Comprehensive Interagency System of Care for Children and Youth

Measuring Outcomes of Collaboration

Nineteen-Year Report
July 1, 1989 - June 30, 2008

Santa Cruz County Children's Mental Health

The following poem comes from a youth participating in Dennis Morton's poetry workshop at Juvenile Hall; the second poem was written by our Chief of Children's Mental Health, Dane Cervine. More poetry is included starting on page 44.

Prove It

A cold breeze blows voices through the mist.
Desperate cries shatter the placid surface
of a sea of presumptions.
I'm screaming for you to please see me for what
I truly am. I am a talented individual.
I hold knowledge unknown to you,
gifts that make me who I am.
I am not composed solely of my mistakes,
so forget that ignorant opinion.
Imagine the good I can do.
Help me to do it.
You say that's what you want to do.
Prove your intentions true.

-- Jackson, *first published in the Beat Within 13.08*

Justice Is Not Blind

The proud girl from Oakland
sits on-stage at the conference,
describes her normal day—
boyfriends shot at, one killed,
purse stolen, cell phone stomped,
avoiding drugs at the party. It is
the only life she has known.
It is why all the therapists are here.
Her life, a light flickering
across the bay, a golden gate, a bridge
America must cross to find
its blind heart.

-- Dane Cervine,
Chief of Children's Mental Health
First appeared in Monterey Poetry Review

The following poem was written during a staff meeting by the School Treatment Team, with each clinician taking turns composing one line. I think it speaks to the sense of celebration and energy inherent in our efforts towards resiliency and recovery—for our families, our children, and our communities.

I am the melody of the rhythm

But I have no voice or drum.

I must remain positive and resolute.

The beat starts from within me

And the tempo is always on the one.

The syncopated echoes answer with

The untold mystery of everything

And the Universe tells its tales

Through the reverberating frequencies

Drifting across the air

Vibrating with the heart-beat of the Universe

Drumming to the same rhythm

Humming the melody that I am becoming.

I am me.

SANTA CRUZ COUNTY CHILDREN'S MENTAL HEALTH

INTERAGENCY SYSTEM OF CARE REPORT

Nineteen Year Anniversary Summary

July 1, 1989 - June 30, 2008

TABLE OF CONTENTS

PREFACE

Welcome to the **19th Year Anniversary Report** of the Santa Cruz County Children's Interagency System of Care. The outcomes and data that follow represent 19 years of effort from the families, staff, interagency partners and community members involved in building our System of Care, and are to be celebrated! Our hope is that this work will continue to demonstrate the value, beauty, and power of communities working together to ensure that our most at-risk children & youth are surrounded with the necessary supports ***to live safely at home, benefit from school, and stay out of trouble.*** To this end, this report:

- Reviews 19 years of cumulative data and outcomes; and
- Focuses on the last two fiscal years of 2006 – 2008 for recent trends.

Systems of Care for children & youth with serious emotionally disturbances, and their families was initially developed at the National Institute for Mental Health in Washington D.C. It came to California as a pilot project in a single county in the 1980's, then to Santa Cruz as part of a three county expansion in 1989. At the turn of the century, it had begun to be implemented in nearly all 58 counties throughout California, though the resources and commitment to ensure fidelity to full statewide implementation was severely challenged through several years of devastating statewide budget cuts. However, **with the passage of the Mental Health Services Act (MHSA)** in November 2004 by California voters (known as Proposition 63), there is a new opportunity to deepen and broaden the transformation begun by Systems of Care, to ensure adherence to transformative values and principles, to refocus on clear outcomes, and to broaden community engagement in creating a context of recovery and resiliency for our children, youth and families.

> **"Children's System of Care (CSOC) and Wraparound,** and the philosophies, values and service standards they incorporate**, are the foundations upon which the MHSA was built…**designed **to operationalize system transformation** and the principles of…W&I Code Section 5850 et seq. that define the core values and infrastructure requirements for Children's System of Care programs and services *(pgs 24-25 of 8/1/2005 MHSA plan requirements)*.

Systems of Care **are the set of values and practices** that point the major child serving agencies of Juvenile Probation, Social Services, Education, Substance Abuse, Mental Health and other partners **toward the families, children and youth they share in common—in order to deliver services and monitor outcomes in a coordinated and integrated way.** Increasingly, through efforts such as the Mental Health Services Act (MHSA), **families and communities are seen as change agents helping to create contexts of recovery and resiliency for all citizens.** ***Systems of Care*** are characterized by strong partnerships with families at every level of the system, as well as special attention to developing cultural relevancy and competencies. A well-functioning System of Care has the ***potential to change community landscapes profoundly***—from fragmented, traditional "turf" programs to communities and agencies truly working together to achieve the best outcomes for children and youth who have fallen between the cracks for too long. Although in some counties the "System of Care" implementation reflects single program modifications rather than true systems change, the groundwork has been laid statewide for systems change to occur.

Indeed, many federal, state, local, and foundation **reform efforts are occurring simultaneously** in these related fields: **Child Welfare Redesign** for foster children; **Balanced and Restorative Justice (BARJ) and Detention Reform** for youth in Probation; advances in treating **Dual Diagnosis Substance**

Abuse & Mental Health issues; increased initiatives at creating **safe and healthy schools.** Communities can help ensure that these become integrated transformational efforts, woven together in a "system of care" for families, rather than stand-alone "silo" reforms.

To help ensure that such efforts result in actual improvements for our children, families and community, Santa Cruz has tracked a series of performance measures for the last 19 years to help ascertain outcomes for our System of Care. These measures include **fiscal outcomes** to help demonstrate the cost effectiveness of delivering family-preservation, community-based services—**system outcomes** to gauge whether youth are improving in school, are safer, committing less crimes—**clinical outcomes** that measure improvements in feeling and behavior—and **satisfaction measures** that gauge youth and family satisfaction with treatment. In addition, we present updates on progress in core program areas, including Family Partnership and Cultural Competence. This report presents 19 years of cumulative data, as well as information on annual outcomes for the last two years.

Highlights of 2006 – 2008:

- Continued to **responsibly manage out-of-home care costs** (residential, hospital, etc.) at levels **significantly lower than pre-reform efforts**.
- **Foster Care penetration rates for mental health services rose to 96%**, compared to the statewide average of 55% and medium county average of 57%.
- **Transition Age Youth penetration rates for mental health services rose to 10.79%**, compared to the statewide average of 6.94% and medium county average of 6.7%.
- **Youth aged 6-17 penetration rates for mental health services are at 12.48%**, compared to the statewide average of 7.71% and medium county average of 7.5%.
- **Young children aged 0-5 penetration rates for mental health services rose to 1.9%,** compared to the statewide average of 1.31% and medium county average of 1.44%.
- **Expenditures per client comparable to the Full Service Partnership (MHSA) model** across a larger span of youth referred from Probation, Child Welfare, Special Education and the community.
- **Increased the total number of children/youth served to 1,896 in 07/08, from 1,362 in 04/05.**
- **Increased the percentage of Latino children/youth served to 55% in 07/08, from 48% in 04/05** (though the percentage has stayed the same the past 3 years—more outreach needs to occur).
- Completed an extensive community planning process for the **Prop 63 Mental Health Services Act (MHSA),** commencing with new services in July 2006. The Children's focus is on System Development with an emphasis on **better engagement of younger Latino children aged 0-11**. New components include: better interface with primary care physicians, expanded school treatment services, differential response for Child Welfare referrals, earlier access for Juvenile Probation youth, early childhood mental health, transition-age services, integrated dual diagnosis substance abuse/mental health, and expanded family partnership services.
- Expansion of **Family Solutions,** an **SB-163 Wraparound** program for court wards at risk of group home placement.
- Post-grant dissemination of best practices from Probation's **Robert Wood Johnson *Reclaiming Futures* grant** (one of 10 national sites) focused on dual diagnosis substance abuse/mental health system redesign to better serve youth in juvenile justice. Best practices have included the design and implementation of the Drug Grid for comprehensive screening/assessment for all Children's clients; continued dissemination of Thinking For A Change cognitive-behavioral curriculum, Seven Challenges dual diagnosis curriculum, and Cara y Corazon cultural/community engagement.

- Implementation of Probation's **California Endowment *Healthy Returns Initiative* grant** focused on improved mental health and health assessment/aftercare of youth detained in juvenile hall, with a special focus on girls.
- Expanded screening, assessment and treatment supports for **Child Welfare dependents**, including collaboration with Child Welfare's *System Improvement Planning* process, expanded **family reunification** treatment, **homeless** family & child supports, and implementation of a comprehensive **interagency differential response capacity** with First Five, Child Welfare, Substance Abuse, and Mental Health.
- Expanded **AB 3632 Mental Health Services to Special Education students** with local SELPA's and the County Office of Education to meet the needs of several new classrooms for pupils with emotional disturbances.
- **Expanded EPSDT mental health services** through community-based agencies, particularly targeted to the Pajaro Valley Unified School District (PVUSD) **to better reach at-risk Latino youth in our largest school district.**
- **Initial planning to improve Primary Care Physician interface** with child/adolescent psychiatric consultation, as well as **improved ACCESS** for community referrals for mental health screening, assessment and treatment (implemented July 2008).

To help **keep the flame alive**, we hope the outcomes in this report not only illustrate the continuing value Systems of Care hold for Santa Cruz, but illuminate its ongoing potential for California's most at-risk children, youth and families.

Dane Cervine
Chief of Children's Mental Health
Mental Health & Substance Abuse
Santa Cruz County

ACKNOWLEDGEMENTS

The Santa Cruz County Interagency System of Care is truly a "village of services", filled with concerned individuals who nurture, maintain, and develop it with great skill and commitment. Without such commitment and hard work, as well as the ***vision*** that keeps us going, the System of Care would become just another "program." To this end, we'd like to acknowledge and thank the many people and groups involved in this effort—too numerous to name them all—but every one of which contribute in significant ways:

The many **families, children and youth** who entrust themselves to our care, and jointly strive for healing, health, and wholeness.

The dedicated, talented, and **hardworking staff from each agency** who give their all every day.

Our **interagency management teams**, supervisors and managers from each agency, who keep us moving forward despite all obstacles—clinical, societal, and bureaucratic.

Our **evaluation and data staff** that condense a lot of raw data into a story that makes sense.

Rama Khalsa, our Health Services Agency Administrator, Leslie Tremaine, our new Mental Health & Substance Abuse Director, as well as Glenn Kulm, Director of HSA Administration, and all the Mental Health staff who do the daily "magic" of fiscal and infra-structure support that keep our efforts afloat.

The agency and program leaders without whose partnership there would be no System of Care:

Judy Cox (retired!), Laura Garnette, Scott MacDonald and staff at the Probation Department
Cecilia Espinola, Ellen Timberlake, Judy Yokel and staff of the Human Services Department
Michael Watkins and many County Office of Education staff
SELPA Directors Dan Cope and Carol Lankford
Bill Manov and staff of Alcohol and Drug Programs in our division
Melody St. Charles and Carol Sullivan of Family Partnership, Mark Silva and Clare Wesley of Youth Services, Cynthia Wells of Early Childhood services, Celia Goeckermann of Parents Center, Linda Perez and Jenny Sarmiento of PVPSA, Dave Bianchi of Family Services Agency, Betsy Clarke of Community Support Services, Andre Chapman of Unity Care, Inc., and many of their various staff.

The County Administrative Officer, Susan Mauriello, and each of the Board of Supervisor members who ultimately answer to this community about the outcomes for the Santa Cruz County families we serve:

District 1	Jan Beautz
District 2	Ellen Pirie
District 3	Neal Coonerty
District 4	Tony Campos
District 5	Mark W. Stone

SANTA CRUZ COUNTY
CHILDREN'S MENTAL HEALTH
1400 Emeline Avenue, P.O. Box 962
Santa Cruz, CA 95060
(831) 454-4900

NINETEEN YEAR REPORT

JULY 1, 1989 - JUNE 30, 2008

INTRODUCTION

Santa Cruz County has developed a comprehensive interagency system of care for seriously emotionally disturbed (SED) children, adolescents, and their families. Many benefits of this System of Care cannot be measured—**the many lives that are touched, the private successes, growth and maturation that occur for the children and youth we serve. The beauty of this effort, though, is that there are many benefits to the community and families that *can* be measured**. The report that follows details these measurable outcomes—outcomes that correspond to our original System of Care goals:

- Maintain children safely in their homes whenever possible.
- Place children in the least restrictive yet clinically appropriate setting when out-of-home placement is required.
- Reduce number and costs of group home and hospital placements by:
  - Providing appropriate alternative services
  - Maintaining family involvement
  - Providing individualized, field-based services
  - Interagency collaboration and coordinated service delivery
- Reduce juvenile justice recidivism and keep juvenile hall occupancy low
- Maintain school attendance and increase benefit from education
- Develop and maintain a family/professional partnership
- Cultivate culturally competent services
- Use evaluation to shape policy and become accountable to families, taxpayers and legislators.

This summary reports progress on System of Care evaluation objectives, core components, and programs. Finally, in order to root the statistics and summaries in the most important aspect of our work, we've included client poetry and vignettes as a reminder of the humanity of our mission.

In essence, these outcomes can be summarized as *Keeping Youth:*

- *Safely At Home*
- *In School*
- *Out of Trouble*

Feel free to contact Dane Cervine, Chief of Children's Mental Health, at the address above with questions or comments. The Children's System of Care 19-year Report is available online at www.santacruzhealth.org/cmhs/2children.htm in the blue "contact information" box.

NINENTEEN YEAR OUTCOMES

I. SYSTEM OF CARE EVALUATION OBJECTIVES

A. Keeping Youth at Home

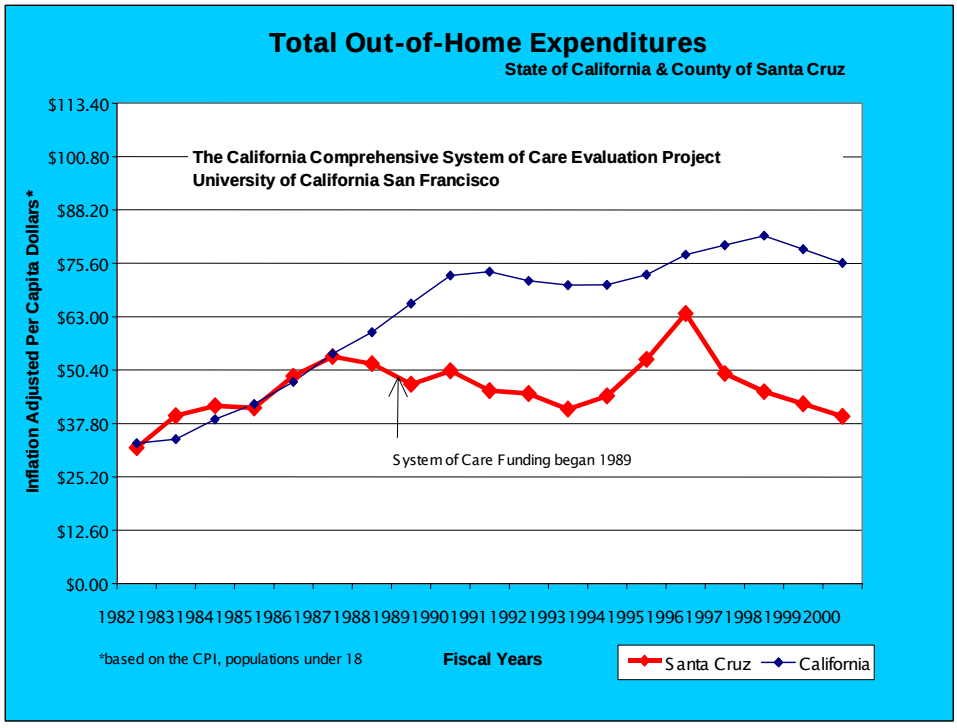
Keeping youth at home is one of the easiest objectives to track. As depicted in the data that follows, **Santa Cruz County is helping children and youth to stay at home, and out of institutionalized care**. By keeping youth in the least restrictive, most home-like setting possible, we are providing quality care at substantial cost savings to local, state, and federal agencies.

1. Reducing and Managing Out-of-Home Expenditures

Historical View: the First Twelve Years 1989 - 2001

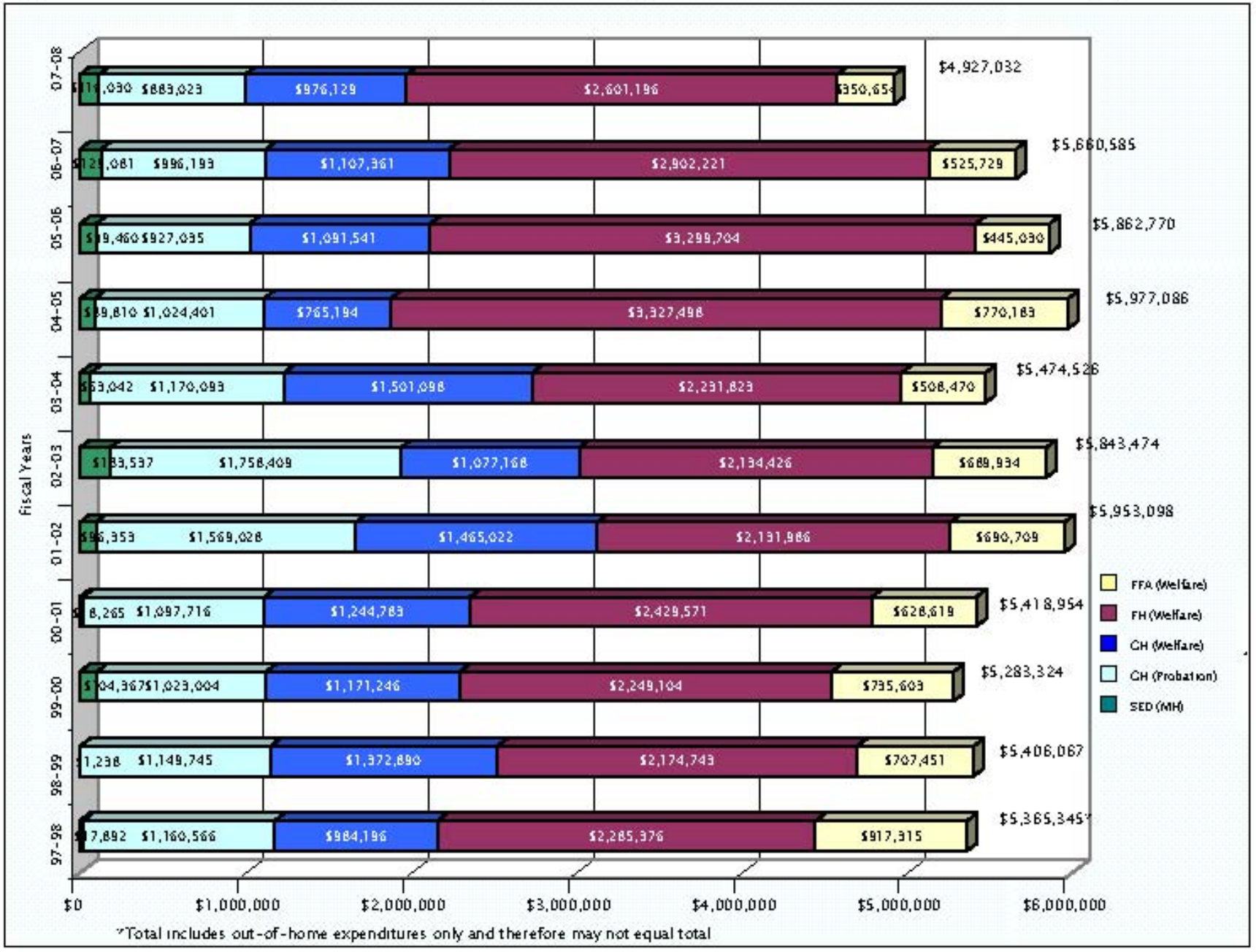
For many years, the Child Services Research Group of the University of California, San Francisco, calculated savings on out-of-home expenditures by comparing Santa Cruz County with the California State average (State Department of Social Services data only available through June 2001). We provide this information, now, as background on the impact of System of Care implementation over the first 12 years in Santa Cruz, which demonstrated dramatic cost savings. Since statewide out-of-home expenditure data is no longer easily available, Santa Cruz will be shifting to local expenditure trends for cost containment tracking in the graphs that follow this first one:

Figure 1. Total Out-of-Home Expenditures through June 30, 2001, Source UCSF



As you can see, for the twelve-year period from April 1, 1989 through June 30, 2001, the cumulative savings for Santa Cruz County are estimated at 22.7 million dollars. The average annual savings during this period were $1.89 million per year. The average annual System of Care (SOC) allocation from the state during this period was $723,000.

Figure 2. Total Out-of-Home Expenditures July 1, 1997 through June 30, 2008, HSD Foster Care Tracking spreadsheets.



*Total includes out-of-home expenditures only and therefore may not equal total

Therefore, the Santa Cruz County annual cost savings for this period is 261% of the average annual SOC budget, or $1.61 savings for every $1 budgeted. **Figure 1 illustrates Santa Cruz County's long history of reducing and stabilizing local, state, and federal costs for residential placement through our System of Care approach.**

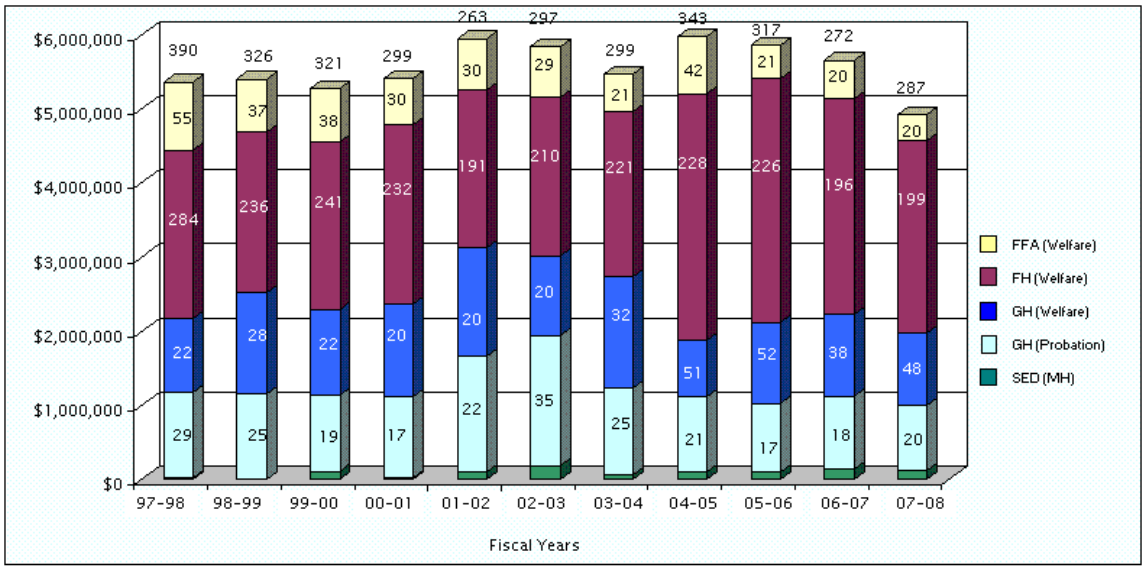
Current Data: Local Out-of-Home Expenditure and Placement Patterns

While Figure 1 compared Santa Cruz County residential expenditures to statewide trends, the **following tables present local data, including comparisons with pre-System of Care placement levels, as well as comparison to local Board of Supervisor approved cost targets.**

In the early days of System of Care implementation (1989), dramatic cost savings were achieved through bringing many group home youth back to their communities and families. Now, the goal is to **maintain expenditures at their current low levels. Hence, in Figure 2 you'll see a relatively stable expenditure pattern from 1998 – 2008 despite the shifting pressures in our state and society**. Expenditures reflect SED/AB 3632 Special Education placements in green, Probation group home placements in light blue, Child Welfare group home placements in blue, Child Welfare foster home placements in purple, and Child Welfare foster family agency placements in yellow. **In 2008, you'll notice a significant decrease in out-of-home expenditures beyond the normal fluctuations of the past 10 years.** While too early to tell, this may be due to increased Child Welfare *System Improvement Planning (SIP)* processes as well as expanded Wraparound capacity for Probation youth.

The next table (Figure 3) includes the **average monthly number of group home (GH), foster home (FH), and foster family agency (FFA) placements by agency**. As you can see amid the **overall stability of placement costs**, variations in number of placements vs. overall costs are caused by **fluctuations in level of placements needed by children and youth**. For instance, in 03/04 there were two more placements (299 total) than in 02/03 (297 total), but overall expenditures were less (due to a combination in 03/04 of fewer FFA placements, more FH placements, more Child Welfare GH placements, but fewer Probation GH placements). **In 2006-08, the trend of reduced COSTS also includes reduced numbers of PLACEMENTS, with the following notes: stable use of group home placements by Probation; decreased group home placements by Child Welfare (due in part to reduction of Crossroads crisis residential treatment program from 6 to 3 beds); and, decreases in Child Welfare foster home foster family agency costs (as relative-care placements have significantly increased).**

Figure 3. Total Out-of-Home Placements through June 30, 2008, HSD Foster Care tracking spreadsheets.

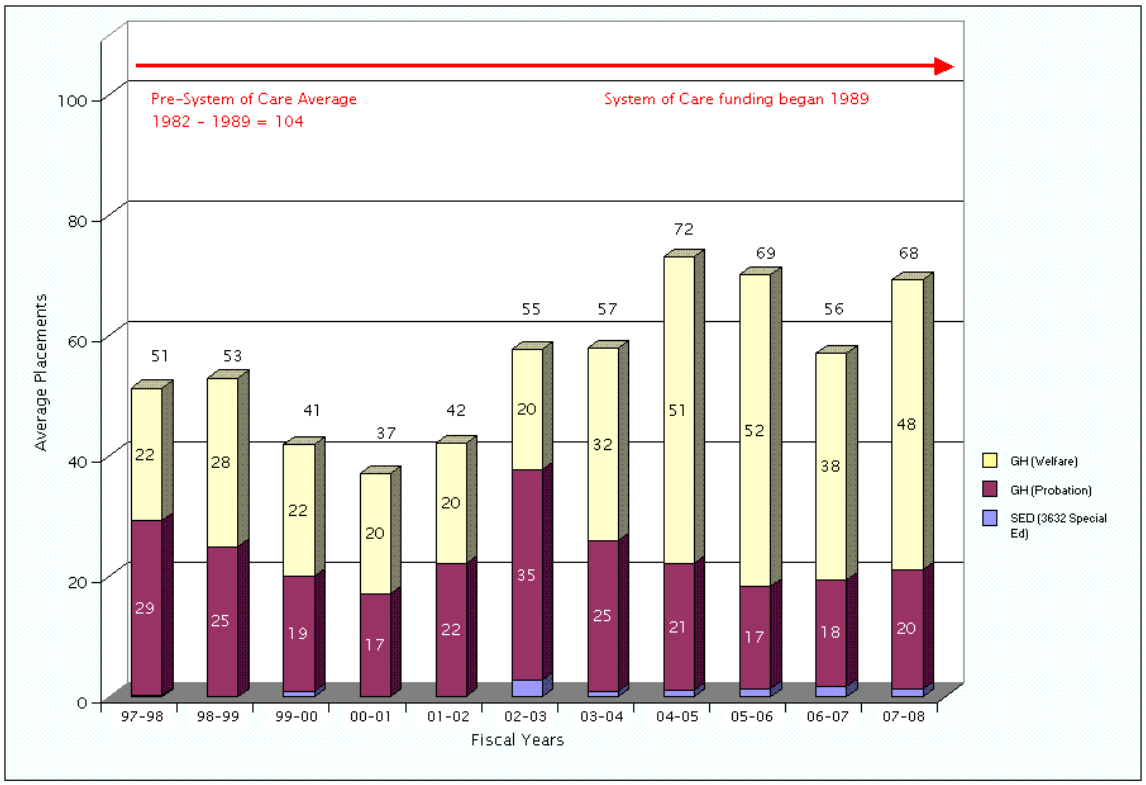


Group Home Placements and Expenditures for Probation Wards, Child Welfare Dependents, and Special Education Pupils

The Santa Cruz System of Care has focused on keeping youth safely at home or in foster homes, with a corresponding focus on **group home placements as a primary area for cost savings,** since this level of care is so expensive. When compared with the State of California, Santa Cruz County has shown a dramatic and significant drop in group home expenditures coinciding with the development and implementation of AB 377 (the initial System of Care legislation). Santa Cruz County was above the California per capita average for group home expenditures before AB 377 was implemented. After System of Care implementation, Santa Cruz showed a significant drop in these expenditures and has continuously spent less than the California average per capita population under 18 years of age.

The table below (Figure 4) illustrates that **despite small annual fluctuations in average monthly group home placements, utilization patterns remain far below the pre-System of Care level** (indicated by the **red line** at the top of the chart). As you can also see, this data helps us track group home placement patterns by agency (e.g., in 02/03 Probation GH placements were up (35), while Child Welfare GH placements were down (20); however in 03/04 Probation GH placements were down (25) while Child Welfare GH placements were up (32)). **This interagency performance outcome data assists our SOC planning efforts as issues/trends vary from year to year (some of which are described in subsequent sections).** For instance, **the last few years have seen targeted increases in Child Welfare group home use due to the establishment of a local crisis residential treatment program for foster youth in transition. This was balanced by some reductions in Probation group home use due to establishment of SB163 Wraparound, and an Evening Center for court wards.** Our overall success can be attributed to the concentrated, focused efforts of everyone involved in the

Figure 4. Average/Month Group Home Placements through June 30, 2008



family preservation programs that help youth to stay at home and in the community.

Increasingly, our System of Care relies on related interagency reforms to continually improve our system and maintain good outcomes in a changing social environment:

- Our **Probation/Mental Health & Substance Abuse sub-system relies on new interagency efforts** to maintain and deepen outcomes (such as the five year Robert Wood Johnson *Reclaiming Future*s grant to better integrate dual diagnosis substance abuse services, SB163 Wraparound, CPA2000, EPSDT Mental Health Medi-Cal, etc.)
- **Child Welfare Redesign** has begun to shape interagency projects with Mental Health & Substance Abuse in ways very consistent with System of Care family preservation efforts, with increased "front-end" ***Differential Response*** services designed to keep families from slipping into more costly & invasive "deep-end" services. Increased focus on the **dual diagnosis substance abuse needs of families in Child Welfare is a key need** being pursued through MHSA planning.
- In addition, you'll note that Santa Cruz County's number of **Special Education/3632 residential placements is extremely low** (averaging 1 or less per year)—a direct result of including Special Education seriously emotionally disturbed (SED/ED) pupils in our System of Care continuum of programs and supports.

Local Out-of-Home Cost Targets: Appropriated vs. Actual Expended

Another important outcome measure for Santa Cruz County's Interagency System of Care is **comparing actual expenditures to our local cost targets** (dollars appropriated in foster care budget). The two tables below compare Total Foster Care (Figure 5: Federal, State, Local) as well as local County Share (Figure 6) appropriated vs. actual expenditures. As you see, in the **Total Foster Care chart** (Figure 5), **actual expended dollars (in burgundy) have been below the appropriated budget (in blue) for years** data was available since 97/98. **In 2008, there was a significant decrease in overall expenditures.** In the local **County Share chart** (Figure 6) that follows, **expended dollars have been under the appropriated budget most years despite rising foster care rates** (given the annual variations in Federal/Non-Federal eligibility and sharing ratios)**. In 2008, there was a significant reduction in County funds expended compared top prior years, and compared to what was appropriated.** Years in which local county savings have occurred in the foster care budget have enabled Santa Cruz County **to re-invest dollars in other community program needs.**

Figure 5. Total Foster Care (Federal, State & Local) Appropriated vs. Expended 1997 - 2008

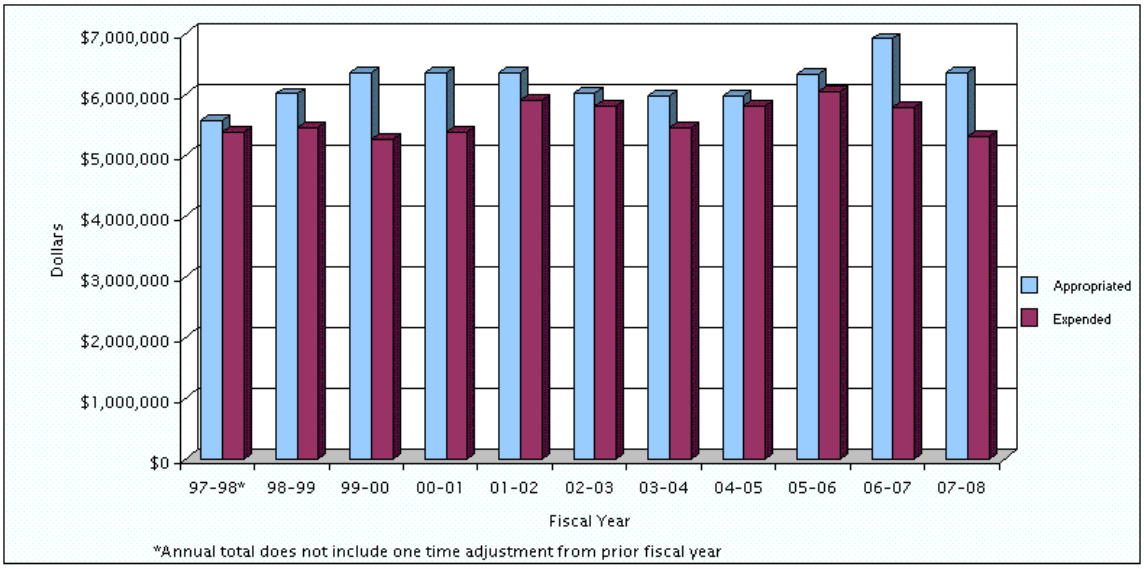
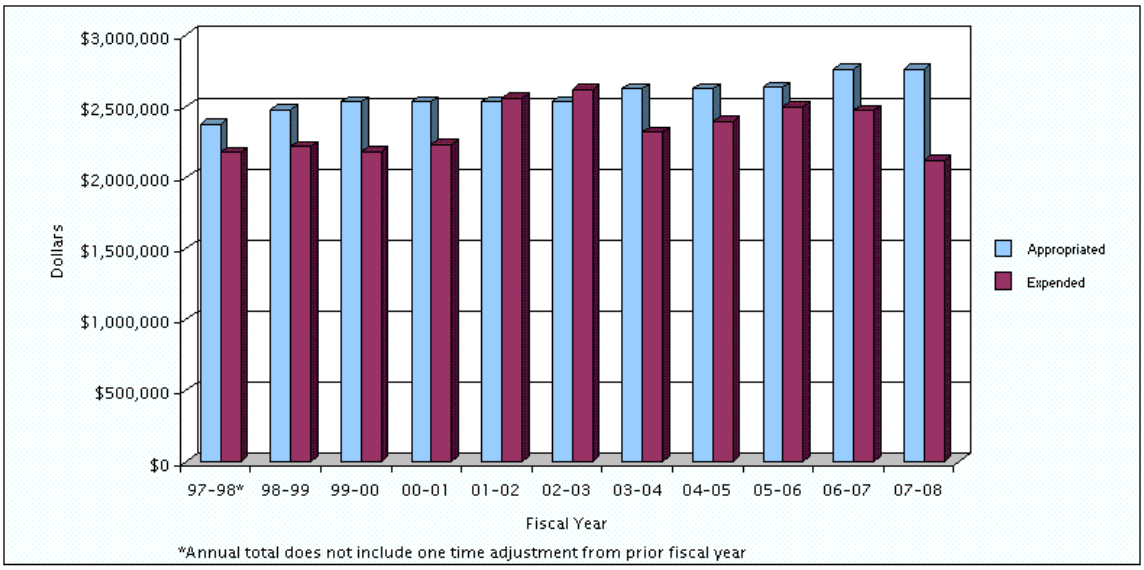


Figure 6. County Share of Foster Care Appropriated vs. Expended Dollars 1997 - 2008



As you can see in the previous graphs, our interagency System of Care approach not only keeps youth and families together in their own community, but **helps save** local communities (as well as the state and federal government) **millions of dollars** in unnecessary placement costs**.** Without our System of Care**, including the diverse community supports that allow children/youth to stay united in their own community,** placement costs would likely increase dramatically to pre-System of Care levels, costing the taxpayer unnecessary dollars, and society unnecessary social costs. **Santa Cruz has achieved these goals by monitoring placement needs and costs closely, using interagency and family/youth focused processes to plan community-based treatment alternatives carefully, and by continuing to develop an effective, community-based continuum of care that is culturally relevant and family focused.**

2. Reducing Hospitalization

Medi-Cal Funded Acute Psychiatric Hospital Utilization

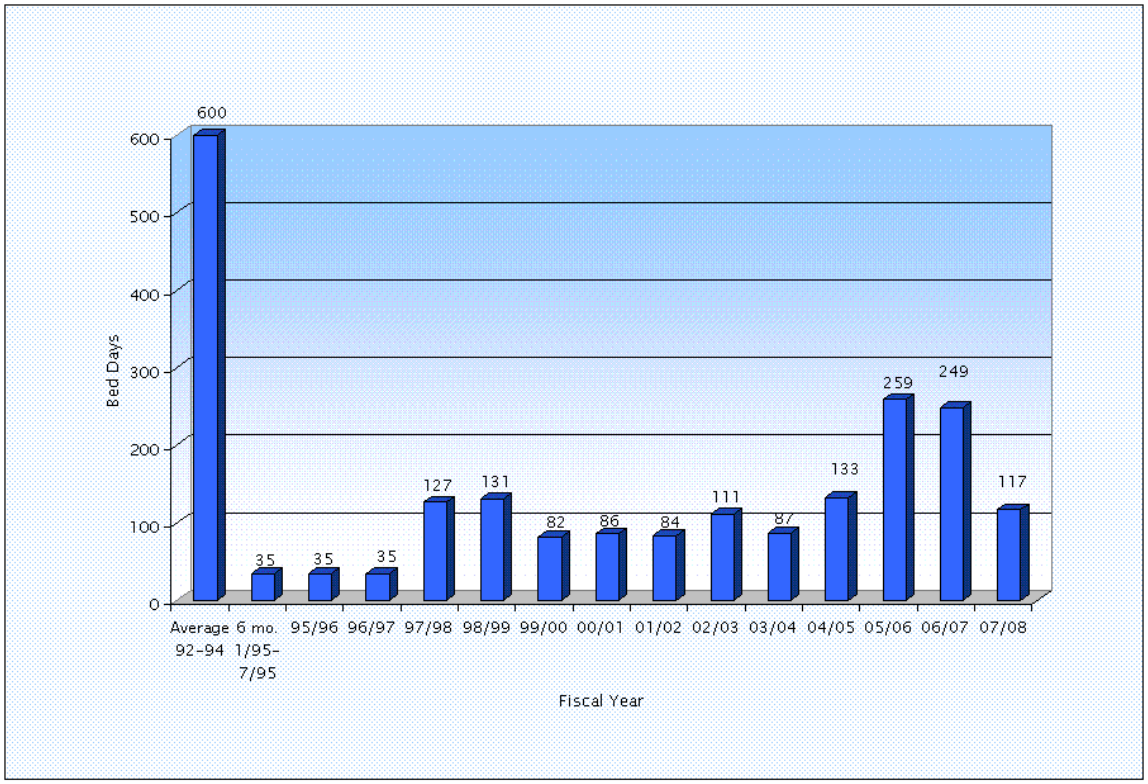
In the three years prior to Medi-Cal managed care inpatient consolidation (which occurred January 1, 1995), Santa Cruz County averaged **600 acute psychiatric hospital days per year** for children and adolescents. When Santa Cruz received these inpatient funds to manage, we redirected a portion of them to a variety of intensive "wrap-around" services in our local community, as an alternative to extended hospital placement out of the county. **The result of these efforts is a dramatic decrease in hospital days (see Figure 7).**

Since inpatient consolidation, we have continued to find local alternatives to out-of-county hospitalization for our children and youth in crisis. **The philosophy that guides us is this: most crisis and intensive follow-up services can be provided in a less intrusive manner in the community, usually in a client's home. This is often less stigmatizing and traumatic, as well as safe. Few services need to be provided in a hospital (short of medical care) that can't be provided in the home and community.**

In the thirteen and a half years since inpatient consolidation, we have utilized a total of 1,571 days, for an average of 116 days annually (far below the 600 annual days previously). The slight increases in bed days during fiscal years 97/98 and 98/99 correlate with the closing of the local crisis house (in January 1998), which had been started when inpatient consolidation began (it proved difficult to maintain census in a county the size of Santa Cruz). In the absence of this local alternative, we were able to once again decrease hospitalization use between 1999 and 2003 through use of in-person clinician response to crisis, and supporting each client's return to the community in a timely way. **In 2005 – 2007, the data**

reflects repeated and lengthy hospital stays for several youth with severe, multiple needs where hospitalization was indeed the most appropriate level of care**.** However, in **07/08 that overall hospitalization rate was back down to expected levels (117 bed days)**, given the range of alternative community services we have in place.

Figure 7. Utilization of Psychiatric Bed Days, 1992 to June 30, 2008.



B. Keeping Youth In School and Learning

1. School Attendance (ED Classes)

School attendance is typically low for children and youth with emotional and behavioral disturbances across the country. One of the System of Care goals is to assist youth in maintaining consistent school attendance, in order to better benefit from their education and progress in school. **In Santa Cruz, we collaborate with the County Office of Education and the Pajaro School District to measure attendance for students** placed in our Special Education ED classrooms who are receiving mental health services. It is an important measure, in that these students were not succeeding in school, and **typically have significant emotional and behavioral issues that make consistent school attendance problematic.**

Nineteen years (7/1/89 - 6/30/08) 87%

In both fiscal year 06/07 and 07/08 attendance of youth in ED classes was 87%.

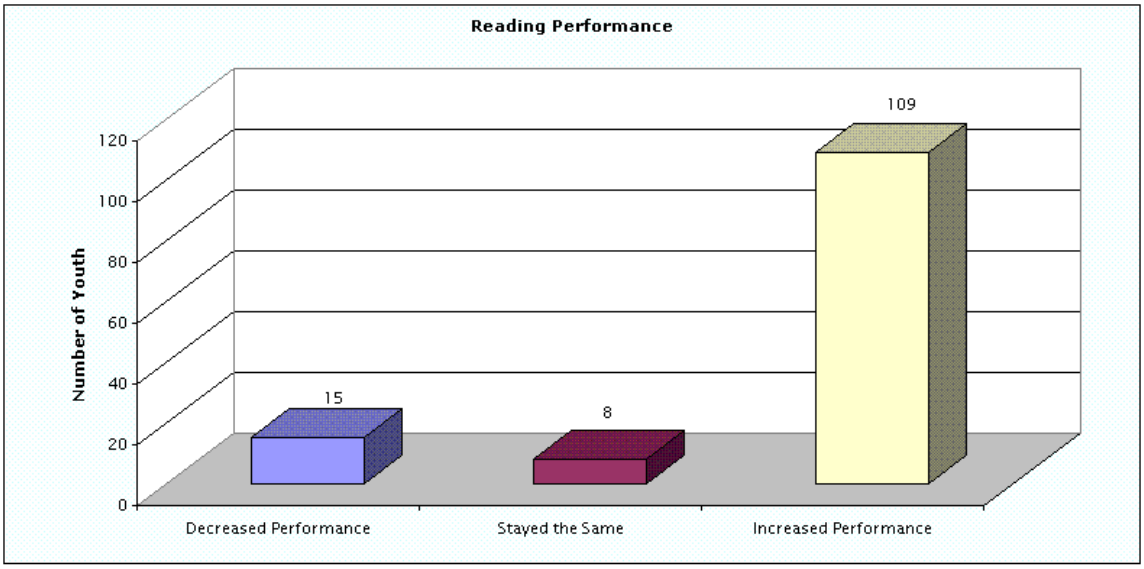
2. School Performance (Woodcock Johnson)

Another measure of success in school is grade level equivalency gains. The school system tests youth in ED classrooms on a triennial basis. **Typically students with serious emotional disturbances tend to fall significantly behind in their education; hence, these mental health services are targeted to help students continue learning and making academic progress.**

Reading Performance

- Students averaged a **0.7 year increase in reading scores** on the Woodcock-Johnson for each year in the ED program
- Of the 132 youth **tested: 109 showed improved reading performances.** 8 stayed the same and 15 decreased performance in reading
- **38 youth gained one year or more improvement in reading for each year spent in the ED classroom.**

Figure 9. Reading Performance as measured by Woodcock-Johnson (N=132) 6/89 to 6/08

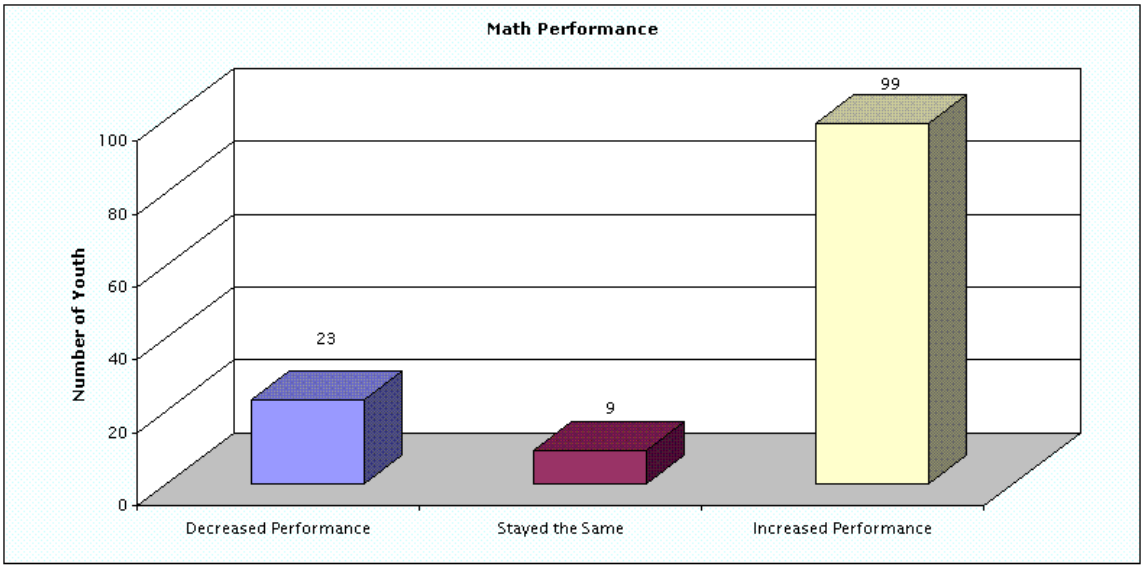


Math Performance

- Students averaged a **0.6 year increase in math scores** on the Woodcock-Johnson for each year in the ED program..

- Of the 131 youth tested: **99 showed improved math performance,** 9 stayed the same and 23 showed decreased performance in math.
- **34 youth gained one year or more improvement in math performance for each year spent in the Ed classroom**

Figure 10. Math Performance as measured by Woodcock-Johnson (n=131) 6/89 to 6/08



C. Keeping Youth Out of Trouble Reducing Recidivism

1. From STAR to WRAP and beyond

The STAR/Redwoods program was an intensive alternative residential treatment program serving court wards in the juvenile justice system for over fifteen years. Per prior year reports, the dual diagnosis substance abuse treatment program enhancements contributed to the ***significant reductions in re-arrest rates and sustained charges*** that STAR/Redwoods graduates showed over the past decade. ***This validates the importance of infusing mental health treatment for court wards with up-to-date substance abuse treatment in an integrated fashion.***

The STAR/Redwoods ***program closed its doors in July 2004***, due to a combination of severe state and local budget reductions, but also due to the evolving needs of our local system of care. Santa Cruz County became one of ten national ***Reclaiming Futures*** sites funded by the ***Robert Wood Johnson Foundation***---focusing on integrating Substance Abuse services into the Mental Health System of Care for court wards. This, combined with the initiation of our ***SB 163 Wraparound*** program for probation youth, our existing ***Family Preservation*** services, a new ***Evening Center*** and other community resources, ***reduced the need for the number of residential beds in our community***. This included the phasing out of Unity Care's 12 residential treatment beds for male court wards. Thus, it was with mixed emotions that we closed the Unity Care and STAR/Redwoods Programs after so many successful years. But it is, at the same time, gratifying to see an even greater shift towards more community-based supports to keep our youth ***at home, in school, and out of trouble.***

2. Keeping Youth Out of Trouble: Reducing Recidivism

Recidivism rates over the fifteen years that STAR/Redwoods was in operation show:

- 43% drop in re-arrests
- 35% drop in sustained charges

While recidivism rates vary from year to year due to many factors, the July 2002 – June 2004 report demonstrated even better outcomes, due in part to the increased dual diagnosis programming:

- For 2002/03, a 59% drop in re-arrests, and a 68% drop in sustained charges.
- For 2003/04, a 71% drop in re-arrests, and a 72% drop in sustained charges.

With the closure of STAR/Redwoods, we utilized new data from the Robert Wood Johnson ***Reclaiming Futures*** grant to track recidivism data for a different, but similar core subset of juvenile justice youth involved in a variety of our residential, wraparound, and family preservation programs. Per our standard analysis, probation violations are utilized in the context of increased monitoring and treatment interventions, so not used as part of outcomes. Of particular note in the 2004 – 2006 data is a dramatic 84.3% drop in sustained felonies, though there was little impact on sustained misdemeanors (though misdemeanor *charge*s were greatly reduced).

Data for the fiscal years July 2006 through June 2008 is shown in the table below:

Recidivism – All Charges, July 2006 – June 2008, N = 70

	Before	After	% Change
Felony Charges	94	32	-66%
Misdemeanor Charges	249	138	-45%
Total Charges	343	170	-50%
Sustained Felony	69	25	-64%
Sustained Misdemeanor	190	111	-42%
Total Sustained Charges	259	136	-47%

II. PROGRESS REPORT ON SYSTEM OF CARE COMPONENTS

A. Juvenile Probation Programs

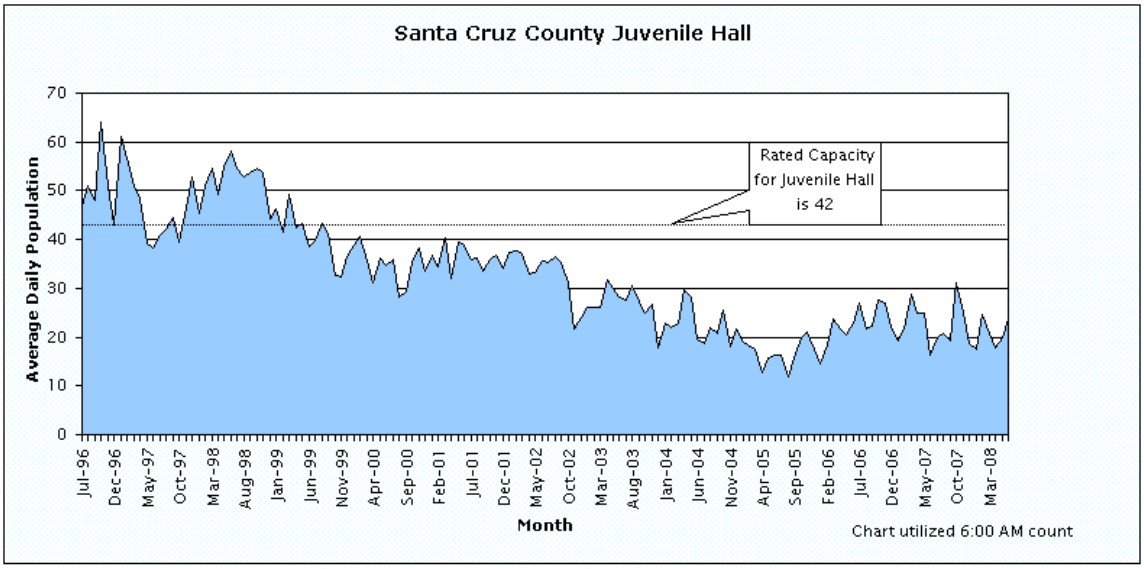
1. Juvenile Hall and Detention Alternatives: Mental Health/Substance Abuse Services

The Santa Cruz County Probation Department serves as an **Annie E. Casey Foundation model site (one of four nationally)** for Juvenile Detention Alternatives Initiative (JDAI) reform, embracing Balanced and Restorative Justice (BARJ) practices and a commitment to Disproportionate Minority Confinement (DMC) reform. These approaches have created a strong System of Care culture between Probation, Mental Health and Substance Abuse staff serving court wards. **These initiatives have resulted in a 52% decrease in the use of detention and a 222 % increase in Alternatives to Detention, as well as a number of efforts resulting in improved conditions of confinement; low rates of Ranch Camp commitments (from 34 in 1994 to 11 in 2007); and very few commitments to the California Youth Authority (now called Department of Juvenile Justice) (11 in 1996 and 1 in 2007).** Much of this success can be attributed to the outstanding partnerships between Probation, Mental Health/Substance Abuse, and our many community agency partners in providing viable alternatives to unnecessary detention. The success of Santa Cruz County's Juvenile Probation efforts in our System of Care has earned national recognition as a model juvenile justice system.

It has also produced the following additional juvenile justice outcomes:

- With a rated bed capacity of 42, Juvenile Hall used to be overcrowded in the late 1990's with an average daily population of over 50 youth. **Detention reform and alternatives (including Mental Health/Substance Abuse support) has significantly reduced the Juvenile Hall census. In 2007/08 the average daily population was 21.6.**

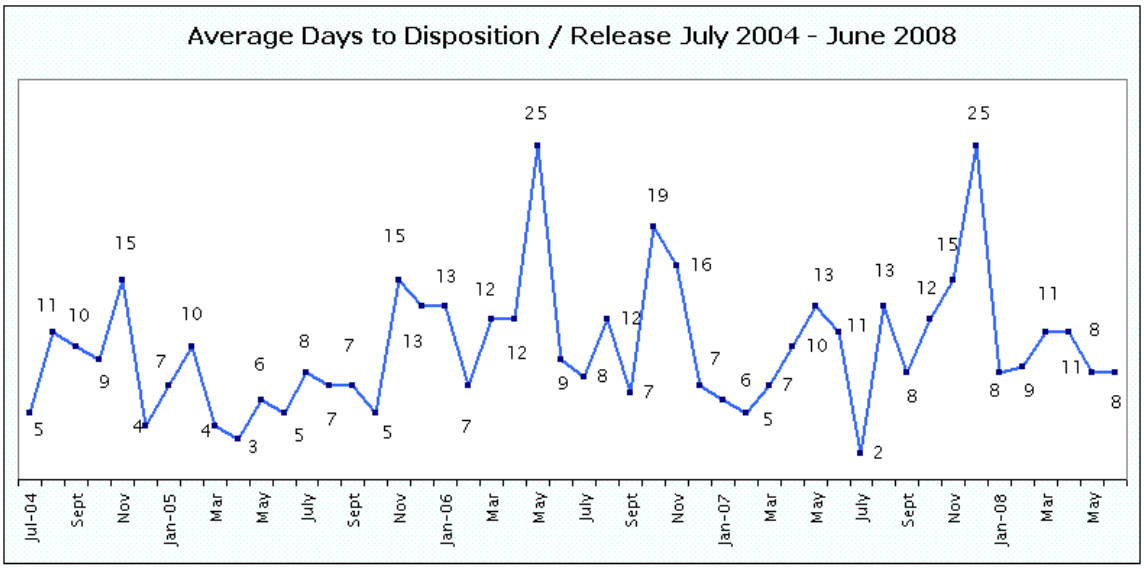
Figure 11. Juvenile Hall Average Daily Population July 1996 to June 2008



- Santa Cruz County Probation has **one of the shortest Juvenile Hall lengths-of-stay in the country** (per DMC advocate James Bell, Executive Director of the W. Haywood Burns Institute; **disposition to release/placement averaged 10.6 days in 2007, compared to**

some jurisdictions where 100 days to one year is not uncommon). Youth are screened twice weekly in an Interagency Placement/Alternatives Screening committee with Mental Health and Substance Abuse staff. Youth do not languish in detention, but are assessed for appropriate level of treatment and transitioned to community or residential placement as quickly as possible.

Figure 12. Juvenile Hall Average Days to Disposition/Release, July 2004 - June 2008



- Juvenile Hall Mental Health/Substance Abuse services have been increasingly linked to improved Health services through the **California Endowment *Healthy Returns Initiative (HRI)* grant begun in March 2005.** The grant builds on existing services targeted to help youth detained in Juvenile Hall as they transition back into the community or placement. Two full-time clinicians provide seven day per week mental health and substance abuse screening (including the MAYSI), short-term treatment, specialized groups, suicide assessment, and crisis services. In addition, three nurses provide seven day per week health care, including immunizations, STD checks, community referrals, as well as visits three days per week from a Health Services physician. **The grant funds additional Probation officer and Health educator time, with a particular focus on improving health care linkage for girls.**

2. Family Preservation Services

Santa Cruz County Mental Health has operated an interagency Family Preservation Program for probation youth since 1996, which has been **one of the main reasons local group home costs have been kept in check.** There have been **significant reductions in group home placements** from pre-System of Care levels (see prior sections). Even before the advent of SB 163 Wraparound, Santa Cruz County utilized a targeted portion of local foster care funds (combined with EPSDT dollars) to create an interagency team of clinicians and probation officers to provide intensive services (1:6-12 staff/client ration for clinicians, 1:15 for probation staff) to keep youth at home with their families rather than placed in group homes. The interagency teams provide intensive case management/treatment within a wrap-around philosophy, which include field based mental health, substance abuse and probation services in a "whatever it takes" effort to achieve family and youth outcomes.

Early efforts to bring youth home from group home placements included the following targeted categories:

- **Early Release** – Accelerated release from out-of-home placement with Family Preservation support while in placement, then supporting the return home.
- **Placement Diversion** – Youth with court orders for placement, ordered into Family Preservation while living at home instead.
- **Short Stay/Mental Health** – Accelerated release from necessary out-of-home placement, with return to Family Preservation services subsequent to release.
- **Cost Avoidance** – Minor placed in an out-of-home placement at a lower RCL level, due to additional support from Family Preservation staff than the minor's situation would normally indicate.

In recent years, lengths of stay in group home care have been reduced by many counties with similar strategies. Locally, we now tend to **focus primarily on Placement Diversion** as our primary strategy for reducing group home costs. In addition to serving court wards as a formal alternative to group home care, the Family Preservation team also serves court wards with low criminality but high mental health needs to help prevent escalation deeper into the juvenile justice system.

3. SB 163 Wraparound *Family Solutions* and Family Preservation Team

With the closure of the STAR/Redwoods program in 2004, our system of care worked with the State Department of Social Services to develop an **SB 163 Wraparound Program for court wards** as an additional strategy for providing enhanced community-based family preservation options. Beginning with 12 slots in September 2004, two Wraparound teams began serving 6 families each, expanding to 14 families with plans to serve 24 by 2008. Each team includes a Wraparound facilitator, a service provider, a half-time Parent Partner, and half-time probation officer as core members (with each family then adding additional family/community members). This greatly enhanced our ability to provide intensive supports for youth who would normally be kept in detention or residential care. Obviously some youth, even with this level of care, require periods of time in detention or residential care, but the ongoing support allows for shorter stays in both, and facilitates re-entry into the community again. Also, the **Family Preservation program** in some ways serves as a **"Wraparound support to the Wraparound team and families"** particularly for emancipating youth without parents willing to engage in the family-led Wraparound process, or when families need additional treatment support. The level of acuity (in terms of juvenile justice issues, and mental health / substance abuse issues) is very high for these youth hence, any gains made are very positive.

The data below provides a view into Wraparound (Wrap) and Family Preservation (FP) client indicators and outcomes. Because the programs are interlinked, it is not so much a comparison between the programs as it is parallel or linked outcomes.

Figure 13. WRAP Family Preservation Summary of Completions, July 2004 – June 2008

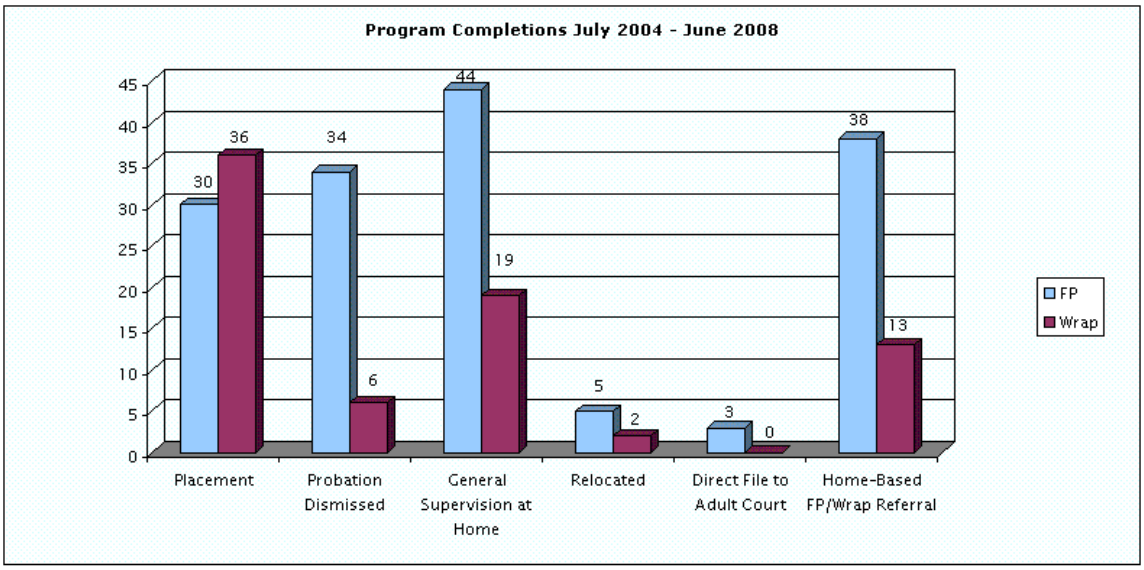
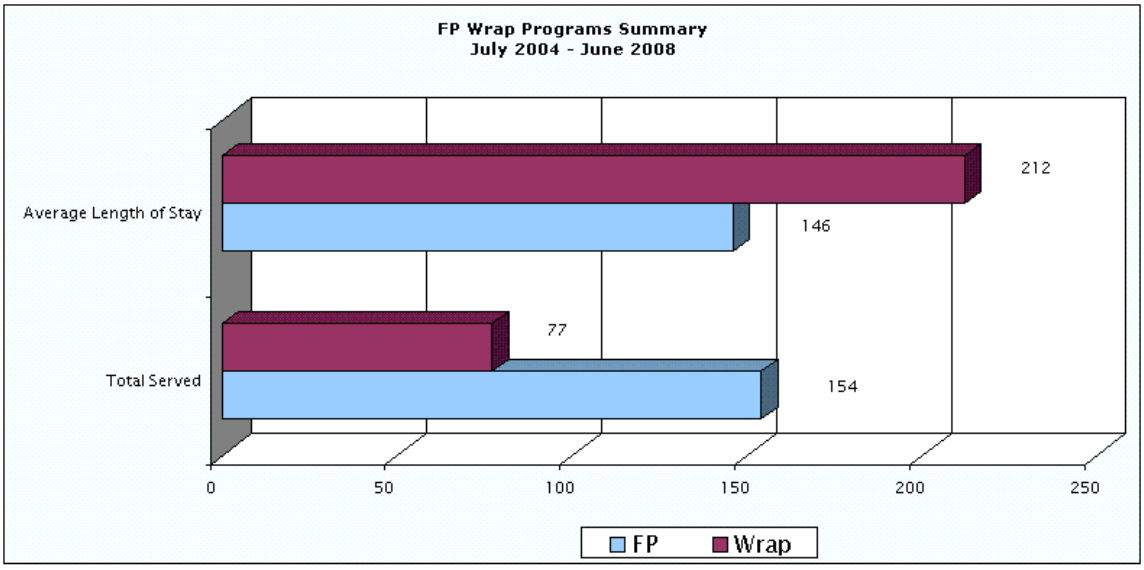


Figure 14. WRAP Family Preservation Summary, July 2004 – June 2008



In the charts above, you'll see that of 154 Family Preservation clients served, 30 youth entered treatment in a residential placement, 34 successfully completed probation, 44 transitioned to a general supervision caseload, 5 relocated out of the area, 3 were direct filed to adult court and 38 were later transitioned to the Wraparound Program for further support

Out of the 77 Wraparound clients who completed the program, 36 entered a residential placement, 6 successfully completed probation, 19 transitioned to a general supervision caseload, 2 youth relocated out of the area and 13 transitioned to Family Preservation for continued supports.

Family Preservation averaged 146 days compared to 212 days for Wraparound clients.

Figure 15. WRAP / Family Preservation by Ethnicity, July 2004 – June 2008

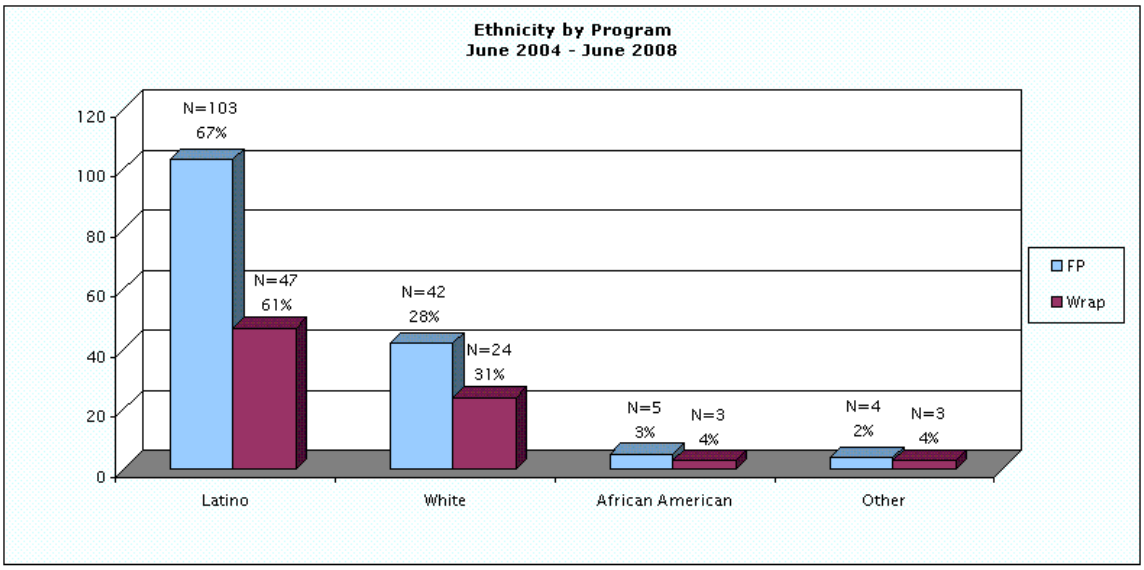
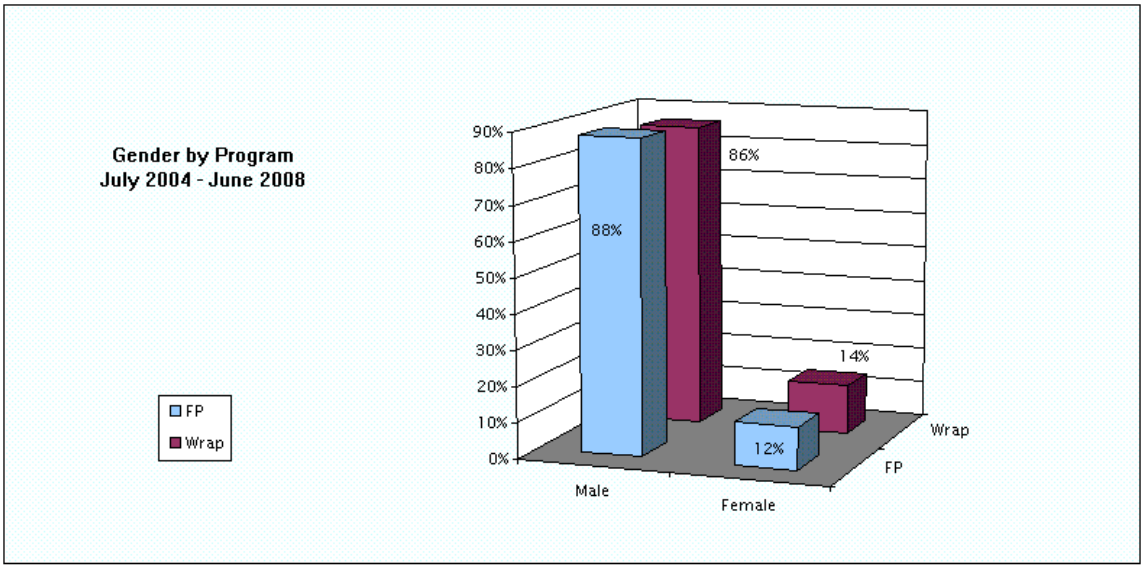


Figure 16. WRAP / Family Preservation by Gender, July 2004 – June 2008



In the two charts above, you'll notice that youth enrolled in either program are similar in gender and ethnicity, with the majority of youth being Latino males.

4. Evening Center

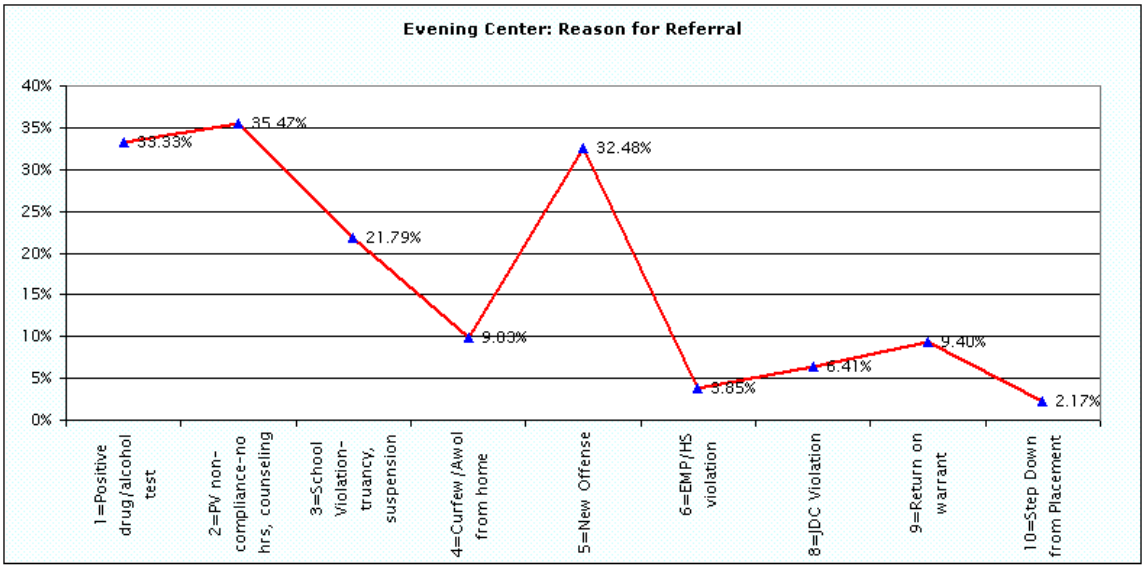
With the closure of the STAR/Redwoods program in 2004, our system of care also determined that there was still a need for some form of site-based, short-term treatment and probation support for youth at-risk of detention or group home, or who were returning to the community from detention and group homes. Because the former Challenge Grant Luna PARK site had proven to be an effective model for serving the mostly Latino population of South County (but was eliminated from the state budget in prior years), the site was maintained and eventually re-opened as an interagency Evening Center in 2005 with evening hours for probation youth diverted from unnecessary Juvenile Hall stays, or at risk of

residential care, or returning from residential care. The chart below includes preview of data in fiscal year 06/07.

Evening Center Summary, July 1, 2006 through June 30, 2008.

Episodes		Ethnicity	
Total Episodes	234	Latino	89.32%
Unique Episodes	106	White	7.69%
Duplicate	68 (64%)	Other	2.56%
Average number Duplicate Episodes	2.81		
Days in Program and Completion		**Gender**	
Successful Completion	66%	Male	94%
Average number days Ordered	16.1	Female	6%
Average number days Completed	12.8		
Average number days for Success	12.435	**Average Age-All**	15.6

Figure 17. Evening Center, Reason for Referral, July 2006 - June 2008



Through a multi-agency collaboration, the program continues to serve probation youth struggling to meet conditions of probation by offering them evening supervision, life skill training and programming that addresses substance use, delinquency, truancy and other high risk behaviors. The program operates Monday through Friday from 4-8 PM and each Saturday youth participate in special community service work projects. Transportation services are provided to and from the program. Nutritious snacks and meals are served each evening

The schedule at the evening is very packed and each day youth participate in a variety of activities which includes job development programs, drug and alcohol groups, mindful relaxation, life skill programs, cultural awareness programs and cognitive behavioral

interventions. In addition to group counseling, special recreational activities take place throughout the week and this may include walks on the beach, art and music programs, basketball games, handball, ping pong, trips to local parks and movie nights. Each night probation staff provides supervision for youth and mental health clinicians and several community partners engage youth in thoughtful and meaningful discussion about making healthy decisions in their life.

Below is a list of services provided at the program:

- Mental Health/Substance Abuse Assessment
- Transportation (adult to adult hand off)
- Evening Supervision (between the hours of 4:00 PM and 8:00 PM)
- Individual and Group Counseling
- Tutoring and Homework Assistance
- Thinking for a Change (Cognitive/Behavioral Programming)
- 7 Challenges (Alcohol and Drug Treatment cognitively based curriculum)
- Computer Lab
- Physical Fitness and Recreational Programming
- Employment Readiness and Mentoring (Job Training and Mentorship through CRP)
- Fresh Life Lines For Youth (FLY)-Law Related Education Program
- Friday Night Live Program-Life skills building program promoting healthy drug and alcohol free activities

5. Youth Services *VISION* Program

This contract provides additional treatment and case management support to youth at risk of further Probation involvement, but who need a lower level of care than the Family Preservation and Wraparound programs offer. Youth Services programs for court wards and youth at-risk of deeper involvement with Probation were expanded through the Mental Health Services Act. (See outcome indicators in Youth Services section under Other SED Community Services.)

SUCCESS STORY

Laurel is an 18 year-old Caucasian female. Two months ago she was semi-homeless and smoking heroin up to 6 times a day. Since age 15 every day of her life was filled with scheming how to get dope, tracking it down, and getting high. She watched with horror and sadness as friends died, or moved on to injecting. Laurel watched her own life slowly fall apart: a boyfriend choked and punched her, she was furious, but couldn't leave him because he had the connection to get heroin. She found that she had to smoke right before meetings with probation or counselors in order to function. Laurel wanted out but didn't know how. Nothing scared her more than going through withdrawal. The scariest place to go through withdrawal would be detention, or its equivalent in Laurel's eyes, rehab.

Laurel now has 3 weeks clean from heroin. Each day is a challenge, but she's making progress. Her story is a testament to the value of partnership between the Santa Cruz Juvenile Justice System and Youth Services Vision Program. Laurel was initially referred to

probation for possession of marijuana, a low level crime. Even so, her probation officer referred her to counseling. She opened up to her counselor about her heroin use and tentatively started to explore what it would mean to get clean. By the time probation tested her positive for heroin, Laurel was ready to take the bold step of going through medically assisted withdrawal. Juvenile probation provided Laurel with the incentive/ ultimatum to get clean. Counseling gives her the motivation, tools, and self-reflection to make it stick. What would have happened to Laurel if only "high-risk" probation cases were referred to care?

B. Education Programs

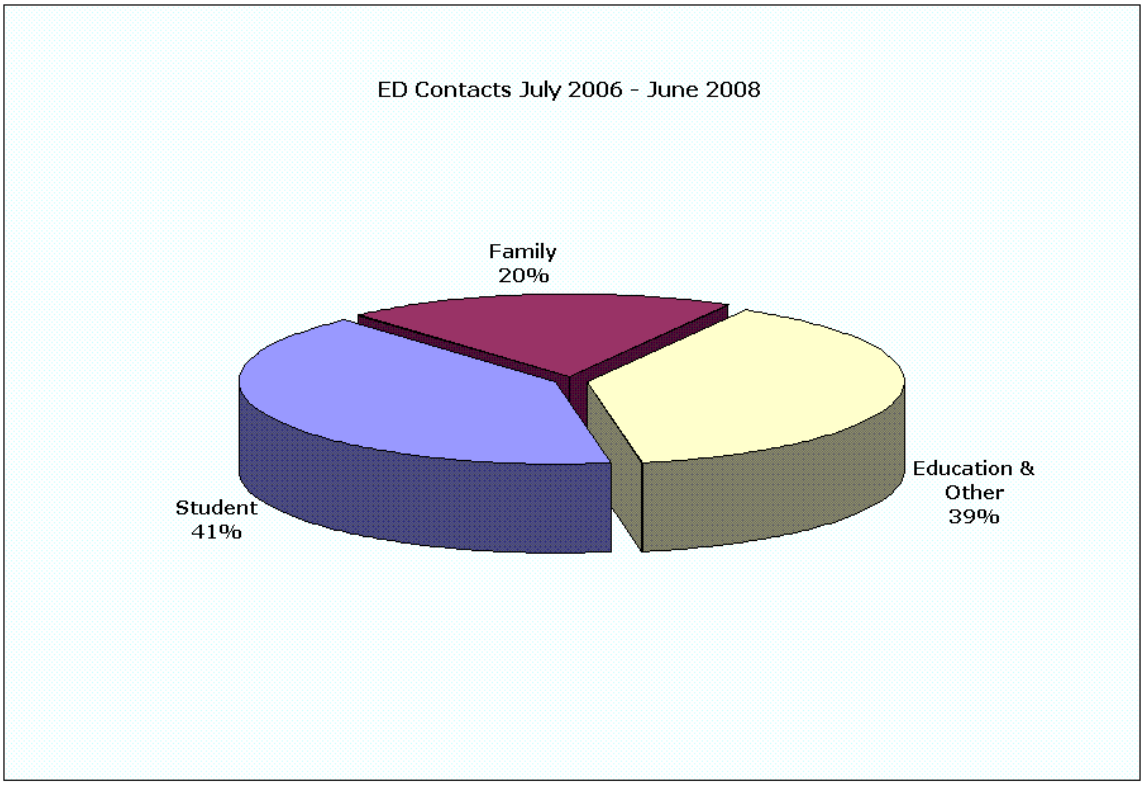
1. Special Education: Intensive Treatment Program for Pupils with Emotional Disturbances

Our collaboration with Special Education was really our first interagency program, begun in 1986 with the advent of AB 3632, and described in section 26.5 of California's government code. It better prepared our county to implement the interagency provisions of our first California state System of Care grant under AB 377 in 1989. Mental Health works closely with the County Office of Education (COE), the Pajaro Valley Unified School District (PVUSD), as well as five other local school districts to serve our county's special education students.

California's unique AB 3632 Special Education/Mental Health service system has recently been a focus of intense debate between the state, local county governments and local education entities attempting to clarify fiscal and program responsibility. For Santa Cruz County, the data in this report is a testament to the many students with special needs who would not have been served without this unique statewide program. ***The educational gains in grade level equivalency, attendance, and the clinical outcomes described in previous sections, would likely not have occurred without this unique program.***

The graph that follows describes the percentage of services delivered by category to *students, families,* and *education or other collateral staff.* A discussion follows about how this data reflects goals we've set for kinds of field/school based contacts with clients.

Figure 18. ED Contacts, July 2006 – June 2008.



Goals:

1. *To coordinate mental health and special education services for ED youth in a school-based program.*

Outcomes:

All of our ED classroom/treatment sites are on public school campuses, with on-site dedicated clinicians. 79% of mental health services are provided on-site to students and their teachers (27% students, 52% teachers and/or other collateral staff). Students are able to mainstream into regular education classes.

Mental Health clinicians **attend every Individualized Education Plan** (IEP) meeting regarding treatment services (we do not just send written reports).

Clinician/client ratios are kept small and intensive (10-12) to improve treatment delivery and outcomes.

Additional non-IEP **intensive treatment supports** (Mobile Emergency Response Team, and Intensive Family Support Program) provide targeted services for students at risk of hospitalization or residential placement, **allowing clients to remain at home and in school.**

Unnecessarily restrictive out-of-home placement for educational/mental health needs has been minimized, with an average of **less than one placement per month over 19 years.**

2. *To involve parents and guardians in the mental health program as it relates to students' education.*

Outcomes:

Families are an important part of achieving educational outcomes for students with serious emotional disturbances. Over the first ten years of the System of Care we averaged 13% of contacts with parents and guardians, with a general trend of rising percentages of contacts with parents and guardians. **Over the last 2 years, family contacts increased to 21%.**

TRANSFORMATION – IN ONE CHILD'S LIFE

He was well known throughout the moderate sized neighborhood school. Some teachers and principals cringed when they heard his name. Yes, Spunky came to my caseload with a reputation that had extreme effects on the people at the I.E.P. meetings. Some teachers or other service providers wanted to barrage me with stories of the difficulty they had with him. Some simply froze, hoping they would not have to deal with him again, ever, hoping he can be somebody else's problem. He had been kicked out more than once, gone to other programs, returned. Wherever he went, he wreaked havoc. Reports indicated there was depression and bi-polar disorders on both sides of the family.

Spunky was a full spectrum kind of kid. Bright, very talkative, clearly articulate, he fit a stereotypic picture of a nerd. He was smart in a kind of know it all way, and happiest when left undisturbed, his head in a book or engrossed in a computer game glaring from a screen. He was a skinny kid, his front teeth looked a little too big for his mouth, his reddish brown hair hung over his eyes and shoulders. His lanky gait reminded me of a giraffe, every joint in every bone moving with exaggerated articulation when he walked. My first impression in our individual session was of a child whose imagination far exceeded the content of his visible world.

For many sessions, he would make a war. The small dolls from the playhouse became his warriors. There were always battles of power and violence. I suggested clay one day to see what might arise from the formless lump. Globby, faceless shapes emerged, each mutilated with the sculpture tools on the clay table. A knife stuck halfway through one, a hammer stuck through another. They were all tortured. We continued, week after week, monster after monster, war after war.

For the first time ever, dad agreed to family therapy, and came regularly every week. Spunky and dad never had an easy time. Dad felt that he had been so frustrated with Spunky ever since he was an odd and troubled screaming, anxious toddler. He felt he had taken his anger out on Spunky and wanted to learn how to have a relationship with him. Therapy allowed them to enjoy some playtime together, to keep them focused on non violent creative ventures such as figuring out puzzles together, building with Jenja blocks or playing sports type activities such as Velcro darts or nerf ball catch

Every session Spunky begged for wrestle time, a favorite activity at home, even though it also frightened him. So, wrestling, this time with rules and feedback from my observations became a weekly event for the last 3 minutes of our sessions. I had to set limits for dad, especially regarding sneak attacks, and deviations from the agreed upon rules. I insisted that personal touch boundaries were to be respected no matter what.

Slowly, Spunky and dad became friendly. They both looked forward to the playtime and the safe, contained environment. However, there were still periods when Spunky was highly agitated at home and school, running around, blurting out, refusing to cooperate, distracting and irritable. I identified each behavior as symptomatic of ADHD and anxiety. I told them that this is the condition the teachers had to try to teach for 6 hours a day. I suggested that Spunky didn't seem like he could absorb much academically in this condition. In fact, I told them, it seemed to me he was suffering.

I asked if they were ready for an evaluation with our child psychiatrist and they agreed. I described the process and assured them that if medication was indicated, it wasn't forced on anyone, they had choices all along the way. But, I added, if nothing is done, Spunky would likely continue this way. Well, the combination of therapy and medication really helped. School work improved, behavior improved, relationships improved, mood improved. There were still issues at home and school, but they fell into the normal range. Dad reported that he became accustomed to this way of being and couldn't even imagine the battles they had for so many years. The family and Spunky were all happier, and developed a kinder and gentler way of being together

2. County Office of Education Alternative Schools

The County Office of Education's (COE) Alternative Education Schools are unique partners in our System of Care, providing targeted alternative classrooms for many of our interagency programs. Wherever there is a need, COE finds a way to create unique classroom opportunities for the youth we share in common, including linkage with mental health supports. Examples include:

- Juvenile Hall classroom (includes linkage with on-site Juvenile Hall mental health/substance abuse staff)
- Clean and Sober classroom/treatment programs at Youth Services Y.E.S. and Esceula Quetzal programs
- Classrooms in key geographical regions of the county, some including targeted EPSDT Mental Health counseling services

While many youth in our system attend local general education classes, COE's Special Education and Alternative Education School programs (as well as the Pajaro Valley Unified School District) provide essential specialized educational opportunities for students who might not otherwise be successful in school.

In addition, Youth Services provides EPSDT services to at-risk youth with an emphasis on cultural and gang-related issues at a variety of schools in the Watsonville area, including:

- New School
- Migrant Education

- Alianza Charter
- Watsonville Charter School for the Arts
- Summit Academy
- Watsonville High School
- Renaissance High School

Y.E.S School Journal Entry

"In the beginning I was sent here after rehab because any other school would not have been safe for me. Before rehab I saw school as just a safe place to be loaded and not worry about parents messing it up. Every day was a party (in my head at least). From kissing random girls, to the bathroom stalls assuming the position to drown. People felt sorry for me and I liked it that way. Obviously I wasn't there to learn. I'm at Y.E.S. because I TRULY believe I'm an addict/alcoholic. If I wasn't at Y.E.S. I'd be using everyday. I've met friends through this program that I know will be at my wedding and my deathbed. I'm very passionate about this school even though it doesn't seem like it, at times. I want to be a miracle kid but I just fuck up too much. This place and these people are family (in more ways than most of my family related by blood). I'm going to try harder to put in an effort to SHOW my love. Rather than just saying it. I promise that none of this is bullshit. But yo, that's basically it."

3. Pajaro Valley Prevention and Student Assistance (PVPSA)

PVPSA provides counseling services to all schools in the Pajaro Valley Unified School District, where there are high concentrations of Latino students and families, Medi-Cal beneficiaries, youth at risk of Juvenile Probation involvement, and families involved with Social Services. This school-linked, interagency collaboration provides critical mental health/substance abuse support services to students to help prevent deeper involvement with probation, child welfare, and special education. Mental Health, school district, and Probation funds help leverage significant service capacity to students and families through the natural environment of schools—which helps to de-stigmatize access to services. In addition, PVPSA is the recipient of a Federal ***Safe Schools, Healthy Students*** grant which provides a wide range of prevention, early intervention and brief treatment services to students. Through the Safe Schools/Healthy Students initiative and EPSDT funding, PVPSA provided mental health services to approximately 4,200 students, and approximately 750 students received drug and alcohol prevention and intervention services during July, 2006-June, 2008.

C. Social Service/Child Welfare Programs

With the advent of Child Welfare Redesign, there has been renewed focus on ensuring the adequacy of a service system for abused and neglected children/youth in California. Santa Cruz County, through the use of targeted EPSDT Medi-Cal and county/state funds, has worked to continually improve and expand mental health service supports to court dependents, their families and foster parents. ***All new foster children/youth are screened by social workers for mental health needs, and referred as appropriate for assessment and varying levels of treatment from County Mental Health, the Parents Center, and other community agencies.***

1. Supportive Intervention Services (SIS): Family Preservation Program for Court Dependents

The SIS Program, open since January 1997, is staffed by clinicians through Community Mental Health and a contract with the Parents Center. These staff work as a team with Human Resources Agency social workers providing wrap-around services in an effort to achieve one of the following outcomes.

- **Reduced length of stay** in placement.
- **Step-down** to a lower level of placement.
- **Placement prevention** – child at imminent risk of placement remains at home with intensive wrap-around services.
- **Prevent step-up** to a higher level of placement.
- **Prevent return to placement.**

Overall, over 90% of referred foster youth have demonstrated significant positive outcomes in our family preservation program, as indicated by clinical measures, minimizing group home placements, and allowing them to live in the least restrictive environment suited to their unique needs.

SIS Success Story

Sonya (age 6) and Isabel (age 4) were referred to Children's Mental Health after they were placed into foster care due to their mother's serious substance abuse issues. They presented with a great deal of anxiety. Sonya, the oldest sibling, acted as the parent/adult in the family to "take care" of her younger sister. These girls were extremely sad, as they missed their mother and father as well as their baby sister who was placed into a different foster placement. Counseling consisted of play therapy, as well as school support for the 6 year old, who was having a very hard time in school, as she found it hard to concentrate, because she was so worried about her family.

The Children's Mental Health clinician worked with the girls individually, as well as together. She also worked with their mother, supporting and encouraging her recovery efforts. The clinician also helped the mother, who is monolingual Spanish speaking, apply for Families in Transition housing as well as financial assistance. The clinician also helped the mother and father with increasing their parenting skills, and following their case plan with Families and Children's services (Child Welfare). Both parents worked very hard, and they were able to reunify with their children. The girls were very happy to be home, and they had learned some coping skills to help them alleviate their anxiety. They also learned how to identify and express their feelings so that they were able to get their needs met. The clinician continued to work with the family to insure their continued success, providing family counseling and she helped the parents learn how to work with their children's teachers to insure their continued success in school.

2. Parents Center

The Parents Center has contracts with both Children's Mental Health (EPSDT) and Family and Children's Services to provide a variety of counseling support to families with children, particularly those that have open child welfare cases and whose children are in out of home care. The overarching focus of their work is on family reunification and preservation, as well

as child abuse prevention and treatment. This is accomplished through parenting education, and individual and family therapy that addresses the counseling goals of court mandated services for families with open child welfare cases. Their EPSDT program focuses on treating children's diagnosable mental health problems while also assisting their adjustment to foster care. Treatment goals include supporting children's parents to more effectively address their children's mental health needs within a family therapy context.

Parents Center Success Story

When I began working with Natalie she was living in foster care with an extended relative. She was highly anxious, having trouble sleeping, had no friends, and was getting into fights at school and defiant at home. She felt responsible for her family's break-up and ashamed about her abuse. She was attending 8th grade.

Natalie's family of origin had a history of substance abuse and domestic violence that resulted in repeated incidences of neglect and trauma for Natalie. Her father was reported to have sexually abused her. The treatment goals for Natalie included: reducing her anxiety, improving her behavior within the home and at school and assisting her with developing communication skills to enhance her relationship with her caregivers as well as processing her ambivalent feelings towards her parents. Treatment included providing Natalie with an age appropriate understanding of how her past experiences were responsible for her high reactivity in the present and teaching her coping skills to reduce the effects of trauma on her current functioning. She also needed to acquire some socialization skills so that she could make and keep friends her own age. Natalie and her mother received support in making a safety plan to prevent further abuse of Natalie. The plan included facilitating her mother in taking responsibility for failing to adequately protect her previously. Natalie initially resisted talking about what had happened to her but was able, over time, to build a therapeutic relationship with her counselor who utilized a variety of cognitive behavioral techniques to reduce Natalie's symptoms. At the conclusion of treatment, Natalie had significantly reduced her mental health issues, regained some trust in her mother's ability to keep her safe and reduced her defiant behaviors with adults. She proudly shared that she had some new friends. She was able to articulate that her abuse was not her fault and looked forward to her upcoming reunification with her mother.

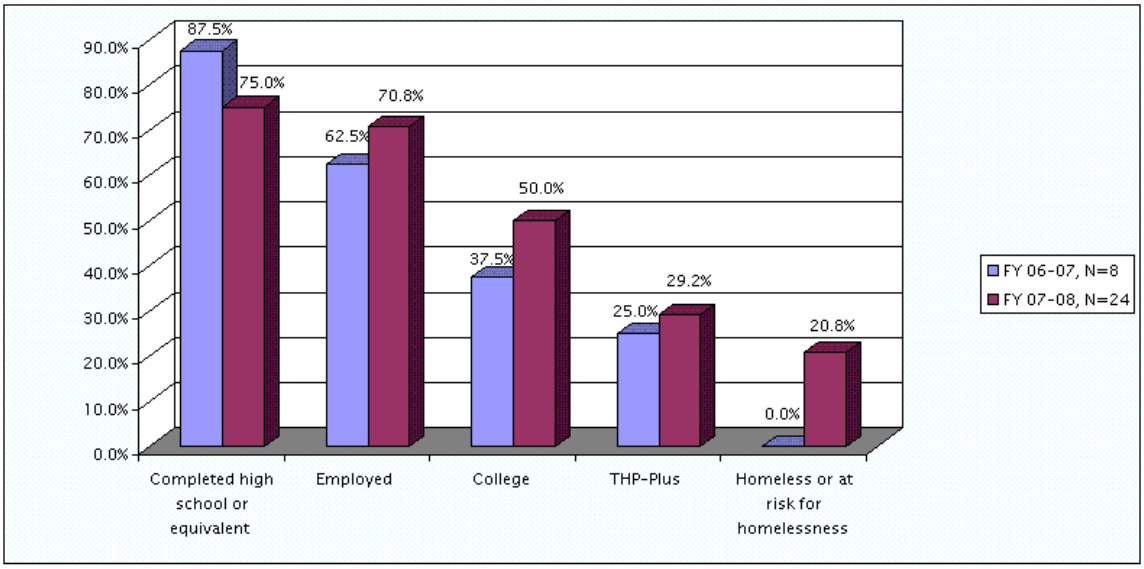
3. Services for Transition Age Youth

There are several programs that focus on interagency planning for transition age youth aging out of the foster system. These programs are the **SAS team (comprised of County Mental Health clinicians and Child Welfare social workers), and a contract with Community Support Services for an integrated ILS program, THP housing support, and mental health counseling/case management**.

Supportive Intervention Services for Adolescents (SAS) focuses on interagency support for transition age youth aging out of the foster system. SAS is a trans-departmental team comprised of HRA Social Workers and Independent Living Skills specialists with Mental Health Clinicians. This team works with teens ages 14-21. According to recent analysis, the SAS team has been successful in several ways: increasing graduation from high school, increasing rates of employment, increasing college attendance, and decreasing homelessness. The chart below indicates actual percentage of youth and young adults who

achieved their diplomas, were employed, participating in college, participating in transitional housing and/or supports, or were homeless.

Figure 19. SAS Outcomes, July 2006 – June 2008



The Independent Living Skills Program (ILP) provides help in finding jobs and developing skills needed to live independently for teens in both Social Services and Probation.

THP is the Transitional Housing Program, which operates a dispersed housing model of psycho-social supports for transition-age youth and young adults up to age 21.

Mental Health Services Act (MHSA) funds established a new Transition Age Youth (TAY) specialist to work with foster and other youth moving into young adulthood. Over the past two years, this specialist intensively served 46 youth, and included the following outcomes:

- 14 secured housing (rooms to rent or apartments); 7 involved with THP+ program, 1 received Section 8 housing, and 1 at Sienna House, a safe pregnancy living program
- Supported 3 youth through birth process (5 total youth with children)
- 12 obtained California ID and certified birth certificates to help with job and benefits
- 2 successfully received California Driver's Licenses
- 14 opened bank accounts
- 17 found employment
- 16 attended Cabrillo College, 1 at Digital Bridge Academy, a targeted community college program
- 11 received financial aid, 3 Chaffee Grants
- 12 received food stamps
- 6 successfully transitioned to Adult Mental Health Transition-age team
- 7 received Social Security Income benefits to assist with adult income and treatment needs

In addition, Transition Age Youth (TAY) penetration rates for mental health services (per EQRO data) rose to 10.79%, compared to the statewide average of 6.94% and medium county average of 6.7%. This was due in part to the new MHSA focus on TAY services,

increased contracted services, and encouragement of all our programs to serve youth past their 18th birthday.

SAS Success Story

Charlie is a 14-yr-old placed with a relative 7 years ago, after CPS removed him from his parents who, needless to say, had enough issues to have a severe emotional impact on Charlie. He had other siblings that were also placed and eventually one was returned to a parent that started making positive changes.

For Charlie, he had to settle for several failed placements before his current one, 2 years after his initial removal at age 5. When I met him, he did not say much and seemed very uninterested in participating, having just lost a therapist after 3 years (due to moving), and moreover believing that he was above needing any help. Charlie was being home-schooled due to a violent history and inability to benefit from public school.

By engaging him through casual chatting about his interests, I discovered that he enjoyed playing golf and thus began a bonding/trust period (lasting several months) where little was said, but much was communicated on the driving range and on the links.

Since that time, our settings have continued to evolve, and I have spent countless hours working with Charlie and his family, as well as social workers, school staff, employment specialists, Independent Living Program coordinators, etc.

Charlie has many ups and downs in his life (and still counting) but he has managed to stay enrolled at a comprehensive high school, get a job, spend increasing time with his father and other siblings, and grow in countless ways. His violent tendencies have all-but-disappeared and his ability to express himself well has improved dramatically.

Charlie (and his family) have a ways to go, but now there is communication and teamwork, where before there was mostly secrets and divisiveness. I owe most of this success to getting as many significant people working together and holding the "system of care" vision as we do this work.

4. Expanded Mental Health Supports for Foster Youth

In collaboration with Social Services, our System of Care created the following additional targeted supports for foster youth over the last two years:

- **Conexiones Familiares** provides targeted mental health support in the context of court-mandated family visitation sessions. These services are proving an essential component of re-uniting foster children with their families in a therapeutically supportive environment. This program shifted to the Parents Center in July 2008.
- **Children and youth of homeless families** (or at risk of homelessness) are now served through a collaboration with Youth Services (EPSDT contract agency), **Homeless Resource Center**, and the **Families In Transition** agency--as well as through targeted services to the **Bridges Homeless Collaborative.**

- In addition to being a part of the SIS Family Preservation team, **Parents Center** provides additional EPSDT treatment supports to foster youth screened by our assessment specialist.
- Child Welfare social workers and Mental Health clinicians collaborate with Education in providing **support services to foster youth under AB 490**. This legislation attempts to support continuity in the education experience of foster youth who, without this interagency collaboration, often experience delays in getting into new schools, delays in record exchange, or unnecessarily change schools when new foster placements occur rather than being supported to stay with the teachers and classmates they know in their home school.

5. Crossroads Transitional Residential Treatment for Foster Youth

The Crossroads Program (operated by Youth Services) is a 6-bed residential/treatment program for foster youth in need of emergency shelter and transitional placement services. Santa Cruz and Monterey counties share access (3 beds each). Crossroads fills a key need for foster youth in need of stabilization, short-term assessment, and transition. Length-of-stay typically ranges from 1-3 months.

6. Families Together (Differential Response services)

Families Together is operated by the Santa Cruz Community Counseling Center, with blended funding from Mental Health, Child Welfare, and First Five. The program provides an array of flexible, field-based supports for families referred to Child Welfare whose children did NOT become court dependents, but are still at high-risk of formally entering the system.

For 144 families studied, 97.2% did NOT have a substantiated re-referral for child abuse or neglect within 6 months of being discharged from Families Together. Total referral activity during this time period includes: 13.2% re-referred, 8.33% investigated, with only 2.78% (or 4 families) with a substantiated case. Following is a brief overview of program demographics:

Families Together Demographics -- Intensive Pathway September 1, 2006 – August 30, 2008

128 Families received services
189 Children 0-5 years old received services

8.5: Mean # months in program
7.5: Median # months in program

5,679 Services & Referrals provided

44: Mean number services/referrals per family
37: Median number services/referrals per family

Examples:

1,182: FAMILY LIFE - Parenting Support and Education
642: FAMILY LIFE – Family Assessment
532: BASIC NEEDS - Food/Transportation/Material Goods
451: MENTAL HEALTH CARE AND COUNSELING – Counseling
349: CHILD DEVELOPMENT - Child Assessment
293: FAMILY LIFE - Domestic Violence & Household Relationships Support

Income Range

75 (58.6%): Less than $10,000
21 (16.4%): $10,000 to $14,999
10 (7.8%): $15,000 to $19,999
12 (9.4%): $20,000 to $24,999
3 (2.3%): $25,000 to $29,999
2 (1.6%): $30,000 to $39,999

Ethnicity

72 (56.3%) Latino
43 (33.9%) Caucasian
5 (3.9%) African American
5 (3.9%) Mixed race/ethnicity
3 (2.3%) Other/Unknown

1 (0.8%): $75,000 to $99,999
4 (3.1%): Unknown

Primary Caregiver Gender
122 (95.3%) Female
6 (4.7%) Male

Primary Residence
50 (39.1%): Watsonville
41 (32%): Santa Cruz
By region
58 (45.3%): South County (Freedom, Watsonville)
50 (39.1%): North County (Ben Lomond, Boulder Ck, Davenport, Felton, Santa Cruz, Scotts Valley)
11 (8.6%): Mid County (Aptos, Capitola, Soquel)
5 (3.9%): Homeless
4 (3.1%): Other

7. Federal and State Child Welfare System Improvement Processes

California's Child Welfare Systems Improvement and Accountability Act (AB 636), in concert with the Federal Child and Family Services Review, initiated a significant county self-assessment and system improvement plan for monitoring and improving Child Welfare services outcomes. As with Juvenile Probation detention and restorative justice reform, these Child Welfare improvement processes and targeted outcomes are entwined with the capacity of community agencies (such as Mental Health) to help support these outcomes. The overarching Child Welfare goals of *Safety, Permanency, and Child Well Being* reflect System of Care values and goals which can be better achieved in the context of a true community system of care. Below is a brief overview of AB 636 outcome measures for Santa Cruz County:

This is a brief summary of each of the AB 636 measures, and where Santa Cruz County performance lies in relationship to the state performance and federal standards for the most recent time period available (data showing recurrence within 12 months will be updated next report). Direct comparisons to the state cannot be made due to the wide range of differences in communities and agencies. However, we can use the state information to better understand our own community.

Summary

- Santa Cruz County **refers more children** to the Child Welfare System compared to the state and also has a **higher rate of children with substantiated allegations**.
- Santa Cruz County has a **similar rate of children entering foster care** compared to the statewide rate.
- Santa Cruz County's performance regarding **no-recurrence** of child maltreatment within a 6 month time frame has **improved in the last three years and nearly meets the federal goal for this measure.**
- Santa Cruz County children, who reunify with their families, **reunify in a timely manner.**
- Santa Cruz County children, who are adopted, are **adopted in a timely manner**.
- Santa Cruz County is able to place the **majority of sibling groups at least partially together.**
- Santa Cruz County has greatly **increased the percentage of children who have experienced two or fewer placements** over the last five years.
- Santa Cruz County places **more children with relatives than foster parents** compared to five years ago. **About half** of Santa Cruz County foster children live with relatives.

- **Almost half** of foster care children who have been **in care 3 years or longer emancipate from the child welfare system**. Santa Cruz County **seeks to reduce this percentage** and increase the percentage of children discharging from care to a permanent home.

(See Appendix E for a full description of Santa Cruz County's AB 636 data and outcomes)

D. Other SED/Community Mental Health Services

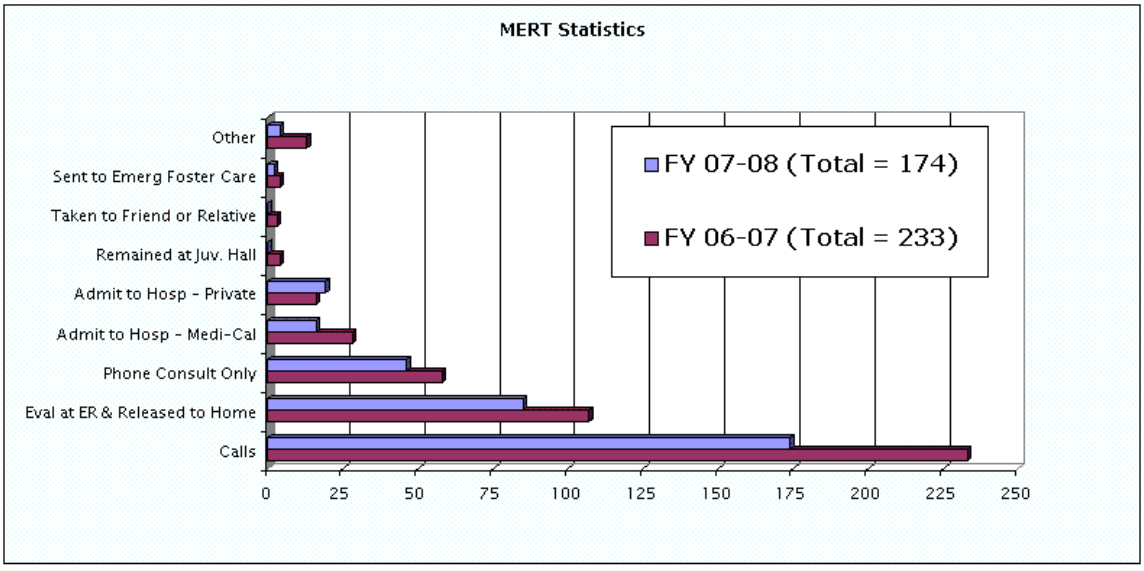
In addition to our primary partnerships with Probation, Education, and Social Services, our System of Care includes core programs that serve children and youth referred from the general community.

1. Mobile Emergency Response Team (MERT)

The Santa Cruz County MERT provides 24-hour, seven day a week, hospital/crisis evaluation for all residents of Santa Cruz County under the age of eighteen. This team of highly trained, licensed clinicians responds to requests for 5150 evaluations at Dominican and Watsonville Community hospitals, as well as Juvenile Hall. Crisis phone response is also available for brief screening, information and referral. Two and one half full time clinicians, our Children's program psychiatrist and a small pool of voluntary, on-call clinicians staff the team. **The MERT team provides services that play a significant and essential role in keeping hospital costs down and providing the least restrictive, most appropriate level of care**. This is particularly important since Santa Cruz County is too small to have its own Child/Adolescent in-patient unit, and hospitalization far from home can be a frightening experience for youth. The **MERT, Other SED, and Intensive Family Support teams** (described in subsequent sections) all collaborate to maintain youth in their own homes, schools and community. Data from previous sections highlight dramatic reductions in the need for out-of-county youth hospitalizations.

The MERT team is often the first contact we have with SED children needing services who are not referred through Probation, Child Welfare or Special Education, and is therefore an

Figure 20. MERT Team Case Dispositions, July 2006 – June 2008

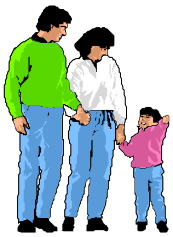


important referral source for our System of Care. Figure 20 shows data describing the results of MERT evaluations over the past two years. As is evident, the majority of assessments and interventions resulted in children/youth being able to remain at home, rather than being hospitalized. NOTE: In July 2008, significant county budget cuts necessitated redesigning the MERT team composition and reducing the number of scheduled response hours to local hospitals and juvenile hall. This will be reviewed in the next report cycle.

2. Other SED: Our Community Gate

Our "Other SED" team serves those youth and families who are either self-referred, or referred through other community based services. These youth and their families are often first identified through our crisis Mobile Emergency Response Team and are in need of intensive services. These youth tend to be our most seriously emotionally disturbed, often experiencing their first psychotic break, or are severely depressed and suicidal. The Other SED team has small clinician to client ratios so that they can provide intensive therapeutic services to prevent hospitalization and keep youth at home and in our community. An integral part of this team is our staff psychiatrist who works closely with our clinicians and the youth and families we serve to ensure coordinated medication management.

3. Intensive Family Support Program



The Intensive Family Support Program continues to be an integral component of our System of Care. This program allows us to intensify home and community based services whenever needed so that families and youth can get the level of support needed to work through crises, remain in the home, and avoid out-of-home placement. This unit serves as an adjunct to all other System of Care programs.

Between July 2006 and June 2008, the Intensive Family Support Program served a total of 49 clients. **All clients are at risk of significant, prolonged stays in hospital and/or residential placement without these intensified services.** As indicated in the chart below, all but 5 of the referred clients were able to be maintained either at home, at same level of placement, or actually decrease level of placement.

Intensive Family Support Placement at Discharge	**FY 06/07**		**FY 07/08**	
	Clients	**Percentage**	**Clients**	**Percentage**
Maintained at home or same level of placement	20	80%	21	88%
Decreased in level of placement	2	8%	1	4%
Living in more restrictive placements	3	12%	2	8%
Total Clients:	25	100%	24	100%

FAMILY SUPPORT TEAM SUCCESS STORY

"I don't think we can keep this up," said foster mom, Cathy, fighting back tears. "Her refusal to get up in the morning is making us so often late for work that I'm afraid we're going to lose our jobs. We love her, and in order for this to work, we need help"

The foster mom saying those words in October was beside herself with worry. Their home was 12-year-old Norma's last chance to grow up in a family. If this didn't succeed Norma would be going to another Level 14 group home. Her oppositional and physically aggressive behaviors had gotten so bad that she was refusing daily to even get out of bed and go to school.

The clinicians working with the family were discouraged; the outcome looked grim, in spite of regular therapy. While discussing treatment strategies, it was decided that Debra or her teammate Jon (of the intensive Family Support Team) , would go to the foster home every school morning and work with the whole family. The foster parents were thrilled at the idea. A plan was developed.

Debra and Jon took turns and showed up between 6 and 6:30AM Monday through Friday. They provided family counseling and helped the parents and Norma develop a behavioral plan with rewards and consequences. Using a Cognitive-Behavioral approach, they worked with her on appropriate verbal communication of feelings and concerns. They offered Norma motivation and non-judgmental reminders about the benefits of compliance and the risks of non-compliance. With Cathy and husband Alex they were able to model effective parenting skills—in the home environment, at the point of conflict. They taught and reinforced positive encouragement, appropriate limit setting and de-escalation techniques. They offered constructive feedback and reminded the parents of the need for consistency and follow-through. The whole family worked hard to make changes.

This went on 5 days a week for several months. Slow progress was made. Over the course of the whole school year, as the foster parents' skill improved and Norma gained more ability to control her rage and express herself verbally, Debra and Jon were able to gradually decrease their level of intervention.

Norma has been on the Honor Roll at school, never fell below 3.5 grade average during 7th and 8th grade, and was awarded the Language Arts top student of her class. Her new teacher said "Norma has been a delight to have in the class and is very caring towards other students. This foster family is stable. The primary clinician continues to provide regular therapy, and the Family Support Team no longer needs to be involved!

4. Youth Services: Outpatient Services in Clean and Sober Classrooms

Since 1995, the Santa Cruz County Mental Health and Substance Abuse divisions have collaborated with a local non-profit agency, Youth Services, to provide **dual diagnosis treatment programs for adolescents**. Youth Services provides programs at North and South county sites, in conjunction with **"clean and sober" classrooms** run by the County Office of Education. Referred youth must have co-existing mental health and substance abuse problems. To date, this collaborative program has been key to beginning a more integrated treatment approach targeted to the many youth abusing or addicted to drugs and alcohol.

The following data provides a broad outcome overview of these and other Youth Service programs (listed in previous sections).

Youth Services Annual Telephone Survey and Recidivism Results
2002 – 2007

5 Year History of Outcomes		06-07	05-06	04-05	03-04	02-03
Recidivism	Youth with Substance Use	71%	87%	73%	81%	76%
(% not re-arrested)	Youth w/o substance use	69%	68%	80%	79%	80%
	ALL CLIENTS	70%	76%	75%	80%	78%
Satisfaction with Services	Youth with Substance Use	97%	80%	90%	69%	75%
% very satisfied & satisfied	Youth w/o Substance Use	92%	95%	88%	70%	81%
	ALL CLIENTS	95%	86%	89%	70%	77%
Service Effectiveness	Youth with Substance Use	83%	77%	84%	63%	64%
% very effective & effective	Youth w/o Substance Use	84%	93%	88%	70%	61%
	ALL CLIENTS	83%	84%	85%	66%	62%
Drug & Alcohol Use (% stopped or reduced substance use)		76%	67%	80%	76%	67%

5. Tyler House: Dual Diagnosis Residential/Treatment for Voluntary Youth and Probation Girls

Tyler House is a 6-bed, 6 to 9 month, co-educational dual diagnosis program operated by Youth Services that provides residential treatment for adolescents between 14 and 17 years old. It gives teens and families the dual diagnosis mental health support and guidance necessary to intervene in the cycle of addiction and create a foundation for ongoing sobriety. Residents attend Youth Services' clean and sober school Escuela Quetzal in Watsonville, a fully accredited high school where the County Office of Education provides a teacher to help students meet all requirements for high school graduation. Participants that graduate from Tyler House transition either to Escuela Quetzal or the Y.E.S. School in Santa Cruz for aftercare and continuing support.

Tyler House Success Story

Rosa, a female client that came from an extremely abusive childhood, was adopted as a preteen. She has been in one treatment program before Tyler House. Rosa was a poly-substance abuser, with her main drug being methamphetamine. At one point, she was admitted to a children's psychiatric ward for being out of control as a result of using drugs. Rosa entered Tyler House as a voluntary placement. Her goals included finishing high school, staying clean and sober, and getting a job after graduating the program. Rosa accomplished all of these goals and entered a Sober Living Home after completing the program. She now has eight months of clean time and attends AA meetings, has a sponsor, and attends after care programs.

6. Family Services Agency

Family Service Agency (FSA) of the Central Coast is a private, non-profit agency serving the community since 1957. FSA is AN EPSDT mental health provider, offering services to children, youth and families in north and south county locations. **They also offer a variety of clinical, crisis, educational, outreach and supportive services designed to maintain and strengthen family and community life. Programs include: Counseling Services, Senior Outreach, Suicide Prevention, I-You Venture, Renaissance, First Step, PEAK, and Continuing Education.**

E. Clinical Outcomes and Youth/Family Satisfaction

Since July 1, 1995, consumer level outcome measures have been implemented in our System of Care. Beginning in October 2003, the State Department of Mental Health changed the method of evaluating consumer satisfaction with services. The **Youth Services Survey (YSS) and the Youth Services Survey for Families (YSS-F)**, both adapted by Molly Brunk, Ph.D. (1999) from the Family Satisfaction Questionnaire, were instituted as the standard measurement of satisfaction. The new surveys, available in Spanish and English, provide more comprehensive data from youth and families about their experience of receiving treatment. They are administered twice yearly to all families receiving services in November and May.

In addition, for many years we've utilized a variety of clinical measures to gauge improvements in functioning from the point of view of the treating clinician, the parent/caregiver, and youth receiving services. For this reporting cycle, the **Ohio Scales** (Benjamin M. Oglas and Southwest Consortium for Children - **Worker & Youth versions)** have replaced the Child and Adolescent Functional Assessment Scale **(CAFAS)** for the clinician assessment. The Child Behavior Checklist **(CBCL)** remains the instrument used for parent/caregiver assessment of child/youth progress. These instruments are administered at admit, six months, twelve months, annually, and at discharge from the System of Care.

1. Clinician Perspective

Ohio Scales - Worker Version

The Ohio Scales data below shows child/youth clinical outcomes *from the point of view of the treating* ***clinician***. The first graph shows an ***improvement in functioning*** for clients administered pre and post tests, The statistics indicate very strongly confidence that these changes represent true change for the clients. The second graph shows ***decreases in problem severity*** for clients tested. The statistics indicate extremely strongly confidence that these changes represent true changes for the clients.

Figure 21. Ohio Worker Function Scale, sampling from July 2006 – June 2008

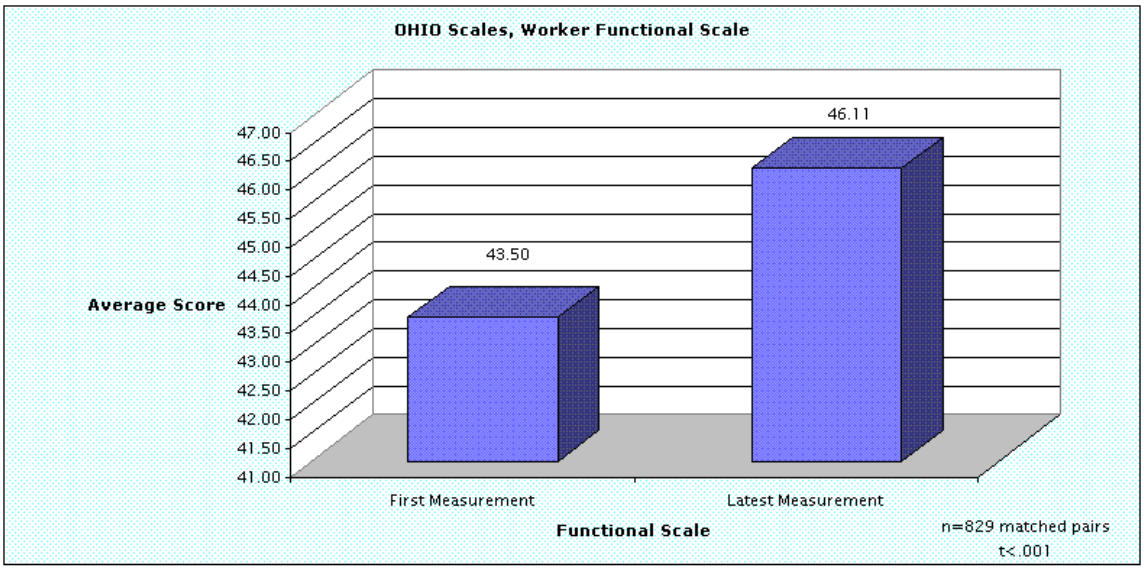
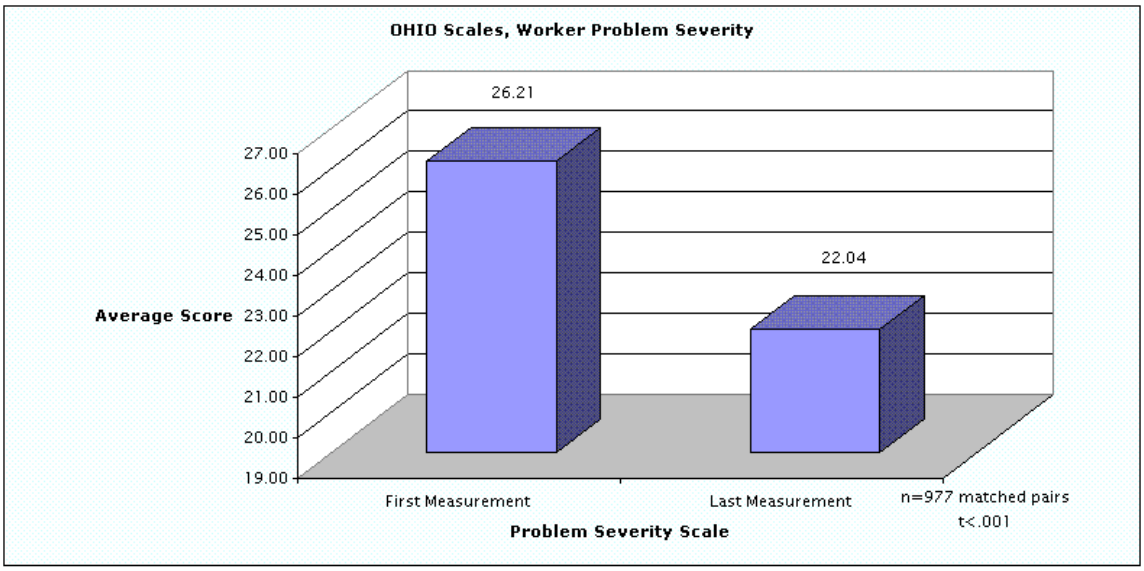


Figure 22. Ohio Worker Problem Severity Scale, sampling from July 2006 – June 2008



Historical View - CAFAS Data

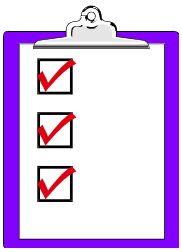
Since the administration of the Ohio Scales is relatively new, we've included the previous 8 years worth of CAFAS data for historical purposes. On the CAFAS the *clinician* is asked to rate the youth's level of functioning in each of eight areas: School/Work, Home, Community, Behavior toward Others, Moods/Emotions, Self-Harmful Behavior, Substance Use, and Thinking.

Between 7/1/95 and 6/30/03, Santa Cruz County clinicians administered 7,010 CAFAS. Of these, 2,823 are admits/screening for coordinated care; 1,157 are at six months of treatment; 1,339 are annual measures, and 1,691 are discharges from treatment.

From the clinician perspective, trends show:

Statistically significant improvement in ALL of the reported CAFAS Scales between admit and the most recent administration of the measure.

2. Parent Perspective: Child Behavior Checklist (CBCL, Achenbach and Adelman, 1991)



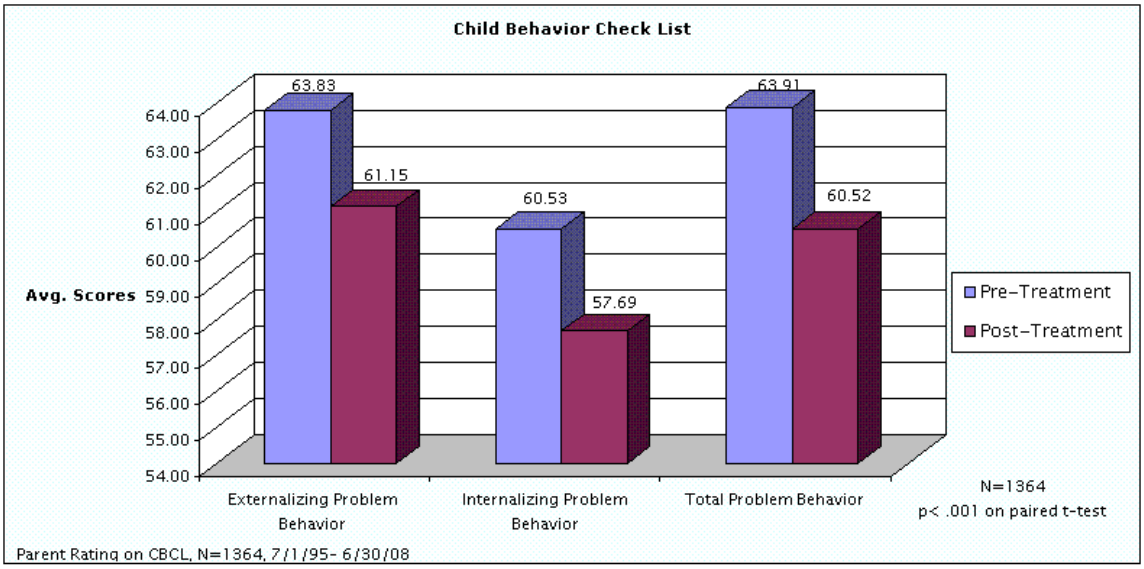
The CBCL, Child Behavior Checklist, was designed to describe a range of problem behaviors of children 4 to 18 years old from the perspective of the ***parent or caregiver.*** The problem behavior section addresses a broad range of behaviors and provides empirically derived Externalizing (e.g., "fights," "argues a lot") and Internalizing (e.g., "unhappy, sad, or depressed," "stares blankly") factor scores as well as a Total Problem Behavior score.

Between 7/1/95 and 6/30/08, Santa Cruz County administered 9,987 CBCL's to youth assessed or being served in the System of Care (which includes those administered at admit, six months of treatment, at the annual mark, or upon discharge).

Changes in scores in problem behaviors on 1,364 youth for whom we have two points of measurement indicate:

- **Significant decrease in internalizing problem behaviors**
- **Significant decrease in externalizing problem behaviors**
- **Significant decrease in total problem behaviors**

Figure 23. Parent Rating Child Behavior Symptoms, 7/1/95 to 6/30/08.

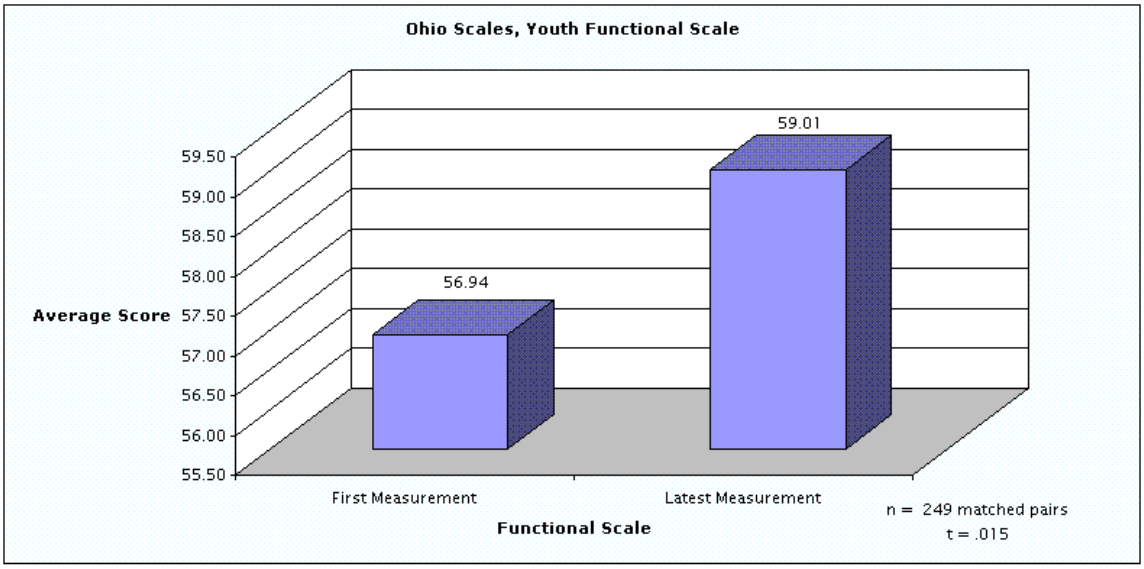


3. Youth Perspective

Ohio Scales - Youth Version

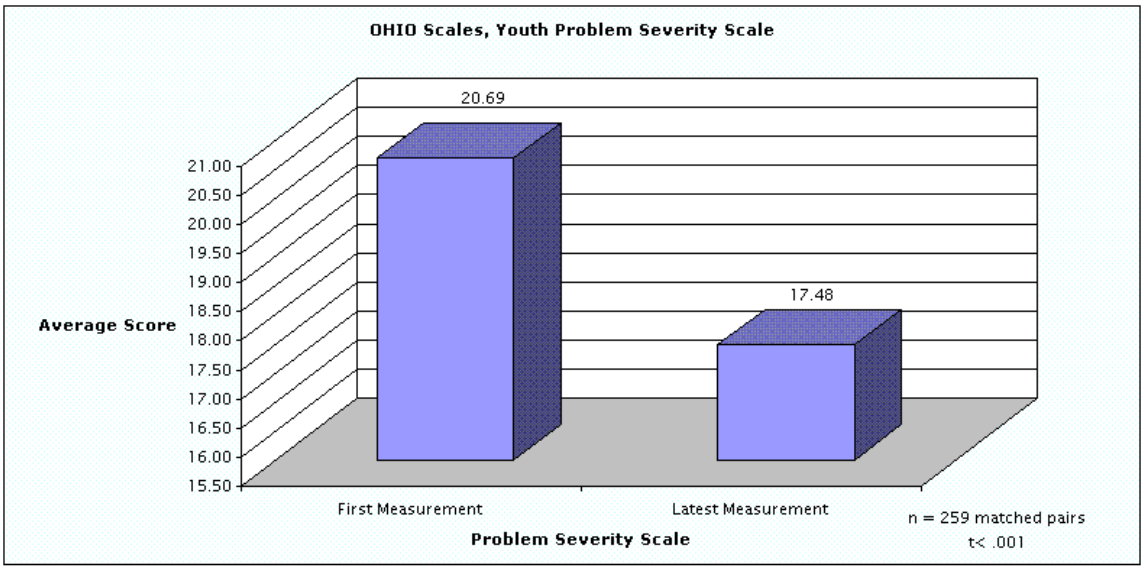
The Ohio Scales data below shows youth clinical outcomes *from the point of view of the* ***youth.*** The first graph indicates that youth see an ***improvement in functioning*** for themselves, for clients administered pre and post tests. In this case the statistics demonstrate a confidence that the changes are genuine for the clients. The second graph

Figure 24. Ohio Youth Functioning Scale, sampling from July 2006 – June 2008.



indicates how youth see the severity of their own problems, with ***decreases in problem severity*** for clients tested. Although the test results were just below statistical significance, in this case, the change reported from pre to post was in a declining direction.

Figure 25. Ohio Youth Problem Severity Subscale, sampling from July 2006 – June 2008.



Historical View - Youth Self Report (YSR, Achenbach and Adelman, 1991)

The YSR is a companion instrument to the CBCL and is **completed by children 11 to 18 years of age**. Similar to the CBCL, the YSR contains a 113 item problem behavior section and a 14 item social competence section, and yields a number of empirically derived scales, including a Total Problem Behavior scale, Externalizing Behavior scale and Internalizing Behavior scale.

Between 7/1/95 and 6/30/03, Santa Cruz County clinicians have administered 5,275 YSR's. Of these 2,397 are admits/screenings, 776 represent six months of treatment, 940 are annual, and 1,162 are discharges from treatment.

Changes in scores in problem behaviors on youth for whom we have two points of measurement, representing an average of 17 months of treatment, indicate:

- **Significant decrease in internalizing problem behaviors**
- **Significant decrease in externalizing problem behaviors**
- **Significant decrease in total problem behaviors**

4. Youth and Family Satisfaction Questionnaires

Since 7/1/95, Santa Cruz County Children's Mental Health has administered family and youth satisfaction questionnaires as part of our ongoing System of Care evaluation. **Research shows a link between consumer satisfaction and improved outcomes, so this measure is important in both domains.**

Youth Services Survey (YSS) and the Youth Services Survey for Families (YSS-F)

The State Department of Mental Health, as part of its Performance Outcome and Quality Improvement (POQI) efforts, now requires all youth and parent/caregivers in local mental health services to be offered a satisfaction survey twice annually. It provides important feedback to state and local leaders about how our services are seen by the families that use

them. The chart below illustrates youth and family feedback for the past two years, with a predominance of scores in the ***strongly agree*** and ***agree*** range regarding overall satisfaction with services received. This is important feedback to our system.

Youth and Family Satisfaction Surveys - Selected Questions

July 2006 – June 2008

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Overall, I am satisfied with the services I received.	Youth	39%	46%	7%	1%	1%
	Family	51%	33%	6%	3%	1%
The people helping me stuck with me no matter what.	Youth	40%	41%	11%	1%	1%
	Family	52%	30%	6%	2%	1%
I participated in my own treatment.	Youth	29%	51%	9%	3%	1%
	Family	42%	42%	6%	2%	1%
The location of services was convenient.	Youth	36%	45%	8%	4%	1%
	Family	45%	41%	5%	3%	1%
Services were available at times that were convenient for me.	Youth	33%	45%	9%	3%	2%
	Family	46%	40%	7%	1%	0%
I got the help I wanted.	Youth	33%	41%	14%	4%	1%
	Family	40%	39%	11%	2%	1%
I got as much help as I needed.	Youth	31%	43%	15%	3%	1%
	Family	41%	35%	12%	3%	1%
Staff respected my family's religious/spiritual beliefs.	Youth	36%	39%	6%	1%	1%
	Family	43%	34%	2%	0%	0%
Staff spoke with me in a way that I understood.	Youth	41%	46%	4%	1%	0%
	Family	58%	32%	3%	1%	0%
Staff were sensitive to my cultural/ethnic background.	Youth	37%	39%	8%	2%	1%
	Family	40%	35%	5%	1%	0%
I am better at handling my life.	Youth	23%	46%	18%	3%	2%
	Family	27%	46%	16%	2%	1%
I get along better with family members.	Youth	22%	41%	21%	5%	2%
	Family	24%	45%	18%	3%	1%
Youth Surveys Total: 617						
Family Surveys Total: 607						

**NOTE: Responses to survey questions were based on averages and do not include "Blanks" (no answer)*

Historical View – Family and Youth Satisfaction Questionnaires

From 1995 through the beginning of 2004, the instruments used were the Family Satisfaction Questionnaire (CSQ-8) developed by Cliff Attkisson of the University of California San Francisco Child Research Service Group, and the Youth Satisfaction Questionnaire,

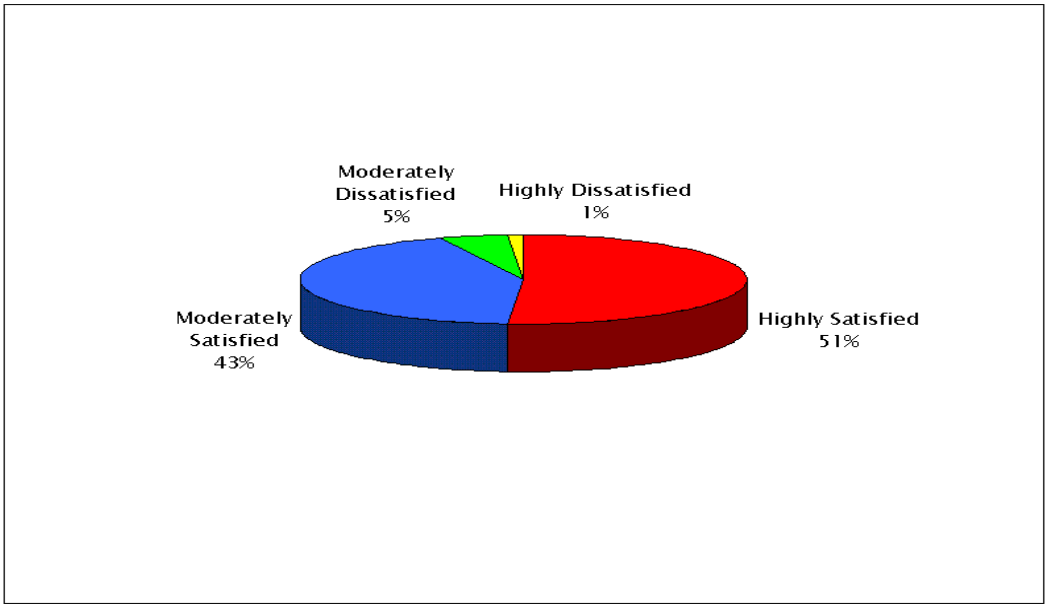
developed by MACRO International as part of the CMHS National Evaluation of Systems of Care. Overall we collected 1,118 Family Satisfaction Questionnaires and 1,034 Youth Satisfaction Questionnaires.

Historical View: Family Satisfaction Questionnaire

On the Family Satisfaction Questionnaire (Client Satisfaction Questionnaire, Attkisson) parents are asked to answer eight questions pertaining to how the services and program have met their needs. The parent scores each item on a scale of one to four. The lowest score represents dissatisfaction, the high score represents high satisfaction.

From 1,118 responses, families indicated a high level of satisfaction with services, consistently rating our services between the highest and second levels of satisfaction.

Figure 26. Parent / Caregiver Satisfaction Ratings (n=1,118)



Historical View: Youth Satisfaction Questionnaire

Youth graded the services they receive using letter grades, in the same way that they are graded at school. Youth also answered five questions about the services they received.

We received the following report card from our youth respondents (1,034 responses):

Report Card – Santa Cruz County System of Care (as of June 2003)

Service	Grade Point Average
Individual Counseling	A-
Family Counseling	A-
Group Counseling	B
Medication Support	B
Family Support Services	B
Recreational Activities	A
Crisis Services	B

In response to five additional questions, youth responded as follows:

Number Respondents = 1,034	Yes	Somewhat	No
Did you like the help you were getting?	75%	20%	5%
Did you get the help you wanted?	66%	27%	7%
Did you need more help than you got?	18%	19%	63%
Were you given more services than you needed?	16%	16%	68%
Have the services helped you with your life?	64%	27%	9%

Overall youth responded positively when rating services.

- 95% of respondents liked/ somewhat liked the help they were getting
- 91% felt the services helped/ somewhat helped with their lives
- 93% felt they got/ somewhat got the help they wanted

III. SYSTEM OF CARE VALUES

A. Family Partnership Program

The Family Partnership Program, initiated in 1995, offers support services to parents, caregivers and family members of children and youth with serious emotional disturbances. Services are offered by trained peer counselors--family members with personal experience as parents or caregivers of children with mental health issues and/or special education needs. The program is operated by the Volunteer Center of Santa Cruz, a non-profit agency, under contract with Santa Cruz County Children's Mental Health. The program provides home and field-based services to families throughout Santa Cruz County. It was designed to give family members a stronger voice in their children's care and treatment by engaging them and honoring their role as full partners in their children's care.

Working closely with Children's Mental Health, the Juvenile Probation Department and other System of Care providers, the Family Partnership Program assigns peer advocate staff members to help families access appropriate mental health services for their child or youth within the System of Care. Family Partner staff work closely with families on a 1-1 basis to assist them in learning about children's mental health issues, about parents' rights to participate in treatment planning, about effective coping skills and parenting strategies and about available mental health services and community resources. Program services include individual consultation, court accompaniment, education workshops, referrals, advocacy, respite care and assistance with family reunification following out-of-home placement. Bilingual/bicultural staff are available to provide culturally-competent support to Spanish-speaking and Latino families. The Family Partnership program provides ongoing, 1-1 support to approximately 50 families per year, including 25 families in the Wraparound Program, a cooperative partnership between Juvenile Probation and Children's Mental Health.

In the spring of 2007, the program was expanded to include a dedicated Family Mental Health Advocate position. The Family Advocate is available to see families whose children are not already enrolled in System of Care services. The Advocate responds to Helpline calls, conducts outreach to un-served or underserved communities, advises families on how to apply for Medi-Cal benefits, helps them access health care and mental health services for their children and offers consultation and referrals on an as-needed, drop-in basis. Initial efforts were devoted to networking with partner agencies in the community who might be able to refer or provide access to families and to gaining familiarity with the public mental health care system. In the first year, the Family Advocate responded to 67 calls and requests for consults, conducted four outreach presentations and helped facilitate a 12-week family education series for Spanish-speaking families (the "Familia de Familia" class).

The Family Partnership and Family Advocate services are supported in part by Mental Health Services Act (MHSA) funds.

In addition to these accomplishments, the Family Partnership Program's proudest achievements are summed up in the feedback they receive from family members. In a recent survey, comments included:

"The program provides us with trust and confidentiality. The result is that it helps us mentally, physically, and spiritually."

" Without the program, I would *probably drown."*

B. Cultural Competence

Santa Cruz County strives to recognize and value cultural differences among its citizens. Children's Mental Health has traditionally sought ways to increase its ability to provide culturally competent services for our children and families. Our Federal System of Care Grant in the 1990's helped Children's Mental Health take a leadership role in cultural competence for our Mental Health department in the 1990's. Since then, the entire Mental Health/Substance Abuse department has undertaken a focused commitment to achieve greater cultural competency.

Over the last two years, we have integrated our **Cultural Competence Council** into our Core Leadership management team, helping to infuse dialogue and data review with a broader array of agency/community stakeholders. The council is made up of staff, contractors, clients and family members charged with the responsibility of moving cultural competence issues forward. The council reviews and makes recommendations on important issues such as access for special populations, evaluating staff for cultural and linguistic competency, and staff recruitment and training.

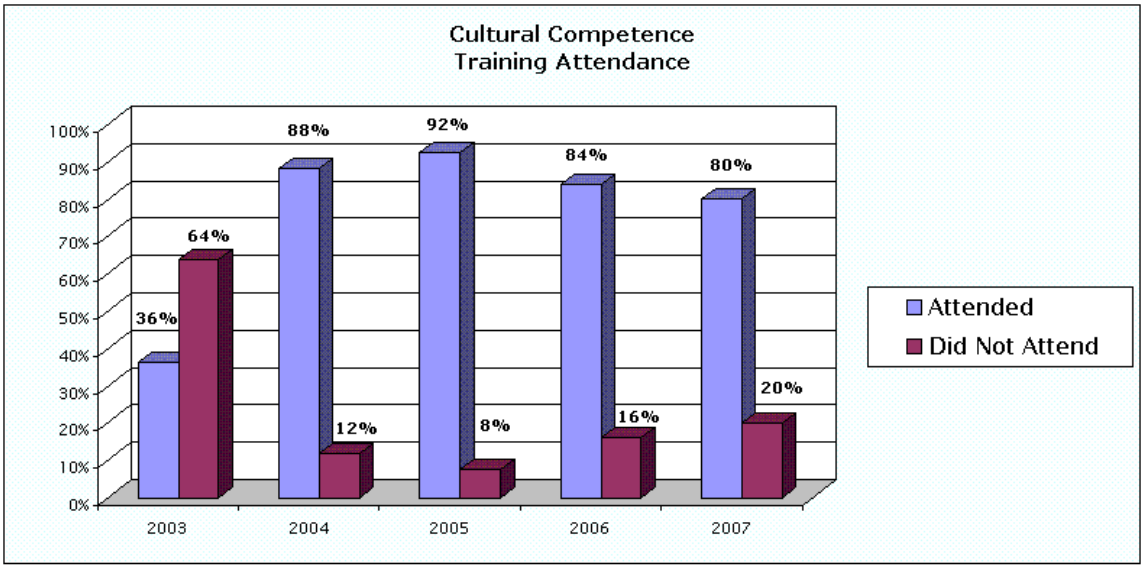
Staff has also provided leadership in cultural competence through **sponsorship of important trainings.** Our department's Cultural Competence coordinators, Alicia Najera and Elizabeth Soria, have worked with staff and external trainers to maintain a rich array of trainings. Topics from the past two years have included:

- *Art of Ana Mendieta*
- *Triangle Speakers*
- *Last Chance for Eden (4 sessions)*
- *The Cultural Significance of Mexican Folklórico Dance*
- *Changing Gendered Constructions of Risk by Mexican Immigrants*
- *Lost in Translation?*
- *Found in Interpretation.*
- *Cultural Considerations in Relapse Prevention Therapy*
- *Whose Holiday is it Anyway?*
- *Opening Communication Using Motivational Interviewing Approach and Techniques*
- *Spirit Possession and Mental Health among Vietnamese-American Spirit Mediums*
- *Sí Se Puede Panel Presentation*
- *Law & Ethics Training (1 session per year)*
- *Understanding and Working with Children from Addicted Families*
- *MHCAN – Client Perspectives*
- *Disabled and Mislabeled*
- *Creating Welcoming Spaces (2 sessions)*
- *Seven Challenges*
- *CBT & Personality Disorders*
- *A Positive Life*
- *Working With Survivors of Sexual Assault*
- *Using New Capacity Assessment Tools*
- *What is Same Sex International Dance Competition*
- *Housing Authority Discussion*
- *Health Care Systems Reform: A Framework to Understand the Options*
- *Culture, Family Factors & The Course of Mental Illness*
- *Access to Health Care*

- *Caring for Aging Parents*
- *Breaking the Barriers - WRAP*
- *Jewish Presentation, Panel Discussion*
- *Healing Oppression*
- *Seeking Safety*

The chart below illustrates a significant rise in our department's overall **cultural competency training attendance from 36% in 2003, to 80% - 92% in subsequent years** based on a concerted effort to increase the range and interest of available trainings, and make such training a division priority.

Cultural Competency Training Attendance										
	2003		2004		2005		2006		2007	
Attended	91	36%	194	88%	193	92%	203	84%	203	80%
7+ hours	*53*	*21%*	*88*	*40%*	*120*	*57%*	*103*	*43%*	*115*	*45%*
Less than 7 hours	*38*	*15%*	*106*	*48%*	*73*	*35%*	*100*	*41%*	*88*	*35%*
Did Not Attend	160	64%	26	12%	16	8%	38	16%	51	20%
Total Employees	251	100%	220	100%	209	100%	241	100%	254	100%



Yet another way that the Children's Program has worked to increase cultural competence is through emphasis on recruitment and retention of bilingual/bicultural staff. The Bilingual Clinician Support Group provides a forum for bilingual/bicultural staff to receive support from others experiencing similar challenges in providing services to a multi-cultural community. In addition, the department's new Cultural Competence plan has helped us better map and understand our client's needs, our staff resources, and how we need to move forward towards even better, culturally relevant services to the families we serve.

C. Other Family and Youth Involvement Approaches

Involving family and youth in the treatment process is a core value of our System of Care. Families are invited to provide feedback to our clinicians and programs on what works and how to improve the delivery of services in a variety of ways.

In addition to some of the real client stories conveyed in previous pages, we've included client poetry as a way of sharing some of the personal experience of youth in our programs. The following come from Dennis Morton's poetry workshop in Juvenile Hall, and other venues:

Stuck

My appointment with life
starts with a cup of coffee.
A crow is watching
as my blessings fail me.
I'm stuck in traffic
with a pocket full of wishes
and dust in my eyes.

-- Kate, *YES School*

This Time

I was with some friends.
It was winter, icy, windy.
We were hanging out
in a car in a dark alley.
We were full of doubt but
we didn't want to show it.
And then, red and blue lights
in the mirrors of the Cadillac.
We took deep breaths, wondered
what we were guilty of,
this time.

-- Michael, *first published in issue 13.01 of the Beat Within*

Together

Creatures of the night
angels of the day
ride the bus together
like cigarettes in an ash tray.

-- Jackson, *first published in issue 13.08 of the Beat Within*

Needless, Needles

Needless to say, needles I say,
on the streets I stay. I play mind games,
seek riddles, dance in the rain.
It's what destiny says to me,
that truly tests the best of me,
confess and we'll see.
We're trespassing to find places to sleep.
Cardboard's all that's between us and concrete.
I don't sleep in a tent anymore.
I've found front porches, cardboard boxes,
alleyways and parking lots.
I steal only what I need,
only take what other people leave.
I live to write but wrote to die.
With unsober mind I lived in spite.
These words are all I've got.
If I didn't have them I'd have no reason to go on.
So I sit here, letting my mind race,
trying to find something to do in this unbearable place.

-- Faith, *first published in issue 13.01 of the Beat Within*

Twice

Inside a confused head
held up by words unsaid
I explore my brain
delving into a realm
from which I can extract the pain.
But that trip comes with a price.
I'm misguided by my own corrupted advice.
If I were my own therapist
I'd have to take my time, drop a rhyme,
and fire myself twice.

-- Jackson, *first published in issue 13.05 of the Beat Within*

Ode To Our President

I represent the corrupt system.
I slang slander and lies
and America listens.
I focus on building more prisons
as well as oil refinery divisions.
I kill to get rich
and stay rich by killing.
All the while the rigs keep drilling.
I don't want to build more schools.
I'd rather spawn a nation of ignorant fools.
I'll recruit more soldiers
and stage another attack
to persuade the upper class
to have my back.
I'll replace mother nature
with roads near and far,
and build bigger, less fuel efficient,
tar burning cars.
If you want Armageddon,
I'll be your man.
Don't worry.
I'll keep doing all I can.

-- Anonymous, *first published in issue 13.11 of the Beat Within*

Thinking

I'm sitting in my room
thinking of the game
that gave me this 'fame'.
It's just a big journey
and sometimes I sleep
through it. I'm thinking
about the past. I wish
I was on the outs
so I could feel the wind
and smell my girl's scent
at night. All I can hear
is the rain, and a moving train.

-- George, *first published in issue 13.16 of the Beat Within*

What Hand

What type of hand
can turn the key
to open a shell
of sorrow?
Or does it take a kiss
to open the abyss
and turn the pain
from yesterday
into happiness tomorrow?

Always more -
greed is a whore.
More lies.
More money.
More anger, hate, and pain.
More corruption.
Who's to blame?
The greatest nation on earth -
an imposter since it's birth.

-- Jackson, *first published in issue 13.09 of the Beat Within*

Wondering

Every hour I think and wonder,
hoping that I could go home,
hoping my mom won't shed that tear.
No space for me to be free,
wishing I could just walk out that door.
Looking at the four corners in my room
gots me wondering if I'll be a ghost soon.
gots my eyes closed tight,
thinking about the history of my
childhood life.

-- Robert, *first published in issue 13.14 of the Beat Within*

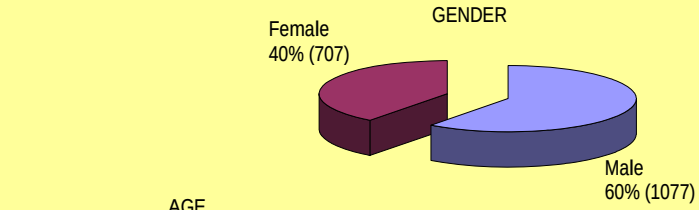
Appendix A

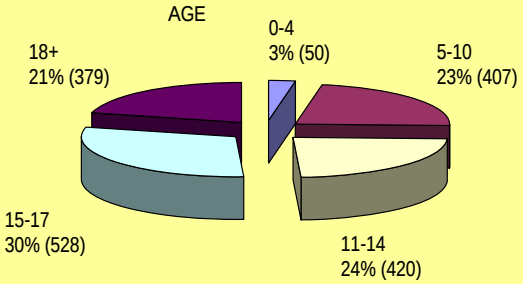
Year Eighteen of System of Care – Demographics

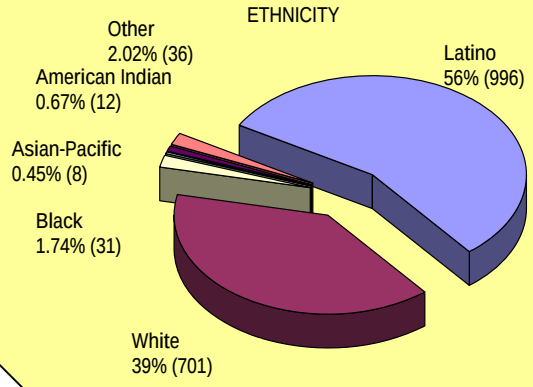
July 1, 2006 – June 30, 2007

FY 06/07 ALL Children's Clients

Total Unduplicated Clients: 1,784
Admissions: 2,930
Discharges: 2,154
Episodes Open as of June 30, 2007: 964







Child Welfare Clients

Total Clients: 386
Admissions: 562
Discharges: 353
Episodes Open as of June 30, 2007: 343

Ethnicity		Age	
Latino:	185	0-4:	32
White:	185	5-10:	122
Black:	8	11-14:	82
Asian-Pacific:	0	15-17:	76
Amer. Indian:	1	18+:	74
Other:	7		

Probation Clients

Total Clients: 326
Admissions: 724
Discharges: 635
Episodes Open as of June 30, 2007: 127

Ethnicity		Age	
Latino:	181	0-4:	0
White:	133	5-10:	4
Black:	3	11-14:	16
Asian-Pacific:	3	15-17:	156
Amer. Indian:	2	18+:	150
Other:	4		

Special Education Clients

Total Clients: 152
Admissions: 157
Discharges: 62
Episodes Open as of June 30, 2007: 114

Ethnicity		Age	
Latino:	38	0-4:	1
White:	103	5-10:	38
Black:	8	11-14:	53
Asian-Pacific:	1	15-17:	40
Amer. Indian:	1	18+:	20
Other:	1		

Crisis Stabilization Clients

Total Clients: 149
Admissions: 189
Discharges: 177
Episodes Open as of June 30, 2007: 13

Ethnicity		Age	
Latino:	55	0-4:	0
White:	85	5-10:	9
Black:	3	11-14:	27
Asian-Pacific:	2	15-17:	78
Amer. Indian:	1	18+:	35
Other:	3		

EPSDT Contract Services Clients

Total Clients: 1054
Admissions: 1231
Discharges: 894
Episodes Open as of June 30, 2007: 518

Ethnicity		Age	
Latino:	689	0-4:	17
White:	313	5-10:	269
Black:	14	11-14:	284
Asian-Pacific:	4	15-17:	308
Amer. Indian:	9	18+:	176
Other:	25		

Community / Other SED Clients

Total Clients: 57
Admissions: 57
Discharges: 37
Episodes Open as of June 30, 2007: 30

Ethnicity		Age	
Latino:	31	0-4:	0
White:	25	5-10:	1
Black:	0	11-14:	4
Asian-Pacific:	0	15-17:	26
Amer. Indian:	0	18+:	26
Other:	1		

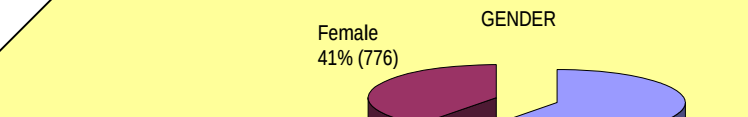
NOTE: Clients may receive services in multiple programs or reporting units.

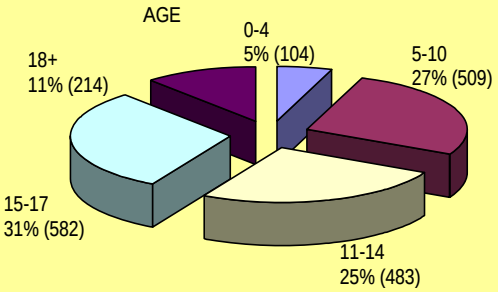
Year Nineteen of System of Care – Demographics

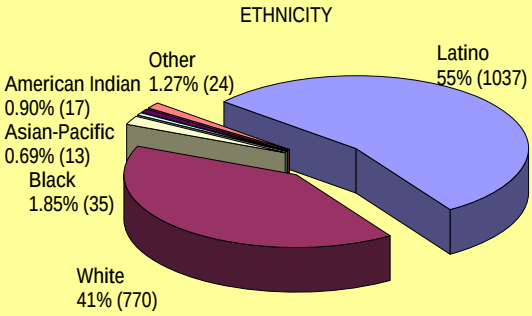
July 1, 2007 – June 30, 2008

FY 07/08 ALL Children's Clients

Total Unduplicated Clients: 1,896
Admissions: 2,825
Discharges: 1,753
Episodes Open as of June 30, 2008: 1,050







Child Welfare Clients

Total Clients: 504
Admissions: 660
Discharges: 396
Episodes Open as of June 30, 2008: 272

Ethnicity		Age	
Latino:	227	0-4:	80
White:	257	5-10:	174
Black:	8	11-14:	101
Asian-Pacific:	5	15-17:	87
Amer. Indian:	3	18+:	62
Other:	4		

Probation Clients

Total Clients: 288
Admissions: 550
Discharges: 426
Episodes Open as of June 30, 2008: 133

Ethnicity		Age	
Latino:	157	0-4:	0
White:	110	5-10:	2
Black:	9	11-14:	50
Asian-Pacific:	2	15-17:	178
Amer. Indian:	4	18+:	58
Other:	6		

Special Education Clients

Total Clients: 179
Admissions: 189
Discharges: 69
Episodes Open as of June 30, 2008: 122

Ethnicity		Age	
Latino:	44	0-4:	1
White:	119	5-10:	58
Black:	6	11-14:	72
Asian-Pacific:	2	15-17:	36
Amer. Indian:	4	18+:	12
Other:	4		

Crisis Stabilization Clients

Total Clients: 121
Admissions: 144
Discharges: 127
Episodes Open as of June 30, 2008: 18

Ethnicity		Age	
Latino:	41	0-4:	0
White:	73	5-10:	8
Black:	2	11-14:	32
Asian-Pacific:	0	15-17:	76
Amer. Indian:	2	18+:	5
Other:	3		

EPSDT Contract Services Clients

Total Clients: 1065
Admissions: 1200
Discharges: 698
Episodes Open as of June 30, 2008: 548

Ethnicity		Age	
Latino:	693	0-4:	30
White:	332	5-10:	299
Black:	14	11-14:	301
Asian-Pacific:	5	15-17:	348
Amer. Indian:	9	18+:	87
Other:	12		

Community / Other SED Clients

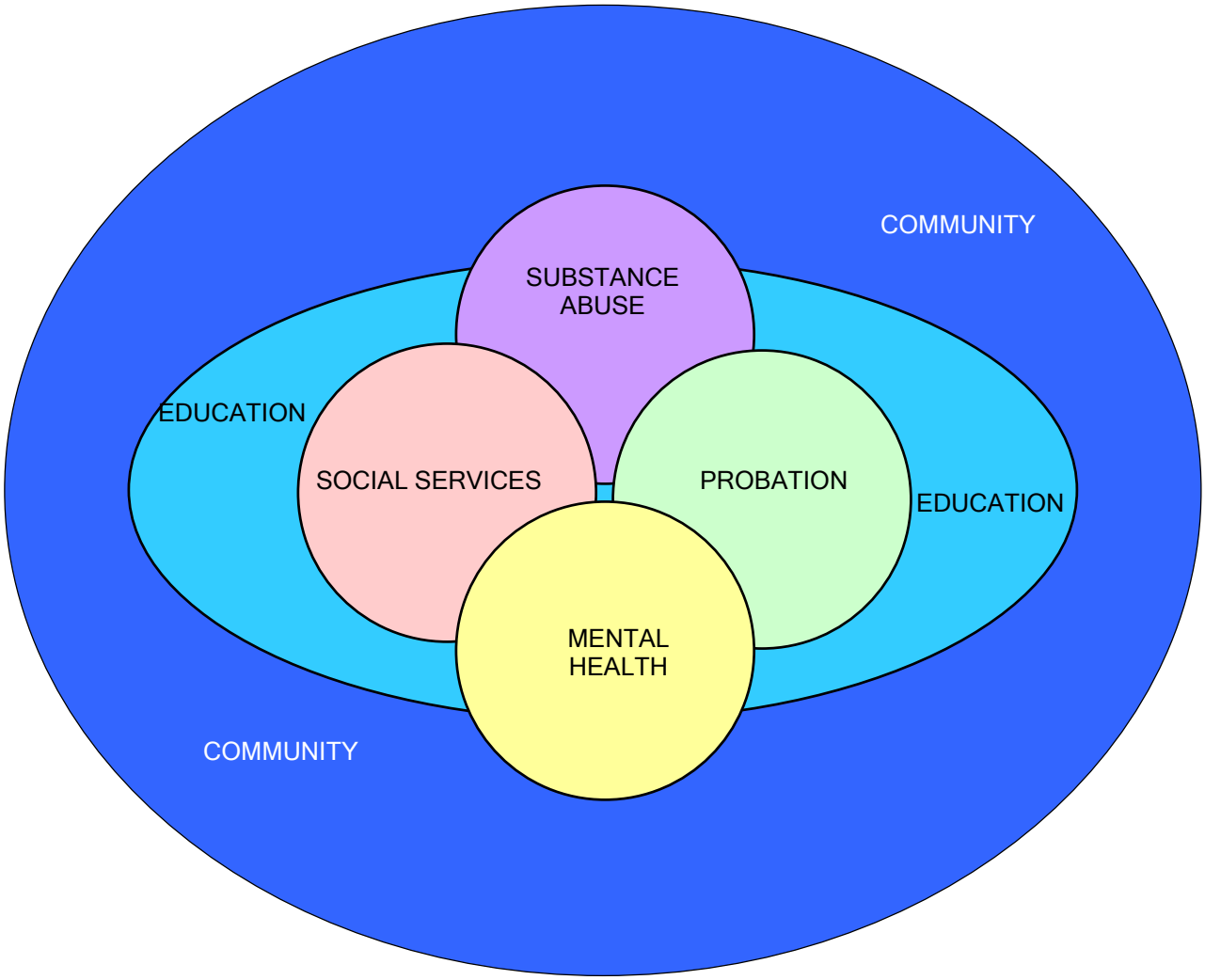
Total Clients: 80
Admissions: 82
Discharges: 47
Episodes Open as of June 30, 2008: 52

Ethnicity		Age	
Latino:	42	0-4:	0
White:	36	5-10:	11
Black:	1	11-14:	10
Asian-Pacific:	0	15-17:	46
Amer. Indian:	0	18+:	13
Other:	1		

NOTE: Clients may receive services in multiple programs or reporting units.

Appendix B

System of Care
COMMUNITY AND INTERAGENCY COLLABORATION



CHILD / ADOLESCENT WITH SERIOUS

EMOTIONAL DISTURBANCES

Appendix C

The Santa Cruz County of Santa Cruz
SYSTEM OF CARE

A CONTINUUM OF
MENTAL HEALTH SERVICES
PROVIDED THROUGH INTERAGENCY COLLABORATION

INTAKE: SCREENING & ASSESSMENT

*

PRIMARY "GATES" TO SERVICE:
Probation, Child Welfare, Special Education, Other/Hospital Diversion
and Community Contractors for EPSDT Services

*

INTENSIVE MENTAL HEALTH SERVICES and CASE MANAGEMENT
With High Staff/Client Ration for Targeted Outcomes
& Focus on Delivering Culturally Relevant, Family-Focused Services

*

MOBILE EMERGENCY RESPONSE
(EVALUATION, CRISIS INTERVENTION, IN-HOME SUPPORT, HOSPITALIZATION)

*

CHILD PSYCHIATRIC/MEDICATION SERVICES

*

INTER-PLACEMENT DIVERSION AND REUNIFICATION SUPPORT PROGRAMS:
Interagency Placement Screening Committees
& Family Preservation Programs

*

RESIDENTIAL TREATMENT OPTIONS:
CROSSROADS (Emergency/Transitional Placement, Assessment & Treatment)
TYLER HOUSE (Dual Diagnosis, Co-ed, Voluntary, Court Dependents & Wards)

*

AB 3632 ED SCHOOL-BASED SERVICES

*

FAMILY PARTNERSHIP SERVICES

Appendix D

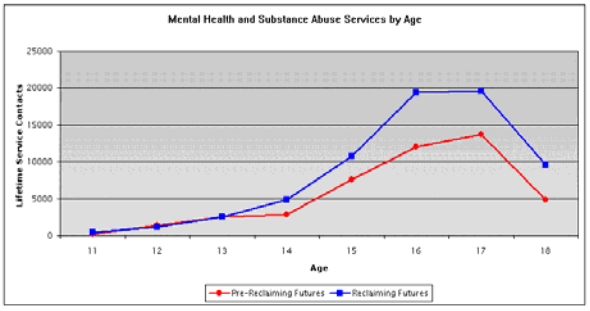
RECLAIMING FUTURES
SANTA CRUZ COUNTY
Communities helping teens
overcome drugs, alcohol and crime

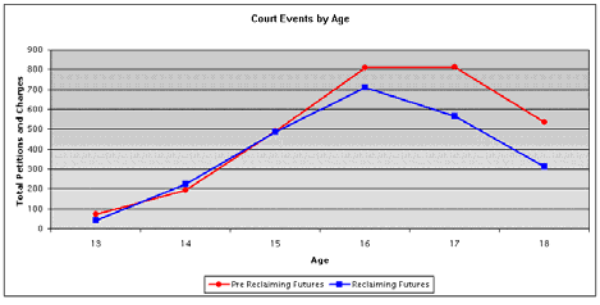
Robert Wood Johnson *Reclaiming Futures* Grant Outcomes in Santa Cruz

As we discussed in prior reports, Santa Cruz County was one of 10 national sites that participated in a four-year systems improvement project focused on improving the treatment of substance use for youth involved with juvenile probation. This project concluded in December 2007. The project resulted in an increase in treatment and a decrease in length of juvenile probation involvement for youth participating in the program. The following excerpts from the Initial Policy Report highlight the findings from the study.

Background:
The Robert Wood Johnson Foundation funded *Reclaiming Futures* Santa Cruz County initiative sought to make significant changes in the service delivery system for youth involved in the delinquency system and struggling with problems with drugs and alcohol. These changes, if successfully implemented, were believed to have the capability to fully integrate alcohol and drug treatment services into the juvenile justice system and result in improved outcomes for the children and families who come before the court. In Santa Cruz County, the goal of *Reclaiming Futures* is to provide more treatment, better treatment and move beyond treatment to reconnect and strengthen youth and families within their communities, so that they may overcome alcohol, drugs and crime.

Conclusion:
The most straightforward, though simplified, goal of *Reclaiming Futures* in Santa Cruz was to create systemic changes that increased the effectiveness and efficiency of community based substance abuse and mental health services for youth who had extensive involvement with juvenile probation so that youth would have less involvement with probation. . . . [T]this initial policy report demonstrates that Reclaiming Futures youth received more mental health and substance abuse services and had less involvement in juvenile probation when compared to Pre-Reclaiming Futures youth during the critical early to mid-adolescent years. The charts presented below provide an illustration of the data presented earlier in this report. The Pre-Reclaiming Futures and Reclaiming Futures groups both show similar patterns of mental health/substance abuse contacts and Probation Involvement until early adolescence. After that point, Reclaiming Futures youth receive more community-based services and have less criminal justice involvement. These results mirror the original goals of the Reclaiming Futures initiative in Santa Cruz.





Excerpts from, "RWJ Reclaiming Futures In Santa Cruz County: Initial Policy Report", Abram Rosenblatt in collaboration with Judith Cox, Laura Garnette, Yolanda Perez-Logan, Jeffrey Bidmon, Bill Manov, Jaime Molina, Stanley Einhorn, Spring 2008.

Santa Cruz County Child Welfare 2007

Child Welfare Services is an important part of our local System of Care and is supported by the spectrum of mental health and community-based services provided to foster children and their families and caregivers. California legislation, AB 636, requires the measurement of a series of indicators for key outcomes organized in the areas of: safety, permanency and well-being. Below is a description of Santa Cruz County's performance in these areas.

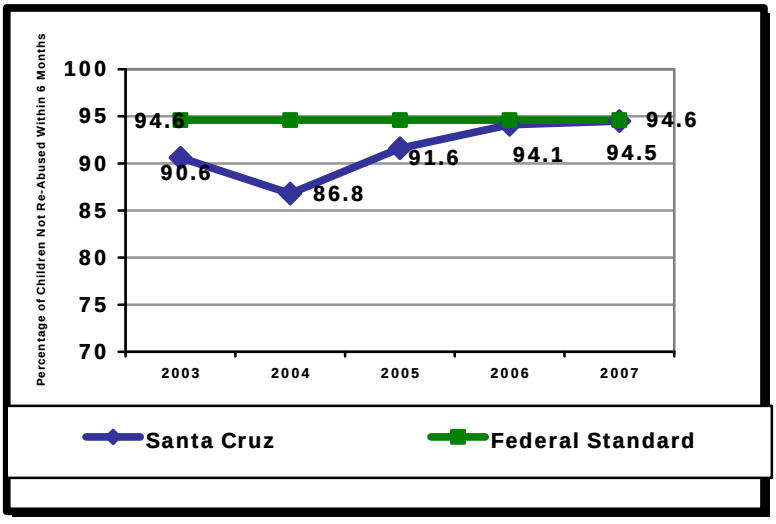
How many children are involved with the Santa Cruz County Child Welfare System?

- In 2007, **3,434** Santa Cruz County children were referred to Family and Children's Services, which is a rate of **59.3 per 1,000 children** in the County's population, **which is higher than the statewide rate of 49. 2 per 1000 children.**
- Among the children referred in 2007 about a quarter **(24%) of children had a substantiated allegation of abuse**. This means 825 children in the year had a substantiated allegation of abuse which is a rate of 14.3 per 1,000 children. Santa Cruz County has a higher rate of substantiated allegations of abuse then the statewide rate. **Thus, Santa Cruz County has more referrals than the state average and more substantiated referrals.**
- **Among children with a substantiated referral in 2007, 26.9% entered foster care**. This means 225 children entered care which is a rate of 3.9 per 1000 children. The statewide rate of entry into foster care was 3.6 per 1000 children.

Safety: Are children who are known to child welfare protected from further abuse and neglect?

- A central measure of safety is the **rate of reoccurrence of child maltreatment**. Recurrence of maltreatment refers to situations in which a child has a substantiated report of abuse or neglect, and then has a second substantiated report within a specified time period.
- As shown in Figure 1, Santa Cruz County's performance regarding **no-recurrence** within a 6 month time frame has **improved from 90.6% in 2003 to 94.5% in 2007**. In addition, in 2006 and 2007 **Santa Cruz County nearly met the federal goal for this measure, 94.6%.**

*Figure 1: Percent of Children with **No Recurrence** within 6 Months*



Permanency: Do children involved with CWS have permanency and stability in their living situations?

REUNIFICATION WITH FAMILIES

- In 2007, **78% of children who returned to their parents, returned within a year**. This is **better** than the statewide percentage for this measure and higher than the **federal goal which is 75%.**
- The median number of **months children are in care prior to reunification was 3.9** in 2007. The **federal goal** for this measure is **5.4 months**. Thus, in 2007 **Santa Cruz County was able to reunify faster than the federal standard.**

Figure 2: Median Time to Reunification (Exit Cohort) for children in care 8 days or more.

	2003	2004	2005	2006	2007
Santa Cruz	4.9	3.8	4.0	6.1	3.9

- An important **indicator of the success of family reunification** is the percentage of **children who re-entered foster care within 12 months** of reunification. The most current Santa Cruz County figure, for calendar year 2006, was **12.3% or 19 children, which is higher than the federal goal of 9.9. However**, as you see in Figure 3, Santa Cruz's **percentages vary greatly** which is most likely **due to the small numbers** of children re-entering care.

Figure 3: Percentage of Children Reentering Placement within 12 Months Following Reunification

	2003	2004	2005	2006
Santa Cruz	12.3% (17 children)	5.9% (7 children)	6.6% (10 children)	12.3% (19 children)

ADOPTION

- **Santa Cruz County is highly successful at placing children for adoption within 24 months**. The **federal goal** for this measure is **36.6%.** Santa Cruz County has consistently exceeded the federal goal over the last five years. The most recent performance is **50% in 2007**

Figure 4: Percentage of Children Adopted Within 24 Months

	2003	2004	2005	2006	2007
Santa Cruz	58.1%	51.4%	60.5%	54.5%	50.0%

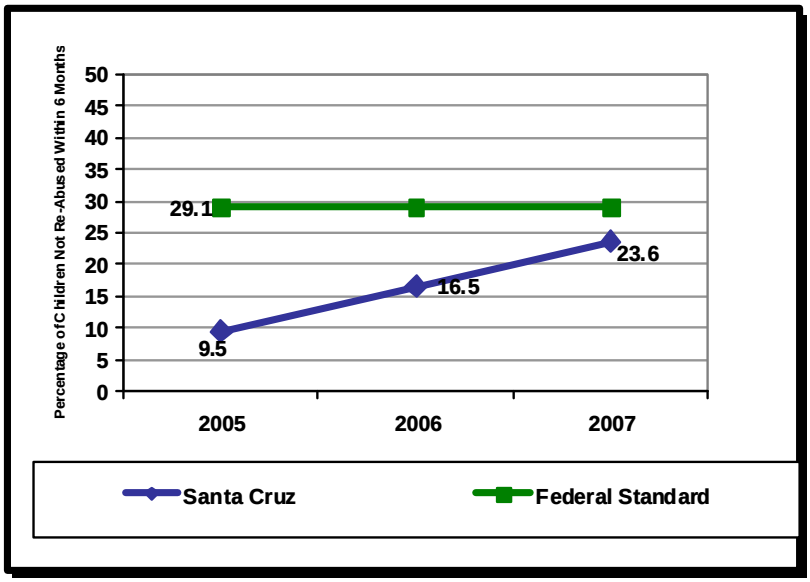
- Not surprisingly, **Santa Cruz County's median time to adoption** is consistently **shorter than the federal goal of 27.3 months**. The most recent performance in 2007 was 24.2 months which is slightly up from 2005 when the median time was quite low at 18.5.

EXITS FROM CARE

- It is the hope of child welfare to discharge a child from foster care to a permanent home. Almost half (48%) of children in 2007 who had been in care 3 years or longer emancipated from the child welfare system – meaning they did not discharge to a permanent home, they discharged from care to independent living. The federal goal is to have only about a third (37.5%) of children who have been in care 3 years or more emancipate. **Santa Cruz County, similar to other counties, needs to improve on this measure. However, Santa Cruz County is performing better than the statewide average,** which is 62.7% of children in care 3 years or longer emancipate from the system.
- The percentage of children **discharged to a permanent home** prior to turning 18, who had been in care for 24 months or longer, was **21.86% in 2007**. The **federal goal** is to have at least **29.1%** of children in care for two years or more discharged to a permanent home prior to their 18th

birthday. Santa Cruz seeks to meet this goal and has **shown marked progress in the last three years** as seen in Figure 6. Santa Cruz is performing similar to the statewide average of 20.7%.

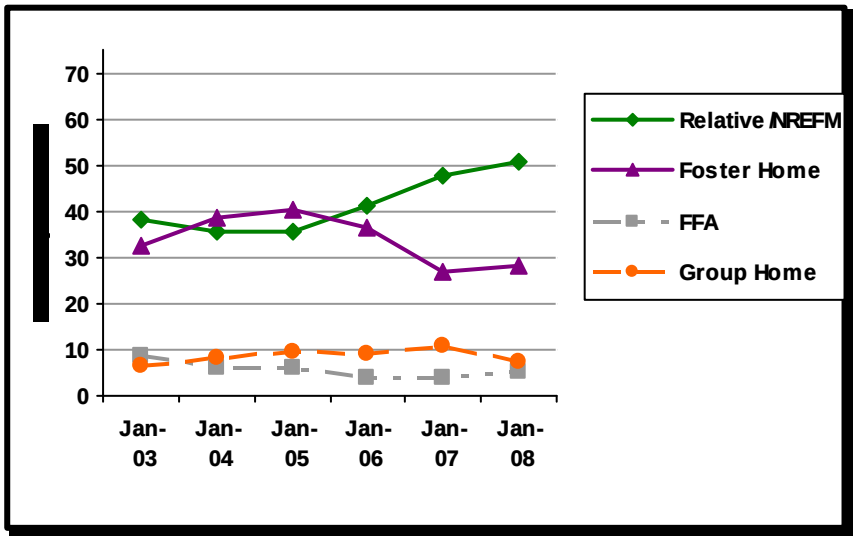
Figure 6: Percentage of children discharged to a permanent home prior to turning 18, who had been in care for 24 months or longer



FAMILY CONNECTIONS

- **75.5% percent of siblings were placed with some or all of their siblings** on January 1, 2008. This is **up from** January 1, 2003 where **65.9%** of siblings were able to be placed with some or all of their siblings and better than the **statewide percentage of 70%.**
- **Relative or Non Relative/Extended Family Member placements have increased substantially over the last five years, while foster home placements have declined**. For the most recent time period, Santa Cruz County's percentage of children in relative/NREFM care on January 1, 2008 was 50.7%.

Figure 7: Percentage of Children in Care (January point in time) by placement type



Well-Being: How is the wellbeing of children involved with child welfare?

PLACEMENT STABILITY

- The percentage of children with **two or fewer placements**, who had been in care **8 days to a**

year, was 88.8% in 2007 which is better then the federal goal of 86%.

- The percentage of children with two or fewer placements, who had been in care longer, 12 to 24 months, was 73.5% in 2007 which is up considerably from 47.4% in 2003. Santa Cruz County now exceeds the federal goal of 64.5%.
- Almost half (47.7%) of children who had been in care at least 24 months had two or fewer placements. This exceeds the federal goal of 41%.

REPORTED CHALLENGES FACED BY YOUTH SERVED BY CWS

- The number one challenge reported by the youth ages 12-18 in telephone survey, who had an open child welfare case in 2005 or 2006, was school. According to the youth surveyed, low grades or failed classes was an issue for 39%, 23% had lots of absences over the last year, and 19% reported problems getting along with friends at school. Moreover about one-half of foster parents and relative caregivers in a telephone survey said their foster/kin child was performing below grade level in one or more subjects.
- In terms of alcohol and drug use, more than one out of four (28%) of the 12 to 18 year olds that were surveyed said that they might have a problem with alcohol or drugs. Foster parents and relative caregivers thought that one out of three (33%) of the children that they cared for, who were 12 and older, had a problem with alcohol or drugs. Finally, some of the children were struggling with the effects of being exposed to drugs in-utero. Fourteen percent of caregivers surveyed said that one of the child's top 2 needs/challenges was alcohol/drug exposure at birth.
- Health issues, in general, were cited as issues for more than one in three youth by foster/relative caregivers and parents who had been involved in the child welfare system. Thirty nine percent of caregivers and 36% of parents said that their child's health was only fair or poor. Thus, only 61% and 64% of the caregivers and parents respectively thought the children had health that was good or very good. Furthermore, half of parents felt that their child had an ongoing health problem, which was mental health or behavior related and 62% of caregivers said that the child had emotional problems when they were first placed.

Summary

- Santa Cruz County refers more children to the Child Welfare System compared to the state and also has a higher rate of children with substantiated allegations.
- Santa Cruz County has a similar rate of children entering foster care compared to the statewide rate.
- Santa Cruz County's performance regarding no-recurrence of child maltreatment within a 6 month time frame has improved in the last three years and nearly meets the federal goal for this measure.
- Santa Cruz County children, who reunify with their families, reunify in a timely manner.
- Santa Cruz County children, who are adopted, are adopted in a timely manner.
- Santa Cruz County is able to place the majority of sibling groups at least partially together.
- Santa Cruz County has greatly increased the percentage of children who have experienced two or fewer placements over the last five years.
- Santa Cruz County places more children with relatives than foster parents compared to five years ago. About half of Santa Cruz County foster children live with relatives.
- Almost half of foster care children who have been in care 3 years or longer emancipate from the child welfare system. Santa Cruz County seeks to reduce this percentage and increase the percentage of children discharging from care to a permanent home.

Mental Health Data Summary

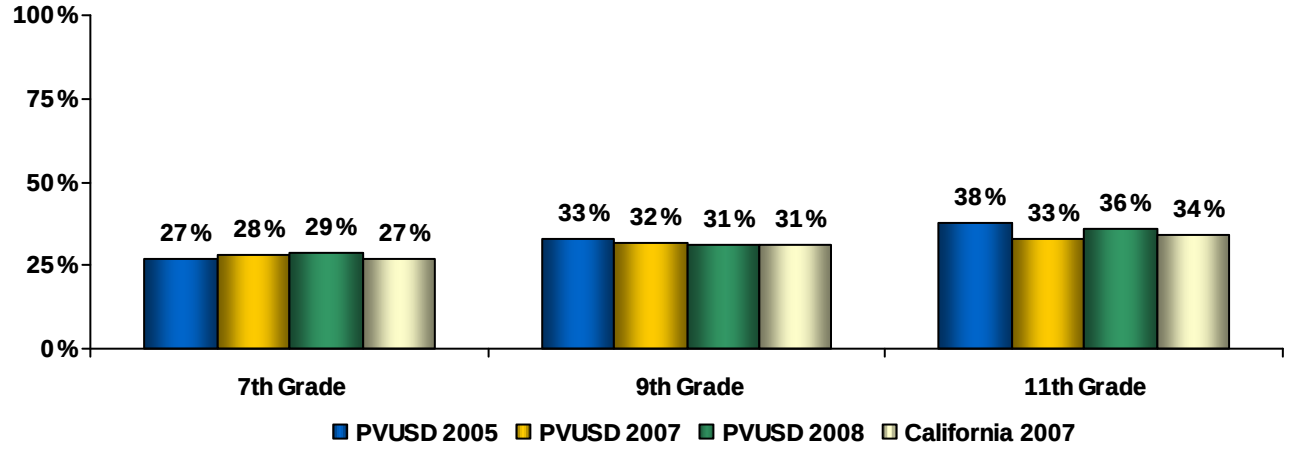
- There are currently 14.5 FTE counselors providing school-based mental health services to PVUSD students
  - School-based counselors have been trained on school policies and procedures, mandated reporting, and general job requirements
- During the 2005/06 school year (baseline year), Safe Schools/Healthy Students school-based counselors served a total of 742 unduplicated k-12 PVUSD students
- During the 2007/08 school year, approximately 872 students were served by Safe Schools/Healthy Students school-based counselors
  - These 872 students received a total of 13,635 contacts from Safe Schools/Healthy Students counselors
- According to 2008 PVUSD CHKS data, girls reported higher levels of symptomatic depression in 7th, 9th and 11th grades
- The percentage of PVUSD CHKS respondents scoring in the "High" on the "School Connectedness" scale increased between 2005 (baseline year) and 2008
- The percentage of PVUSD CHKS respondents scoring in the "High" on the "High Expectations: Adult in School" scale increased between 2005 (baseline year) and 2008 in 7th, 9th and 11th grades

Mental Health Data

Symptomatic Depression

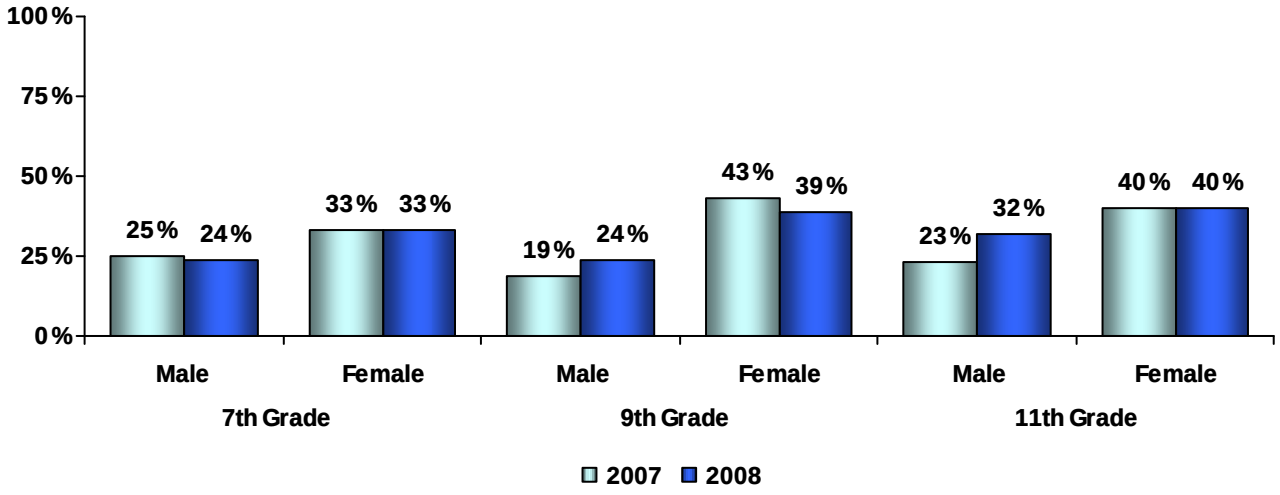
Data presented here are based on the CHKS question "During the last 12 months, did you ever feel so sad and hopeless almost every day for two weeks or more that you stopped doing some usual activities?"

Figure 1: Percentage of PVUSD Respondents Who Reported Symptomatic Depression in the Last 12 Months



Source: California Healthy Kids Survey, 2008.

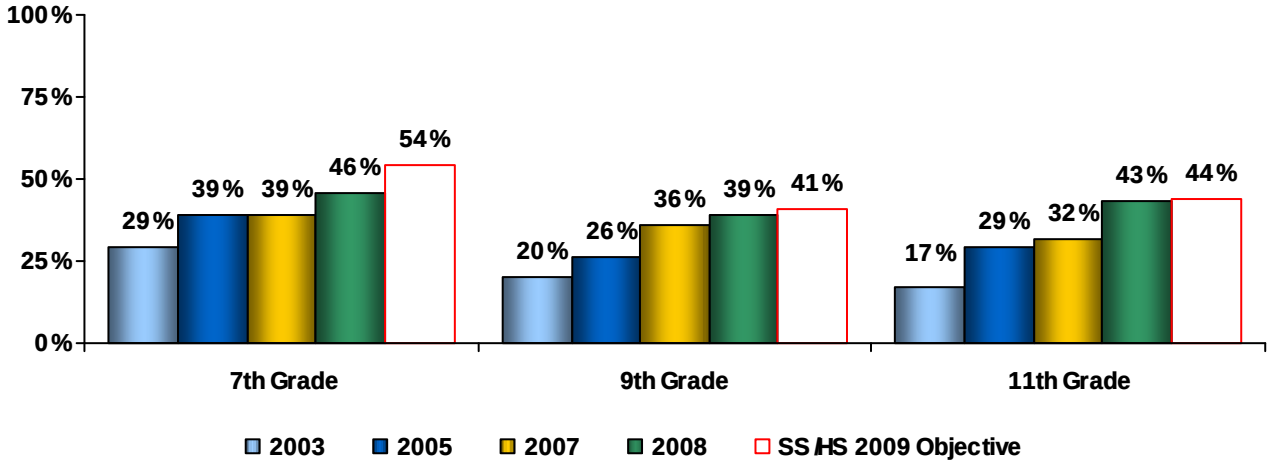
Figure 2: Percentage of PVUSD Respondents Who Reported Symptomatic Depression in the Last 12 Months by Gender



Source: California Healthy Kids Survey, 2008.

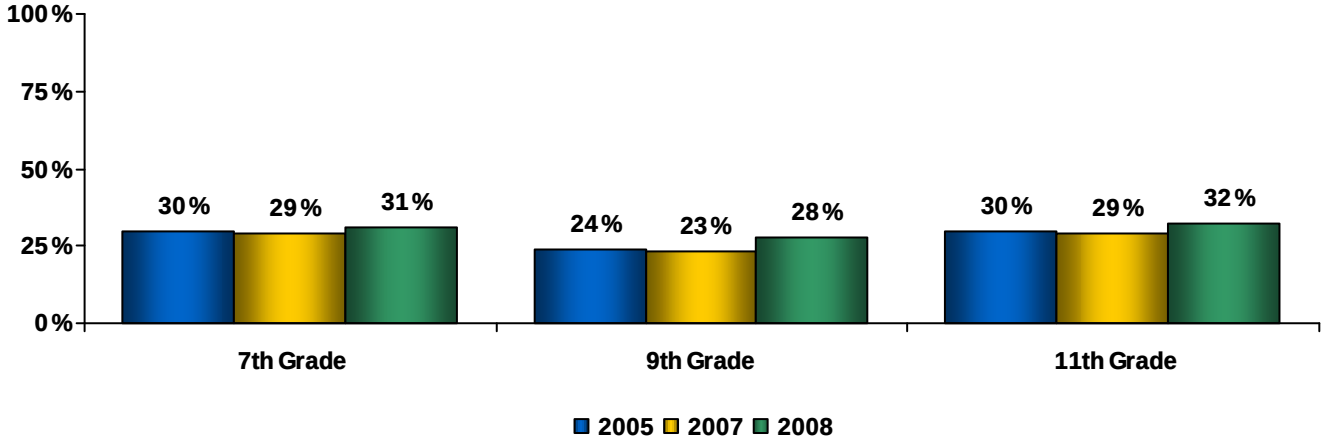
School Connectedness

Figure 3: ✸Percentage of PVUSD Respondents Scoring in the "High Connectedness" Range on the "School Connectedness" Scale



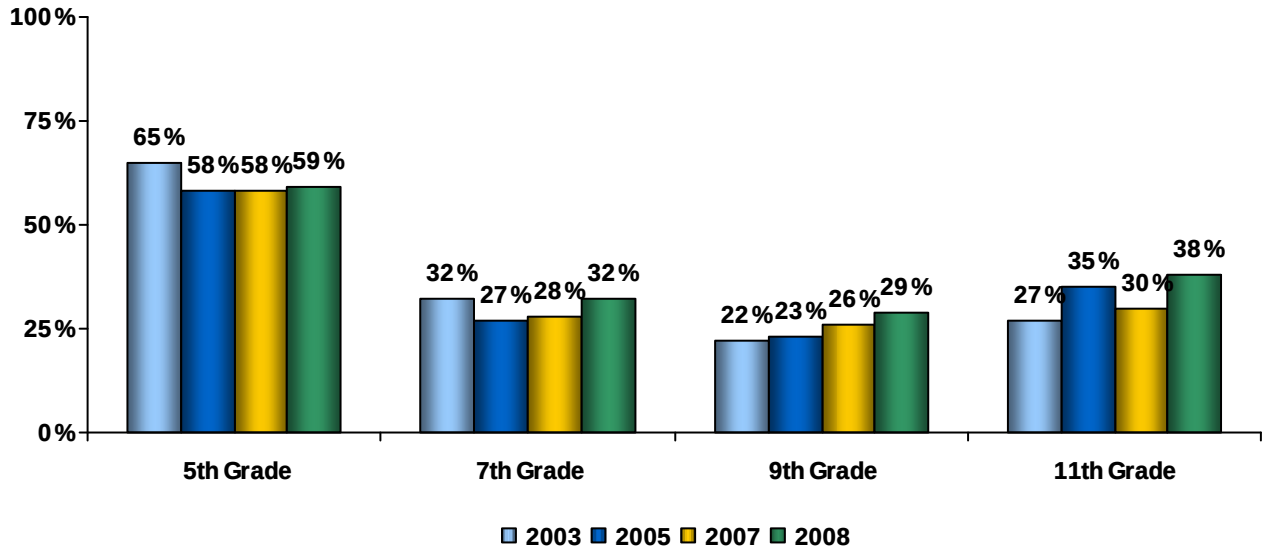
Source: California Healthy Kids Survey, 2008.

Figure 4: Percentage of PVUSD Respondents Scoring High in "Total Assets" on the "School Environment" Scale



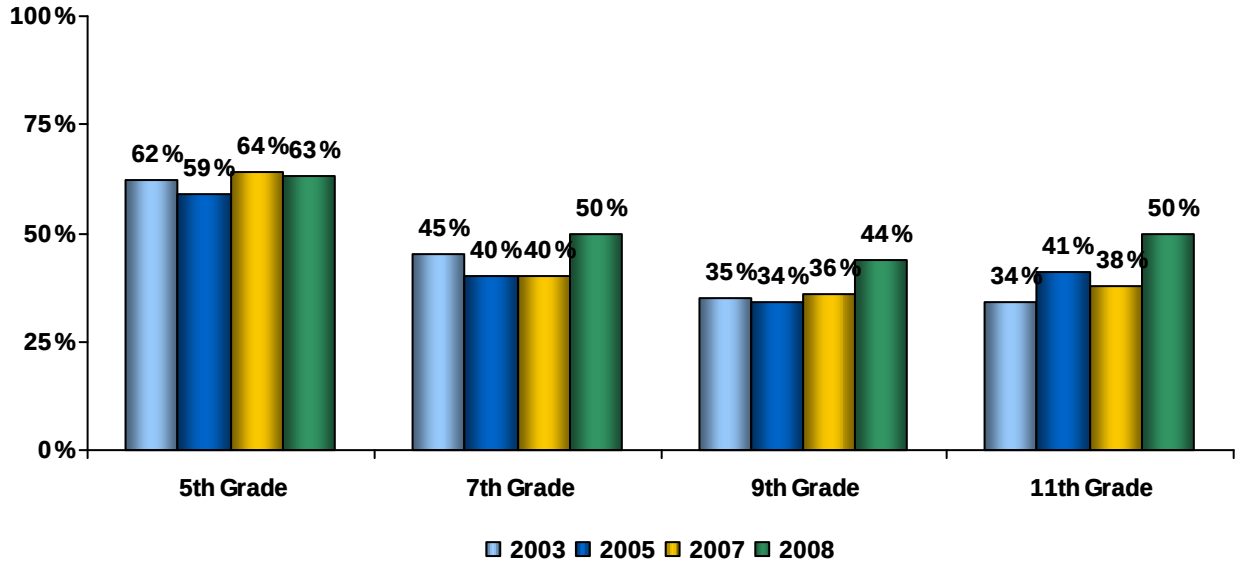
Source: California Healthy Kids Survey, 2008.

Figure 5: Percentage of PVUSD Respondents Scoring High on the "Caring Relationships: Adult in School" Scale



Source: California Healthy Kids Survey, 2008.

Figure 6: Percentage of PVUSD Respondents Scoring High on the "High Expectations: Adult in School" Scale



Source: California Healthy Kids Survey, 2008.

Cover Art Bio

The cover art was beautifully designed and painted by local artist, Elizabeth Williams in 2005.

Elizabeth Williams lives and works in Santa Cruz, California. "Her images are emotive, imaginative expressions of her dreams and fantasies. Like dreams, they evoke a sense of a subconscious inner meaning".

www.artists.com/artists/elizabeth_williams

The art is currently painted on the garage of owner, Betsy Clark.

Thank you both, for allowing us to use your art!