nominee will be determined by the member of the Board of Supervisors making the nomination.

b) The following rules shall apply to membership on the Commission:
1) One **(1)** member of the Board of Supervisors shall be a member of the Commission. The Board of Supervisors shall also appoint one (1) Supervisor to serve as an alternate member.
2) Fifty percent (50%) of the Commission membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least twenty-percent of the Commission membership shall be Consumers and at least twenty-percent shall be Family Members. If at least twenty percent of the total Commission membership is not comprised of Consumers and/or if at least twenty-percent of the total Commission membership is not comprised of Family Members, a Commissioner for the underrepresented category may be selected from any Supervisorial district, if there are no applicants from the impacted district. If it is not possible to secure membership as specified from among persons residing in the

County, the Board may substitute representatives of the public interest in mental health who are not employees of County Mental Health, Department of Health Care Services or on staff or a paid member of a governing body of a mental health contract agency.

c) On this Mental Health Commission, membership shall consist of:
   1) One (1) member of the Board of Supervisors
   2) Five (5) members shall be Consumer Representatives - individuals who are receiving or have received mental health services, preferably in Contra Costa County.
   3) Five (5) members shall be Family Members - parents, spouses, registered domestic partners, siblings or adult children of consumers who are receiving or have received mental health services, preferably in Contra Costa County.
   4) Five (5) members shall be Members-at-Large - individuals who have experience and knowledge of the mental health system, preferably in Contra Costa County.

1.2 Demographic and Ethnic Representation
   a) The Commission membership should reflect the ethnic diversity of the client population in the County.
   b) The composition of the Commission shall represent the demographics of the County as a whole, to the extent feasible.

1.3 Membership Restrictions
   a) No member of the Commission or his or her spouse shall be:
      1) A full-time or part-time employee of any Contra Costa County department that is directly involved in the provision of mental health services; or
      2) An employee of the State Department of Health Care Services; or
      3) An employee of, or a paid member of, the governing body of a mental health contract agency.
   b) Commission members must be eighteen (18) years of age or older and, except as otherwise provided in these Bylaws, must reside in Contra Costa County.
   c) Members of the Commission shall abstain from discussing or voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

SECTION 2. ATTENDANCE

2.1 Attendance requirements
   a) Regular attendance at Commission meetings is mandatory for all Commission members.
      1) A member who is absent from four (4) regularly scheduled Commission meetings in any calendar year shall be deemed to have resigned from the Commission. In such event the former Commission member's status will be noted at the next scheduled Commission meeting and shall be recorded in the Commission's minutes. The Chairperson shall, without further direction from the Commission, apprise the Board of Supervisors of the member's resignation and request the appointment of a replacement.
      2) Each Commissioner will ensure that when s/he attends Commission-sponsored meetings (excluding Commission and Commission Committee meetings) or activities representing her/himself as a Commissioner, s/he expresses only those views approved by the Commission.

SECTION 3. TERMS

3.1 Duration

The term of each member of the Commission shall be three (3) years in duration. Terms shall be staggered so that approximately one-third (1/3) of the appointments end each year. All terms end

on June 30 in the appropriate year. The Supervisor appointed to the Commission serves until replaced by the County Board of Supervisors.

SECTION 4. VACANCIES AND RECRUITMENT

4.1 Role of the Commission

At the discretion of and to the extent requested by the Board, the Commission shall be involved in the recruitment and screening of applicants.

When an application is received, the Commission will appoint an Ad Hoc Applicant Interview Committee, pursuant to Article VIII, Section 5.1. Following an interview by the Ad Hoc Applicant Interview Committee, it will forward its recommendation to the Commission. After Commission vote and approval, the recommendation for nomination of the applicant shall be forwarded to the appropriate member of the Board of Supervisors for that Supervisor's consideration.

4.2 Applications

The Commission shall receive applications on an ongoing basis.

4.3 Commission Recommendation

a) Pursuant to Article IV, section 1.2, the Commission shall, to the extent possible, recommend for appointment those persons who will assist the County in complying with the ethnic and demographic mandates in the Welfare & Institutions Code.

b) To the extent possible, the Commission shall recommend for appointment applicants who have experience and knowledge of the mental health system, preferably in the County.

ARTICLE V
MEETINGS

SECTION 1. REGULAR MEETINGS

1.1 Regular Meetings

Meetings of the Mental Health Commission shall be held monthly.

1.2 Schedule of Meetings

The meeting schedule for the following year shall be set in the month of December. If no meeting will be convened during the month of December, the meeting schedule shall be set at the last regular meeting of the calendar year. Meeting schedules shall be available online.

1.3 Minimum Number

A minimum of eleven (11) meetings shall be held per year.

1.4 Holidays

If the regular meeting date falls on a holiday, a new meeting date shall be selected.

SECTION 2. ORDER OF BUSINESS

2.1 Agendas

Agendas shall be prepared for regular Commission and Executive Committee meetings at the direction of the Commission Chairperson. When feasible, agendas shall be e-mailed and mailed seven (7) days prior to the meeting, but at a minimum 96 hours prior to the meeting. Agendas shall be posted, e-mailed and mailed and made available to the public in accordance with the Brown Act and the County's Better Government Ordinance. 5

SECTION 3. QUORUM

A quorum is one person more than one-half of the appointed members. The Commission must have a quorum present in order to hold a meeting.

SECTION 4. CLOSED SESSION
The Commission may not conduct closed sessions.

SECTION 5. SPECIAL MEETINGS
Special meetings of the Commission may be called at any time by the Chair or by a majority of the members of the Commission in accordance with the Brown Act and the County's Better Government Ordinance.

SECTION 6. OPEN MEETINGS
All meetings of the Commission, including all meetings of its Executive Committee, standing committees, task forces and ad hoc committees shall comply with the Brown Act and the County's Better Government Ordinance.

SECTION 7. DECISIONS AND ACTIONS OF THE COMMISSION
Unless otherwise stated, all matters coming before the Commission for action shall be determined by a majority of the Commissioners appointed.

SECTION 8. ADDRESSING THE COMMISSION
Public Comment shall be allowed on any items of interest to the public that are within the subject matter jurisdiction of the Commission, both agendized and non-agendized items, in accordance with the Brown Act and the County's Better Government Ordinance. The Chairperson may limit the amount of time a person may use in addressing the Commission on any subject, provided the same amount of time is allotted to every person wishing to address the Commission.

ARTICLE VI
NOMINATION, ELECTION AND REMOVAL OF OFFICERS

SECTION 1. NOMINATION OF OFFICERS AND EXECUTIVE COMMITTEE MEMBERS

1.1 1 Ad Hoc Nominating Committee
An Ad Hoc Nominating Committee shall be appointed in the month of August. During the September meeting, the Ad Hoc Nominating Committee shall announce the solicitation of nominations from the Commission members and obtain the nominee's consent to serve. At the October meeting, a slate of nominees will be announced.

1.2 Nominations
In the event of a vacancy in the office of Chairperson, Vice Chairperson or an Executive Committee member during the term of office, nominations will be taken, nominees' consent to serve will be obtained, and nominees will be announced at the next regularly scheduled Commission meeting.

SECTION 2. ELECTION

2.1 Timing of
The Commission shall elect a Chairperson, Vice Chairperson and members of the Executive Committee at the November or next regular meeting of the Commission following the announcement of nominations as set forth in Section l.

2.2 Assumption of Office

The newly-elected Chairperson, Vice Chairperson and Executive Committee shall assume office January 1 and serve through December 31 of that year. In the case of a mid-term appointment, the elected Chairperson, Vice Chairperson or members of the Executive Committee will complete the remainder of the normal term.

2.3 Conduct of Election

The election will be conducted publicly through the use of signed ballots. Ballots will be announced and counted publicly by the Ad Hoc Nominating Committee. The election of each officer will carry with a majority vote of the Commission. In the case of a tie vote, the Commission may re-cast ballots until the tie is broken. If, in the opinion of the Chairperson, the tie will not be broken within a reasonable number of attempts, the election may be deferred until the next scheduled Commission meeting and the current seated officer will remain in office until a new officer is elected.

SECTION 3. TERMS OF OFFICE

The Officers of the Commission, the Chairperson and Vice Chairperson, shall serve no more than three (3) consecutive terms of one year each in the same position. This will not preclude an individual from serving as Chairperson or Vice Chairperson after one (1) year of having not served.

SECTION 4. REMOVAL OF OFFICER

4.1 Grounds for Removal

The Commission, by a majority of the Commissioners appointed, may remove the Chairperson and/or Vice Chairperson from office and relieve him/her of his/her duties

4.2 Nominations After Removal

In the event of removal of the Chairperson and/or Vice Chairperson, the Ad Hoc Nominating Committee shall meet and present nominations for the vacant position(s) at the next regularly scheduled Commission meeting.

ARTICLE VII
DUTIES OF OFFICERS

SECTION 1. DUTIES OF THE CHAIRPERSON

1.1 Meetings

a) The Chairperson shall preside at all meetings of the Commission and perform duties consistent with these Bylaws and the Welfare and Institutions Code
b) The Chairperson shall conduct meetings, maintain order and decorum, and decide questions of procedure in accordance with these Bylaws and in consultation with County staff via the Executive Assistant to the Commission.
c) The Chairperson shall conduct all meetings in the manner required by the Brown Act and the County's Better Government Ordinance.

1.3 Other Duties

The Chairperson shall be in consultation with the Mental Health Director.

SECTION 2. DUTIES OF THE VICE CHAIRPERSON

In the event of the Chairperson's absence from a Commission meeting or inability to act, the Vice Chairperson shall preside and perform all duties of the Chairperson. In the case of removal of the Chairperson, the Vice Chairperson shall perform all duties of the Chairperson until new elections can be held.

SECTION 3. TEMPORARY CHAIRPERSON

In the event both the Chairperson and Vice Chairperson are absent from a Commission meeting or are unable to act, the members shall, by order fully entered into their records, elect one of their members to act as Chairperson *Pro Tern*. The Chairperson *Pro Tern* shall perform the duties of the Chairperson until such time as the Chairperson or Vice Chairperson resumes his or her duties.

ARTICLE VIII
COMMITTEES

SECTION 1. CREATION OF COMMITTEES

Pursuant to the rules set forth herein, the Commission may create committees which can be standing committees, task forces or ad hoc committees as needed.

SECTION 2. STANDING COMMITTEES

2.1 Mission Statement

Each standing committee shall develop a Mission Statement. The Mission Statement is subject to approval by the Commission and shall be submitted to the Commission for approval no later than 60 days after establishment of the committee.

2.2 Composition

Each standing committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Commission.

2.3 Appointment and Terms

a) The Commission may appoint Commission members to standing committees.
b) The terms of the Committee Chairpersons and Vice Chairpersons shall be one (1) year.
c) There are no limits on the number of terms an individual may serve as Committee Chairperson or Vice Chairperson.

2.4 Meetings/Actions

a) All matters coming before a standing committee shall be determined by a majority of the Commissioners on the committee.
b) All standing committee meetings shall be conducted in accordance with the Brown Act and the County Better Government Ordinance.
c) All actions approved by a standing committee will be referred to the Commission for final approval.

2.5 Chairpersons, Vice Chairpersons

a) Selection
   1) Each standing committee shall have a Chairperson and may have a Vice Chairperson who are selected by the Committee.
   2) In the event of a vacancy in the position of Chairperson or Vice Chairperson of a standing committee, the Commission Chairperson may serve as temporary Chairperson of the standing committee for up to sixty (60) days while the Committee selects a new Chairperson or Vice Chairperson.

b) Duties
   1) The Chairperson shall preside at all meetings of the standing committee and perform his or her duties consistent with the procedures outlined herein. The Chairperson shall work in consultation with the Commission Chairperson.
   2) The Chairperson shall direct the preparation and distribution of agendas for their respective standing committee meetings as required by the Brown Act and the County's Better Government Ordinance.

3) The Chairperson shall provide monthly reports to the Commission regarding the activities of the standing committee and is encouraged to provide an outline of the monthly report to the Executive Assistant to the Commission for use in preparation of the Minutes.

SECTION 3. EXECUTIVE COMMITTEE

3.1 Purpose

The Executive Committee is charged with acting on the decisions of the Mental Health Commission. Its primary focus is to identify and avail any reasonable resources needed to deliberate over agenda items of the general membership, committee, task force or ad hoc committee meetings

3.2 Composition

The Commission Chairperson, and Vice Chairperson shall be members of the Executive Committee. Additional members shall be elected by the Commission. The Executive Committee shall consist of a minimum of three (3) members and a maximum of five (5) members.

3.3 Term

Elected members of the Executive Committee shall serve for one calendar year.

SECTION 4. TASK FORCES

4.1 Purpose

Task forces shall be time-limited and have a stated purpose beyond the scope of regular Commission responsibilities approved by the Commission and shall be required to report back to the Commission regarding progress toward its stated purpose.

4.2 Composition

Each task force shall consist of a minimum of three (3) members and a maximum of five (5) members. Non-Commissioners may be appointed from the community as non-voting members when special expertise, advice or opinion is desired, at the discretion of the Commission, but shall not exceed one half (1/2) of the membership of the Task Force. All task force members shall conform to the Mental Health Division client confidentiality statement.

4.3 Appointment and Terms

The Commission shall appoint Commission and non-Commission members to task forces based upon a majority vote of the Commission. The terms of all task force members shall be until the task force has completed its stated purpose.

4.4Meetings/ Actions

All meetings shall be conducted in accordance with the Brown Act and the Contra Costa County Better Government Ordinance. All matters coming before a task force shall be determined by a majority of the members of the task force.

4.5 Chairpersons

a) Selection

1) Each task force shall have a Chairperson and may have a Vice Chairperson, selected by the members of the task force. In the event of a vacancy in the position of Chairperson of a task force, the Commission Chairperson may serve as temporary Chairperson of the task force for up to sixty (60) days while the Task Force selects a new Chairperson.

b) Duties

1) The Chairperson shall preside at all meetings of the task force and perform his or her duties consistent with the procedures outlined herein. The Chairperson shall work in consultation with the Commission Chairperson.

2) The Chairperson shall direct the preparation and distribution of agendas for the task force in the manner required by the Brown Act and the County's Better Government Ordinance.

3) The Chairperson shall provide monthly reports to the sponsoring standing committee or the Commission.

4.6 Removal

The Chairperson of the task force may request of the Chair of the Commission replacement of a member who fails to regularly attend the task force meetings.

SECTION 5. AD HOC COMMITTEES

5.1 Purpose

Ad Hoc Committees shall be established by the Commission as needed to address issues within the normal course of Commission responsibilities, including but not limited to applicant interviews and officer nominations. They shall be required to report back to the Commission.

5.2 Composition

An ad hoc committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Commission.

5.3 Appointment

The Commission shall appoint Commission members to an ad hoc committee.

5.4 Meetings/Actions

All matters coming before an ad hoc committee shall be determined by a majority of the members of the ad hoc committee.

5.5 Chairpersons

a) Selection

Each ad hoc committee shall have a Chairperson, and may have a Vice Chairperson, selected by a majority of the members of the ad hoc committee. In the event of a vacancy in the position of Chairperson of an ad hoc committee, the Commission Chairperson may serve as temporary Chairperson of the ad hoc committee for up to sixty (60) days while the ad hoc committee selects a new Chairperson.

b) Duties

1) The Chairperson shall preside at all meetings of the ad hoc committee and perform his or her duties consistent with the procedures outlined herein. The Chairperson shall be in consultation with the Commission Chairperson.
2) The Chairperson shall direct the preparation and distribution of agendas for the ad hoc committee in the manner required by the Brown Act and the County's Better Government Ordinance.
3) The Chairperson shall provide monthly reports to the Commission.

5.6 Removal

The Chairperson of the ad hoc committee may request of the Chair of the Commission replacement of a member who fails to regularly attend the ad hoc committee meetings. 10

SECTION 6. COMMISSION REPRESENTATIVE

The Commission shall appoint an officer or other member of the Commission as the Commission Representative to the California Association of Local Mental Health Boards/Commissions. The Commission Representative shall represent the Mental Health Commission at statewide meetings and to report back to the Commission.

SECTION 1. STAFF SUPPORT
The County's Mental Health Division provides clerical support services to assist the Commission in the management of its operations and activities. The Executive Assistant shall maintain all necessary records. The budget of the Mental Health Division shall fund the position of the Executive Assistant to the Mental Health Commission.

SECTION 2. STAFF ATTENDANCE AT MEETINGS
The Mental Health Division staff provides information to the Commission and its committees regarding agenda items and attends meetings on a regular basis.

SECTION 3. ACTIONS
The Commission by its Chairperson shall regularly inform the Mental Health Director of Commission actions.

ARTICLE X
BYLAW AMENDMENTS

SECTION 1. AMENDMENTS
These Bylaws may be amended by a majority vote of the Commission in a regularly scheduled meeting as defined at Article V, Section 1. Before the Commission may consider or vote on Bylaw amendments, proposed amendments shall be submitted in writing to Commission members at least thirty (30) days prior to the meeting date at which they are to be considered.