County of Santa Clara
Behavioral Health Board

**DATE:** January 13, 2020, Regular Meeting  
**TIME:** 12:00 PM  
**PLACE:** Downtown Mental Health Center Rm#3  
1075 E. Santa Clara Street, 2nd Floor – Training Room 3  
San Jose, CA 95116

**AGENDA**

In compliance with the Americans with Disabilities Act and the Brown Act, those requiring accommodations in this meeting should notify the Clerk of the Behavioral Health Board no less than 24 hours prior to the meeting at (408)885-5782, or TDD (408) 993-8272.

Please note: To contact the Commission and/or to inspect any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to all or a majority of the Board of Supervisors (or any other commission, or board or committee) less than 72 hours prior to that meeting, visit our website at [http://www.sccgov.org](http://www.sccgov.org) or contact the Clerk at (408)885-5782 or 828 South Bascom Avenue, Suite 200, San Jose, CA 95128, during normal business hours.

Persons wishing to address the Commission on a regularly scheduled item on the agenda are requested to complete a request to speak form and give it to the Deputy Clerk. (Government Code Section 54953.3.) Individual speakers will be called by the Chairperson and are requested to limit their comments to two minutes. Groups of speakers on a specific item are asked to limit their total presentation to a maximum of twenty minutes for each side of the issue.

COMMUTE ALTERNATIVES: The Board of Supervisors encourages the use of commute alternatives including public transit, bicycles, carpooling, and hybrid vehicles.

For public transit trip planning information, contact the VTA Customer Service Department at (408) 321-2300 Monday through Friday between the hours of 6:00 a.m. to 7:00 p.m., and on Saturday from 7:30 a.m. to 4:00 p.m. Schedule information is also available on the web at [www.vta.org](http://www.vta.org).

Bicycle parking racks are available in the James McEntee, Sr., Plaza in front of the County Government Center building. If this Board or Commission does not meet in the County Government Center, please contact VTA for related routes.

### Opening

1. Call to Order/Roll Call.
2. Welcome/Introductions.
3. Approve Agenda of January 13, 2020, Behavioral Health Board Meeting and Minutes of the November 18, 2019 Behavioral Health Board Meeting
4. Public Comment.

The public may comment on any item of public interest within the jurisdiction of the Behavioral Health Board. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the Chair's direction). In accordance with the Brown Act, if a member of the public addresses an item, not on the posted agenda, no response, discussion, or action on the item may occur. Time will be provided for Public Comment on the posted Agenda as they occur during the meeting. Request to Speak Form is available on the table by the entrance. Please turn in to the Behavioral Health Board Liaison.

Page 1 of 3
Announcements

5. Judge Stephen V. Manley, Mental Health Treatment Court Santa Clara County, California, has accepted our invitation to speak at the May 6, 2020 Behavioral Health Community Heroes Awards at Three Flames Restaurant in San Jose.

6. The County of Santa Clara Behavioral Health Board is seeking Nominees and the nomination period will close on Friday, January 31, 2020. The link to the nomination form is available here.

Regular Agenda - Items for Discussion

7. Receive Reports
   a. Receive report from Maja Marjanovic, Board Aide, Office of Supervisor Cindy Chavez.
   b. Receive report from the Behavioral Health Services Department - Toni Tullys, Director
   d. Receive report from the Behavioral Health Board Chair
      BHB Restructuring Ad Hoc Committee Meeting Update/Timeline

8. Presentation/ Discussion
   b. The BHB Executive Committee is required to complete the BHB Annual Work Plan and Annual Report (BHB Bylaws Section V C) Please review the attached instructions, template and timeline; be prepared to begin the work on January 24, 2020 Meeting.
   c. Review and Approve the 2019 Santa County Data Notebook
   d. Discuss Future Presentations to the BHB from the 11/25/19 CCAC Meeting
      Dr. Jei Africa, Director of Behavioral Health and Recovery Services, County of Marin ~ The challenges of providing services to communities of color and LGBTQ.
      Dr. John Tran, Chief of Psychiatry for UCSF Fresno, and Medical Director of the Fresno County Department of Behavioral Health~ What are the challenges for persons of color with MH and Substance Issues as well as older adults who also have physical issues.
      Nick Kuwada, Manager, County Executive’s Office of the Census ~ Census outreach plan and challenges facing the census because of the immigration situation we heard about and a) what they are doing about it and b) how the census can impact services at the county level.
Approve Consent Calendar

9. Review and Open Motions
   a. Review and Accept Motions # 208, 212 and 213 from CCAC 11/25/19
   b. Close Motion # 209, 210 and 211

BHB Sub-Committee Reports

10. Receive Behavioral Health Board Committee Reports:
    a. Adult System of Care Committee.
    b. Cultural Competence Advisory Committee.
    c. Family, Adolescents and Children's Committee.
    d. Older Adult Committee.
    e. System Planning and Fiscal Committee.

11. Receive Behavioral Health Board Ad Hoc Committee Reports:
    a. CALBHB/C Representative (Vigil/Miles)
    b. Community Heroes Planning Committee- Update from 11/25/19
    c. HHC Representative (Jurgensen)
    d. MHSA-SLC (Miles, Pontious, Klein)
    e. Recruitment Committee (Mukoyama, Wolfberg and Crocker Cook)
    f. Reentry Network (Crocker Cook/Mukoyama)

Future Presentations

12. April 13, 2020 - Public Hearing of the Combined Draft FY20 MHSA Annual Plan Update and FY21-23 MHSA Programs and Expenditure Plan - Tentative

13. May 11, 2020 - NAMI FaithNet Grant Update for the Behavioral Health Board- Cindy McClamont

14. Call Center Update - Bruce Copley, Director, Alcohol Drug Access Services, BHSD - TBD

Adjourn

15. The next Regular BHB meeting convenes on Monday, February 10, 2020, at 12:00 pm at 1075 East Santa Clara Street, San Jose, CA 95112.
MINUTES

Opening

1. Call to Order/Roll Call. Chair Miles called the meeting to order at 12:04 pm; a quorum was established at 12:21 pm.

<table>
<thead>
<tr>
<th>Attendee Name</th>
<th>Title</th>
<th>Status</th>
<th>Arrived</th>
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<tbody>
<tr>
<td>Klein, June</td>
<td>Chair</td>
<td>Absent</td>
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<tr>
<td>Miles, Gary</td>
<td>1st Vice-Chair</td>
<td>Present</td>
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<td>Pontious, Charles</td>
<td>2nd Vice-Chair</td>
<td>Present</td>
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<tr>
<td>Crocker Cook, Mary E</td>
<td>Behavioral Health Board Member</td>
<td>Present</td>
<td>12:08 pm</td>
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<td>Fitzgerald, J Patrick, Rev</td>
<td>Behavioral Health Board Member</td>
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<td>Gill, Robert</td>
<td>Behavioral Health Board Member</td>
<td>Present</td>
<td>12:32 pm</td>
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<td>Ha, Brandon</td>
<td>Behavioral Health Board Member</td>
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<td>Jurgensen, Thomas</td>
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<td>Mukoyama, Wesley</td>
<td>Behavioral Health Board Member</td>
<td>Absent</td>
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<tr>
<td>Pinsky Sigrid</td>
<td>Behavioral Health Board Member</td>
<td>Present</td>
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<td>Tran, David</td>
<td>Behavioral Health Board Member</td>
<td>Present</td>
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<td>Vigil, Evelyn, Rev</td>
<td>Behavioral Health Board Member</td>
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<td>12:21 pm (Q)</td>
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<td>Wolfberg, Joel</td>
<td>Behavioral Health Board Member</td>
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2. Welcome/Introductions.

3. Approve Agenda of November 18, 2019, Behavioral Health Board Meeting and Minutes of the October 21, 2019, Behavioral Health Board Meeting
   - RESULT: ITEMS APPROVED [UNANIMOUS]
   - MOVER: Vigil SECONDER: Wolfberg

4. Public Comment.
   Lorraine Zeller informed meeting participants about the upcoming Access/ MHSA Leadership Training on November 20, 2019.

Announcements

5. The BHB and BHB Sub-Committees will be on recess in December 2019; all meetings will resume in January 2020.
6. The November 22, 2019, BHB Executive Committee Meeting is cancelled and will reconvene on January 24, 2020, at this location.

**Regular Agenda - Items for Discussion**

7. Receive Reports
   a. Receive report from Maja Marjanovic, Board Aide, Office of District 2 Supervisor Cindy Chavez.
      - Ms. Marjanovic gave an update from Supervisor Chavez’s office.
   b. Receive a report from the Behavioral Health Services Department - Toni Tullys, Director/Deputy Director, Dr. Deane Wiley.
      - Director Tullys and Deputy Director Wiley updated on the Timely Access projects, Netsmart implementation, and other efforts by BHSD.
      - On October 30th, 2019, THE BHCA and the San Jose City College Alcohol and Drug Studies Department held the “Convening on the Complexity of Legalized Marijuana” workshop. The event was co-sponsored with the Behavioral Health Services Department (BHSD) and BHB Member Mary Crocker Cook. Darryl Inaba, PharmD, CATC V, CADC III, Director of Clinical and Behavioral Health Service, Addictions Recovery Center, and Director of Research and Education at CNS Productions, Inc. in Medford Oregon was the keynote speaker.
      - Several members are participating in the County’s Health Care Stakeholder Group to provide input on the State’s proposed changes to its MediCal waivers. If you would like to learn more about what the State is doing, there is a CalAIM website with more details and how to provide feedback: [https://www.dhcs.ca.gov/calaim](https://www.dhcs.ca.gov/calaim).
      - On November 15th, 2019, BHCA held its annual retreat. Thank you to BHSD Director Toni Tullys for providing a presentation by Harbage Consulting. Don Kingdon and Lucy Pagel presented on State and Federal Behavioral Health Policy and considerations for the future.
   d. Receive update from the Behavioral Health Board Chair
      - The BHB Executive Committee is required to complete the BHB Annual Work Plan and Annual Report. Please review the attached instructions, template and timeline; be prepared to begin the work on January 24, 2020 Meeting.
      - BHB Restructuring Ad Hoc Committee Meeting Update

8. Presentation/ Discussion
a. Approve System Planning and Fiscal Committee's Request to Move Monthly Meetings to the 3rd Tuesday.
   ▪ RESULT: ITEMS APPROVED [UNANIMOUS]
   MOVER: Pontious SECONDER: Vigil

b. Approve to Temporarily Discontinue Rotating BHB Executive Committee Meetings.
   ▪ RESULT: ITEMS APPROVED [UNANIMOUS]
   MOVER: Vigil SECONDER: Gill

c. Approve the 2019 BHB Annual Report - Defer to January 13, 2019

d. New BHB Member’s Brandon Ha will serve on the Family Adolescent and Children’s Sub-Committee and David Tran will serve on the System Planning & Finance Sub-Committee.

e. Receive 2020 Heroes Awards Luncheon Speaker Recommendations
   Stephen V. Manley, Judge, Mental Health Treatment Court Santa Clara County, California (bio included). Chair Klein will with a letter to Judge Manley inviting him to be the Keynote Speaker on May 6, 2020.
   ▪ RESULT: ITEMS APPROVED [UNANIMOUS]
   MOVER: Crocker Cook SECONDER: Tran

Approve Consent Calendar

9. Review and Open Motions

a. Approve Consent Calendar Motion # 205-207
   ▪ RESULT: ITEMS APPROVED [UNANIMOUS]
   MOVER: Pontious SECONDER: Crocker Cook

b. Motion # 208 To have the Cultural Competency Advisory Committee write a letter to the Board of Supervisors to address the incident involving a cheerleader at Wilcox High School and recommend education programs around LGBTQ issues to support students who are affected by recent homophobic slurs so that they can seek the help they need from BHSD.
   RESULT: APPROVED [UNANIMOUS]
   MOVER: Klein SECONDER: Gill.
   • Motion #208 the CCAC will review the motion for clarification.

BHB Sub-Committee Reports

10. Receive Behavioral Health Board Committee Reports: The BHB Sub Committees update on current efforts.
    a. Adult System of Care Committee.
    b. Cultural Competence Advisory Committee.
    c. Family, Adolescents and Children's Committee.
d. Older Adult Committee.
e. System Planning and Fiscal Committee.
11. Receive Behavioral Health Board Ad Hoc Committee Reports: The BHB Ad Hoc Committees updated on current activities.
   a. CALBHB/C Representative (Vigil/Miles)
   b. Community Heroes Planning Committee.
   c. HHC Representative (Jurgensen)
   d. MHSA-SLC (Miles, Pontious, Klein)
   e. Recruitment Committee (Mukoyama, Wolfberg and Crocker Cook)
   f. Reentry Network (Crocker Cook/Mukoyama)

**Future Presentations**

12. April 13, 2020 - Public Hearing of the Combined Draft FY20 MHSA Annual Plan Update and FY21-23 MHSA Programs and Expenditure Plan - Tentative
13. May 11, 2020, NAMI FaithNet Grant Update for the Behavioral Health Board- Cindy McClamont
14. Call Center Update - Bruce Copley, Director, Alcohol Drug Access Services, BHSD - TBD

**Adjourn**

15. The meeting adjourned at 1:45 pm and will reconvene on Monday, January 13, 2020, at 12:00 pm on 1075 East Santa Clara Street, San Jose, CA 95112.
# CLARA COUNTY BEHAVIORAL HEALTH BOARD PUBLIC MEETING

Behavioral Health Board, Monday, November 18, 2019, (12:00 pm-2:00 pm)

Downtown Mental Health Center
1075 E. Santa Clara Street, 2nd FL - Room 3; San José, CA 95116

## Sign-In Sheet

<table>
<thead>
<tr>
<th>Print Name (attendees list Optional)</th>
<th>Organization/Program</th>
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<tbody>
<tr>
<td>1. Klein, June, Chair</td>
<td>Behavioral Health Board Member</td>
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<tr>
<td>2. Miles, Gary, 1st Vice Chair</td>
<td>Behavioral Health Board Member</td>
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<td>3. Pontious, Charles 2nd Vice Chair</td>
<td>Behavioral Health Board Member</td>
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<td>4. Crocker Cook, Mary E.</td>
<td>Behavioral Health Board Member</td>
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<td>5. Fitzgerald, Patrick</td>
<td>Behavioral Health Board Member</td>
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<td>6. Gill, Robert (Bob)</td>
<td>Behavioral Health Board Member</td>
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<td>7. Ha, Brandon</td>
<td>Behavioral Health Board Member</td>
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<td>8. Hancock, Marsali</td>
<td>Behavioral Health Board Member</td>
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<td>9. Jurgensen, Thomas</td>
<td>Behavioral Health Board Member</td>
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<td>10. Mukoyama, Wesley</td>
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<td>11. Pinsky, Sigrid</td>
<td>Behavioral Health Board Member</td>
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<td>12. Tran, David</td>
<td>Behavioral Health Board Member</td>
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<tr>
<td>13. Wolfberg, Joel</td>
<td>Behavioral Health Board Member</td>
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<tr>
<td>14. Vigil, Evelyn - Rev.</td>
<td>Behavioral Health Board Member</td>
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<tr>
<td>15. Supervisor Cindy Chavez /Maja Marjanovic</td>
<td>Office of the Board of Supervisors</td>
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<td>16. Toni Tullys, MPA - Director</td>
<td>Behavioral Health Services Dept.</td>
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<td>17. Deane Wiley, Deputy Director</td>
<td>Behavioral Health Services Dept.</td>
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<td>18. Debra Boyd, BHI Board Liaison</td>
<td>Behavioral Health Services-Admin.</td>
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<tr>
<td>19. Lorraine Zeller</td>
<td>ACCESS and MHSA SCC</td>
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<td>20. Victoria Lupaccio</td>
<td>Adult Program - wellness</td>
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<td>21. Elisa Koff-Ginsborg</td>
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<td>23.</td>
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</table>
December 2, 2019

The Honorable Stephen V. Manley

c/o The Superior Court of California, County of Santa Clara
191 N. First Street
San Jose, CA 95113

Dear Judge Manley:

My name is June Klein, Chair of the Santa Clara County Behavioral Health Board, an advisory Board to the Santa Clara County Board of Supervisors. The Board is comprised of 15 volunteer members who are either behavioral health consumers, family members of consumers, or professionals, and one elected official, Supervisor Cindy Chavez.

We are excited that you have accepted our invitation to deliver the keynote address at this year's Behavioral Health Community Heroes Awards. Every year we recognize individuals and organizations who have demonstrated exemplary service to County residents suffering the effects of mental health and substance use challenges. Heroes are community members, professional service providers, law enforcement, as well as those in the faith-based community, who have performed tirelessly to improve the lives of those they serve.

Our tradition has been to feature a keynote speaker who has worked extensively with those suffering mental health and substance use challenges. The subject or theme of the keynote’s speech should encompass the needs of the community concerning behavioral health.

The 9th Annual Behavioral Health Community Heroes Awards will take place on May 6, 2020, from 11:00AM-3:00PM at Three Flames Restaurant, 1547 Meridian Ave, San Jose, CA 95125.

Your speech can be up to 20 minutes, and we invite you to join us for lunch and the awards ceremony. I am available to answer any questions or discuss the event in greater detail or you may contact BHB Liaison Debra Boyd at 408.885.5782.

Respectfully,

June Rukimo Klein, ED.D, MBA, CPA
Santa Clara County Behavioral Health Board

CC: Supervisor Joe Simitian, President
Supervisor Cindy Chavez
Supervisor Mike Wasserman
Supervisor Dave Cortese
Supervisor Susan Ellenberg
Behavioral Health Services Director, Toni Tullys
Please save the date for the Behavioral Health Community Heroes Awards where we will recognize programs and individuals who have made an extraordinary difference in the lives of people with behavioral health challenges. The nomination period is now open and will close on January 31, 2020.

Please submit nominations here: https://www.surveymonkey.com/r/bhbheroes

For additional information or help with completing the nomination form, please contact:
Jessie Ferguson
408.885.3642
jessie.ferguson@hhs.sccgov.org

MAY 6, 2020
11AM - 3PM
THREE FLAMES RESTAURANT
1547 MERIDIAN AVE, SAN JOSE
January 13, 2020

DRAFT BHB RESTRUCTURING COMMITTEE REPORT

The Restructuring Ad Hoc Committee met in September, October, and November 2019 and drafted the following recommendations for consideration by the BHB.

**BHB RESTRUCTURING COMMITTEE TIMELINE**

<table>
<thead>
<tr>
<th>September 2019</th>
<th>October 2019</th>
<th>December 2019</th>
<th>January 2020</th>
<th>February/March 2020</th>
<th>April 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Ad Hoc Committee</td>
<td>Meet to determine the mission and goals of the new committees, how we will get a commitment for making quorum and a goal for the year for making quorum</td>
<td>Finalize our recommendations to the full SCC BHB for a vote</td>
<td>BHB to vote on the proposal and forward to the Board of Supervisors</td>
<td>Board of Supervisors approves proposal</td>
<td>SCC BHB to assign board members to new committee structure for FY20-21 fiscal year</td>
</tr>
</tbody>
</table>

**Recommendations to the BHB**

1. COMBINED Mission Statements for Access and Recovery
   a. The mission of the ACCESS committee is to improve access to county behavioral health services.
   b. The mission of the RECOVERY committee is to improve recovery outcomes of county behavioral health services.

2. GOALS/FOCUS Access and Recovery
   ACCESS
   a. Review and evaluate access to behavioral health needs, facilities, and special challenges.
   b. Advise county leaders regarding programs;
   c. Submit annual reports on the County’s Behavioral Health System’s performance.
   RECOVERY
   a. Review and evaluate how Behavioral Health programs foster the recovery of behavioral health clients
   b. Advise county leaders regarding programs
   c. Submit annual reports on the County’s Behavioral Health System’s performance.

3. The BHB and BHB Sub Committees will attempt to maintain Quorum Goals as follows:
   a. 80% of the committee meetings meet quorum
   b. 100% of the BHB meetings (full board and executive) meet quorum
c. Strategies
   ▪ Hold quarterly BHB Committee meetings
   ▪ At the beginning of the year, do a “doodle” to find a consistent quarterly date
     and time that works for the BHB members for each committee - make sure
     that space and staff are available
   ▪ Assign odd numbers of board members to committees
   ▪ BHB Members Increase commitment to meetings
   ▪ Have fewer meetings – increase action items on the agenda, establish ad hoc
     meetings to do the work between sessions, and submit reports to the BHB for
     review and approval.

4. The following committee names be reflected as:
   a. Cultural Competence Advisory Committee to Cultural Competency Advisory
      Committee
   b. System Planning & Fiscal to BHB Finance Committee

5. So we may begin training BHB members to become potential BHB Officer (Chair, 1st
   Vice, 2nd Vice), each member is asked to rotate to two subcommittee meetings a year.

6. The chair will assign a BHB member to lead on all projects. Ex. Data notebook, heroes,
   annual report, work plan, retreat, and other special projects or action items.

7. The Executive Committee meets every other month unless there is urgent business to be
   addressed. Refer to the BHB Bylaws role of the Executive Committee.

V. BHB-Executive Committee.
   (A) Membership.
      (1) The officers of the BHB and the chairs of standing committees shall
          constitute the Executive Committee. Each chair of a standing committee
          shall have an alternate, who is the co-chair of the chair’s standing
          committee. A quorum of the BHB-Executive Committee is five (5),
          constituting half plus one of the BHB-Executive Committee membership
          seats.

   (B) Meetings.
      (1) Except with respect to special meetings, the BHB-Executive Committee
          shall set the time and location of meetings as authorized above.

      (2) All BHB-Executive Committee meetings shall be noticed and held in
          accordance with the Brown Act (Gov. Code § 54950 et seq.).

   (C) The BHB-Executive Committee shall prepare the annual report and work
       plan (see Section IX) by March 1 for submission to the BHB. Following the
       BHB’s approval by April 1, the Annual Report and Work Plan will be
       submitted to the Health and Hospital Committee in May, and to the Board of
       Supervisors for approval in June.

   (D) The BHB-Executive Committee shall be subject to the directions and orders
       of the Board of Supervisors and of the BHB, and none of its actions shall
       conflict with such directions or orders of the Board of Supervisors or the
       BHB.

   (E) No member will have more than one vote on the BHB-Executive Committee.
8. An attendance acknowledgment will be sent out before each meeting. If you are unable to attend a BHB meeting, please inform the committee members and Jessie or myself. If a quorum cannot be established, the meeting should be cancelled unless otherwise directed by the chair.
Instructions for Completion of Annual Boards & Commissions Work Plans and Prior Year Accomplishments

A committee comprised of Board Policy Aides and the Office of the Clerk of the Board have developed a standard template for use by Boards and Commissions in completing their annual work plans. A significant change is that work plans will be based on a fiscal year rather than a calendar year. The new work plans are to be completed by each Board and Commission and approved at a regular Board or Commission meeting no later than April 1 of each year. The Clerk’s Office will then transmit the work plans to the appropriate Board Committee for review in May of each year and to the Board of Supervisors for approval in June.

Please use the following instructions when completing the work plans:

Cover Sheet (Page 1)

This area should include the name of the Board or Commission, the timeframe covered by the work plan (i.e. Fiscal Year 2007 July 1, 2006 – June 30, 2007) members’ names, chair’s name, and vacancies as of April 1. Do not put commissioner addresses or phone numbers on the work plan. The Board offices have access to that information if necessary. This page will need to be updated each year.

Mission Statement: (Page 2)

This area of the work plan should clearly state the mission of the Board or Commission. This information may be extracted from the enabling legislation (i.e. Ordinance, Board action, Resolution) that formed the Board or Commission or may be a purpose statement approved by the Board or Commission and derived from the enabling legislation. This section may also contain the roles and responsibilities of the Board or Commission. This page may not need to be updated each year.

Historical Background: (Page 2)

This area should provide the reader with some historical information about the Board or Commission (i.e. when it was formed, issues of focus in years’ past, significant outcomes of work by the Board or Commission. NOTE: Accomplishments from the previous year should not be discussed here – there is another area on the work plan where this is done. This page may not need to be updated each year.
Fiscal Year Work Plan: (Page 3)

This area should provide the goals/objectives (no more than 5) of the work plan, the activities planned to accomplish the goals, the priority ranking of each goal and the timeline anticipated to accomplish the goal. This page will need to be updated each year.

Prior Year Accomplishments: (Page 4)

This area should address the prior year work plan accomplishments including the goal/objective, activities that supported the successful completion of the goal and the status of the goal. The status column should inform the reader whether the goal was a) completed, b) not started and why, c) in process and expected completion date, or d) eliminated and why. This page will need to be updated each year.

Ongoing Projects: (Page 5)

This area provides the Board or Commission with an opportunity to inform the reader of ongoing projects that the Board or Commission is continuing to work on. This page may not need to be updated each year.
### BHB Work Plan and Annual Report Timeline

<table>
<thead>
<tr>
<th>Jan/Feb/Mar 2020</th>
<th>Mar/Apr 2020</th>
<th>Apr/May 2020</th>
<th>May/June 2020</th>
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<tbody>
<tr>
<td>Prepare the annual report and work plan by</td>
<td>Submitted to the BHB for review and approval by</td>
<td>Submitted to the Health and Hospital Committee by</td>
<td>Submitted to the Board of Supervisors for approval by</td>
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<td>March 1, 2020</td>
<td>April 1, 2020</td>
<td>May 1, 2020</td>
<td>June 1, 2020</td>
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COUNTY OF SANTA CLARA

(Board or Commission)

FISCAL YEAR 2019-2020 WORK PLAN

AND

2018-2019 ACCOMPLISHMENTS

Members
MISSION STATEMENT:

HISTORICAL BACKGROUND:
# FISCAL YEAR 2020 WORK PLAN

<table>
<thead>
<tr>
<th>GOAL/OBJECTIVE</th>
<th>PROPOSED ACTIVITIES</th>
<th>PRIORITY RANKING</th>
<th>TIMELINE FOR COMPLETION</th>
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PRIOR YEAR ACCOMPLISHMENTS

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<tbody>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<tr>
<td>5.</td>
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# ONGOING PROJECTS

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SANTA CLARA COUNTY: DATA NOTEBOOK 2019
FOR CALIFORNIA
BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by the 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.

Acknowledgments: Most of the trauma-informed care information and data presented in the following pages were 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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Santa Clara County


Total Medi-Cal Eligible Beneficiaries (FY 2016-17): 461,228

Total Specialty Mental Health Service (SMHS) Recipients: (FY 2018-19): 19,544

<table>
<thead>
<tr>
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<th>FY 18-19</th>
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<tbody>
<tr>
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<tr>
<td>All</td>
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<tr>
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<tr>
<td>Youth 18-20</td>
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<table>
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<th>Adults and Older Adults, SMHS</th>
<th>FY 18-19</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Adults and Older Adults with 1 or more SMHS visits</td>
</tr>
<tr>
<td>All</td>
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<td>Adults 21-44</td>
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<td>Adults 45-64</td>
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<td>ASIAN or Pacific Islander</td>
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<tr>
<td>Male</td>
<td>3,903</td>
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</table>
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 policymakers, 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 that will be addressed each year to help us detect any trends. Monitoring these trends will assist in the 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

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\(^1\) 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 is 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, significant 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, the 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 the 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) 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 236 licensed Adult Residential Care Facilities (ARF) in Santa Clara County, according to the list 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? __104____

2) What is the total number of ARF bed-days paid for these individuals during the last FY? __14,042____

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.  X Yes. If yes, how many IMDs? __3____

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: __239____  Out-of-county: ___0_____

6) What is the total number of IMD bed-days paid for these individuals by your county during the same period? __39,264____

---

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 and June 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).

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5 www.NYTimes.com, April 10, 2019. California Today: How Large is the Bay Area’s Homeless Population?
7 Your county data may be grouped with other counties, depending on the assigned group for federal “Continuum of Care” (CoC) designation. One example of data is that for the CoC CA-516, which includes Redding/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.
Table: Summary of Number of Homeless Persons in each Household Type, ‘CoC’ Region CA-500 (Includes Santa Clara County)

<table>
<thead>
<tr>
<th>SUMMARY of PERSONS in each TYPE of HOUSEHOLD</th>
<th>SHELTERED: in Emergency Shelter</th>
<th>SHELTERED: In Transitional Housing</th>
<th>UNSHELTERED</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons in Households without any Children</td>
<td>748</td>
<td>361</td>
<td>4,652</td>
<td>5,761</td>
</tr>
<tr>
<td>Persons in Households with at least one adult &gt;18 and at least one child&lt;18</td>
<td>397</td>
<td>294</td>
<td>296</td>
<td>987</td>
</tr>
<tr>
<td>Persons in Households with only Children &lt;18</td>
<td>6</td>
<td>0</td>
<td>500</td>
<td>506</td>
</tr>
<tr>
<td><strong>Total Homeless Persons</strong></td>
<td><strong>1,151</strong></td>
<td><strong>655</strong></td>
<td><strong>5,448</strong></td>
<td><strong>7,254</strong></td>
</tr>
</tbody>
</table>

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. _X_ Transitional housing
   d. ___ Housing/Motel vouchers
   e. _X_ Supportive housing
   f. ___ Safe parking lots
   g. ___ Rapid re-housing
   h. _X_ 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.

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

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 is 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.

An 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: **Santa Clara 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?

<table>
<thead>
<tr>
<th>Children in Congregate Care, by Facility Type</th>
</tr>
</thead>
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<tr>
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<tr>
<td>Q1</td>
</tr>
<tr>
<td>2017</td>
</tr>
<tr>
<td>2018</td>
</tr>
</tbody>
</table>

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

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

CCR/AB 403 has given the opportunity to look at planned permanency and attachment. To that goal, we can be doing better with planned permanency and family finding for all children, including those in congregate care and STRTPs.
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__ X __. If yes, how many? ____

11) Has your county placed any children into another county?
   Yes __X __   No __. If yes, how many? 18 (11 presumptively transferred and an additional 7 placed at Chamberlain’s in San Benito County through a Mental Health Patch).

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.

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9 SAMHSA, Treatment Improvement Protocol (TIP) 57.
Regardless of the 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**

- 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

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11 SAMHSA, TIP 57, page 47.
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). 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 before 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.

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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 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 experiences 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 does 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 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 be an 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 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.

**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.

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

<table>
<thead>
<tr>
<th>California</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ACEs</td>
<td>Households with Children</td>
</tr>
<tr>
<td>0 ACEs</td>
<td>36.8%</td>
</tr>
<tr>
<td>1-3 ACEs</td>
<td>46.7%</td>
</tr>
<tr>
<td>4 or More ACEs</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

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

---

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.

14 Your county data may be found at: [https://www.kidsdata.org/](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 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.

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

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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.
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 is 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).

Prevalence of ACEs in California’s Children\(^\text{16}\)

\(^{16}\) https://www.kidsdata.org
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 is collected from questions asked of a parent about their children’s experiences 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:

Santa Clara County: 14.1% of children have experienced two or more adverse experiences.

Most 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 receives specific attention in county departments of child welfare and behavioral health. There are now legal requirements for early and prompt screenings and referrals 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

18Definitions and descriptions from background research material provided at www.KidsData.org.
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%. Data 20 for the largest 40 counties can be found at KidsData.org.

**Santa Clara County:** data show that 52.5% of children are ‘resilient;’ that is, they stay calm and in control when faced with a challenge (as reported by the 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 of 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 a  

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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).

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.

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

21 http://www.focuscalifornia.org
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**

<table>
<thead>
<tr>
<th><strong>40 Developmental Assets:</strong></th>
<th>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.’</th>
</tr>
</thead>
</table>

**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 allow parents 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 prenatal to 5 years of age and their families. Since 1998, the 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? 
   __X__ Yes   ____ No

If yes, what type of information/training was it? Please state or list briefly:
   _Monthly training offered on T² Trauma-Informed Systems 101 since 2016_.

The Behavioral Health Services Department added language to contracts for contracted providers to offer and participate in training staff.

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

If yes, what evidence-based practices for trauma-informed care are being used in your county? Please state or list briefly: Child-Parent Psychotherapy, Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Motivational Interviewing, Seeking Safety, Strengthening Families Program, Triple P.

14) Are you aware of service areas in your county that are not using trauma-informed practices that should be doing so? _____Yes   __X__ 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. Shared understanding and common language on toxic stress and trauma.
2. Cultivate healing environments by increasing organization resilience, improving workforce experience, and ultimately supporting organizations in responding to and reducing the impact of trauma.
3. Embed the core principles of trauma-informed care in everyday practices.

Priorities for Adult services, please state or list briefly:

1. Both county & contracted mental health programs
2. Inpatient services- increase awareness
3.

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

1. Home bound – under served
2. Develop new program – Elder story telling; In home care giver/peer respite
3.
Appendix I. Types of Trauma. (per SAMHSA)\textsuperscript{22}

<table>
<thead>
<tr>
<th>Caused Naturally</th>
<th>Caused by People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tornado</td>
<td>Arson</td>
</tr>
<tr>
<td>Lightning strike</td>
<td>Terrorism</td>
</tr>
<tr>
<td>Wildfire</td>
<td>Sexual assault and abuse</td>
</tr>
<tr>
<td>Avalanche</td>
<td>Homicides or suicides</td>
</tr>
<tr>
<td>Physical ailment or disease</td>
<td>Mob violence or rioting</td>
</tr>
<tr>
<td>Fallen tree</td>
<td>Physical abuse and neglect</td>
</tr>
<tr>
<td>Earthquake</td>
<td>Stabbing or shooting</td>
</tr>
<tr>
<td>Dust storm</td>
<td>Warfare</td>
</tr>
<tr>
<td>Volcanic eruption</td>
<td>Domestic violence</td>
</tr>
<tr>
<td>Blizzard</td>
<td>Poisoned water supply</td>
</tr>
<tr>
<td>Hurricane</td>
<td>Human trafficking</td>
</tr>
<tr>
<td>Cyclone</td>
<td>School violence</td>
</tr>
<tr>
<td>Typhoon</td>
<td>Torture</td>
</tr>
<tr>
<td>Meteorite</td>
<td>Home invasion</td>
</tr>
<tr>
<td>Flood</td>
<td>Bank robbery</td>
</tr>
<tr>
<td>Tsunami</td>
<td>Genocide</td>
</tr>
<tr>
<td>Epidemic</td>
<td>Medical or food tampering</td>
</tr>
<tr>
<td>Famine</td>
<td></td>
</tr>
<tr>
<td>Landslide or fallen boulder</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{22} www.samhsa.gov, Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP) 57.
Appendix II.

Examples of Trauma Screening tools 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 (Falsafati, 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, 1999b); 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.

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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 the 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 the majority of the Data Notebook
__X__ County staff and/or Director completed the majority of the Data Notebook
___ Data Notebook placed on Agenda and discussed at Board meeting
___ MH Board workgroup 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 bodies as part of their reporting function.
___ Other; please describe: ____________________________________________.

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

Yes XX__  No___

If yes, please provide their job classification Behavioral Health Board Liaison and Behavioral Health Board Support.

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

Name and County: Debra Boyd, Santa Clara County
Email Debra.Boyd@hhs.sccgov.org
Phone # (408) 885-5782

Signature: ________________________________________________
Other (optional): _________________________________________

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

Name and County: __Chair Gary Miles, Santa Clara County
Email: ______bhb@hhs.sccgov.org or Debra.Boyd@hhs.sccgov.org
Phone # (408) 885-6779 OR (408) 885-5782

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
# Clara County Behavioral Health Board Motions (Recommendations)

<table>
<thead>
<tr>
<th>Motion Number</th>
<th>BHB Meeting Date/Committee</th>
<th>Motion</th>
<th>Action</th>
<th>Assigned To</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCAC 11/25/19</td>
<td>To have the Cultural Competency Advisory Committee write a letter to the Board of Supervisors to address the incident involving a cheerleader at Wilcox High School and recommend education programs around LGBTQ issues to support students who are affected by recent homophobic slurs so that they can seek the help they need from BHSD.</td>
<td>Follow up-to motion from 10/28/19 CCAC Meeting: A letter to be reviewed/approved by the BHB at the next scheduled meeting on January 13, 2020.</td>
<td>June</td>
<td></td>
</tr>
</tbody>
</table>
# Clara County Behavioral Health Board Motions (Recommendations)

**Purple - needs action**

**Red - recommend to close**

Updated 1-13-20db

<table>
<thead>
<tr>
<th>Motion Number</th>
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</tr>
</thead>
<tbody>
<tr>
<td>210</td>
<td>BHB 11/18/19</td>
<td>RESULT: APPROVED [UNANIMOUS] MOVER: Vigil SECONDER: Gill</td>
<td>Approve to Temporarily Discontinue Rotating BHB Executive Committee Meetings.</td>
<td>Rotating meetings may resume after the restructuring. Debra will update the BHB calendar</td>
<td>Debra</td>
</tr>
<tr>
<td>211</td>
<td>BHB 11/18/19</td>
<td>RESULT: APPROVED [UNANIMOUS] MOVER: Crocker-Cook SECONDER: Tran</td>
<td>2020 Heroes Awards Luncheon Speaker 1st choice Judge Stephen V. Manley, , Mental Health Treatment Court Santa Clara County, California 2nd choice Maureen O'Connor, Ph.D., J.D., Palo Alto University</td>
<td>Chair Klien will write the invitation letter, and Debra will finalize. Judge Manley accepted, and the letter will be sent 11/26/19</td>
<td>Chair Klien</td>
</tr>
<tr>
<td>212</td>
<td>CCAC 11/25/19</td>
<td>RESULT: APPROVED [UNANIMOUS] MOVER: Klein SECONDER: Vigil</td>
<td>The Cultural Competency Advisory Committee recommends the Board of Supervisors designate funding for self-care and compassion fatigue training for Behavioral Health providers and staff who deliver services. <strong>NOTE:</strong> Please note the language was reworded and requires approval by the CCAC</td>
<td>Awaiting letter from Chair Klein</td>
<td>BHB Chair</td>
</tr>
<tr>
<td>Motion Number</td>
<td>BHB Meeting Date/Committee</td>
<td>Motion</td>
<td>Action</td>
<td>Assigned To</td>
<td>Status</td>
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<td>213</td>
<td>CCAC 11/25/19</td>
<td>RESULT: APPROVED [UNANIMOUS] MOVER: Klein SECONDER: Vigil</td>
<td>BHB Chair will write a letter to BOS, noting the correct name.</td>
<td>Klein</td>
<td>OPEN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Committee members recommend the BHB update the bylaws and official BHB documents to correctly reflect the committee name as Cultural Competency Advisory Committee and adopt the mission statement for the committee as follows:</td>
<td>Bylaws will be updated once the restructuring is finalized.</td>
<td>Emily</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NOTE: Please note the language was reworded and requires approval by the CCAC</td>
<td>Jessie will update her records and files.</td>
<td>Jessie</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The County of Santa Clara Behavioral Health Board Cultural Competency Advisory Committee advocates for the service needs of diverse community groups. We achieve this by studying the cultural attributes that affect our ability to reach and service our citizens supported by the Behavioral Health Services Department and recommend improvements to programs and services to achieve better outcomes in all communities.</td>
<td>Debra will notify COB</td>
<td>Debra</td>
<td></td>
</tr>
</tbody>
</table>


# Clara County Behavioral Health Board Motions (Recommendations)

**Purple** - needs action  
**Red** - recommend to close  

Updated 1-13-20db

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<td>217</td>
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</tbody>
</table>
### FY 2019-2020 SCC Behavioral Health Board and Subcommittee Public Meetings

Downtown Mental Health Center (LP), 1075 E. Santa Clara Street, 2nd Floor, San Jose | Training Room 3 unless otherwise specified

* **BOLD** - Meeting pushed out one week / *RED* - location rotation

Contact the BHB BHB@hhs.sccgov.org | BHB Webpage

BHB Line (408) 885-5779 | Debra Boyd (408) 885-5782 | Jessie Ferguson (408) 885-3642

Revised 1/3/20

<table>
<thead>
<tr>
<th>Q=9</th>
<th>Behavioral Health Board, 2nd Monday 12:00 -2:00 pm</th>
<th>Behavioral Health Board, 2nd Monday 9:00-10:30 am</th>
<th>Behavioral Health Board, 2nd Monday 9:00-11:00 am</th>
<th>Behavioral Health Board, 2nd Monday 12:00-2:00 pm</th>
<th>Behavioral Health Board, 2nd Monday 11:00 a.m.</th>
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<td></td>
<td>J. Klein - CHAIR</td>
<td>J. Wolfberg - CHAIR</td>
<td>G. Miles - CHAIR</td>
<td>P. Fitzgerald - CO-Chair</td>
<td>J. Klein - Member</td>
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<td>G. Miles 1st Vice-Chair</td>
<td>W. Mukoyama - CO-Chair</td>
<td>D. Tran - Member</td>
<td>B. Gill - Co-Chair</td>
<td>E. Vigil - Member</td>
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<td>C. Pontious 2nd Vice-Chair</td>
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**FY 2019-2020 Behavioral Health Board Membership**

The Behavioral Health Board is comprised of 16 members; 9 constitutes a quorum.

**SCC Behavioral Health Board Delegate** | District 2 Supervisor Cindy Chavez

**2019-2020 BHB Officers:** June Klein, Chair | Gary Miles, 1st Vice-Chair | Charles Pontious, 2nd Vice-Chair

**BHB Members:** Mary Crocker Cook, J. Patrick Fitzgerald, Robert Gill, Brandon Ha, Thomas Jurgensen, Wesley Mukoyama, Sigrid Pinsky, David Tran, Rev. Evelyn Vigil, Joel Wolfberg

**SCC District 2 Supervisor Cindy Chavez, Board Delegate or Maja Marjanovic, Liaison, BOS Representative.**