OVERVIEW REPORT: THE 2019 DATA NOTEBOOK PROJECT ON CALIFORNIA BEHAVIORAL HEALTH

PREPARED BY

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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

Data and Research Sources: 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, among others: www.cdc.gov, www.samhsa.gov, www.kidsdata.org, Center for Youth Wellness, and the research studies of Vincent Felitti, M.D., Robert Anda, M.D. and associates (1998).

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The California Behavioral Health Planning Council expresses deep gratitude to the forty-one local behavioral health boards/commissions and the county staff of their Departments of Behavioral Health for their participation in the Data Notebook Project, as follows.

Counties That Submitted 2019 Data Notebooks

RECEIVED REPORTS: 41 County Mental Health Plans (representing 43 Counties)[1]

Small population: (19)	**Medium: (11)**	**Large: (11)**
Alpine	Butte	Fresno
Amador	Merced	Kern
Del Norte	Marin	Los Angeles
El Dorado	Monterey	Orange
Glenn	Placer/Sierra	Sacramento
Humboldt	San Joaquin	San Bernardino
Imperial	Santa Barbara	San Diego
Inyo	Santa Cruz	San Francisco
Lassen	Sonoma	San Mateo
Kings	Tulare	Santa Clara
Mariposa	Yolo	Ventura
Mono		
Napa		
Nevada		
San Benito		
Shasta		
Siskiyou		
Sutter/Yuba		
Tuolumne		

Summary Notes: The 43 reporting counties represent 74% of the 58 total counties, and together comprise 83% of the population of California in 2019.

Because there are two pairs of counties that are combined into one Mental Health Plan (Sutter-Yuba and Placer-Sierra), and therefore one Data Notebook per MHP, the data are commonly described as “responses from 41 counties,” used informally to refer to the responses received in Data Notebooks from the 41 MHPs and their local boards.

Missing Data: 15 counties did not submit Data Notebook reports for 2019. Five of these had communicated that the reports were ‘in progress.’

[1] Sutter and Yuba Counties are covered by one Mental Health Plan (MHP) and therefore by one Data Notebook. Similarly, Placer and Sierra Counties share one MHP, one Data Notebook and one BH board.

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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 (local boards) are required to review performance outcomes[2] data for services in their county and to report their findings each year to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year the Planning Council creates a Data Notebook for local boards to complete. 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 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[3] 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 input and perspectives of local boards on specific topics,
- To identify unmet needs and make recommendations.

This year, we have developed a section (Part I) with standard data and related questions to be answered each year to help us detect any trends. Monitoring these multi-year trends will assist in identification of unmet needs or gaps in specific services, which may occur due to changes in the population, resources available, or public policy. These standard questions address extremely important issues for populations with serious behavioral health challenges for which there are no publicly available sources of data, so the Planning Council sees an urgent need to collect such data in order help inform policy about how to meet the needs of the vulnerable groups.

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 and other systems as well. This year the focus topic will comprise only part of the Data Notebook (Part II).

[2] Performance outcomes data for provision of services by an agency or system, or for aggregated client outcomes.
[3] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

The Planning Council encourages all members of local boards to participate in developing responses for the Data Notebook in partnership with their behavioral health departments. This work informs county and state leaders about local services and needs, as well as the Council's advocacy to the legislature and input to the state mental health block grant application to SAMHSA[4].

This report presents the analyses of responses by the local boards in 43 counties (comprised of 41 Mental Health Plans) in response to the questions provided in each Data Notebook for 2019. There are two groups of questions included: (Part I) standard yearly data questions about certain vulnerable groups, and (Part II) focus topic questions following the Trauma-informed Care information. (Note that not all counties answered every question, so totals may not equal 100% of counties).

California Data

In recent years, major improvements in data availability include extensive Medi-Cal data provided online by the Department of Health Care Services (DHCS). These 'paid claims' data describe both children and adult populations that receive Specialty Mental Health Services[5] (SMHS) and substance use treatment. Related data are analyzed for yearly evaluations of county programs by the External Quality Review Organization.[6]

Other sources of mental health information include the 'MHSA Transparency Tool' (www.mhsoac.ca.gov) for Mental Health Services Act (MHSA) data. Also, the 'Open Data Portal' site[7] of the California Health and Human Services Agency presents public health, mental health, and social services data, but prior technical knowledge is helpful.

The Council has tended to focus on the data for Medi-Cal funded care that covers the SMHS provided to children with serious emotional disturbances (SEDs) and to adults with serious mental illness (SMI). For fiscal year (FY) 2017-18, out of our California state population[8] of 39,740,508, there were 14,186,599 Medi-Cal beneficiaries in total. Only 604,873 of those individuals (or 4.26%) received SMHS. The demographic data for those who received these services are summarized in the next Table.

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[4] 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.
[5] California Department of Health Care Services: MHS Performance Dashboard Archived Reports, www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx.
[6] California External Quality Review Organization: www.CalEQRO.com
[7] For specific examples: https://data.chhs.ca.gov/dataset?q=mental+health, and more generally: https://data.chhs.ca.gov/dataset/dataset-catalog/resource/2d60ad30-db63-43c8-a4b6-0861f27856ff.
[8] State of California, Department of Finance, E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change – January 1, 2018 and 2019. www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1.

Table 1. **California: Specialty Mental Health Services (SMHS)**[9]

Children and Youth:

	FY 17-18		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	267,088	6,122,476	4.4%
Children 0-2	7,763	865,511	0.9%
Children 3-5	20,425	900,677	2.3%
Children 6-11	88,057	1,837,315	4.8%
Children 12-17	118,181	1,735,264	6.8%
Youth 18-20	32,662	783,709	4.2%
Alaskan Native or American Indian	1,230	20,158	6.1%
Asian or Pacific Islander	7,456	404,868	1.8%
Black	28,412	415,774	6.8%
Hispanic	155,971	3,554,652	4.4%
White	47,201	856,903	5.5%
Other	9,013	329,099	2.7%
Unknown	17,805	541,022	3.3%
Female	123,253	3,000,612	4.1%
Male	143,835	3,121,864	4.6%

Adults and Older Adults, SMHS:

	FY 17-18		
	Adults and Older Adults with 1 or more SMHS Visits	Certified Eligible Adults and Older Adults	Penetration Rate
All	337,785	8,064,123	4.2%
Adults 21-44	175,068	4,220,683	4.1%
Adults 45-64	139,123	2,504,499	5.6%
Adults 65+	23,594	1,338,941	1.8%
Alaskan Native or American Indian	2,392	40,330	5.9%
Asian or Pacific Islander	21,644	1,034,213	2.1%
Black	50,631	707,648	7.2%
Hispanic	88,142	3,022,958	2.9%
White	114,312	2,025,747	5.6%
Other	18,726	546,350	3.4%
Unknown	41,938	686,877	6.1%
Female	174,454	4,473,167	3.9%
Male	163,331	3,590,956	4.5%

[9] 'Certified eligible' individuals refers to those deemed eligible for Medi-Cal funded services.

Part I. Standard Yearly Data and Questions for Counties and Local Boards

Members of the Planning Council believed that it was important to examine some county-level BH data that are not readily available online. Collecting this information fills one gap in what is known about key services that might be needed or provided in the course of a fiscal year (FY), and may help advocates and policy makers to identify unmet needs for services.

The topics for the standard annual questions included (a) Adult residential care facilities that accept clients with serious mental illness, (b) Use of beds in Institutions of Mental Diseases (IMDs), (c) Data about homelessness and programs for those with BH needs, and (d) Foster children with BH needs in a type of congregate care called 'Short-Term Residential Treatment Program' (STRTP). Not all counties had readily available data for some of the questions.

Adult Residential Care Facilities that Serve Clients with SMI

There is little public data available about who is residing in licensed facilities 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 services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. Assembly Bill (AB) 1766, as presented to the legislature, would authorize and require collection of data from licensed operators of adult residential facilities about how many residents have SMI and whether these facilities have services these clients need to support their recovery or transition to other housing. Note that this bill is currently on hold.

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)[10] that 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. 'Bed day' is defined as a treatment slot (or bed) occupied by one person for one day.

There were more than 3,712 licensed Adult Residential Care Facilities (ARFs) in California in June 2019, according to the CA Department of Social Services website.[11] The 43 counties that submitted Data Notebook responses had in excess of 2,750

[10] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.
[11] California Dept. Social Services: https://secure.dss.ca.gov/CareFacilitySearch/Search/AdultResidentialAndDaycare

facilities with ARF beds. The numbers are stated that way because the CDSS website caps the number of facilities for larger counties as "exceeds 250" when applicable. Unfortunately, those numbers do not reflect how many of those beds were available to serve persons with chronic or serious mental illness, nor how many were able to serve elderly clients with mental illness who also have physical disabilities or chronic medical conditions. Furthermore, since the point in time that we released the 2019 Data Notebook to the counties, we have heard many anecdotal and news media reports of facilities closing during FY 2019-2020 that previously had been serving clients with mental illness. We cannot adequately convey the heavy import of such losses in the face of California's ongoing dual crises of homelessness and the shortage of affordable housing in multiple categories and in many regions of the state.

We asked the local advisory boards and their county departments a series of questions. Following is the summation of statewide data for the reports received from the 43 counties who submitted 41 Data Notebook reports for 2019. Considering that these numbers represent the summation of data from small population counties as well as large counties, the numbers are perhaps quite shocking for their magnitude and their implications for:

- the costs to counties for those they are able to serve,
- the total need for these services in the SMI population, and
- the potential amount of unmet need, which is to some extent measured from county waiting lists, or estimated from various sources, or remains unknown.

1) **For how many individuals did California counties pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last FY?** 6,845 individuals

2) **What is the total number of ARF bed-days paid for these individuals, during the last FY?** 1,771,816 total bed days.

3) **Unmet needs: how many individuals served by California counties need this type of housing but currently are <u>not</u> living in an ARF?** The estimates that were provided exceed 1,517 persons, but about half of the responding counties stated that this number was unknown.

4) **Do counties in California have any 'Institutions for Mental Disease' (IMD)?** We found that 23 counties stated 'No;' 18 counties stated 'Yes.'

   If 'yes,' how many IMDs? The counties reported 60 IMDs, including some skilled nursing facilities (SNFs) qualified to serve this population. A few counties without in-county IMDs or with only one in-county IMD stated that they had contracts with as many as 12 to 14 out-of-county IMD facilities.

5) **For how many individual clients did California counties pay the costs for an IMD stay (either in or out of your county), during the last FY?**
In-county: 7,287 individuals. Out-of-county: 2,185 individuals.

6) **What is the total number of IMD bed-days paid for these individuals by California counties during the same time period?** The total number of IMD bed days that were paid for by the responding counties was 1,152,868.

Homelessness: Programs and Services in California Counties

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 recent 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 occurred in spite of large resources allocated by public agencies to address homelessness and affordable housing.

Studies indicate that about one-third of individuals who are homeless also have SMI and/or substance use disorders (SUD). The Council does not endorse the idea that homelessness is caused by mental illness, nor that the public behavioral health system is responsible to solve homelessness, financially or otherwise. We do know that recovery happens when a person has a safe, stable place to live, so we are interested in the strategies used by counties. Because this issue is so complex and will not be resolved in the near future, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD.

News articles[12,13] in 2019 reported that California was experiencing a surge in numbers of homeless, based on data from "Point-in-Time" (PIT) counts taken in January of 2018 and 2019. State and local officials were dismayed by the nearly 17% increase in just one year. Federal officials also were quick to note that the nation's overall 27% increase in homelessness was heavily weighted by California's numbers that comprised about one-quarter (26.6%) of all homeless persons within the 50 states, the District of Columbia, Puerto Rico, and other territories. California's unsheltered homeless persons represented half (51.3 %) of the nation's total unsheltered homeless population.

[12] www.NYTimes.com, April 10, 2019. California Today: How Large is the Bay Area's Homeless Population?
[13] www.NYTimes.com, June 5, 2019. California Today: Homeless Populations Are Surging. Here's Why.

The next table shows the January 2019 'Point in Time Count' for the number of homeless persons in California, taken from data at www.hud.gov.[14]

Table 2: State of California Homeless PIT Count (January 29, 2019).

Summary of Number of Homeless Persons in each Household Type

SUMMARY of PERSONS in each TYPE of HOUSEHOLD	SHELTERED in Emergency Shelter	SHELTERED in Transitional Housing	UNSHELTERED	TOTAL	Per Cent Increase over 2018
Persons in Households without any Children	18,413	6,665	102,686	127,764	18.8%
Persons in Households with at least one adult ≥18 and at least one child<18	12,117	5,406	4,978	22,501	7.3%
Persons in Households[15] with only Children <18	193	52	768	1,013	-29.6% (decrease)
Total (2019) Homeless Persons in CA	30,723	12,123	108,432	151,278	16.5%
Total (2019) Homeless Persons, USA	279,327	77,095	211,293	567,715	26.9%

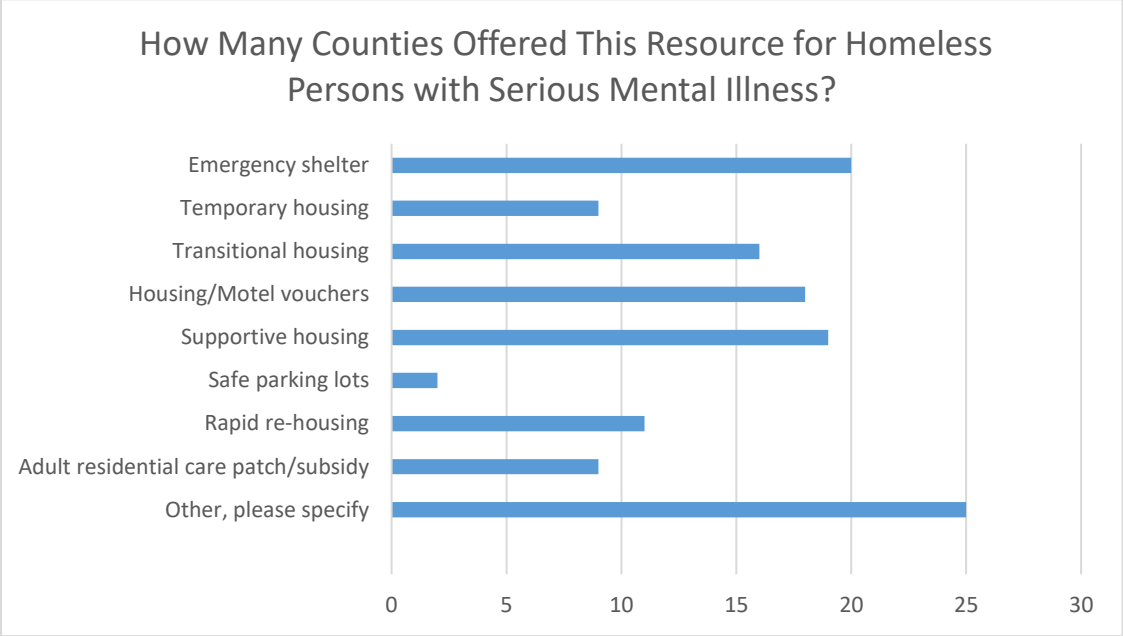
7) We asked: During the most recent fiscal year (FY) for which you have data, what new programs were implemented, or what existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?

[14] 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 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.

[15] 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.

The responses to this question were tabulated and are summarized in the graph show below. The horizontal bars show the number of responding counties that selected that answer for programs/services that were begun or expanded. In addition, a variety of programs were described under the option of "Other." These efforts often used community or multi-agency partnerships to combine funding and expertise to provide services targeted for homeless individuals with mental health and/or substance use disorders (SUDs).

Figure 1. County Resources for Homeless Persons with SMI.



Examples of the 'Other' category:

- Inyo County has a Wellness Center that provides showers, physical health services, and 'Strengths-based Training'.
- Tulare County provided 'warming centers' arranged with community partners,
- Many counties provided outreach/diversion services and emergency shelter for those who may have SMI.
- Butte County worked with multiple state and federal agency partners to provide emergency housing for large numbers of traumatized people abruptly displaced after major fires in and around the city of Paradise.

- Imperial County expanded services through a PATH[16] Grant, which resulted in more homeless individuals' admissions to Mental Health Triage Unit, to Emergency Department, to 'detox' programs, and jail.

- Nevada County started a Homeless Outreach Medical Engagement' (HOPE) Team including an RN, case management, and housing.
- Santa Barbara County expanded their substance use treatment capability through initiation of DMC-ODS[17] waiver programs, with 93 residential treatment beds for withdrawal management, 'detox' and other services, and expanded outreach to homeless individuals in need of these services.

- San Diego County provided Acceptance and Commitment Therapy[18] (ACT) program services for 300 clients and Tenant Peer Support Services, among many other programs.

8) We presented an optional question for counties: If you have data for 2019, please enter that total number and compare to the prior year's (2018) number to get the percentage change for one year. This number may indicate whether the problem is getting worse and if so, by how much.

In comparison to all other states, as reported by the federal Housing and Urban Development Department in 2019, California had the largest total number of homeless persons and the largest percent increase compared to the numbers in 2018. Nearly all counties, regardless of size, experience challenges meeting the needs of their homeless populations, including families with children and those persons who are unsheltered.

Not surprisingly, the largest sources of the statewide homeless numbers are in large population counties. The largest of these is Los Angeles (L.A.) County, with a population over 10 million. L.A. County had 58,936 homeless persons in January 2019, an increase of 11.7 % (or 6,171 persons) over the prior year. Although L.A. County contains 26% of the state population, it contributed fully 39% of the surge in the 2019 statewide homeless PIT count. The table shows the range of increases in 2019 homeless counts (compared to 2018) for the other fourteen large population counties.

[16] PATH Grants: The Federal grant program 'Projects for Assistance in Transition from Homelessness (PATH)' provides assistance to individuals who are homeless or at risk of homelessness and have serious mental illnesses. PATH grant award recipients must adhere to specific requirements in order to maintain their funding and must demonstrate financial need. Reference: www,SAMHSA.gov and www.benefits.gov

[17] Drug Medi-Cal Organized Delivery System, a program to offer more comprehensive substance use treatment services funded by Medi-Cal and administered by counties contracting with Department of Health Care Services.

[18] Acceptance and commitment therapy (ACT) is an action-oriented approach to psychotherapy that stems from traditional behavior therapy and cognitive behavioral therapy. Reference: www.PsychologyToday.com

Table 3. Large Counties Drove the Increase in 2019 P.I.T. Homeless Counts

COUNTIES > 750,000	Percent Change	COUNTIES > 1,500,000	Percent Change
San Joaquin	56.6	Sacramento	54.4
San Mateo	19.0	Alameda	46.0
Ventura	27.6	Santa Clara	33.8
San Francisco	17.2	San Bernardino	20.9
Kern	50.3	Riverside	21.4
Fresno	17.0	Orange	38.4
Contra Costa	2.7	San Diego	- 5.5 (decrease)

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

In California, about 60,000 children under the age of 18 are in foster care each year. They are removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determine that these children cannot live safely with their caregiver(s). Most of these children are placed with foster families., also called 'resource families.' However, from 2017 through 2019, a small percentage (averaging between 1.9 and 4.4%) of these children needed placement in a group home for a higher level of care. The total numbers placed in congregate care on first entry to foster care may seem small compared to the overall total of children and youth in foster care. However, some who enter foster care do so for reasons involving profound trauma with severe BH consequences.

California has had a long-standing goal of moving away from the use of long-term group homes ('congregate care'), while increasing the placement of youth in family settings. The Child Welfare Continuum of Care Reform,[19] provides requirements to reform the foster care system and to decrease the reliance on congregate care as a long-term placement setting. Short-Term Residential Treatment Programs (STRTP) should only be used for children in crisis or whose needs cannot be met safely in a family setting. STRTPs must transition children to a less restrictive placement as rapidly as possible.

An STRTP is a residential facility that provides specialized and intensive care and supervision, and treatment to children. STRTPs are required to provide trauma-informed and culturally-relevant services including specialty MH services; transition services; education, physical, behavioral, and extracurricular supports; transition to adulthood services; permanency support services; and Indian child services.

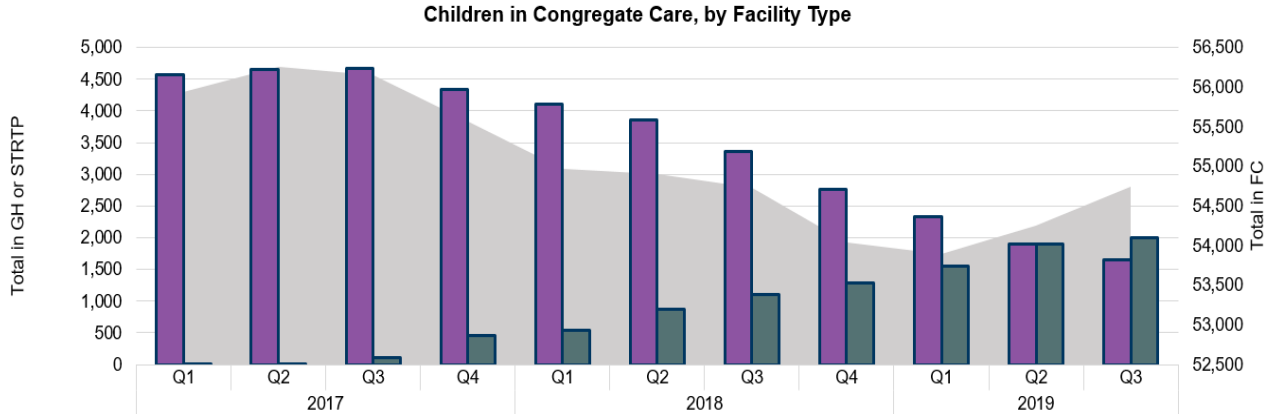
[19] Child Welfare Continuum of Care Reform (CCR) is included in AB 403.

All California counties are working to close group homes and establish licensed STRTPs, a transition that will continue to take time. Because foster children and youth comprise an extremely vulnerable population, the Council will review foster care system placement and outcomes data as part of a multi-year project.

The next figure shows statewide data[20] for the children age 0-17 years who were in a group home, compared to the number of children who were in an STRTP at some time during that 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 in each group.[21]

Figure 2. State of California (2017-2019): Foster Care Use of Higher Intensity Behavioral Health-Related Congregate Care in Comparison to Group Homes.

How Does the Number of Foster Children in Group Homes Compare to the Number in STRTP Facilities during Each Quarter of these Three Years?



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
Total in FC	55,943	56,255	56,149	55,561	54,970	54,904	54,733	54,035	53,892	54,254	54,750
Group Home	4,575	4,658	4,669	4,347	4,110	3,859	3,361	2,766	2,330	1,904	1,659
STRTP	13	15	106	454	538	868	1,105	1,287	1,556	1,902	2,001

Above, the left axis shows data ranges from zero to 5,000 for foster children placed in either Group Homes or STRTPs. The right hand axis shows the total number of foster

[20] Data source: Child Welfare Services/Case Management System (CWS/CMS). Presented in the California Department of Social Services Child Welfare Data Dashboard. Updated February 2020. *Comparison of numbers of foster children/youth in Group Homes to numbers in Short-Term Residential Treatment Programs (STRTP).* http://www.cdss.ca.gov/inforesources/Data-Portal/Research-and-Data/CCR-Data-Dashboard.

[21] When examining county-level data, note that if there were no children in a category, then a zero was entered. Blanks in the table indicate that data were suppressed due to small numbers (<11 cases), to protect privacy.

children in the entire system; but only displays the part of the range from 52,000 to 56,000. The “pale blue cloud” behind the vertical bars shows the total number of foster children at each time. Note that the total number of children in Group Homes (shown by purple bars) gradually decreased from a high point during the first three quarters of 2017, to a lower point during the third quarter of 2019, when this group contained less than the numbers in STRTP facilities (shown in blue bars). These data show that early 2017 through 2019 represented a period of transition as counties began developing facilities to qualify as STRTPs capable of serving foster youth with intensive BH needs.

We asked the local boards a series of questions about care of these foster youth.

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

Boards in 22 counties answered ‘Yes’, and 19 answered ‘No.’

If not, what is your recommendation? Please list or describe briefly.

Several respondents indicated that neither the U.S. nor the state of California have ever done enough to provide for foster youth or children who have mental health needs. One of the most common suggestions was that there should be an increase in the ability to serve more children within the county, increase the number of facilities certified as STRTPs, and that this increase should include availability to serve girls, not just boys.

One comment stated that counties should ensure that the contracted STRTPs actually offer the types of good-quality services that they claim to offer, and that the programs and staff should provide trauma-informed care. For those children/youth transferred out of county, regular transportation should be available so that youth can visit in their ‘home’ county to maintain relationships with their natural support systems.

Some responses described the ongoing process to develop more STRTP facilities, and the process of certifying those group homes that are able to transition to the higher level of care and types of services needed. Further, county and group care providers were in need of more education, resources, and funding to provide appropriate levels of care.

Many counties do not yet have STRTPs and therefore need to place children/youth in another county. Recent legislation (AB 1299) directs that the child’s Medi-Cal eligibility is to be transferred to the receiving county. This ‘presumptive transfer’ means that the county receiving the child is then financially responsible for his/her Medi-Cal costs.

We asked the local boards and their county BH departments these questions:

10) Has your county received children from another county? If yes, how many? Of 40 responding counties, 33 counties answered 'Yes;' 7 counties answered 'No.'

At least **11,124** children/youth were transferred **into** one of the 33 counties that reported receiving children during the most recent fiscal year (2018-19). This number is likely an underestimate due to some entries being approximated, some counties reported 'zero,' some boards were unable to access data from child welfare services, and 15 counties did not submit a Data Notebook.

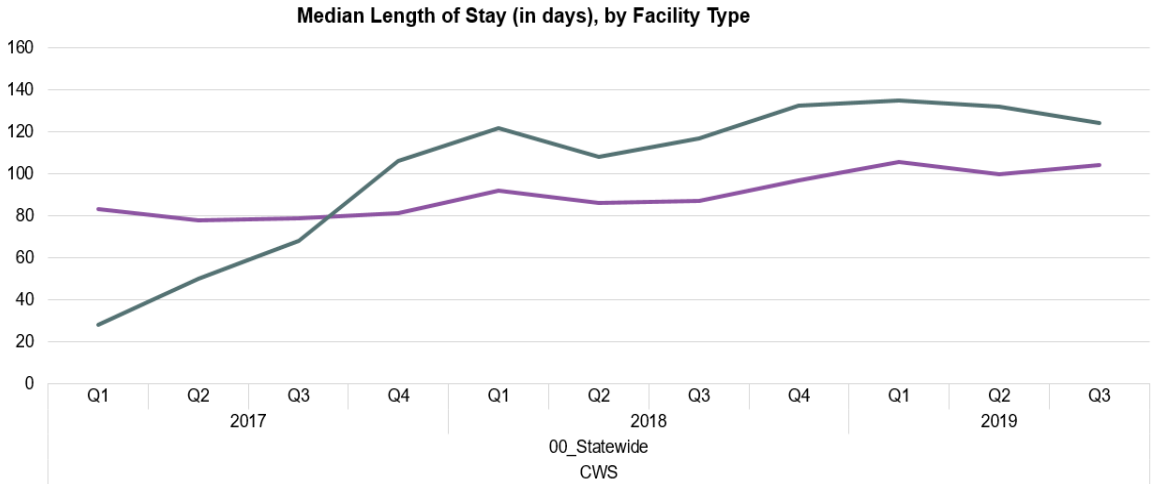
These data should be interpreted with caution, as some responses indicated a lack of clarity about whether the answer should include only youth who needed an STRTP, or count all foster and dependent/probation youth transferred in or out of the county.

(11) Has your county placed children into another county? If yes, how many?

During the most recent fiscal year (2018-19), at least **15,039** foster children/youth were transferred **out** of the 36 responding counties, but another 5 counties either answered 'zero' or were not able to obtain data from the relevant agency**.** Again, that number of youth is likely an underestimate for the reasons stated previously.

Next, this discussion of specialized STRTP facilities returns to one of the goals of the reform: to provide care comprised of the types and quality of services necessary to enable foster youth to shorten their stays in congregate care and move to family settings. The next figure shows CDSS data about the length of stay of children in Group Homes compared to length of stay of children in STRTPs.

Figure 3. Group Homes and STRTPs: Progress Remains Elusive in the Attempt to Reduce Average Length of Stay of Children in Two Types of Congregate Care.



	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Group Home	83	78	79	81	92	86	87	97	106	100	104
STRTP	28	50	68	106	122	108	117	133	135	132	124

Summary and Conclusions of Part I

The Planning Council chose these specific areas for annual data and questions because there is no other source for these data besides the individual counties, and these data address urgent matters and highly vulnerable populations. These are all critical areas of concern affecting separate but potentially overlapping populations:

- Adult residential facilities that serve persons with chronic or serious mental illness
- Numbers and utilization of IMD beds by counties (and beds in specially qualified SNFs) for persons with serious mentally illness
- Homeless persons with serious mental illness and/or substance use disorders
- Foster youth with significant mental health needs or who are in crisis and cannot be placed safely within a foster family (or 'resource family').

These 2019 responses represent a baseline that will be better understood after several years of information collection. An inspection of the numbers leads to the conclusion that there are potentially large numbers of individuals that both need and utilize these intensive and expensive services. However, in spite of attempts to quantify or at least estimate the number of individuals with unmet needs for these services, we simply do not have sufficient data to estimate the size or scale of these unmet service needs.

Conclusions about these data are limited by any lag times in data reporting at the state or county levels that could contribute to an undercount for any of the listed categories. We greatly appreciate the local boards and county staff that provided these data.

RECOMMENDATION

Need for Data. The fact that the Planning Council has created a Part I in the annual Data Notebook to solicit data from each county about the need for and numbers of individuals the county pays to reside in a licensed Adult Residential Care Facility or to stay in an Institute for Mental Disease; and how many children/youth are in congregate care, are placed out-of-county or require behavioral health treatment in the county foster care program points to a deficit of needed data. For too long, the behavioral health system has endeavored under a dearth of data to quantify the need, understand who is served and identify where there are gaps. Without such data being available on a statewide basis, how can state-level policy and funding decisions be made that are effective from a fiscal, population, or resource perspective?

The State of California can and must do better. The Planning Council recommends moving away from funding-driven data collection toward system-based data reporting. Developing a state-level data collection and reporting system is difficult, but California can no longer continue to operate under imperfect, inadequate and untimely information. Engagement with technology experts in the private sector could significantly improve the use of data for policy, program and funding decision making.

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

The focus of Part II of the 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 recognized 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.

The Council began planning and developing this topic in 2016, based on the experience and concerns of members of the Planning Council. In 2019, California Governor Gavin Newsom appointed the state's first Surgeon General, Dr. Nadine Burke Harris, a pediatrician with extensive experience providing medical care to children and youth who have experienced trauma and often have multiple adverse childhood experiences (ACEs).

What is Trauma and How Common is It?[22]

Trauma depends on the individual and their responses to events:

- 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)[23] found that 72% of adults reported witnessing a traumatic event, 31% experienced trauma due to injury, and 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 even 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 deemed to be so important that the state of California has designated specific funding for trauma screenings of all children and adults with full-scope Medi-Cal (FY 2019-20).

[22] SAMHSA, Treatment Improvement Protocol (TIP) 57. www.SAMHSA.gov.
[23] NSARC: National Epidemiological Survey on Alcohol and Related Conditions, 2012.

Multiple, Complex, or Cascading Traumatic Events[24]

The effects of trauma are exacerbated by multiple, complex, or cascading traumatic events, of which there are many common examples.

- 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.
- California residents may experience consecutive and/or simultaneous natural disasters without sufficient time to heal 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, which in turn can lead to negative life outcomes.

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. 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.

[24] SAMHSA, TIP 57, page 47.

ACEs: Early Studies Linked Health Effects to Childhood Trauma

Researchers are concerned about the consequences of childhood trauma, hardship, and adversity. Many of their 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).[25] They collected data from over 17,000 adult patients of Kaiser Permanente in the San Diego area. This research was the largest epidemiological study of its kind ever done to examine the health and social effects of adverse childhood experiences over the lifespan.

These researchers found that a specific subset of ten traumatic childhood experiences were highly correlated to physical and mental health problems in adulthood. They defined these traumatic experiences as "adverse childhood experiences (ACEs)" 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 (100%), 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 of 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. It did not make sense to study one category of adversity at a

[25] 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).

time. It made more sense to study the accumulation of ACEs. Scientists made a simple score with the experience of each ACE receiving one point for a maximum total of 10. ACE scores in the study ranged from 0 to 10. 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 events of physical abuse do not yield any kind of cumulative score. This procedure for assigning or counting number of ACEs was an arbitrary choice made by the researchers to find some method to analyze what would 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 average life expectancy of a population with six or more ACES is 20 years shorter than that of the population with no 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 no ACEs, the population 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, the population 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 a 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 in the study populations were found. Larger percentages of our state residents live in poverty, have poor access to safe neighborhoods, lack health insurance and therefore lack access to regular healthcare.

Recent California Data Confirm Link of early Trauma to Health Outcomes[26]

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 the population with no ACEs, data show that the population 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 3: Adult Retrospective Data (2008-2013)[27]

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%

Adult retrospective data are shown above. In this retrospective survey, adults were asked about their life experiences prior to age 18. 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).

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 those in a specific county,

[26] These findings (and those on the following pages) are from a report on four years of statewide data from 27,745 adults that were collected by the annual California Behavioral Risk Factor Surveillance Survey [BRFSS, 2008-2013] and were reported by the Center for Youth Wellness, using analyses by the Public Health Institute. These data are remarkable for the health effects they found.

[27] State and individual county data may be found at: https://www.kidsdata.org. In tables for some small population counties, LNE means data are suppressed due to a 'low number event.'

local advocates 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. Based on statewide data, 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 cardiovascular disease: the population in California[28] 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 clear association with ACEs. In California, when compared to the population with no ACEs, the data show that the population that has experienced four or more ACEs is:

- 5.1 times more likely to have depression,
- 4.7 times more likely to seek help from a mental health professional,
- 4.2 times more likely to be diagnosed with Alzheimer's disease or dementia,
- 3.2 times more likely to engage in binge drinking,

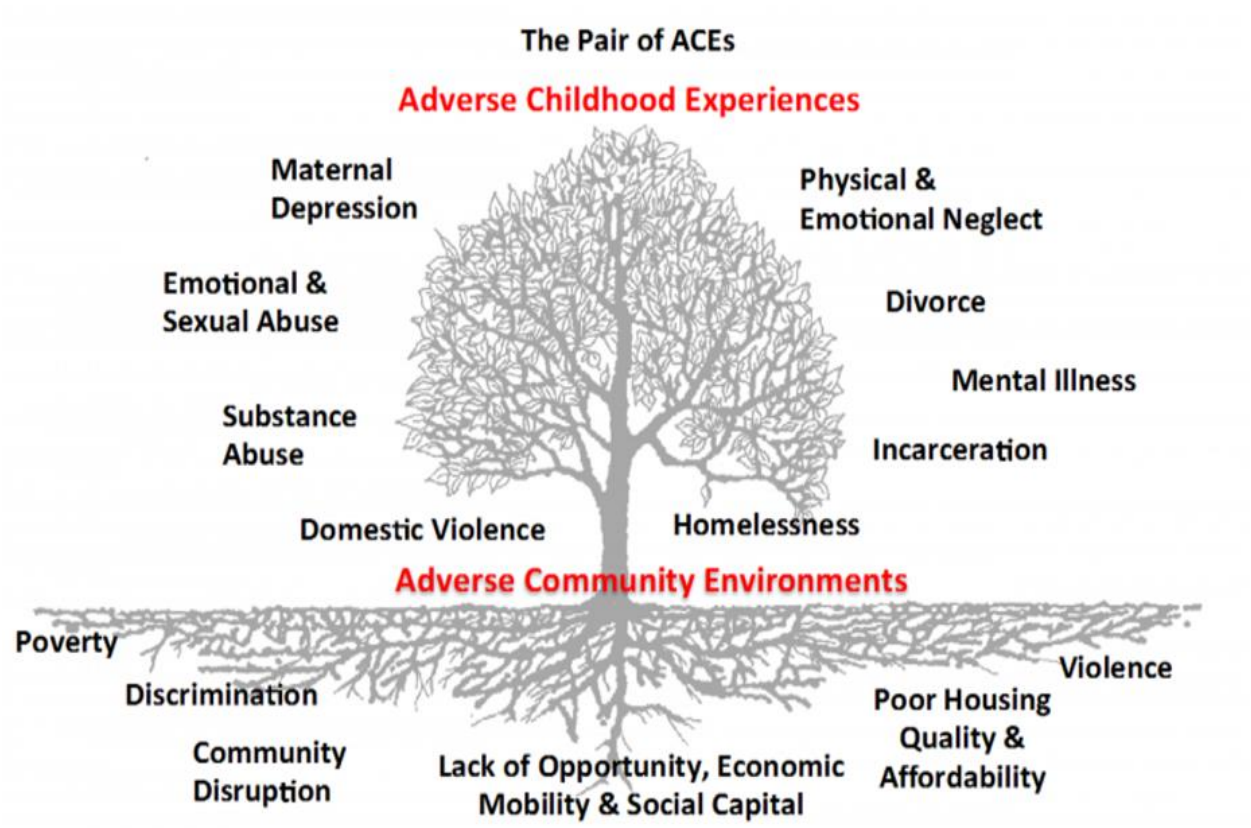
[28] These data are from BRFSS and CDC statewide data collection in California during the years 2008-2013. The numbers are similar, but not identical, to the findings from the early studies (1998) of Drs. Felitti and Anda on San Diego area patients of Kaiser Permanente, which were cited earlier in this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

- 2.5 – 3.0 times more 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 conclusions of these adult retrospective studies help us to recognize the consequences of childhood trauma and the urgency of providing early screening and treatment for trauma, and continued ongoing screening and treatment at every stage of a person's life.

There are several kinds of therapy available 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.

Figure 4. The Pair of ACEs: Include the Community Environment



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

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 for children and youth, trauma is linked to deleterious outcomes in behavioral health, physical health and overall life outcomes. Although parental hardship, (poverty, violence and lack of resources) plays a significant role, the community environment that includes poverty, discrimination, lack of education, violence, poor housing and more also has an effect. When ACEs are experienced in adverse community environments, the effects are compounded and often lead to multi-generational stress and poor health outcomes. Community resilience is an essential factor in improving public health outcomes.

The Prevalence of ACEs in California's Children[29]

Compared to the retrospective adult data described earlier, we want to examine what the data show for how common ACEs are in today's children. This type of data[30] was collected from questions asked of a parent about their children's experience of hardships that correspond to ACEs. The available data (2016) show that an estimated 16.4% of California children had 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, agency, or healthcare provider that touches the lives of children.

In particular, foster youth experience many stressors, many emotional losses, and are challenged constantly to make adaptations to changes in their placement, 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

[29] https://www.kidsdata.org

[30] 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).

to address identified mental health needs. Foster youth are a key demographic in need of trauma-informed care as they interact with multiple agencies.

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 experienced trauma. These methods are used increasingly in systems and settings that involve young people and their families.

Strategies 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. 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 is strengthened by having safe, stable, nurturing relationships and environments within and outside the family.

Schools are a front line 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.

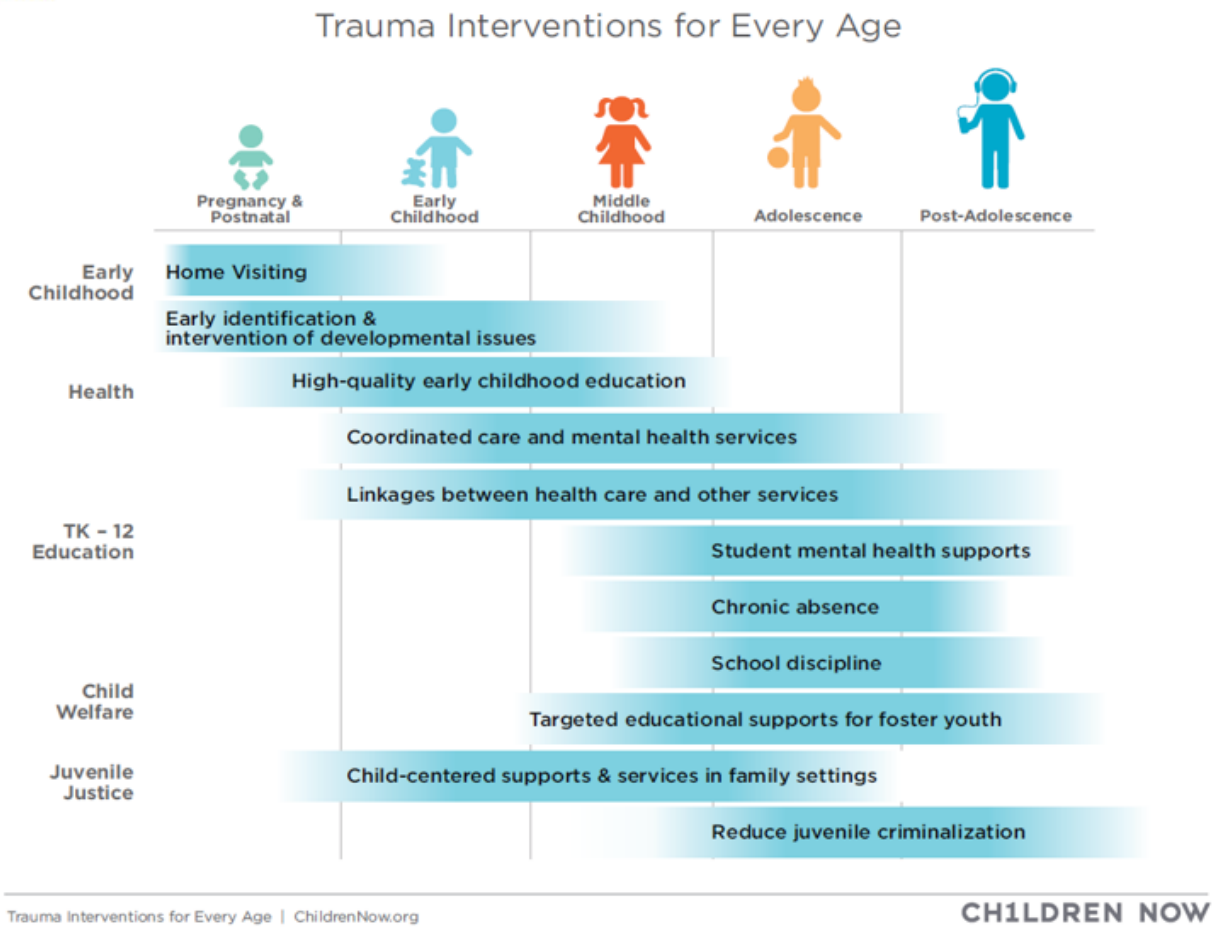
An example of one important trauma-informed approach that interfaces between the school and first-responders is the FOCUS model, where 'FOCUS' stands for 'Focusing on Children Under Stress.' Many communities refer to the program as 'Handle With Care.' This is a program that responds when a child is a witness or a victim of traumatic events in the child's home or neighborhood. First responders notify the school that the child is under stress and to focus on the child with a "handle with care' approach.[31]

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 types of trauma-related interventions for children have been designed for every stage of growth and development, as shown in the next figure.

[31] http://www.focuscalifornia.org

Figure 5. Types of Trauma-informed Interventions for Children of Each Age



The next table lists specific programs developed for children and families. These examples are evidence-based practices rooted in the principles of trauma-informed care and recognize the need to learn how to develop strategies for coping and resilience when meeting life's challenges. These programs are common in California and it is important to publicize those found in each community. Often, parents may not be aware of the resources available to help them learn about parenting skills and strategies. Some programs are offered in Spanish and other threshold languages.

Table 4. Examples of Trauma-informed Evidence-based Therapy for Families

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 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.

Focus on the Child Under Stress (FOCUS) This program responds when a child is a witness or a victim of traumatic events where they live. First responders notify the school to focus on the child and use a **'Handle With Care'** approach.

Help Me Grow is a new program that will give parents the opportunity to complete a developmental assessment of their child and that will 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.

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.

Next, we present a brief summary of the data and information submitted by local boards and their BH departments in response to questions about trauma-informed care. We also asked about their county's need for those types of programs and related training.

(12) **We asked: Has your behavioral health board/commission received information or training on trauma-informed practices and/or their importance?**

No: 22 Counties. Of the ones that answered 'No', 11 local boards either had planned training session(s), or had requested that their county department arrange such training for board members.

Yes: 18 counties

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

Some local boards took an approach that adapted the content to the needs of their community. One example is Sacramento County. At their March 2018 Public Hearing about the Mental Health Services Act Fiscal Years 2017-20 Three-Year Plan, community members commented regarding an observed gap in services to address trauma experienced in the African American community.

In response, a community planning process was convened to gather feedback from the African American community and provide recommendations for a new prevention program to address mental health and wellness needs of African American community members who have experienced or have been exposed to trauma.

At the October 2018 Mental Health Board meeting, a policy brief presentation was given by the My Brother's Keeper Sacramento Youth Fellowship. This presentation provided local statistics of traumatic events affecting teen African American males and real life examples of traumatic events experienced by teens as well as examples of support that helped them to overcome trauma.

This is just one example of how the local boards gained from their training about ACEs and trauma-informed care. All of the other county programs and training responses are detailed in Appendix III, which comprises a unique resource for this type of county data.

A few highlights are summarized below. Examples include:

- Trauma Informed Care Practices/Initiatives
- Trauma Informed Systems
- Infant Mental Health: Laying the Foundation for Healthy Communities
- Presentation on ACEs (many local boards attended an introductory ACEs talk).
- Town Hall: Brain Science and the Impacts of Trauma

- Supporting Youth Wellness: a Collaborative Approach
- Training: ACEs and Trauma for Law Enforcement and Community Partners
- Trauma Informed Care and Toxic Stress Reduction
- Attend screening of the Resilience film
- Presentation and training about the Neurosequential Model of Therapeutics (NMT) based on work of Dr. Bruce Perry, of the Child Trauma Academy
- 'T^2 Trauma Informed Systems 101', offered once every month in one county.
- One board's annual retreat included an overview of trauma-informed care, re:
    - Trauma: Events, Experiences, and Effects
    - Adverse Childhood Experiences study
    - Trauma-Informed Approach: Realization, Recognize, Respond, Resist Re-traumatization
    - Principles of Informed Care: Safety, Choice, Collaboration, Trustworthiness, Empowerment, and
    - The implications for the MH/BH Advisory Boards
- One board attended presentations about ACEs and '40 Developmental Assets.'

(13) **We asked: Is your county currently implementing trauma-informed practices for youth and for adults?**

A total of 39 counties answered 'Yes,' for both adults and youth services. One small rural county answered 'No', but that they were in the process of training staff and revising policies to be able to do so, for all age groups**.**

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

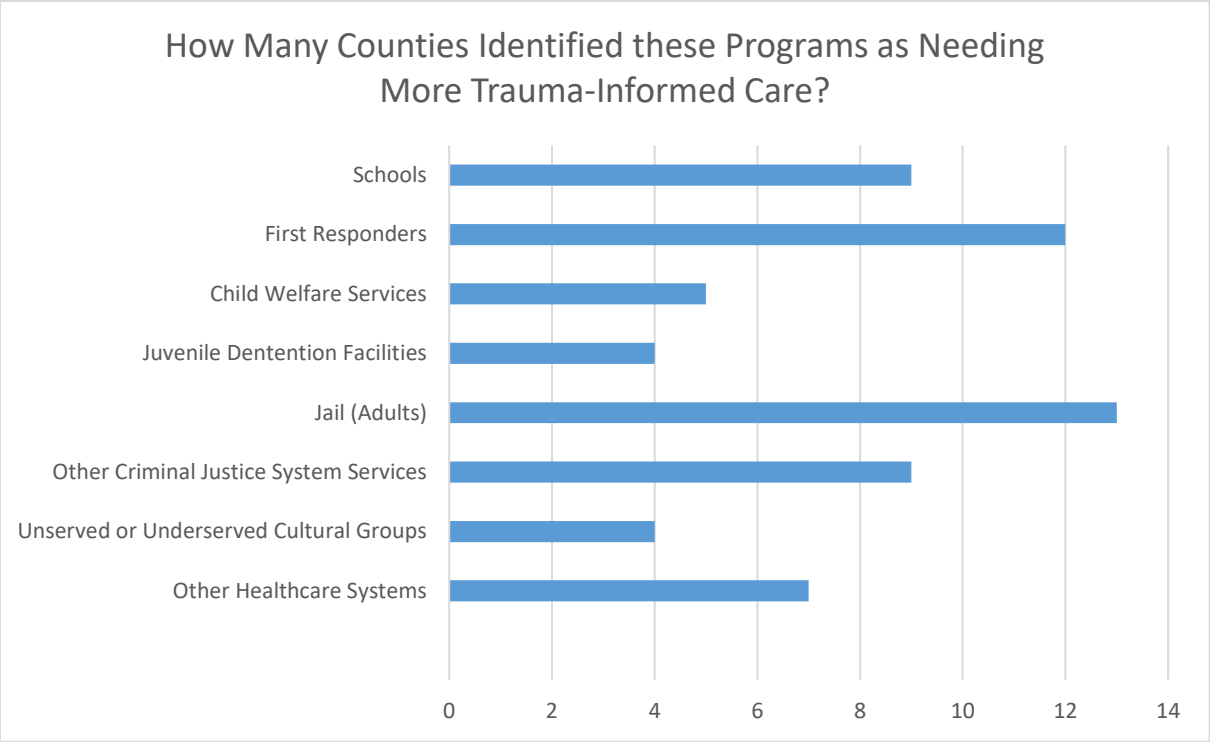
The responses indicate that most counties employ trauma-informed care of some type for children/youth and adults. Some of the answers listed programs or services for additional age groups, such as older adults. The number of programs and types of therapeutic practices described varied among the counties, but all of these drew from well-established therapies and evidence-based practices. A detailed listing of programs for youth and adults for each responding county is provided in Appendix IV.

(14) **We asked: Are you aware of service areas in your county that are <u>not</u> using trauma-informed practices that should be doing so?**

Out of 40 Data Notebooks with responses to this question, a total of <u>20</u> counties answered 'Yes' and provided examples; <u>20</u> counties answered 'No.'

If yes, please identify or list those service areas briefly. The responses were tabulated and are summarized in the next figure.

Figure 6. Counties Need Trauma-Informed Practices in More Service Areas



Other criminal justice system services that were perceived as needing more trauma-informed practices included: Sheriff's Office, Probation (Adult and Juvenile), Courts, District Attorney's Office, Public Defender's Office, Immigration's detention of asylum seekers and their family separation practices.

Other healthcare systems that were perceived to need better understanding of trauma-informed care included: Emergency Departments, primary health care, Senior Centers, skilled nursing facilities, and individual board and care providers.

Unserved or underserved cultural groups identified by respondents as needing services that better incorporated trauma-informed practices included: Latinos/Hispanics, Native Americans, older adults, LGBTQ persons, and homeless individuals.

(15) **We asked: If you recommend the expansion of trauma-informed practices in your county for children/youth, adults, or older adults, what are your top three priorities for services (or programs) for each age group? Please list briefly.**

Detailed responses from each county for each age group are listed in Appendix V.

Aside from increased services using a particular therapeutic modality, an important recurring theme was the priority to provide training about trauma-informed principles of care for community partner agencies that serve each age group. An extensive list of community and agency partners would benefit from training, as suggested below.

Priorities for trauma-informed training for providers of Children/Youth services:

- Improve statewide educational messaging and programming about Adverse Childhood Experiences, the consequences of trauma, and the pathways to recovery across the lifespan.
- Training of all faculty, library staff, and school resource officers
    - Impact the practice of school suspension and expulsions by offering therapeutic alternatives.
    - Reduce/eliminate practice of handcuffing youth for emergent MH transport by law enforcement whenever possible.
- Youth programs (e.g. recreational, sports, churches)
- 'Handle with Care' programs for children who witness a traumatic event
- 'First Five' programs and preschool staff
- Nutrition and food bank services, including school lunch programs)
- Co-occurring MH and SUD treatment services
- CPS foster care (including families and foster parents)
- Staff of STRTPs, a type of foster youth congregate care with BH services
- Primary care providers and pediatricians
- Pilot Youth Trauma Informed Cognitive Behavioral Therapy (TFCBT) for all youth services, including trauma-informed Cognitive Behavioral Therapy for early psychosis programs (CBTp).
- First responders, hospital Emergency Departments, and Crisis Response Teams for youth
- Trauma-informed training modalities for those who work with the 'Commercial Sexual Exploitation of Children' (CSEC) population.

Priorities for trauma-informed training for providers of adult services:

- County Adult Services
- Department of Social Services
- Crisis Stabilization Services (for all staff, including security guards)
- Church groups that provide adult BH and other support services
- Eligibility and employment services

- Presentations at Peer-run programs
- Homeless and Housing-related services
- Adult and crisis residential facilities
- Veterans' service providers and the Veterans Administration
- County and contracted mental health programs and services
- Substance Use Treatment programs (e.g. Seeking Safety, others)
- Agencies or partners that serve older adults
- Hospitals and Emergency Departments
- First responders/emergency medical personnel, should include training in Mental Health First Aid for paraprofessionals
- Health care and primary care providers (e.g., assessment of everyone for ACEs), including pediatricians, Ob/Gyn specialists
- Admissions processes: avoid or minimize re-traumatization by avoiding repetitious re-statements to describe the traumatic events
- Justice System and law enforcement agencies:
    - Corrections
    - Jail Custodial Staff
    - District Attorney's Office
    - Judges
    - Police Departments
    - Probation
    - Public Defenders Office
    - Sheriff
    - Providers of BH services in jails**.**

Priorities for trauma-informed training for providers of older adult services:

- All agencies for adult services that also serve needs of older adults, including agencies that promote or support affordable housing options for seniors, to help prevent late-life homelessness and the trauma of social dislocation
- Area Agency on Aging service providers
- Senior Centers: train staff and volunteers
- Senior nutrition centers and programs such as 'Meals of Wheels', food banks.
- Hospitals, assisted living facilities, and Skilled Nursing Facilities
- Church groups that provide adult behavioral health and other support services
- Disaster preparedness and response services; training related to trauma.
- Specific training about older adult issues and treatment
- Focus on grief and loss issues
- Trained peer support specialist in trauma-informed practices

- Mobile unit to provide behavioral health services to the homebound or those in rural areas
- Providers of In-Home Support Services (IHSS)
- Peer respite for in-home family caregiver
- Adult Protective Services
- Prevention, Suicide Prevention, and Outreach services
- Crisis continuum services (crisis response, crisis stabilization, follow-up needs)
- Staff of programs to decrease isolation and increase social connectedness (other areas as part of the clubhouse services promote healthy lifestyle, develop meaningful activities, improve management of chronic health conditions, including pain management). May include 'Tele-friend' programs, Elder Storytelling programs, etc.

Summary and Conclusions for Part II: Trauma-Informed Care

We selected trauma-informed care and ACEs as our focus topic because of the importance of childhood adversity and hardship to children and their immediate mental health as well as to their later life outcomes in mental and physical health, and to their success as adults in the community. An equally important reason for choosing this topic is that adults may also experience intensely tragic or catastrophic events that can lead to post-traumatic stress disorder and other serious outcomes in both physical and mental health, including substance use and even suicide. Our goal is to promote understanding of these issues and implementation of evidence-based practices for trauma-informed care across the life span.

Based on the responses received in the 2019 Data Notebooks, nearly all of the responding counties had implemented some form of training of department staff in the topics of ACEs and trauma-informed care. Most of those counties had also presented information to the local mental/behavioral health boards on the concepts of trauma-informed care and ACEs. Several counties had found these concepts so important and foundational to behavioral health services that they have implemented recurring training (i.e., once per year, or per quarter, etc.) The remainder expressed definite plans for establishing such training for board members in the near future, including a focus on underserved populations specifically including the African American community and youth.

Nearly all responding counties reported that they had implemented trauma-informed practices in their therapeutic services and programs offered by the county and its contractors for each major age group as appropriate. Some programs also offered

trauma-informed concepts within parenting classes and as a foundation for parent-child therapy.

Because of the ongoing commitment to trauma-informed practices, counties in partnership with their local boards identified service or program areas where these concepts could help to improve services and outcomes. The greatest needs for improved understanding and implementation of trauma-informed concepts were identified as lying within the justice and corrections systems that interact with both youth and adults, the foster care system, and all parts of the physical health care system, especially the first responders and emergency department personnel most likely to be involved in the response to a crisis. Some respondents noted that they were aware of use of trauma-informed practices in the K-12 schools but thought there needed to be increased use and awareness by all school staff, not just teachers and counselors.

Clearly, the understanding of trauma-informed care and its implementation are both embraced and evolving in each county to meet the needs of Californians of all ages. It will be crucial to keep in mind the principles of trauma-informed care and an awareness of the ways in which hardship and adversity affect our fellow Californians in the coming months of 2020 and beyond when we begin to recover from the present public health emergency of a viral pandemic and its accompanying economic crises.

In June 2020, the DHCS will award $14.46 million in ACEs Aware grants. ACEs Aware is an initiative led by the California Office of Surgeon General and Department of Health Care Services to give Medi-Cal providers training, clinical protocols, and payment for screening both children and adults for adverse childhood experiences. Awarded grant types will include provider training, provider engagement, and communications grants.

RECOMMENDATION 1:

California should ensure that instruction about ACEs and trauma-informed care is part of the training provided to first responders. Crisis Intervention Teams represent a first responder model designed to improve officer and consumer safety, and to redirect individuals [living] with mental illness from the judicial system to the health care system.

RECOMMENDATION 2:

California should maintain adequate funding for trauma screening of all children and adults to assess the possibility of trauma-induced serious health conditions. Data should be compiled to provide information for public health purposes.

Appendix I. Types of Trauma[32]

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

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

Appendix II. Trauma Screening Tools

Examples of some commonly used Trauma Screening tools[33] designed for specific age or 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.

[33] www.samhsa.gov, SAMHSA: Treatment Improvement Protocol (TIP) 57.

Appendix III: Information and Training on Trauma-Informed Care Received by local Behavioral Health Boards

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

NO:

Alpine County BHS Clinician Janet Stevens, LCSW, will present training on trauma-informed practices for the Alpine County behavioral health board/commissions. The Training will be: "Trauma Informed Practices."

Amador County. Plans to schedule a trauma-informed training during a behavioral health advisory board meeting in 2020 are being discussed.

Calaveras County

Del Norte County

El Dorado County: While there has not been specific training for Commissioners on trauma-informed care, BH staff and Health and Human Services Agency staff were provided information on ACEs, ACEs specific to El Dorado County, Protective Factors to increase resiliency in order to offset ACEs.

Fresno

Imperial

Inyo: not as formal training, but we do talk about these subjects, 're: skills as a Board'

Kern: The board reported that while no formal information or training specific to trauma-informed practice has been provided at behavioral health board meetings, there have been many presentations on trauma-informed practices occurring at BHB sub-committees, specifically the System Quality Improvement Committee.

Lassen County: The County is currently working with The Change Company to see if they can provide Trauma Informed Care training for the Behavioral Health Board. The County Behavioral Health Staff did receive training on Trauma Informed Care on November 1, 2019 in Quincy, CA.

Marin

Mariposa: However, the Probation Dept. is organizing ACEs training for the community in near future.

Merced

Napa: Not yet. We will share the trauma-informed care information contained within this document with mental health board members. Also, we will ask for a presentation to learn the progress of the Napa ACEs Innovation Project.

Nevada County: While not specific for the Mental Health Board, our Department of Behavioral Health has provided community trainings on trauma.

San Benito County: But we highly recommend having a training for the BHB on Trauma Informed Services.

San Francisco: The Board/Commission has not received this training. However, such training is offered elsewhere for staff/providers in the county.

San Joaquin County

Siskiyou County

Sonoma County: No, but the MH Board members will request a training at their next retreat. As MH Board members, we have not been trained in trauma-informed practices, but some individual members have seen the practice in their own experiences in some of the schools.

Tulare County

Yolo County. No, not yet.

YES. If Yes, what type of Trauma-informed Practices did your board/commission receive?

Butte County

- Mandatory Training for all Butte County Department of Behavioral Health and contracted providers on Trauma Informed Care Practices/Initiatives and Trauma Informed Systems training.
- Behavioral Health Board has been offered similar information & training on Trauma Informed Care Practices/Initiatives and Trauma Informed Systems.

Glenn County

- Safe Talk

Humboldt County

- Brief Overview of the subject.

Los Angeles County

- Best Practices
- Data Notebook info on ACEs and trauma-informed care

Mono County

- Some board members have received a full-day training
- Others received information as part of the Data Notebook process

Monterey County

- Infant Mental Health: Laying the foundation for healthy communities
- Mental health services to Foster Children & Youth
- Mental health therapeutic visitation
- Mental Health Juvenile Justice programs
- We would like to have a county-wide Trauma informed care training for 100% of staff and volunteers in agencies that deal with individuals affected by Trauma. We do not have the funding for this huge effort.

Orange County

- Dr. Anne Light, OC SSA Medical Director, presented about ACEs.

Placer-Sierra Counties

The Placer County MHADAB Children's Committee receives regular updates regarding these efforts in Placer County. Educational events, activities, and a review of the research occurs in this committee. One committee member was part of founding ***Resilient Placer,*** which is our local ACEs committee.

Resilient Placer is leading collaborative efforts between Child Welfare, Behavioral Health, Probation, Placer County Office of Education, First 5 Placer, CASA, and cultural providers such as the Latino Leadership Council and Sierra Native Alliance. Other entities in this group include family resource centers, mental health and substance use services providers, and some faith organizations. All of these groups work to provide joint educational opportunities for each other and the wider community about ACEs and trauma, and knowing the signs and symptoms of those who may need help.

Several activities that have been sponsored or supported by this group have been a 350 person attendee Trauma Summit two years ago, a town hall event on Brain Science and the Impacts of Trauma, a Poverty Simulation as a known chronic traumatic condition, and trainings led by national experts on how to become a Trauma-Informed Community.

Activities for ***Resilient Placer*** also include a "Handle with Care" program that is still under development due to technical electronic platform issues. However, with the new emphasis on the development of a county-wide 211 system, this program is anticipated to begin within the next year.

Other activities continued our focus on Trauma and the use of Marijuana and the developing teen brain, and further developed our Placer ACEs community webpage.

Sacramento County

The following information was presented. At the March 2018 Public Hearing, conducted by the Mental Health Board regarding the Mental Health Services Act Fiscal Years 2017-20 Three-Year Plan, community members commented regarding an observed gap in services to address trauma experienced in the African American community. In response, a community planning process was convened to gather feedback from the African American community and provide recommendations for a new prevention program to address mental health and wellness needs of African American community members who have experienced or have been exposed to trauma.

At the October 2018 Mental Health Board meeting, a policy brief presentation was given by the My Brother's Keeper Sacramento Youth Fellowship. This presentation provided local statistics of traumatic events affecting teen African American males and real life examples of traumatic events experienced by teens as well as examples of support that helped them overcome trauma.

San Bernardino County

Information was provided to Commissioners via formal presentations that included:

- Services for Children and Transitional Age Youth (TAY), November 3, 2016.
- Working with School Districts for More Effective Mental Health Services to Students, January 5, 2017.
- Behavioral Health Services in Rural San Bernardino County, July 6, 2017.

- Patient Care Process Behavioral Health Services Collaborative Partnership Between Arrowhead Regional Medical Center (ARMC) and the Department of Behavioral Health (DBH), September 7, 2017.
- Drug and Alcohol Services and Treatment for Youth, June 7, 2018.
- Supporting Youth Wellness: a Collaborative Approach, July 5, 2018.
- Promoting Youth Wellness through Prevention and Early Intervention, September 6, 2018.
- Training Program for Law Enforcement and Community Partners, November 1, 2018.
- Behavioral Health Services in Rural San Bernardino County, March 7, 2019.
- Trauma Informed Care and Toxic Stress Reduction, May 5, 2019.
- Suicide Prevention Support in San Bernardino County, June 6, 2019.
- Criminal Justice Partnerships, August 1, 2019.

Four Commissioners rotate every year to attend the annual Southern Region Student Wellness Conference. This five-day conference provides commissioners with formal training on integrating health services into the daily lives of students, information on family engagement, community involvement and the relation to behavioral health.

San Diego County

- Invitation to the Resilience Film Screening at CSU San Marcos
- Presentations on Trauma-Informed practices to BHAB included: The Ten-Year Roadmap for Behavioral Health Services, annual Operating Plans, Procurement Board Letters, and the Suicide Prevention Action Plan.
- Training opportunities, reference materials, and resource materials from external partners that include trauma-informed practices are shared regularly with BHAB by County staff.

San Mateo County

The Commission's Children's Committee has had several presentations in their monthly meetings about this within the Youth Division, and also related to our NMT Program. The NMT Program for Adults had developed and implemented training for adult clinicians. It has 18 months of training completed and is the only program of its kind in the country. [NMT= Neurosequential Model of Therapeutics, Dr. Bruce Perry, of the Child Trauma Academy].

Santa Barbara County

- The Commission has received training presentations following four distinct incidents since last October. These among others include,
    - The Thomas Fire,
    - The 1/9 Debris Flow,
    - Isla Vista Mass Casualty,

    - Two local family murder/suicides, and
    - The Conception Dive Boat Mass Casualty incident.
- The Commission is also aware of the Department's role in providing a response to many other community traumas, providing critical incident debriefings for First Responders, and other groups following a traumatic event. Other groups include Amtrak, Coast Guard, Harbor Patrol, CalTrans, Schools and Business.
- The Commission is aware of the Department's leadership of the Community Wellness Team which is comprised of 13 local organizations and which collectively responds to community needs for support after traumatic events.
- The Commission has been informed of the many roles the Department plays following significant tragedies such as leading Family Assistance Centers, supporting Local Assistance Centers, leading the community information call line operating out of the Emergency Operations Center, work in the Joint Information Center of the Emergency Operation center when activated, and serving as a County Public Information Officer.
- Behavioral Wellness led the FEMA-funded 'HOPE 805' team that provided broad community crisis counseling following the Thomas Fire and the 1/9 Debris Flow, supported disaster information line, and was prominent in the Montecito Center.

Santa Clara County

- 'T² Trauma-Informed Systems 101', training offered monthly since 2016.

Santa Cruz County

- At the Board's annual retreat on September 18, 2019, an overview of trauma-informed care was presented, and included these topics:
    - Trauma: Events, Experiences, and Effects
    - Adverse Childhood Experiences study
    - Trauma-Informed Approach: Realization, Recognize, Respond, Resist Re-traumatization
    - Principle of Informed Care: Safety, Choice, Collaboration, Trustworthiness, Empowerment, and
    - The implications for the MH Advisory Board.

Shasta County

- ACEs, and 40 Developmental Assets were presented to the Mental Health, Alcohol and Drug Advisory Board
- the Board also watched the "Resiliency" film

Ventura County

- Presentation by Dr. Kathleen Van Antwerp, Child Behavioral Specialist, at a Board General Meeting.

- Presentations at Board's Youth & Family Committee meeting on Commercial Sexual Exploitation of Children (CSEC) and at Prevention Committee meeting.
- All presentations and updates since 2013 to present on Pathways to Wellbeing (Katie A. Reform) and Continuum of Care Reform have highlighted trauma informed practices, cross system collaboration and improvement, joint trainings, evidence informed/based treatment, culturally response treatment and program development.
- SAMHSA's GAINS Center provided a training on 9/27/17: "How Being Trauma-Informed Improves Criminal Justice System Responses"; VCBH and CIT staff attended, including Dr. Sevet Johnson and Dr. John Schipper.
- A SAMHSA's Gains Center/Policy Research Associates training called "How Being Trauma-Informed Improves Judicial Decision-Making" presented on 12/3/19, tailored to Court professionals and sponsored by VCBH.
- In 2018: Provided our own Cognitive Behavioral Therapy (CBT) trainings; because CBT is foundational for complex trauma treatment, is age appropriate, and culturally appropriate for our threshold population.

Appendix IV: Types of Trauma-Informed Practices Implemented by Counties for Youth, Adults, and Older Adults

Question 13 (A): Is your county currently implementing trauma-informed practices for youth?

NO:

Lassen County: The county was just recently trained on Trauma Informed Care and is developing policy to implement trauma informed practices within the Department.

YES: If yes, what evidence-based practices for trauma-informed care are being used in your county for YOUTH?

Alpine County

- Play Therapy
- Primary Intervention Program (School based early intervention)
- Trauma Awareness Training for teachers (2017)
- Play Group

Amador County

- For youth, staff are trained in Trauma-Focused CBT.
- Two new staff will be trained in Trauma-Focused CBT in October 2019.

Butte County

- Trauma Focused Cognitive Behavioral Therapy (TFCBT) for Youth

Calaveras County

- Seeking Safety, EMDR, TF-CBT

Del Norte County

- School Based Therapy
- Dialectic Behavioral Therapy
- Cognitive Behavioral Therapy
- Integrated Dual Disorder Treatment
- Anger Management Therapy

El Dorado County

- Our contracted providers attend quarterly ACEs meetings and monthly subcommittees,
- Brief Intervention for High School Students models,

- Protective Factor promotion for families in the Community Hubs programs, and
- DBT Therapy for Behavioral Health clients.

Fresno County

- Fresno County Superintendent of Schools provides school district personnel with training in trauma as part its partnership with the Department of Behavioral Health's specialty mental health services.
- Trauma-Focused Cognitive Behavioral Therapy
- Eye Movement Desensitization and Reprocessing
- Dialectical Behavioral Therapy

Glenn County

- Wellness and Recovery Action Plan
- Parent Child Interactive Therapy (PCIT)
- Strengthening Families
- Transition Age Youth Center activities.

Humboldt County

- Some of the trauma-informed services are evidence-based and some are a result of generalized training of staff regarding ACEs and trauma.
- The juvenile hall and regional facility (special mental health-focused long-term care unit co-located with the juvenile hall) have specialized training to help staff appropriately provide custodial care for juveniles.
- The staff are trained in non-violent verbal de-escalation.
- These trainings help prevent trauma and are trauma-informed.

Imperial County

- Trauma screening and assessment
- Trauma-specific services such as parent education and outreach

Inyo County

- FOCUS (Families Overcoming Under Stress) – UCLA program
- PCIT (Parent Child Interactive Therapy).
- Triple P Parenting (component)

Kern County

- Trauma Informed Kern County
- Transition to Independence (TIP)
- Seeking Safety
- Cognitive Behavior Therapy (CBT) for Suicide
- Aggression Replacement Therapy (ART)

- Critical Incident Stress Management (CISM)
- Narrative Therapy and Dialectic Behavior Therapy.

Los Angeles County
- Child-Parent Psychotherapy
- 40 Development Assets
- Strengthening Families
- Triple P Parenting

Marin County
- Child-Parent Psychotherapy (Trauma-Informed EBP)
- Trauma-Focused Cognitive Behavioral Therapy
- Seeking Safety

Mariposa County
- TF-CBT
- EMDR

Merced County
- Seeking Safety,
- Cognitive Behavioral Therapy – trauma focused
- Motivational Interviewing.

Mono County
- MCBH and the Behavioral Health Advisory Board know that there have been trainings on trauma-informed care, and
- Staff members in various agencies served as champions for trauma-informed care, [however] we do not know if there are evidence-based practices in place
- Several trainings were coordinated by a foster youth school liaison who is no longer in this position.
- These trainings were optional and were not consistently attended by school personnel and teachers.
- Within MCBH, there has been more a focus on strengths-based approaches rather than trauma-informed approaches.
- Other Mono County departments have also had some training in trauma-informed care as it relates to Wraparound services, multi-disciplinary teams, and child and family teaming.

Monterey County
- Seeking Safety
- Child-Parent Psychotherapy
- Attachment Self-Regulation and Competency (ARC)

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- EMDR

Napa County

- Child Parent Psychotherapy (CPP)
- Cognitive Behavioral Therapy - Early Psychosis (CBT – EP)
- The Napa County Office of Education's Juvenile Court and Community Schools trains staff in Trauma Informed Practices.
- Juvenile Hall adheres to guidelines as set forth in Title 15. In January 2019, substantive changes were implemented which included trauma. Throughout Title 15 there are stipulations that require the use of trauma-informed approaches. Juvenile Hall Staff have had the opportunity to participate in various Trauma-Informed trainings.

Nevada County

- Trauma Focused Cognitive Behavioral Therapy
- Understanding Trauma Informed Care.
- Suicide Prevention Task Force

Orange County

- Screening and assessment of children through the lens of ACE study,
- Adhere to SAMHSA's Tip 57; provide trainings on evidenced-based practices, i.e.
  - Eye Movement Desensitization Reprocessing (EMDR),
  - TF-CBT,
  - CBITS (Cognitive Behavioral Intervention for Trauma in Schools)
  - Seeking Safety.

Placer and Sierra Counties

- **Trauma Focused Cognitive Behavioral Therapy (TF-CBT)** has been offered at our Family Resource Centers (KidsFirst and Lighthouse Counseling) and many other treatment providers for many years with good results.
- **Protective Factors** counseling is offered by Lighthouse through First 5 funding to help prevent child abuse and neglect by also building parental resilience.
- **Parent Child Interaction Therapy** is a hands-on, direct skill-building intervention that has changed over the years to incorporate a focus on understanding trauma reactions and resilience building.
- **Incredible Years** including Dinosaur School for younger children is an evidenced-based practice designed to work through early trauma with the development of resiliency as a focus and this program is offered by 'KidsFirst.'

- **First 5 Placer** has sponsored and funded **Home Visitation** programs in the Family Resource Centers for many years.
- **Help Me Grow** is still being developed in Placer and includes developmental screenings offered by First 5 contractors and Placer County Children's System of Care nurses. **Ages and Stages** is the preferred tool used in the county.
- **Triple P Positive Parenting Program** is being offered by many providers that work with Placer children and youth, but most are through the group home and STRTP providers when children are placed out of the home.
- **Positive Behavioral Interventions and Supports (PBIS)** is a robust program in most of Placer County's schools aimed at improving the social, emotional, and academic outcomes for all students, including those with trauma histories and reactions. Schools implementing PBIS have demonstrated improved outcomes in a variety of areas, including a reduction in suspensions and expulsions, as well as increased academic improvement and improved graduation rates.

A host of trauma-informed interventions and programs are happening in local Placer schools (many funded through MHSA). These include **Mental Health First Aid** to train educators and students to recognize the signs and symptoms of distress, A**pplied Suicide Intervention Skills (ASIST)** training, and **SafeTALK** are aimed at training everyone to be able to find the words to talk about suicide alertness and prevention.

- **Teen Wellness Centers** were developed in the Tahoe-Truckee Unified School District to have safe places for teens to drop in to talk to peers and others, as well as focus on interventions such as **Mindfulness** training to work on healthy responses to trauma.
- They are also continuing to use the **Columbia Teen Screen** in their wellness centers to identify mental health-related to trauma and other issues early on and be better equipped to refer and give services. Many are peer-led groups.
- A large grant from the Mental Health Oversight and Accountability Commission is funding **additional Wellness Centers** to be developed over the next several years in South Placer through a collaboration between Children's System of Care, PCOE, and Roseville School Districts.

Placer County spent several years developing a **trauma-informed pre-school program** for the 2-6-year-old population specifically to address trauma reactions and intervene as early in a family as possible to ensure the developmental trajectory of a child is changed to a better path for mental wellness and school readiness. The program was originally intended to be a regional program but is most often utilized by Placer County child welfare, early childhood education, and other local referral sources. It is currently in its 5th year of operation and is funded with MHSA, ESPDT Medi-Cal, First 5 and child welfare realignment ffunds and has had very good results to date.

Sacramento County

- Sacramento County uses trauma-informed practices for both children and adults.
- Assessments screen for types of trauma, and providers utilize trauma-informed practices with trauma-specific interventions for type of trauma and symptoms.
- These therapies include the following:
    - Trauma-Focused Cognitive Behavioral Therapy (CBT),
    - Seeking Safety,
    - Parent-Child Interaction Therapy,
    - Alternatives for Families CBT, and
    - Dialectical Behavior Therapy.

San Benito County

- County Behavioral Health utilizes the following evidence-based practices to deliver trauma-informed care services:
    - Cognitive Behavioral Therapy (CBT)/Trauma-Informed CBT,
    - Motivational Interviewing,
    - Dialectical Behavior Therapy (DBT), and
    - Mental Health First Aid (MHFA) Training for the community.

San Bernardino County

Department of Behavioral Health uses the following forms of trauma-informed practices:

- Trauma Focused-cognitive Behavioral Therapy (TF-CBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Seeking Safety
- Parent-Child Interaction Therapy (PCIT)
- Incredible Years
- Attachment, Regulation and Competency (ARC)
- ACEs
- Functional Family Therapy (FFT)
- Trauma Resiliency Model
- Disaster Mental Health
- Intro to Trauma-Informed Care
- Vicarious Traumatization, Vicarious Transformation

Although the responsibilities of the public MH system often limit the counties' ability to provide an end-to-end trauma-informed care model (such as changing the design of clinic waiting rooms), the county has adopted policies, procedures and a culture of an organization that supports trauma survivors. All levels of the organization have the awareness, knowledge, and skills needed to support those impacted by trauma.

San Diego County:

- Short-term treatment models such as Trauma-Based Cognitive-Based Therapy and Solution-Focused Brief Therapy, and
- Trauma Informed Parenting training (which pull from Positive Discipline and ACEs research) is provided to the Children, Youth, and Families System of Care.

San Francisco County:

- Trauma Module on CANS Assessment Tool
- Trauma Focused CBT
- Trauma Systems Therapy
- Trauma-Focused CBT for Complex Trauma
- Integrative Treatment of Complex Trauma

San Joaquin County

- Trauma Focused Cognitive Behavioral Therapy
- Seeking Safety
- Parent and Child Interactive Therapy (PCIT)
- Cognitive Behavioral Interventions for Trauma in Schools

San Mateo County

- The **Neurosequential Model** of Therapeutics (NMT)—during the last nine years in the Youth division

Santa Barbara County

- Our county's Alcohol and Drug Program (ADP) pioneered trauma informed treatment services for adults and adolescents over fifteen (15) years ago.
- County ADP and its contracted treatment providers have institutionalized '**Seeking Safety'**, a trauma informed model that treats clients with co-occurring Substance Use Disorder (SUD) and Post Traumatic Stress Disorder (PTSD).
- The Behavioral Wellness Department has established the '**Strengthening Families Program'** (SFP) in each region of the county.
- The SFP is not only an integral part of our primary prevention system of care, but has also been piloted in two of our mental health clinics as part of our family driven mental health treatment system of care.
- Our models include the **Trauma Resiliency Model**, **Youth Mental Health First Aid**, Mental Health First Aid, and Psychological First Aid (Evidence Informed).

Santa Clara County

- Child-Parent Psychotherapy,
- Trauma-Focused Cognitive Behavioral Therapy,
- Dialectical Behavioral Therapy,

- Motivational Interviewing,
- Seeking Safety,
- Strengthening Families Program,
- Triple P Parenting Program

Santa Cruz County

- Providers use a comprehensive Psycho-Social Assessment at Intake to guide treatment planning, and use either of two tools to identify/record potentially traumatic and adverse childhood experiences:
    - The Child and Adolescent Needs and Strengths (CANS) or
    - Adult Needs and Strengths (ANSA) tool.
- Within Children's Behavioral Health, numerous clinicians have training in:
    - Child Parent Psychotherapy (CPP, an evidence-based therapy for children age 0-5 and their parent/caregiver)
    - Eye Movement Desensitization and Reprocessing (EMDR)
    - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
    - Dialectical Behavioral Therapy (DBT) and
    - HeartMath, an intervention aimed at increasing mental and physiological regulation.
    - Skills to facilitate and participate in Child Family Team (CFT) meetings, which are family-driven, solution-focused, trauma-informed, and aimed at ensuring that a comprehensive shared plan is developed.
    - Trauma-informed Functional Family Therapy
    - Parent-Child Interaction Therapy
- Collaborates with the County of Education (COE) strategic plan and the local school districts and nonprofit agencies to craft a system of care that addresses mental health, substance use, and suicidal ideation at multiple levels. The COE takes deliberate steps to destigmatize mental health among students, families, and the community. With the hope that social-emotional skills will be interwoven throughout curricula, so that school climate will reflect inclusiveness, and both will shorten the distance between need and services for all youth. Mental health is a fundamental component for all students to belong, thrive, and succeed.

Shasta County

- Seeking Safety,
- Cognitive Behavioral Therapy,
- Bruce Perry 'Neurosequential model'
- Teaching resource families about attachment-based, trauma informed intervention for caregivers, called 'Trust-Based Relational Intervention'.

Siskiyou County

- Help Me Grow
- First 5
- Strengthening Families
- Trauma Informed CBT

Sonoma County

- Staff have been trained to use trauma-informed care with adults and children.

Tulare County

- EMDR
- Prolonged Exposure Therapy
- TFCBT
- Critical Incident Stress Debriefing

Ventura County: Adults and Youth Evidence-Based Practices (EBPs)

- CBT (Train the Trainer Model) /Advance Peer Mentors 50 trained since 2013. Trained Diplomats of the Academy are now 15 as of 2017. In 2019, CBT Operational Guide established for the Department and VCBH able to certify clinicians at a department standard.
- Seeking Safety
- Parent-Child Interaction Therapy (PCIT)
- Theraplay
- Depression Treatment Quality Improvement (DTQI)
- Dialectical Behavior Therapy (DBT)
- Integrated Dual Disorder Treatment (IDDT)
- Aggression Replacement Therapy (ART)
- HOMEBUILDERS
- Brief Strategic Family Therapy (Trained to Fidelity New Dawn)
- Moral Reconation Therapy (MRT)

Yolo County

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT),
- Parent-Child Interaction Therapy (PCIT),
- EMDR, Seeking Safety, and
- In Home Psychotherapy Program (IPP).
- Additionally, Yolo County has a community collaborative, ‘Resilient Yolo’, that works to infuse ACEs awareness and resiliency building practices throughout the community.

Question 13 (B):

Is your county currently implementing trauma-informed practices for ADULTS?

NO:

Lassen County: The county was just trained on Trauma Informed Care and is currently developing policy on implementing trauma informed practices within the Department.

YES: If yes, what evidence-based practices for trauma-informed care are being used for ADULTS in your county?

Alpine County, for Adults

- Seeking Safety
- Mindful Based Stress Reduction (2019)
- Staff and Community Member training in community approach to trauma-informed prevention opportunities (2018)

Amador County

- County Behavioral Health has not adopted an EBP for trauma-informed care for adults at this time.
- However, all clients receive a biopsychosocial assessment at the time of intake, which includes a trauma component for all clients.
- Treatment staff are encouraged and invited to attend ongoing trauma-focused training.

Butte County

- Adult modality currently being vetted by the Butte County Department of Behavioral Health Trauma Informed Care Work Group.

Calaveras County: Seeking Safety, EMDR, TF-CBT

Del Norte County

- Dialectic Behavioral Therapy
- Cognitive Behavioral Therapy
- Integrated Dual Disorder Treatment
- Anger Management Therapy

El Dorado County

- Administering the ACEs and Resiliency questionnaires to all new and existing clients, effective Oct. 1, 2019.

- We are not specifically trained in our clinic to provide any specific trauma-informed, evidence-based practices at this time.
- However, in Spring 2020, MHSA is hosting a “Trauma-Informed Approaches” best practices training for our staff and community partners.
- The Behavioral Health Commission also noted that the County’s agreement with Telecare, the contracted provider who runs the Psychiatric Health Facility, mentioned using trauma-informed approaches in their contract.

Fresno County

- Trauma-Focused Cognitive Behavioral Therapy
- Eye Movement Desensitization and Reprocessing
- Dialectical Behavioral Therapy

Glenn County

- Trauma-Informed Cognitive Behavioral Therapy (TI-CBT)
- Mindfulness
- Didactic Therapy

Humboldt County

- Some of the trauma-informed services are evidence-based and some are a result of generalized training regarding ACEs, trauma, and trauma-informed care.
- Adult PHF (Psychiatric Health Facility) trained all staff in these practices in Feb. 2019. New staff at CSU/PHF all get TIP training as part of the on-boarding process.
- The staff at the Adult PHF are trained in non-violent verbal de-escalation as are staff at the county correctional facility.
- These trainings help to prevent trauma and are trauma-informed.
- The county trains some staff in the EBPs ‘Seeking Safety’ and ‘Trauma Informed Cognitive Behavioral Therapy.’

Imperial County

- Trauma-informed care for substance use disorders
- Trauma screening and assessment
- Trauma-Focused Cognitive Behavioral Therapy and Interpersonal Therapy

Inyo County

- Seeking Safety
- Trauma CBT

Kern County

- Seeking Safety

- Cognitive Behavior Therapy (CBT) for Suicide
- Aggression Replacement Therapy (ART)
- Critical Incident Stress Management (CISM)
- Narrative Therapy
- Dialectic Behavior Therapy.

Los Angeles

- Seeking Safety
- Trauma Focused CBT
- Health Dept. Protocol

Marin County

- Trauma-Focused Cognitive Behavioral Therapy
- Seeking Safety
- Dialectical Behavior Therapy

Mariposa County

- TF-CBT
- EMDR

Merced County

- Beyond Trauma
- SUD utilizes the ACES screening tool that is delivered within orientation groups and information from that is then shared with the primary counselor to help with treatment planning.
- SUD evidenced based curriculum with Trauma include:
    - Beyond Trauma,
    - Helping Men Recover,
    - Helping Women Recover and
    - Seeking Safety.

Mono County

- While MCBH and the Behavioral Health Advisory Board know that there have been trainings on trauma-informed care and that staff members in various agencies have served as champions for trauma-informed care, we do not know if there are evidence-based practices in place.
- Several trainings that took place were coordinated by a foster youth school liaison who is no longer in this position.

Monterey County

- Seeking Safety
- Attachment Self-Regulation and Competency (ARC)

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- EMDR

Napa County

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Cognitive Behavioral Therapy - Early Psychosis (CBT – EP)
- Dialectical Behavioral Therapy (DBT)
- Cognitive Behavioral Therapy for Psychosis (CBTP)

Nevada County

- Trauma Focused Cognitive Behavioral Therapy
- Understanding Trauma Informed Care.
- Suicide Prevention Task Force

Orange County – Adults and Older Adult Behavioral Health (AOABH):

- AOABH uses
  - Motivational Interviewing,
  - EMDR,
  - Seeking Safety,
  - Mindfulness practices

Orange County: Agency and System Change

- *BHS has participated in a trauma-informed learning collaborative, awarded by the National Council, to create a more trauma-informed system of care.*
- *The staff has received a series of four trauma-informed training modules, and several other interventions are underway.*
- *BHS is also developing a Trauma-Informed Care Practice Guideline, expanding its peer workforce (an essential element of trauma-informed practices).*
- *Orange County recently received a SAMHSA GAINS Center 2-day train the trainer opportunity entitled, "How Being Trauma-Informed Can Improve Criminal Justice Responses." The Health Care Agency will train 20 persons across the County's justice and behavioral health system to help create a common language and understanding of the best ways to respond to justice-involved populations.*

Orange County Examples:

- Strong Families/Strong Children (SFSC) is a MHSA funded consortium of five non-profits (*Child* Guidance Center, Human Options, *Children* and Family Futures, Families Forward and *Veterans* Legal Institute) to *support veteran and active service member families in Orange County by addressing the impact on*

children who have parents with Post-Traumatic Stress Disorder (PTSD) resulting from military service.

- *Expands the number of trained trauma therapists in the County who specialize in working with children in military families and*
- *Establishes veteran and active service member peer support and action groups to reduce the effects of secondary trauma on children.*

- Children's Hospital of Orange County (CHOC) hosts trainings on ADHD for pediatricians and on anxiety and trauma-informed- care for health professionals.

- Human Options and the UCI Elder Abuse Forensic Center both currently provide comprehensive Trauma-Informed Care training to other organizations and agencies.
  - Particular emphasis is on treating older adults and young children who are especially vulnerable populations
  - The goal is to recognize symptoms and signs of trauma, be more empathetic, and client-centered with individuals who may have experienced many different types of traumas.
  - Trauma-Informed Care approaches help to reduce the adverse effects of traumatic experiences from violence, elder/child abuse, fires, car accidents, robberies, assaults, sexual abuse, natural disasters, etc.

- Human Options, Women's Transitional Treatment Center, St. Jude Medical Center, among others, provide counseling and group support resources to victims of traumatic events from several agencies, i.e., (see below).

- Orange County Probation Department (Adult Operations) is in the fifth year of teaching Trauma Responsive Practices.
  - To date, approximately 800 of the total 1,200 staff have completed this mandatory training.
  - After four years of experience, the department changed from the initial National Child Traumatic Stress Network (NCTSN) curriculum to the current experience- based curriculum, including information, videos, etc., taken from multiple sources.
  - Currently, a team is participating in the county-wide TIC training.

Placer and Sierra Counties

- See responses to Question 12 about adult-oriented trainings and therapy.

- Extensive information about children, their parents, and youth is provided in response to question #13 (A) for Youth.

Sacramento County

- Sacramento County uses trauma-informed practices for both children and adults.
- Assessments screen for types of trauma and providers utilize trauma-informed practices along with trauma-specific interventions according to the type of trauma and related symptoms.
- These therapies include the following:
    - Trauma-Focused Cognitive Behavioral Therapy (CBT)
    - Seeking Safety
    - Parent-Child Interaction Therapy
    - Alternatives for Families CBT, and
    - Dialectical Behavior Therapy.

San Benito County

- County Behavioral Health utilizes the following evidence-based practices to deliver trauma-informed care and services:
    - Cognitive Behavioral Therapy (CBT)/Trauma-Informed CBT,
    - Motivational Interviewing,
    - Dialectical Behavior Therapy (DBT), and
    - Mental Health First Aid (MHFA) Training for the community.

San Bernardino County

Department of Behavioral Health uses the following forms of trauma-informed practices:

- Trauma Focused-cognitive Behavioral Therapy (TF-CBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Seeking Safety
- Parent-Child Interaction Therapy (PCIT)
- Incredible Years
- Attachment, Regulation and Competency (ARC)
- ACEs
- Functional Family Therapy (FFT)
- Trauma Resiliency Model
- Disaster Mental Health
- Intro to Trauma-Informed Care
- Vicarious Traumatization, Vicarious Transformation

Although the responsibilities of the public MH system often limit the counties' ability to provide an end-to-end trauma-informed care model (such as changing the design of clinic waiting rooms), the county has adopted policies, procedures and a culture of an

organization that supports trauma survivors. All levels of the organization have the awareness, knowledge, and skills needed to support those impacted by trauma.

San Diego County

- Motivational Interviewing
- Promotion of the ACES Study
- Seeking Safety
- Eye Movement Desensitization and Reprocessing (EMDR).

San Francisco County

- Trauma Module during Assessment
- Trauma Focused CBT
- Trauma Systems Therapy
- Trauma-Focused CBT for Complex Trauma
- Integrative Treatment of Complex Trauma

San Joaquin County

- Trauma Focused Cognitive Behavioral Therapy
- Seeking Safety

San Mateo County

- The 'Neurosequential Model of Therapeutics' (**NMT**)—for the last 18 months.

Santa Barbara County

- County of Santa Barbara Alcohol and Drug Program (ADP) pioneered trauma informed treatment services for adults and adolescents over 15 years ago.
- Initially begun through a series of SAMHSA grants, County ADP and its contracted treatment providers have institutionalized 'Seeking Safety', a trauma informed model that treats clients with co-occurring Substance Use Disorder (SUD) and Post Traumatic Stress Disorder (PTSD).
- In addition, the Behavioral Wellness Department has established the 'Strengthening Families Program' (SFP) in each region of the county.
- The SFP is not only an integral part of our primary prevention system of care, but has also been piloted in two of our mental health clinics as part of our family driven mental health treatment system of care.
- Additional models include the Trauma Resiliency Model, Youth Mental Health First Aid, Mental Health First Aid, Psychological First Aid (Evidence Informed).

Santa Clara County

- Trauma-Focused Cognitive Behavioral Therapy,
- Dialectical Behavioral Therapy,
- Motivational Interviewing,

- Seeking Safety.

Santa Cruz County

- Providers use a comprehensive Psycho-Social Assessment at Intake to guide treatment planning, and use Adult Needs and Strengths (ANSA) tool to identify/record potentially traumatic and adverse childhood experiences:
- Within Adult BH, staff have training in Motivational Interviewing (MI), Illness Management and Recovery (IMR), Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT).
- Contractors throughout the county use MI (e.g. Encompass), trauma-informed Functional Family Therapy(FFT), and Parent-Child Interaction Therapy (PCIT)

Shasta County

- Seeking Safety,
- Cognitive Behavioral Therapy,
- Bruce Perry 'Neurosequential model'

Siskiyou County: Trauma Informed CBT

Sonoma County

- County staff have been trained in and use trauma-informed care in their work with clients, both adults and children.

Tulare County

- EMDR
- Prolonged Exposure Therapy
- TFCBT
- Critical Incident Stress Debriefing

Ventura County:

Adults and Youth Evidence-Based Practices (EBPs)

- CBT (Train the Trainer Model) /Advance Peer Mentors 50 trained since 2013. Trained Diplomats of the Academy are now 15 as of 2017. In 2019, CBT Operational Guide established for the Department and VCBH able to certify clinicians at a department standard.
- Seeking Safety
- Parent-Child Interaction Therapy (PCIT)
- Theraplay
- Depression Treatment Quality Improvement (DTQI)
- Dialectical Behavior Therapy (DBT)
- Integrated Dual Disorder Treatment (IDDT)
- Aggression Replacement Therapy (ART)

- HOMEBUILDERS
- Brief Strategic Family Therapy (Trained to Fidelity New Dawn)
- Moral Reconation Therapy (MRT)

Yolo County

- We train staff in Team CBT.
- Yolo also provides Seeking Safety through CCHC contracts (Navigation and Proposition 47 programs).
- Through our **TPCP-ACT/AOT** contract, we also provide Seeking Safety.
- Our TAY, Adult FSP, and Forensic teams, are trained in the Transition into Independence Process Model (evidence-supported practice) that comes from a trauma-informed lens

Appendix V. Priorities for Expansion of Trauma-Informed Practices

For each major age group, what are your top three priorities (if any) for the expansion of trauma-informed practices in your programs and services?

Question 15-A. Top Priorities for CHILDREN/ YOUTH Services:

Alpine:

1. Train Trauma Informed Practices to Partnership Agencies
    - TANF
    - WIEC
    - Library Staff
    - Alpine Kids
    - DVS – Alpine County office of Education
    - Recreation Dept.
2. Mental Health First Aid Youth

Amador:

- Increase training/EBP in school settings
- Training/education for parents and caregivers

Butte:

- Changes/updates to county policy, practice, and environment for Youth Services
- Pilot Youth TFCBT Modality at all Youth services
- Identify & implement strategies to support service staff in Youth services

Calaveras:

- More EMDR Available

Del Norte:

- Increased trauma informed care training
- Additional clinical staff for the delivery of these treatments

El Dorado:

- All Schools
- All youth treatment services
- Law enforcement

Fresno: NR

Glenn:

- Collaboration between Behavioral Health and Schools
- Bullying
- Preschools

Humboldt County:

- Support for children or youth who are victims of physical, emotional or sexual abuse.
- Support for children or youth who have been exposed to family violence.
- Support for children or youth who were recently diagnosed with a serious mental illness or another serious health condition.
- Support for Houseless youth who have left the Foster Care system.
- Expansion of Family Therapy, Trauma-based Cognitive Behavioral Therapy, and support for families with adopted members.

Imperial:

- Pediatricians/ OBGYN: trained in ACES
- School Resources Officers: Crisis
- School Faculty

Inyo:

- Bullying programs
- Crisis/responders informed
- Early programs for prevention

Kern:

- EMDR (Eye Movement Desensitization & Reprocessing
- UCLA EMPWR Program: Promoting Well Being and Resilience in LGBTQ Youth

Kings:

- Expansion of STRTPs within Kings County
- Placing Social Workers in schools
- Mobile Crisis Team for Stabilization

Marin:

Strengthening early childhood mental health through:

- Staff training in trauma treatment
- Partnerships with community partners and schools
- Better screenings and assessments.

Increase care coordination and support for high-risk youth, especially from underserved communities that require bilingual language capacity.

Increase collaboration with the juvenile justice system and schools (i.e., ACT for youth in FSP, DBT skill building for youth).

Mariposa:

- Three staff trained in TF-CBT
- Parent support groups
- Increased coordination with schools

Merced:

- Trauma Informed Training
- Training for Community Partners
- Training specific for age 0-5 population

Mono:

- Rather than focusing on the expansion of trauma-informed practices, Mono County is presently working towards a comprehensive project around ACEs or Adverse Childhood Experiences.
- This project would implement the use of the ACE assessment and resulting score and create an infrastructure that would wrap services around individuals with high ACE scores.
- This project would likely include trauma-informed practices, but would focus squarely on resilience and ensure that the vocabulary used is empowering.
- Mono Children/Youth: School staff, First Five, local preschools.

Monterey:

- Trauma-Informed Systems training for county and community partner agencies.
- Co-Occurring mental health and Substance Use Disorder (SUD) training; and expansion of child and adolescent SUD services.
- A 12-14 bed residential facility for Acutely Mentally Ill children and youth emphasizing a trauma informed treatment philosophy.

Napa:

- Mental Health First Aid at all schools
- Crisis Stabilization Services (for all staff, including security guards)

Nevada

- Early Childhood Education

Orange:
As a result of receiving the SAMHSA GAINS Institute "Train-the-Trainer" grant for trauma-informed care practices, a learning collaboration was formed countywide for the Behavioral Health Department and Contracted Providers (below):

- Corrections
- District Attorney's Office
- Judges
- Police Departments
- Probation
- Public Defender
- Sheriff

The plan is to teach trauma-informed care countywide, ensure that our whole system is working from a trauma-informed perspective that addresses all age groups:

- Priority 1: Behavioral Health Department
- Priority 2: County Staff
- Priority 2: Contracted Providers

Placer and Sierra

- Handle with Care – Resilient Placer
- TF-CBT in all STRTPs
- Trauma Focused Home Visitation

Sacramento

- Services to ages 0-5
- Prevention & Early Intervention services for all youth
- Crisis continuum services for all youth

San Benito

- Train staff across agencies to increase collaboration
- Schools are a pit for bullying (especially for children/youth who are overweight/obese); there is a need to address this issue
- Provide support for LGBTQ through BH And First 5 partnerships

San Bernardino

- Screen for ACEs throughout our MHP
- Increase training to STRTP's on Trauma Informed Care
- Increase access to Trauma-Informed Trainings for MHP staff

San Diego

- Reduce/eliminate practice of handcuffing youth for emergent mental health transport by law enforcement whenever possible.
- Impact the practice of school suspension and explosions by offering therapeutic alternatives.
- Expanding services specific to supporting immigrant youth and families throughout the County and specifically along the southernmost border.

San Joaquin:

- Prioritize in-county STRTPs for residents of San Joaquin County.
- Recruit and retain more psychiatrists and clinicians.
- Improve whole family involvement in treating youth, including the promotion of healthy living.

San Mateo:

- Universal screenings for both trauma and sensory disorders at the start of all treatment for both youth and adults.
- Expansion of somatosensory services and vendors for service referrals.
- Continued training for all county staff in any kind of service position on trauma-informed practices and system change.

Santa Barbara:

- Expansion of Youth Mental Health First Aid
- Stigma reducing campaigns
- More Substance Use Disorder (SUD) and Mental Health Outreach Activity including Early Intervention Services
- Continued training on Strengthening Families, TRM and other evidence based and informed practices

Santa Clara

- Shared understanding and common language on toxic stress and trauma.
- Cultivate healing environments by increasing organization resilience, improving workforce experience, and ultimately supporting organizations in responding to and reducing the impact of trauma.
- Embed the core principles of trauma-informed care in everyday practices

Santa Cruz

- Expanded capacity to serve children 0-5 exposed to ACEs/trauma, via Child Parent Psychotherapy (CPP) and its group-based intervention ‘Attachment Vitamins.’

- Universal ACEs screening within pediatric/family practice clinics (AB340)
- Trauma-informed Neuropsychological/ Psychological Testing and Evaluation Services in client/ family's preferred language to support clarification of complex presentations.
- Expansion of Family Partner Services and/or Family Navigators to support parent/caregivers in navigating complex systems.
- Expanded services for Boys and Men of Color exposed to ACEs and Trauma.

Shasta

- Expansion of trauma-informed practices in schools
- Youth programs (e.g. recreational, sports, churches)
- Community education

Siskiyou

- Nutrition
- Health outlet activities
- Education

Sonoma

- All School staff, including public, charter and private, should be training in trauma-informed practices.
- All students should be aware of the purpose of trauma-informed care for themselves, i.e., how and why would they benefit?
- Develop public service announcement.

Tulare

- TFCBT Training
- EMDR

Ventura

- Additional family treatment modalities.
- Modalities with Commercial Sexual Exploitation of Children (CSEC) population and for individuals with Eating Disorders.
- Community law enforcement and jail custody staff.

Yolo

- Parenting Assistance and education, using the well-regarded "*promotoras*."
- Quarterly outreach and involvement activities in the rural as well as urban areas of the county by a *promotora* of the appropriate ethnic and language group for each community.
- Additional efforts to improve the low penetration rates for Latino families.

Question 15-B. Top Priorities for ADULT Services:

Alpine:

1. Train Trauma Informed Practices to Partnership Agencies
   - Crisis Intervention Team
   - First Responders
   - Library Staff
   - Probation
   - County Court

2. Mental First Aid Training for Adults

Amador:

- EBP for Older Adults
- Training for partner agencies who serve adults

Butte:

- Changes/updates to county policy, practice, and environment for Adult Services
- Identify & Pilot Trauma Informed Care Modality for all Adult services
- Identify & implement strategies to support service staff in Adult services

Calaveras:

- More EMDR needs to be made available.

Del Norte:

- Increased trauma informed care training
- Additional clinical staff for the delivery of these treatments

El Dorado:

- Jail
- All treatment services
- Law enforcement

Glenn:

- Jail Services
- Probation
- Eligibility and Employment Services

Humboldt:

- Support for victims of domestic violence.
- Support for family members with individuals with mental illness.

- Support for individuals who have been recently diagnosed with a severe mental illness and or a substance use disorder.

Imperial:
- Law Enforcement
- Hospitals
- Primary Care Physicians: trained in ACES

Inyo:
- Crisis responders and physical health care need to have raised awareness.
- For practitioners: assessment for everyone using ACE's.
- Increase trauma-informed care such as EMDR, DBT.

Kern:
- EMDR (Eye Movement Desensitization & Reprocessing
- Expansion of Seeking Safety
- Prolonged Exposure Therapy

Kings:
- Increased Housing
- More Psychiatrists
- Mobile Unit to provide services in the rural areas

Marin:
- Staff training on Trauma Informed Care and Trauma Informed Systems
- Improve care coordination practices with housing, medical, and criminal justice partners
- Increase statewide educational messaging and programing regarding Adverse Childhood Experiences, the consequences of trauma, and the pathways to recovery across the lifespan.

Mariposa:
- Expand specialized trauma services
- Train peer support specialist in Trauma-informed practices
- Maintain increased trauma-focus groups

Merced:
- Caseload control to implement effective Trauma Informed Care
- Increased focus on Dual Diagnosis Programs
- Implement ACEs at all levels of practice

Mono

Rather than focusing on the expansion of trauma-informed practices, Mono County is presently working towards a comprehensive project around ACEs or Adverse Childhood Experiences. This project would implement the use of the ACE assessment and

resulting score and create an infrastructure that would wrap services around individuals with high ACE scores. This project would likely include trauma-informed practices, but would focus squarely on resilience and ensure that the vocabulary used is empowering.

Mono Adult Services: Law Enforcement Agencies, IMACA, Department Social Services.

Monterey:

- Harm Reduction Training.
- Seeking Safety
- Strength-based Case Management
- Reaching Recovery
- Motivational Interviewing
- Cognitive Behavioral Therapy

Napa

- BH in Jails
- Crisis Stabilization Services (for all staff, including security guards)

Nevada

- Jail Custodial Staff
- Hospital Emergency Department
- Veterans

Orange: As a result of receiving the SAMHSA GAINS Institute "Train-the-Trainer" grant for trauma-informed care practices, a learning collaboration was formed countywide:

Behavioral Health Department and Contracted Providers:

- Corrections
- District Attorney's Office
- Judges
- Police Departments
- Probation
- Public Defender
- Sheriff

The plan is to teach trauma-informed care countywide, ensure that our whole system is working from a trauma-informed perspective that addresses all age groups:

- Priority 1: Behavioral Health Department

- Priority 2: County Staff
- Priority 2: Contracted Providers

Placer and Sierra

- Enhance the integration of Trauma Focused services with Crisis response
- Continue to implement trauma focused services and interventions within BH
- Increase Trauma focused services within Mental health Court

Sacramento:

- Prevention & Early Intervention services
- Crisis continuum services
- Trauma-Informed Training

San Benito

- Church groups
- Jail and probation
- CPS Foster Care: Families and Foster Parents

San Bernardino

- Safe sleeping sites for the homeless.
- Trauma informed training for Primary Care providers.
- Further collaborate and promote with schools to develop new practitioners

San Diego

- Mental Health First Aid training for paraprofessionals.
- Increasing Person First Language.
- Avoid re-traumatization through admission process (having to repeat their story each time admitted to a service).

San Joaquin:

- Expand and add recovery facilities to provide more drug and alcohol detox services for those with a dual diagnosis.
- Recruit and retain more psychiatrists and clinicians.
- Promote socialization as part of living a healthy lifestyle.

San Mateo

- Universal pre-treatment screenings for both trauma and sensory disorders
- Expansion of provider network to increase somatosensory services.
- Train more adult services staff to deploy the NMT model and practice effectively.

Santa Barbara:

- Stigma reducing campaigns
- More Substance Use Disorder (SUD) and Mental Health Outreach Activity including Early Intervention Services
- Continued training on Strengthening Families, TRM and other evidence based and informed practices

Santa Clara

- Both county & contracted mental health programs
- Inpatient services- increase awareness

Santa Cruz

- Provision of trauma-informed Cognitive Behavioral Therapy for Psychosis (CBTp) for Transitional Age Youth (TAY)/Young Adults
- Trauma-informed Crisis Residential Facilities

Shasta

- Law enforcement
- Jail
- First responders/emergency medical personnel

Siskiyou

- Job skills/education
- Employment
- Health care/mental health care, first responders

Sonoma

- Presentations at peer-run programs
- Consistent and ongoing training of all County staff, including contractors.
- Develop Public Service announcement

Tulare

- TFCBT Training
- CISD or other early crisis response intervention
- Additional EMDR training for non-staff on an annual basis.

Ventura: No expansion requested.

Yolo

- Helping to identify housing resources for the homeless and those in danger of homelessness

Question 15-C. Top Priorities for OLDER ADULT Services:

Alpine:
Train Trauma-Informed Practices to Partnership Agencies

- 50+ Club Involvement
- Tribal Elders Council
- Washoe Housing Authority
- First Responders
- Tribal First Responders

Amador:

- EBP for Older Adults
- Medical provider training in trauma-informed care practices

Butte:

- Changes/updates to county policy, practice, and environment for Older Adult services
- Identify & Pilot Trauma Informed Care Modality for Older Adult services
- Identify & implement strategies to support staff who provide Older Adult services

Calaveras: More EMDR needs to be available.

Del Norte:

- Increased trauma informed care training
- Additional clinical staff for the delivery of these treatments

El Dorado:

- Jail services
- All treatment services
- Law enforcement

Glenn:

- Veterans
- Senior Nutrition Center
- Hospital (Adults and Older Adults)

Humboldt:

- Support for Older Adults who are victims of physical abuse or other forms of elder abuse such as sexual abuse or financial abuse.
- Grief Support

Imperial:

- DSS: APS and IHSS

- Public Administrator/ Area Agency on Aging
- Emergency Rooms

Inyo:
- Practices as related to Substance Use and trauma.
- Disaster preparedness and related trauma.

Kern:
- EMDR (Eye Movement Desensitization & Reprocessing)
- Prolonged Exposure Therapy

Kings:
- Mobile Unit to provide services to the rural areas
- Senior Centers with trained staff
- Mental Health Services provided in the home

Marin:
- Trauma Informed Practices across the Lifespan
- Better coordination with Primary Care Physicians to identify issues of trauma in older adults.

Mariposa:
- Expand specialized trauma services
- Train peer support specialist in Trauma-informed practices
- Maintain increased trauma-focus groups

Merced:
- Specific training on Older Adult issues and treatment
- Focus on Grief and Loss issues
- Focus on community-based treatment

Mono
Rather than focusing on the expansion of trauma-informed practices, Mono County is presently working towards a comprehensive project around ACEs or Adverse Childhood Experiences. This project would implement the ACE assessment and resulting score and create an infrastructure that would wrap services around individuals with high ACE scores. This project would likely include trauma-informed practices, but would focus squarely on resilience and ensure that the vocabulary used is empowering.

- IHSS for elderly; Adult Protective Services, Eastern Sierra Area Agency Aging.

Monterey:
- Harm Reduction Training
- Seeking Safety
- Strength-based Case Management

- Reaching Recovery
- Motivational Interviewing
- Cognitive Behavioral Therapy

Nevada
- Assisted Living
- Residential Senior Services
- Hospital Emergency Department

Orange:
As a result of receiving the SAMHSA GAINS Institute "Train-the-Trainer" grant for trauma-informed care practices, a learning collaboration was formed countywide for the Behavioral Health Department and Contracted Providers (below):
- Corrections
- District Attorney's Office
- Judges
- Police Departments
- Probation
- Public Defender
- Sheriff

The plan is to teach trauma-informed care countywide, ensure that our whole system is working from a trauma-informed perspective that addresses all age groups:
- Priority 1: Behavioral Health Department
- Priority 2: County Staff
- Priority 2: Contracted Providers

Placer and Sierra
- Crisis Response Involving trauma informed practices
- Increase collaboration with community partners and an understanding of the impacts of Trauma on the Older Adult.
- Enhance services that focus on clients with frequent hospital ED Visits.

Sacramento:
- Prevention, Suicide Prevention, and Outreach services
- Crisis continuum services
- Trauma-Informed Training

San Benito
- First Responders
- Veterans
- Senior Center

San Bernardino

- Promote training for care facilities.
- Further collaboration with Department of Aging and Adult Services.
- Promote levels of care that can address the co-occurring needs for older adults.

San Diego

- Substance Use Treatment specific to Older Adults.
- Decrease Isolation/Increase Social Connectedness via a Mobile Rural Clubhouse specific to Older Adults (other areas as part of the clubhouse services promote healthy lifestyle, develop meaningful activities, improve management of chronic health conditions, including pain management).
- Trauma-Informed Care/EBPs such as ACEs are excellent for Older Adults, and help avoid emotional triggers and help heal/avoid re-traumatizing the client.

San Joaquin:

- Recruit and retain more psychiatrists and clinicians.
- Create a one-stop-shop for medical and psychiatric health services.
- Promote socialization as part of living a healthy lifestyle.

San Mateo

- Universal screenings for both Trauma and Sensory disorders at the start of all treatment for older adults.
- Expansion of provider network to increase somatosensory services.
- Adequately train older adult stuff, increasing the number of staff proficient in the NMT model and practice.

Santa Barbara:

- Stigma reducing campaigns
- More Substance Use Disorder (SUD) and Mental Health Outreach Activity including Early Intervention Services
- Continued training on Strengthening Families, TRM and other evidence based and informed practices

Santa Clara

- Home bound – under served
- Develop new program – Elder story telling
- In home care giver/peer respite

Santa Cruz

- Expansion of Tele-friend Program
- Education on hospitalization for Older Adults in our facilities
- Need of Residential Facilities for Older Adults

Shasta County

- Food Banks and Meals on Wheels programs

Siskiyou

- Nutrition
- Identifying isolation
- Health & mental health screening

Sonoma

- Training of family members, county In-Home Support Staff and private caretakers
- Consistent and ongoing training of all County staff, including contractors
- Develop Public Service announcement
- Training of peers support staff going out in the community

Tulare

- TFCBT Training
- CISD or other early crisis response intervention
- Additional EMDR training for non-staff on an annual basis.

Ventura: No expansion requested.

Yolo: Better coordination of mental health care and physical health care, especially with regard to medication monitoring.