

Comprehensive Interagency System of Care for Children and Youth



Measuring Outcomes of Collaboration

**Seventeen-Year Report
July 1, 1989-June 30, 2006**

Santa Cruz County Children's Mental Health

The following client poems come from Dennis Morton's poetry workshop in Juvenile Hall, some of which were included in the Santa Cruz County High School Poetry Contest, and annual chapbook. More youth poetry is included on page 42.

DAMAGE

My heart is my window.
It's been damaged by my history
and thieves who tried to vandalize my soul
when they thought it was asleep.
I feel myself falling through my fingers
like grains of sand. My only relief
is when I breathe in the energy of faith.

— Jessica

MILES FROM HOME

As I walked the narrow road of loneliness
I saw a vulture soaring.
I was ablaze in the sunlight, yet cold as ice.
The wind carried me like a feather
and dropped me like dice
on the hard surface of life.
I prayed for fortune and fame.
All I ever got was blame.
I'm miles from home
for a cause with no name.

— Joseph



SANTA CRUZ COUNTY CHILDREN’S MENTAL HEALTH INTERAGENCY SYSTEM OF CARE REPORT

Seventeen Year Anniversary Summary

July 1, 1989 - June 30, 2006

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PREFACE

Welcome to the **17th Year Anniversary Report** of the Santa Cruz County Children’s Interagency System of Care. The outcomes and data that follow represent 17 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 17 years of cumulative data and outcomes; and
- Focuses on the last two years of 2004 – 2006 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 still 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 17 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 17 years of cumulative data, as well as information on annual outcomes for the last two years.

Highlights of 2004 – 2006:

- An extensive community planning process for the **Prop 69 Mental Health Services Act (MHSA)**, commencing with new services in July 2006. The focus will be on expanded System Development with an emphasis on **better engagement of younger Latino children aged 0-11**. New components will 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.
- Addition of an interagency **Evening Center** for court wards needing after-hours structure and treatment.
- Initiation of **Family Solutions**, an **SB-163 Wraparound** program for court wards at risk of group home placement.
- Continued implementation in years 5 & 6 of 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.
- Initiation 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 interagency linkages through **AB 490** supports for foster youth education stability, expanded **family reunification** treatment, **homeless** family & child supports, and planning for a comprehensive **interagency differential response capacity** with First Five, Child Welfare, Substance Abuse, and Mental Health.
- Navigating continued state funding and local coordination of **AB 3632 Mental Health Services to Special Education students** with local SELPA's and the County Office of Education.
- **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**.

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.

A handwritten signature in black ink that reads "Dane Cervine". The signature is written in a cursive, flowing style.

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, and Norm Wyman, our retired Mental Health & Substance Abuse Director, who have always supported the Children’s programs each step of the way—as well as Glenn Kulm, Director of H.S.A. Administration, and Mental Health staff who do the daily “magic” of fiscal and infra-structure support that keep our efforts afloat. Going forward, our new Mental Health/Substance Abuse Director, Leslie Tremaine, has already been a guiding lamp of support and inspiration.

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

Judy Cox, Laura Garnette, and staff at the Probation Department
Cecilia Espinola, Ellen Timberlake, Judy Yokel and staff of the Human Resources Agency
Diane Siri, 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 of Youth 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, and many others 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

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SEVENTEEN YEAR REPORT

JULY 1, 1989 - JUNE 30, 2006

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
- 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 17-year Report is available online at www.santacruzhealth.org/cmhs/2children.htm in the blue "contact information" box.

SEVENTEEN YEAR OUTCOMES

I. SYSTEM OF CARE EVALUATION OBJECTIVES

A. Keeping Youth at Home

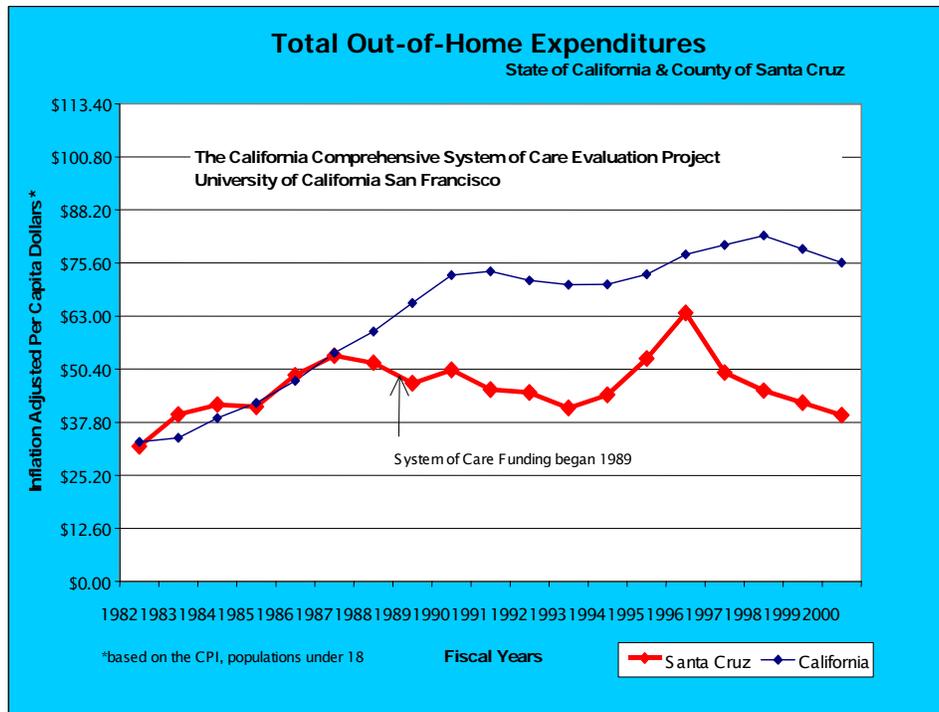
Keeping youth at home is one of the easiest objectives to track. As depicted in the data that follows, **Santa Cruz County is helping children and youth to stay at home, and out of institutionalized care.** By keeping youth in the least restrictive, most home-like setting possible, we are providing quality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

1. Reducing and Managing Out-of-Home Expenditures

First Twelve Years 1989 - 2001

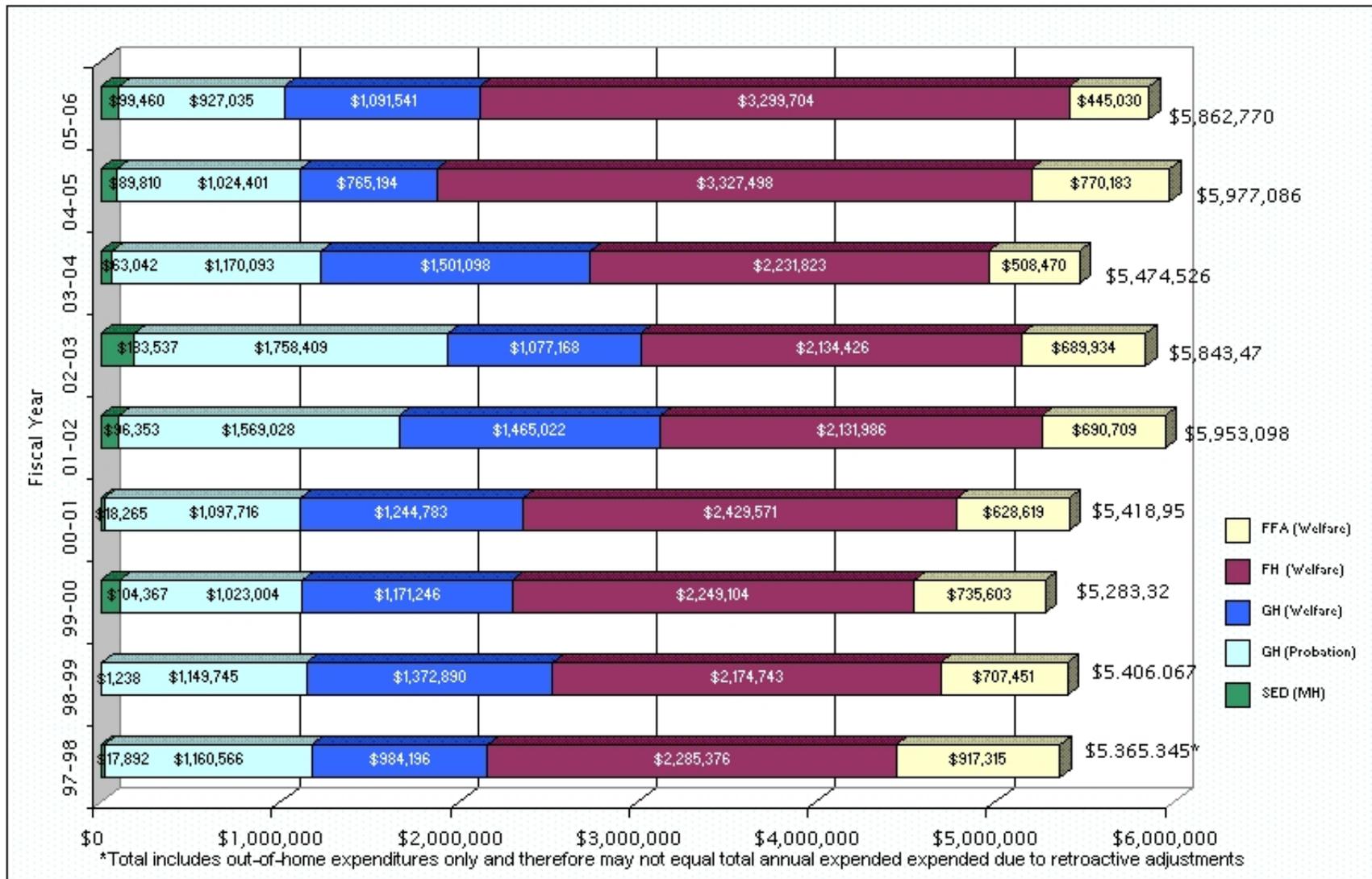
For many years, the Child Services Research Group of the University of California, San Francisco, calculated savings on out-of-home expenditures by comparing Santa Cruz County with the California State average (State Department of Social Services data only available through June 2001). We provide this 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 were 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, 2006, HRA Foster Care tracking spreadsheets.



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.**

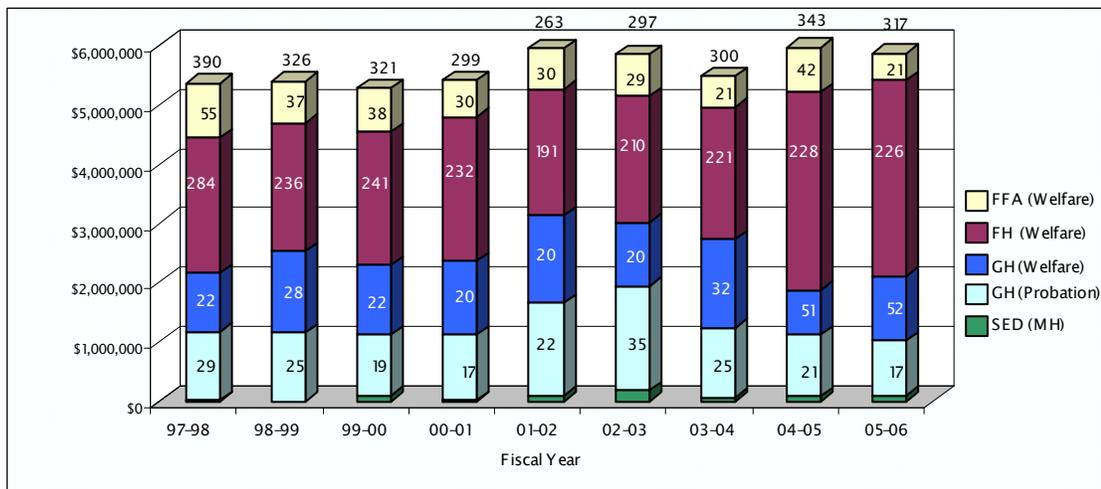
Current Data: Local Out-of-Home Expenditure and Placement Patterns

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 - 2006 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.

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 2004-06, trends include: reduced group home placements by Probation (due in part to initiation of SB163 Wraparound); increased group home placements by Child Welfare (but at lower cost than previous year, due in part to establishment of local crisis residential treatment program or foster youth in transition); and, the reduced group home expenditures in Probation and Child Welfare balancing an increase in Child Welfare foster home costs.**

Figure 3. Total Out-of-Home Placements through June 30, 2006, HRA Foster Care tracking spreadsheets.



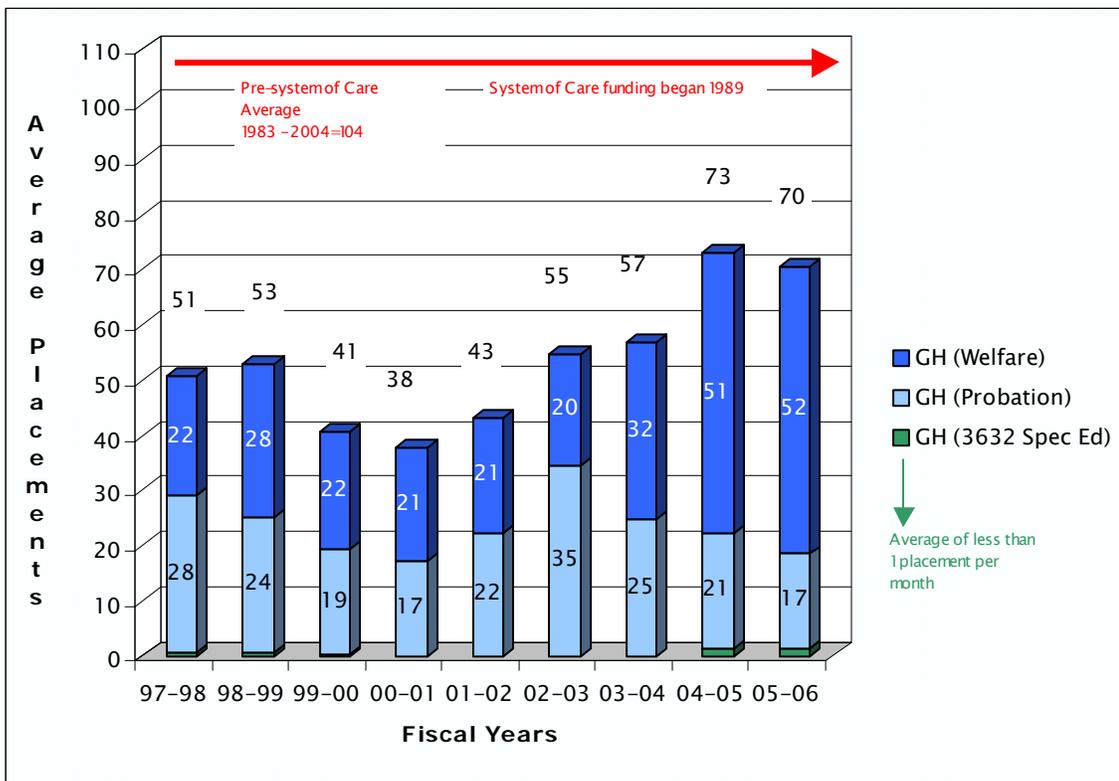
Group Home Placements and Expenditures for Probation Wards, Child Welfare Dependents, and Special Education Pupils

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 two 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, 2006



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 Futures* 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 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). **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 - 2006

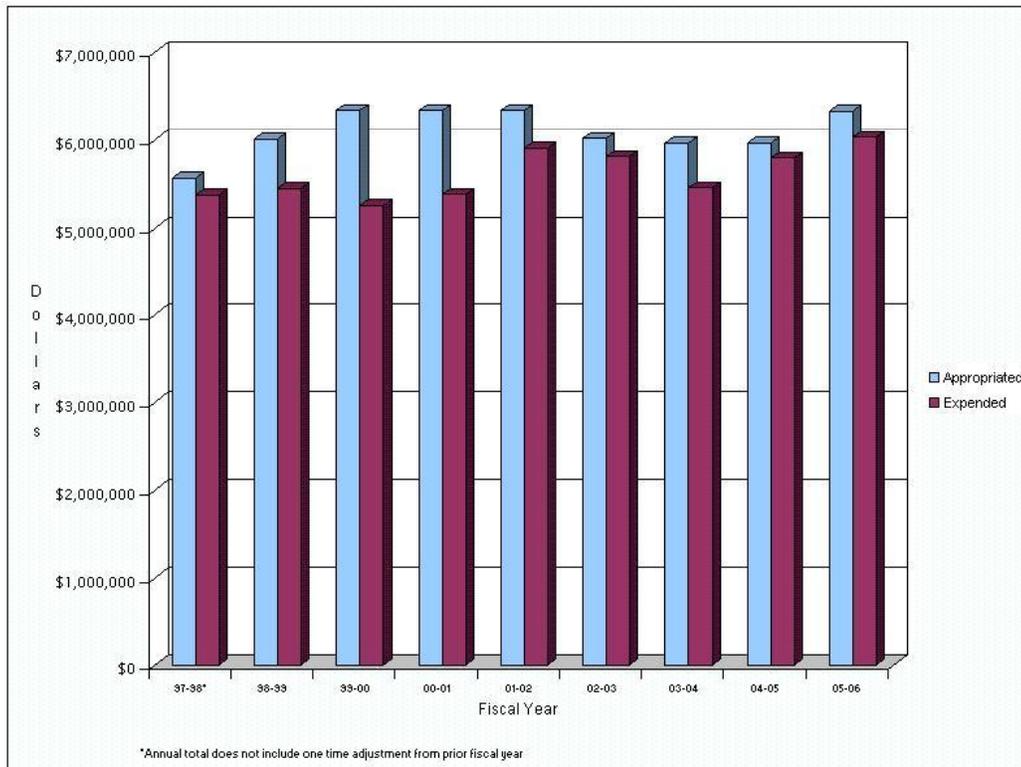
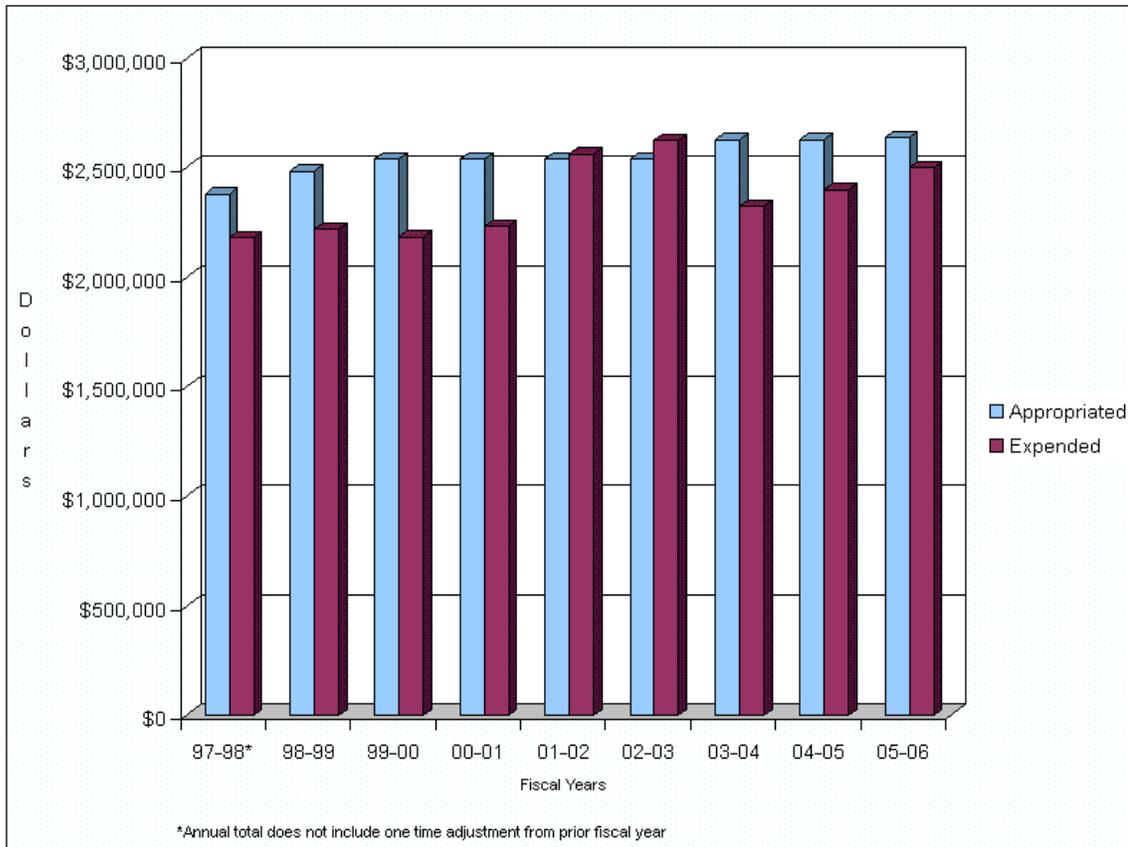


Figure 6. County Share of Foster Care Appropriated vs. Expended Dollars 1997 - 2006



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

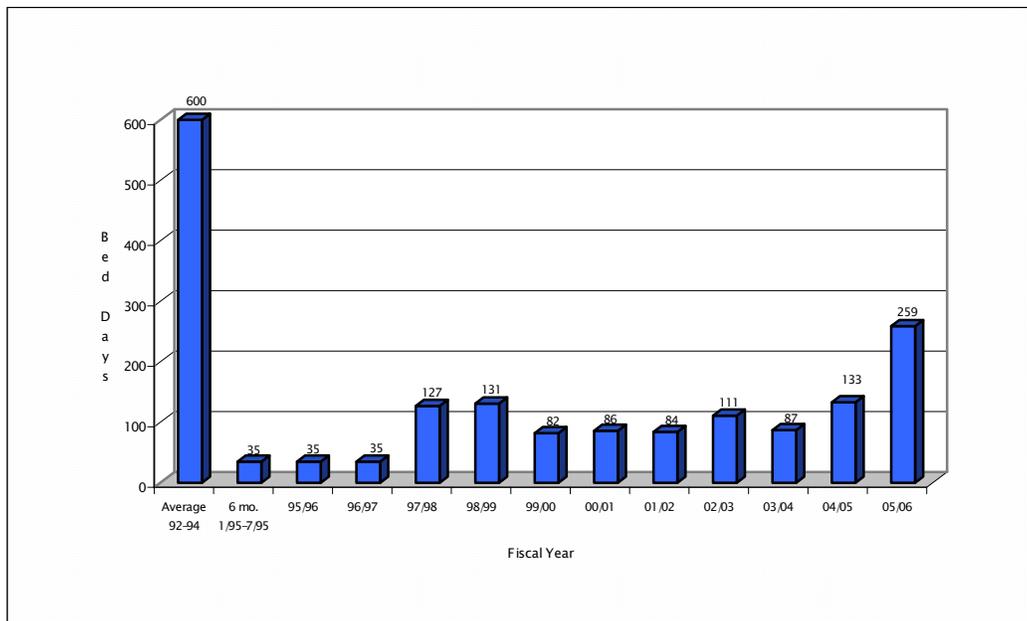
In the three years prior to Medi-Cal managed care inpatient consolidation (which occurred January 1, 1995), Santa Cruz County averaged **600 acute psychiatric hospital days per year** for children and adolescents. When Santa Cruz received these inpatient funds to manage, we redirected a portion of them 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 eleven and a half years since inpatient consolidation, we have utilized a total of 1,205 days, for an average of 104 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 2004 - 2006, budget cuts eliminated our Intensive In-home Family Support services, which contributed to a significant rise in hospital days (since there were fewer in-home services to support families in crisis).** This data provides important feedback to our system as we plan for how to re-institute these important services. **In addition, the data in 2006 reflects repeated and lengthy hospital stays for one particular youth with severe, multiple needs.**

Figure 7. Utilization of Psychiatric Bed Days, 1992 to 6/30/06

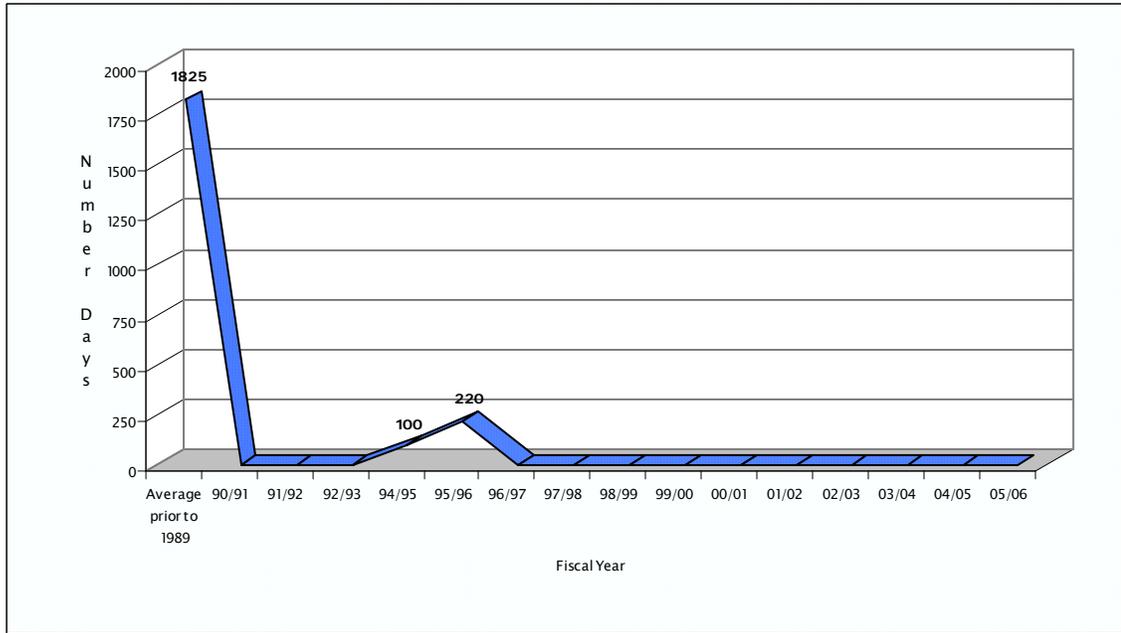


State Hospital

While State hospital beds for children and youth have declined statewide (Napa State Hospital no longer serves youth, and Metro State Hospital is facing declining use), it is historically important to note that pre-System of Care use of State hospital beds was widespread and very expensive for local counties. In the years prior to 1989, Santa Cruz County averaged five placements per year in the State hospital. At an average State hospital rate of \$387 per day (it is even more expensive now), the annual cost for five placements would have been \$706,275 per year. **If Santa Cruz County's System of Care were not in place, we would expect a return to similar levels of State Hospital placement (meaning the loss of entire local programs to cover the costs of just a few youth).**

Our goal, ultimately, is to provide local residential options for children and youth requiring the highest levels of supervision and support. **Over the past ten years there have been no placements in the State hospital.** For the highest risk children and youth that might normally have been placed in a State hospital, **residential or community alternatives are used that provide a similar level of intensive support, at a lower cost, and in a more normalized environment.**

Figure 8. State Hospital Utilization Days Through 6/30/06



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.**

Seventeen years (7/1/89 - 6/30/06)..... 87%

In both fiscal year 04/05 and 05/06 attendance of youth in ED classes was 85%.

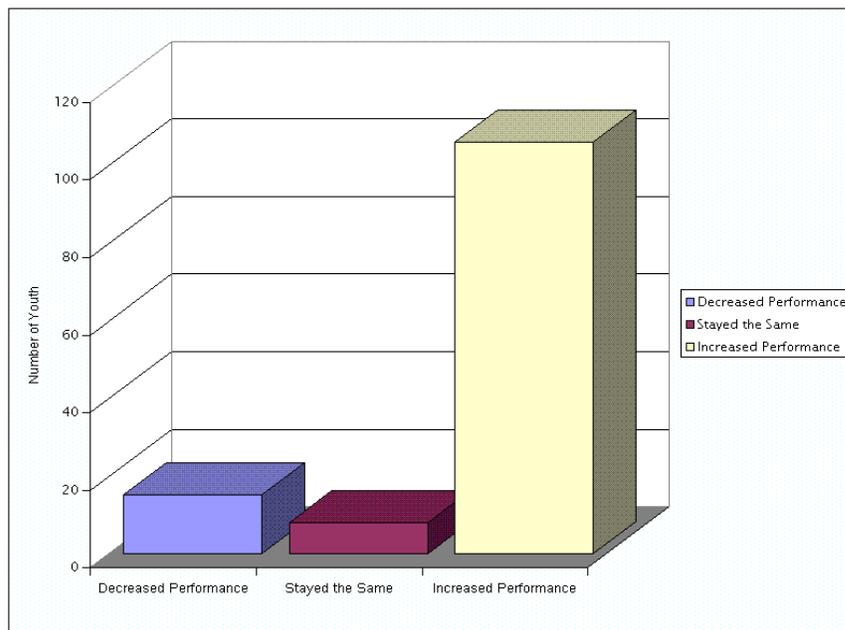
2. School Performance (Woodcock Johnson)

Another measure of success in school is grade level equivalency gains. As of 6/30/06, we have pre- and post-tested 129 students who have been in the ED classrooms. **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 129 youth tested: **106 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.**

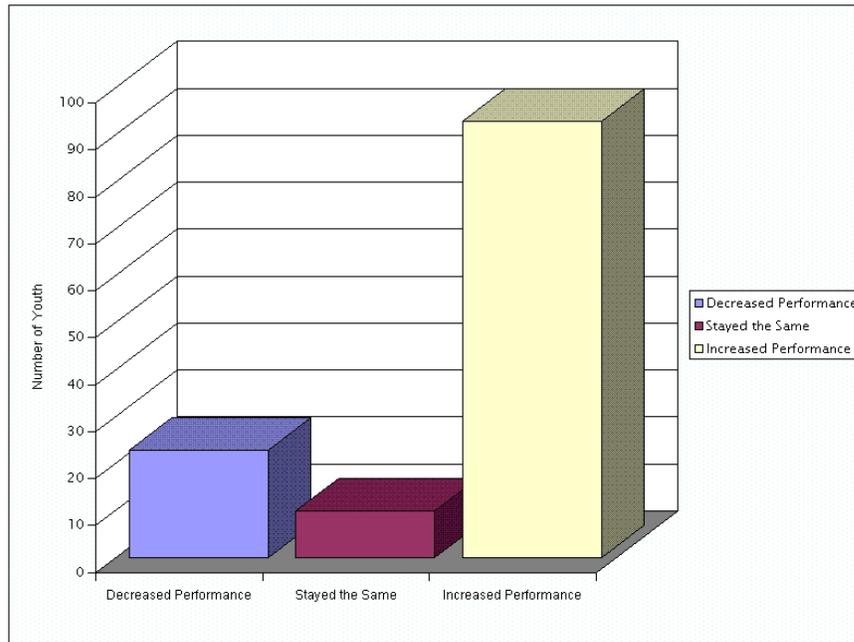
Figure 9. Reading Performance as measured by Woodcock-Johnson (N=129) 6/89 to 6/06



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 126 youth tested: **93 showed improved math performances.** 10 stayed the same and 23 decreased performance in reading.
- **36 youth gained one year or more improvement in reading for each year spent in the Ed classroom**

Figure 10. Math Performance as measured by Woodcock-Johnson (n=126) 6/89 to 6/06



II. PROGRESS REPORT ON SYSTEM OF CARE COMPONENTS

A. Juvenile Probation Programs

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—demonstrating significant clinical outcomes and reductions in recidivism. As the Redwoods Program, it served as the primary alternative to out-of-county group home placement—with shortened lengths of stay, and intensive family work allowing timely return to the community. In recent years, **research began to point our system towards developing a better treatment response to the high rate of co-occurring mental health and substance related issues among our juvenile justice involved youth.** While Redwoods offered four to eight months of intensive day treatment, STAR focused on short-term assessment, stabilization and transition-support of youth that often cycled from the community, to juvenile hall, to traditional placement and back again. *Juvenile Justice CPA 2000* funds were used to hire specific Alcohol and Drug Program personnel for integration into the day-treatment program, infusing early recovery oriented interventions with cognitive behavioral and strength-based approaches.

Per prior year reports, these dual diagnosis program enhancements have 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 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 System of Care for court wards. This, combined with the success of our other local residential treatment options, 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.***

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:

- **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 similar core subset of juvenile justice youth involved in a variety of our residential, wraparound, and family preservation programs. Data for the fiscal years July 2004 through June 2006 is shown in the table below:

Recidivism - Excluding Probation Violations, July 2004 – June 2006, N = 73

	Before	After	% Drop
Felony Charges	52	14	73.1%
Misdemeanor Charges	149	40	73.2%
Total Charges	201	54	73.1%
Sustained Felony	51	8	84.3%
Sustained Misdemeanor	45	46	-2.2%
Total Sustained Charges	96	54	43.7%

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 two most recent years above is a **dramatic 84.3% drop in sustained felonies**, though there was little impact on sustained misdemeanors (though misdemeanor *charges* were greatly reduced).

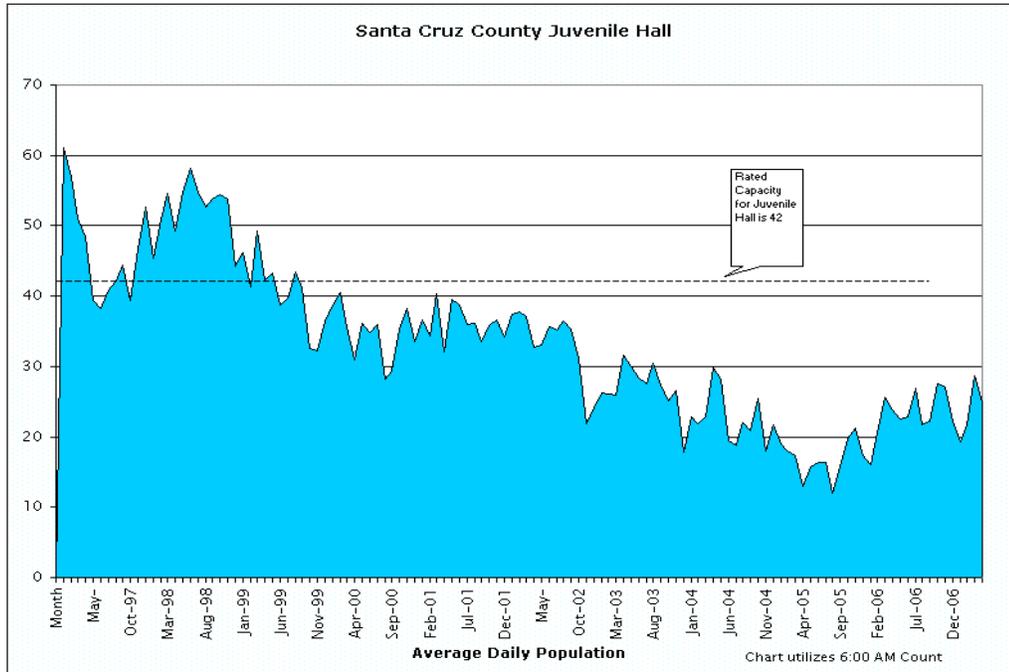
2. Juvenile Hall and Detention Alternatives: Mental Health/Substance Abuse Services

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 43% decrease in the use of detention and a 417 % 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 3 in 2006); and very few commitments to the California Youth Authority (11 in 1996 and 1 in 2006).** 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:

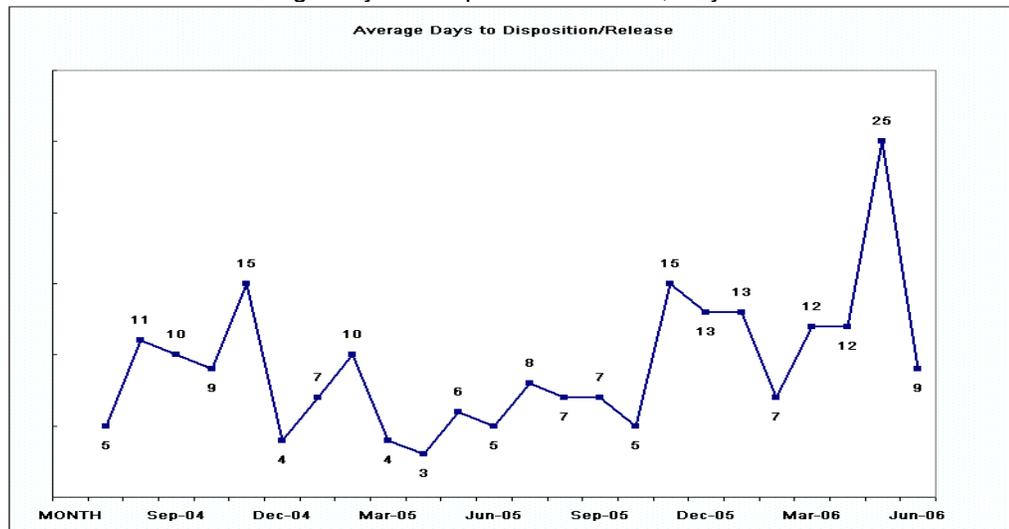
- With a rated bed capacity of 42, Juvenile Hall used to be overcrowded in the late 1990's with an average daily population of over 50 youth. **Detention reform and alternatives (including Mental Health/Substance Abuse support) has reduced the Juvenile Hall census to below 20 in 2005/06 when the average daily population decreased to 18.5.**

Figure 11. Juvenile Hall Average Daily Population 1/97 to 4/07



- 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 8.6 days in 2006, 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 2006



- 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. (See Appendix for Healthy Returns Initiative overview).**

3. 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 (1:6-8 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.

4. 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, with each team including 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 2006

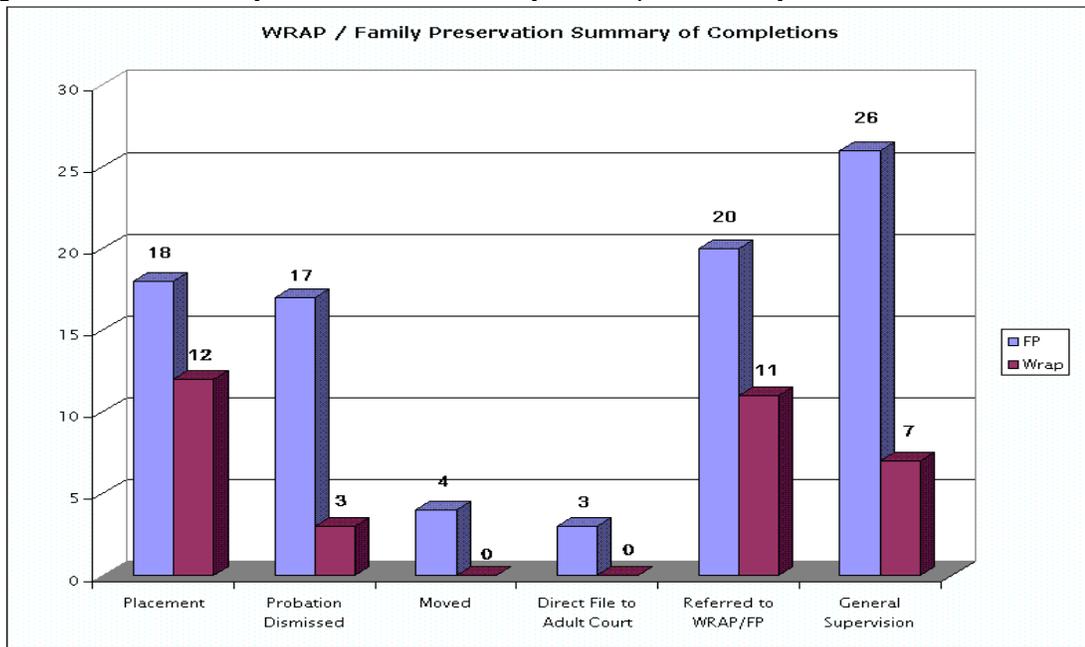
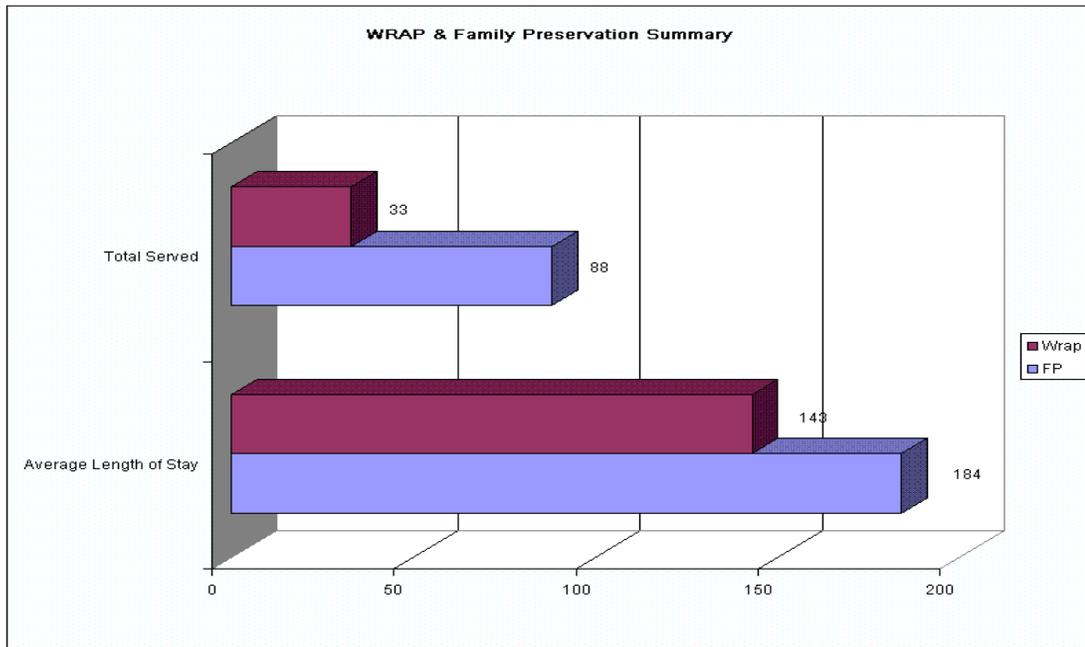


Figure 14. WRAP Family Preservation Summary, July 2004 - June 2006



In the charts above, you'll see that of 88 Family Preservation clients served (9 duplicates), 18 returned to placement for some period of time, 17 successfully completed probation, 4 moved, 3 were direct filed to adult court, and 20 were later transitioned to Wraparound services for further support. Of 33 Wraparound clients served, 12 returned to placement for some period, 3 successfully completed probation, 0 moved, 3 had their probation dismissed, 7 transitioned to a general supervision caseload, and 11 were transitioned back to Family Preservation for continued supports. Family Preservation averaged 184 days of treatment compared to 143 for Wraparound clients.

Figure 15. WRAP / Family Preservation by Ethnicity, July 2004 - June 2006

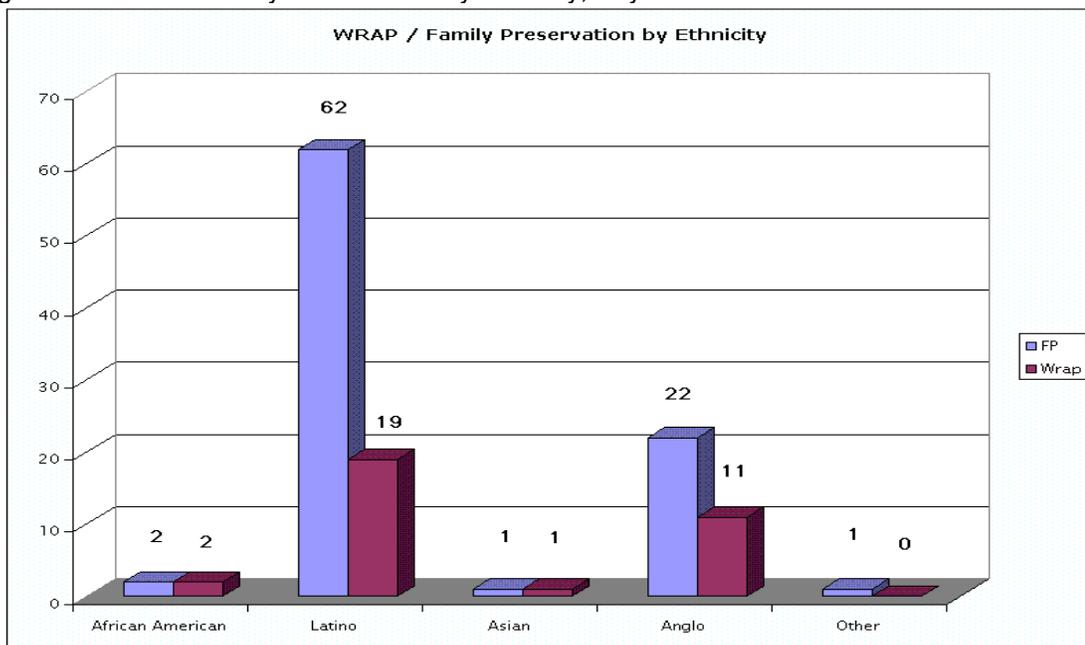
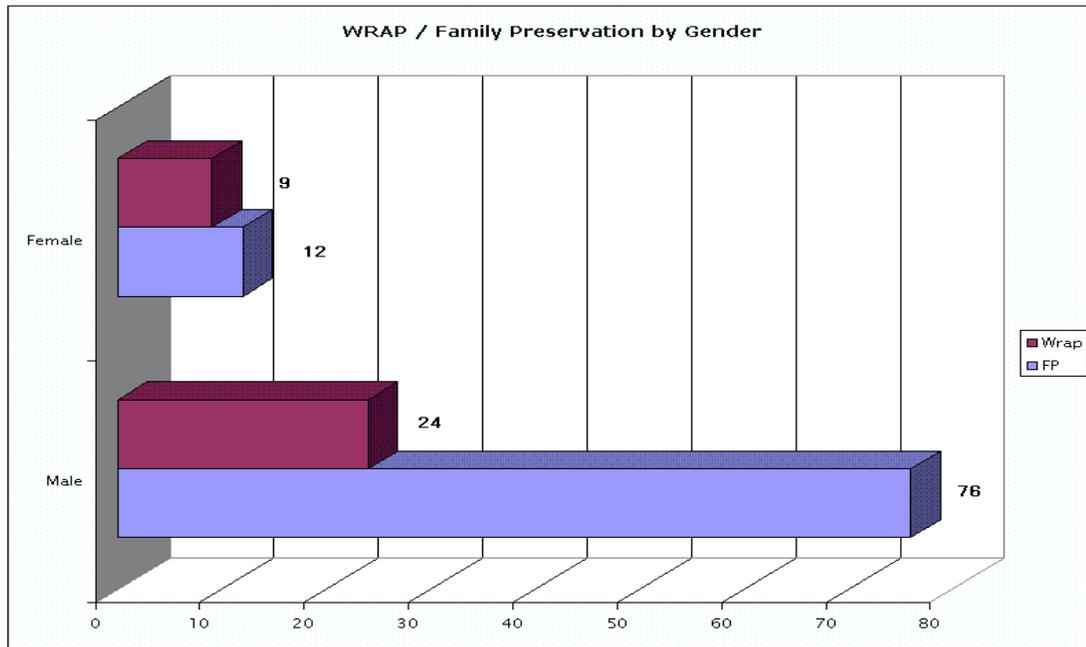


Figure 16. WRAP / Family Preservation by Gender, July 2004 - June 2006



In the two charts above, you'll notice somewhat higher rates of Latino boys served by Family Preservation, though Wraparound also serves a majority of Latino boys.

5. 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 Data (through 4/16/07)

Episodes		Ethnicity	Number	Percent
Total Episodes	277	Latino	231	83%
Unique Episodes	119	Anglo	38	14%
Duplicate	83 (69%)	Other	8	3%
Average number Duplicate Episodes	3.17	Total	277	100%
Days in Program and Completion		Gender	Number	Percent
Successful Completion	72%	Male	248	90%
Average number days Ordered	14.8	Female	29	10%
Average number days Completed	11.2	Average Age-All		15.8
Average number days for Success	9.72			

6. 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. (See outcome indicators in Youth Services section under Other SED Community Services.)

7. Unity Care: Dual Diagnosis Residential/Treatment for Probation Youth

Unity Care was a Dual Diagnosis Residential Treatment Program that worked primarily with **probation youth (male only) with some gang affiliation and substance abuse issues**. The program originally included two group homes with a maximum total population of 12 residents, though eventually this declined to one 6-bed house, closing finally in July 2006. Clinical services were delivered through an Intensive Day Treatment program staffed by Day Treatment counseling staff and a Family Therapist. Services offered included a variety of groups and individual and family counseling focused on dual diagnosis issues, gang diversion and cultural sensitivity. As mentioned earlier, the residential program was closed, but Unity Care continues to provide Therapeutic Behavioral Services (TBS) to Santa Cruz County clients.

B. Education Programs

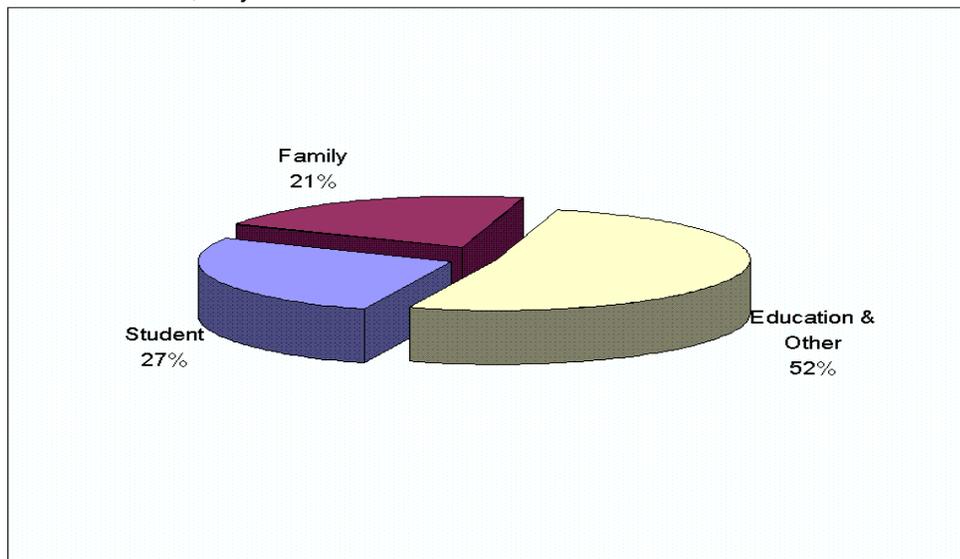
1. Special Education: Intensive Treatment Program for Pupils with Emotional Disturbances

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 17. ED Contacts, July 2004 - June 2006



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 15 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%.**

ED Success Story

This is a story with a happy ending.

A H-T, now 15, was referred to MH about 7 years ago for a multitude of presenting problems; his family was considering out-of-home placement due to violent outbursts, fire-setting, learning disabilities, enuresis, depression...the family was suffering terribly.

A H-T saw two of our clinicians over the span of 4 years, and was almost closed to services because he wasn't appearing to benefit. The parents were frustrated because nobody, myself included, could seem to land on a diagnosis that accurately explained what the root of the problem was, so we couldn't treat it effectively. He was taking medication, being monitored by Dr. Brown, and a lot of the danger seemed to be contained over time, but something was missing.

I was helping this youth get involved in every after-school activity I thought would help, trying to keep the parents committed to him until a miracle happened. We had marathon sessions to problem-solve and strategize and negotiate and repair. The parents, bless their hearts, hung in there, even after this child set fire in one of the bedrooms of a dependent adult living in the board-and-care home this family operates.

The miracles started to happen when I began to utilize the approach taught by Ira Chasnoff, M.D., (doortohope.org) the nationally-recognized expert in in-utero substance exposure. It's not that we didn't know A H-T had been exposed in-utero; it's just that we didn't know how that exposure had altered his brain and body to create the symptoms which had him at risk of residential placement. Utilizing these strategies began to change everything. I brought handouts and books to the parents, helped the family to process the effect of A H-T's adoption, and we implemented interventions suggested by Dr. Chasnoff.

This included a re-referral to an Occupational Therapist certified in Sensory Integration Disorder, and an evaluation at Stanford Sleep Clinic, to get a regulator for sleep apnea.

This child, once feared by his family, is becoming one of their pride and joys. He made the high school wrestling team, and is now training for fall football. He is passing all his SDC classes (although neuropsychological tests showed he was in the 1st percentile in most areas when tested 2 years ago).

What's more telling to me, though, is the sparkle in his eyes. He truly smiles now. When looking at this child, the exhausted, rageful, confused and overwhelmed haze is completely gone. He is IN there, living, experiencing, and responding, instead of just going through the motions and reacting when something goes wrong. He laughs and cooperates and feels joyful initiating his own interests.

We said goodbye two months ago; he no longer meets criteria. That's a miracle.

2. Court and Community Schools

The County Office of Education's (COE) Court and Community 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 Court and Community 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.

3. Pajaro Valley Prevention and Student Assistance (PVPSA)

In the fall of 2003, a new EPSDT expansion (in collaboration with Probation CPA2000 funding) targeting students in Pajaro Valley Unified School District (PVUSD) was begun. PVPSA provides counseling services to all schools in the southern part of our county, 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 new 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.

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, minimizing the necessity of group home placement, and allowing them to live in the least restrictive environment suited to their unique needs.

SIS Success Stories

Success #1

Our SIS team works with children who have been placed into foster care and provides support to the youth and family with mental health issues, as well as family reunification when possible, and adjustment to long term foster care or adoption when reunification is not possible. We began working with a young lady when she was 8 years old who was born with a cleft palate. Her father had recently committed suicide, and her mother had severe drug and alcohol issues, there was also severe domestic violence in the home. This young lady was extremely angry, both verbally and physically aggressive, she had difficulty connecting with her therapist, and was removed from many different foster homes due to her behavioral and emotional challenges. Also during this time her mother had multiple relapses, which meant that this young lady was unable to reunify with her mother. She also had about 8 surgeries to correct the physical deformities she had. Our SIS team never gave up on her. We provided intensive individual and family therapy with foster parents, group homes, and with her and her mother. She saw our Child Psychiatrist, who prescribed medication for her severe depression symptoms. At age 15 she was able to stop taking her psychotropic medications and had stabilized her placement. This young lady also had learning disabilities. However, she was able to overcome those obstacles and we are very happy to report that she recently graduated high school. This is a big success as she is the first in her family to receive a high school diploma. She asked her therapist, who has been with her for the past 6 years, to attend her graduation and thanked her over and over again

for never giving up on her. Currently she is focused on a career in nursing, is a very confident young lady, and looks forward to having a family of her own. We are very proud of her.

Success #2

Our SIS team works with children who have been placed into foster care and provides support to the youth and family with mental health issues, as well as family reunification when possible, and adjustment to long term foster care or adoption when reunification is not possible. A 17-year-old female was referred to us when she was removed from her home due to an abuse issue. When this young lady was placed into foster care she was having problems that included being easily distracted, preoccupied with abuse experiences, feeling anxious - including having hives, was feeling "stressed out" and she was also feeling very challenged by feeling "in the middle" of conflicts between her foster mother and her biological mother. All of this resulted in many challenges at school, including poor grades and poor attendance and she was at risk for not graduating high school. We provided intensive individual and family therapy, as well as support with her educational challenges. We are happy to report that this young lady successfully reunified with her family, graduated high school, and won an award for successfully overcoming obstacles. We are very proud of her.

2. Parents Center

The Parents Center has contracts with both Children's Mental Health (EPSDT) and Child Welfare Services (CWS) to provide a variety of supports to families with children, particularly those which have open Child Welfare cases. The focus is on family reunification and preservation, by supporting, educating and providing the counseling component of court mandated services for CWS families. There is also a focus on assisting children to adjust to foster care through the provision of mental health treatment.

Parents Center Success Story

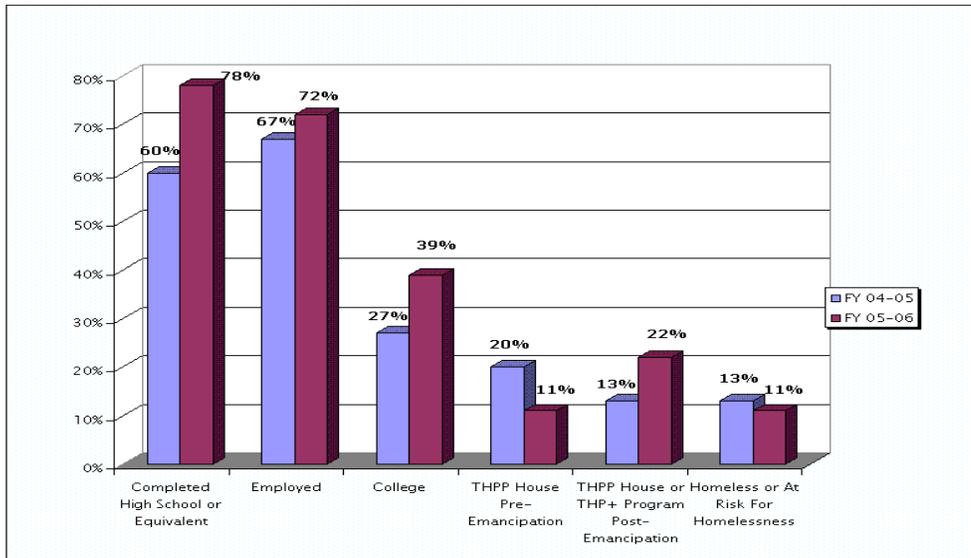
When I started working with Julie she was living in foster care with the parents of her best friend. She was attending 6th grade. There was a history of substance abuse and domestic violence with Julie's mother and father. There was reported sexual abuse by her father. The Treatment Plan for Julie included increasing self esteem, resolving guilt feelings toward her family issues, identifying and addressing her anger at her parents, coping with molest by her father, and building a general safety plan. Julie was resistant to counseling as evidenced by a difficult time trusting and talking with me. At the conclusion of treatment Julie had grown significantly in knowing how to deal with various issues in her life. She was reunified with her natural mother and was able to address problems with her mother in a healthy way. She also met her Service Plan goals, accepted the need for a safety plan and demonstrated the ability to use it when necessary. I see Julie as a wonderful young woman with a strong sense of self and as a person who can now stand up for herself.

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 18. SAS Outcomes, July 2004 - June 2006



The Independent Living Skills Program (ILS) 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.

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.
- **Children and youth of homeless families** (or at risk of homelessness) are now served through a collaboration with Youth Services (EPSDT contract agency) and the non-profit **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. This new program 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. 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.

- **Recurrence of child maltreatment within 6 months:**
 - In alignment with the federal standard
 - Lower than the state percentage
- **Foster care re-entry:**
 - In alignment with the federal standard
 - Lower than the state percentage
- **Adoption timeliness:**
 - Higher than the federal standard
 - Higher than the state percentage
- **Placement with siblings:**
 - Under the state percentage
- **Placement with relatives:**
 - Higher than the state percentage

On the majority of these measures, Santa Cruz County exceeds or is in alignment with the federal standard and are better than the statewide performance. However, there are outcome measures that need improvement, for example the placement of foster children with their own siblings, and reducing rates of maltreatment recurrence even lower.

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

D. Other SED/Community Mental Health Services

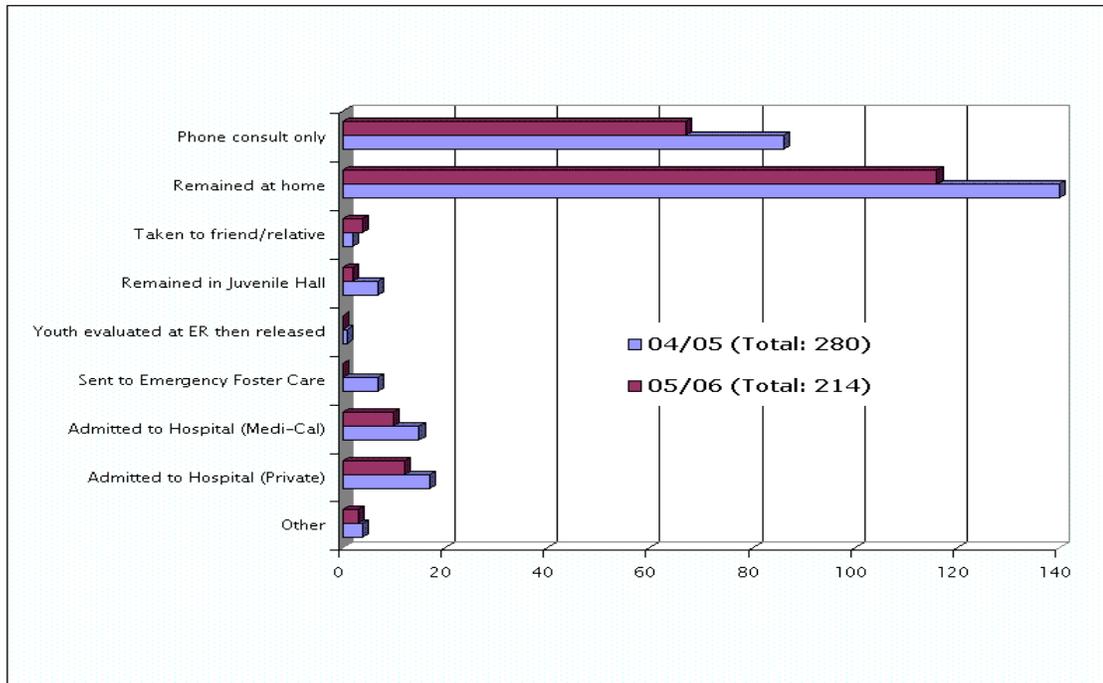
In addition to our primary partnerships with Probation, Education, and Social Services, our System of Care includes core programs that serve children and youth across our system, including community referrals.

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

Figure 19. MERT Team Case Dispositions, July 2004 - June 2006



therefore an important referral source for our System of Care. Figure 19 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:

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 2004 and June 2006, the Intensive Family Support Program served a total of 38 clients. These clients have been served from 60 days to two years, with an average length of ten months. **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 7 of the referred clients were able to be maintained either at home, at same level of placement, or actually decrease level of placement.

<u>Intensive Family Support Placement at Discharge</u>	FY 04/05		FY 05/06	
	Clients	Percentage	Clients	Percentage
Maintained at home or same level of placement	21	81%	7	58%
Decreased in level of placement	1	4%	2	17%
Living in more restrictive placements	4	15%	3	25%
Total Clients:	26	100%	12	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 the help that was promised to us."

The foster mom saying those words in October of 2005 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 with the Coordinator and extra help from our Family Support Team. While discussing treatment strategies with primary clinician Donna Rowilson, Debra Cerna--of the Family Support Team--had a suggestion. She, or her teammate Jon Payne, 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. They did on the spot counseling with Norma. 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.

When the unstructured summer months presented new challenges, the Family Support Team again stepped up to the plate. Debra offered milieu counseling and support for Norma (and three other clients) during their participation in a community-based activity program. This activity program was designed to build social skills and compliance with rules. When the physical nature of the activity was hard and Norma said, "I can't," Debra would not let her give up. In the course of the summer program, Norma was able to experience success being physically active--and positive peer relationships--in ways that she had never known before.

After the summer break, there was concern that Norma might slip back into old habits with the start of school in 2006. But we are happy to report that no such regression was seen. In fact, Norma had a 4.0 grade point average her 1st quarter of 8th grade. She 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.

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

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 2001 - 2005

Years 1-5		04-05	03-04	02-03	01-02	00-01
Recidivism (% not re-arrested)	Youth with Substance Use	73%	81%	76%	71%	71%
	Youth w/o substance use	80%	79%	80%	75%	75%
	ALL CLIENTS	75%	80%	78%	74%	73%
Satisfaction with Services % very satisfied & satisfied	Youth with Substance Use	90%	69%	75%	86%	85%
	Youth w/o Substance Use	88%	70%	81%	74%	82%
	ALL CLIENTS	89%	70%	77%	81%	83%
Service Effectiveness % very effective & effective	Youth with Substance Use	84%	63%	64%	64%	78%
	Youth w/o Substance Use	88%	70%	61%	69%	80%
	ALL CLIENTS	85%	66%	62%	66%	79%
Drug & Alcohol Use (% who's substance use stopped or reduced)						
	Youth with Substance Use	80%	76%	67%	80%	76%
Outcome Framework						
All responses are 6-18 months after the end of counseling						
All responses are the combined results of youth and parent answers						
All survey participants were open to counseling for at least one month						

Data for Year 6 is included below in a slightly different format. In general, the feedback indicates fairly good satisfaction with services from youth and parents, a sense that they were effective, reduced recidivism, and reduced drug and alcohol use.

Year 6

Recidivism (%not re-arrested)	05-06
YSVSN and YSALT	74%
YSOPS and YSYES	67%
Satisfaction with Services	
% Youth - Very Satisfied & Satisfied	97%
% Parent's - Very Satisfied & Satisfied	87%
Service Effectiveness	
% Youth - Very Effective & Effective	88%
% Parent's - Very Effective & Effective	73%
Drug & Alcohol Use	
% Stopped Using	61%
% Reduced Use	39%

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 a new 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 20. Ohio Worker Function Scale, sampling from July 2004 - June 2006

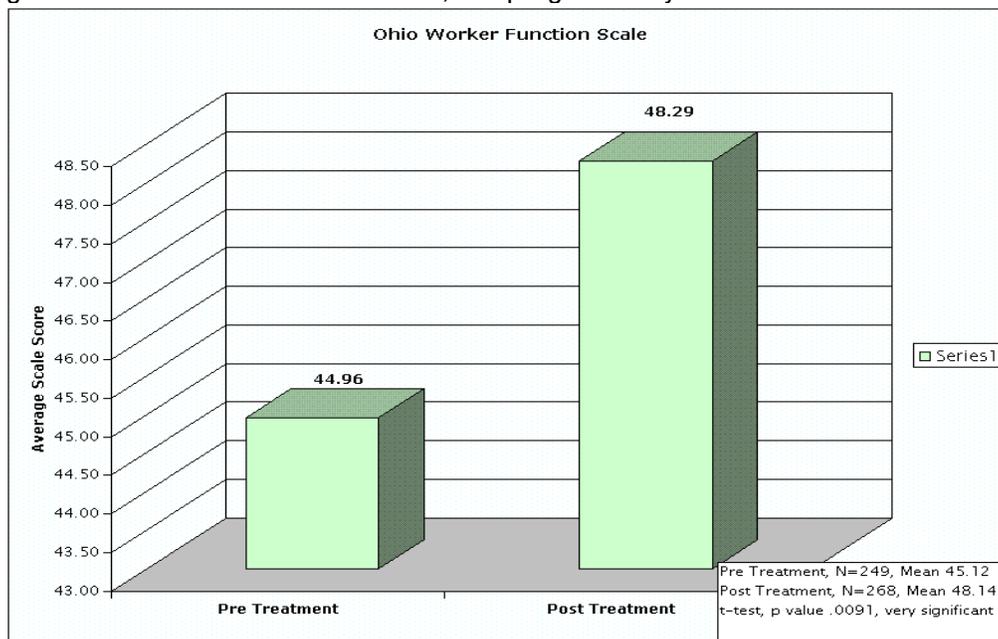
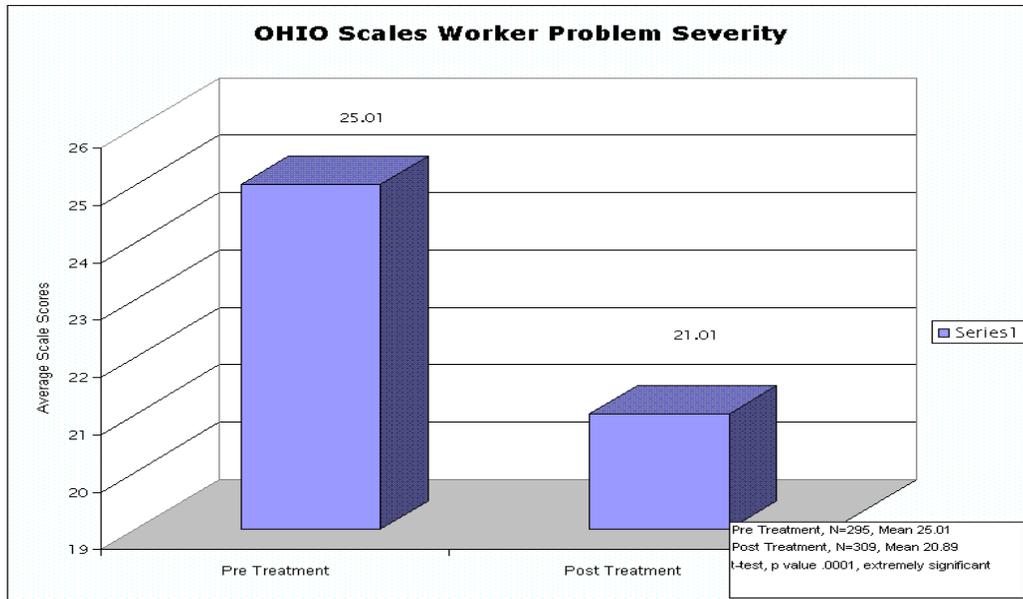


Figure 21. Ohio Worker Problem Severity Scale, sampling from July 2004 - June 2006



Historical View - CAFAS Data

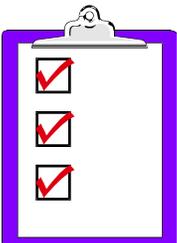
Since the administration of the Ohio Scales is relatively new, we've included the previous 8 years worth of CAFAS data for historical purposes. On the CAFAS the *clinician* is asked to rate the youth's level of functioning in each of eight areas: School/Work, Home, Community, Behavior toward Others,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



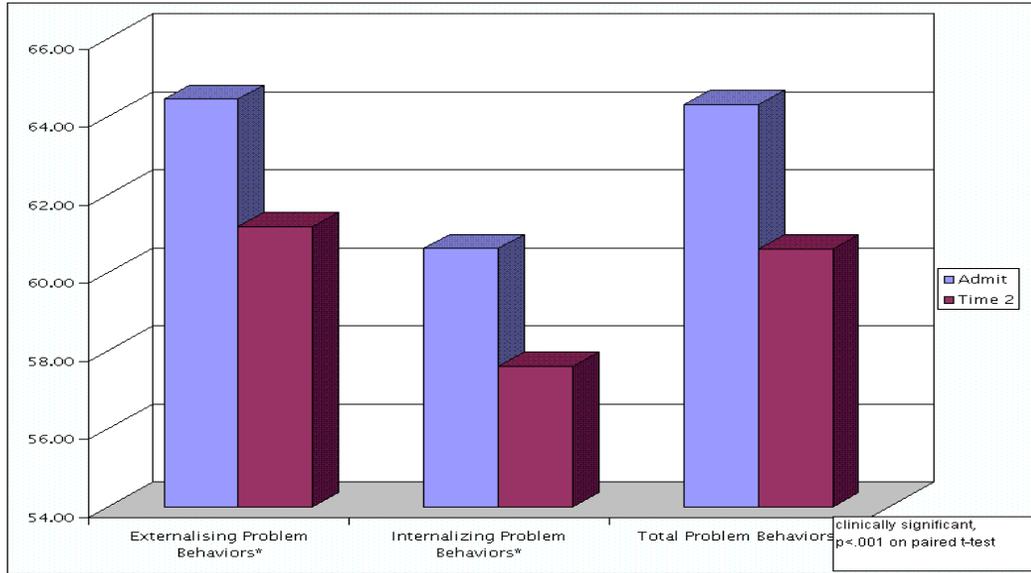
The CBCL, Child Behavior Checklist, was designed to describe a range of problem behaviors of children 4 to 18 years old from the perspective of the **parent or caregiver**. The problem behavior section addresses a broad range of behaviors and provides empirically derived Externalizing (e.g., "fights," "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 6/30/06, Santa Cruz County administered 8,890 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 1,193 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 22. Parent Rating Child Behavior Symptoms, N=1,193, 7/1/95 to 6/30/06

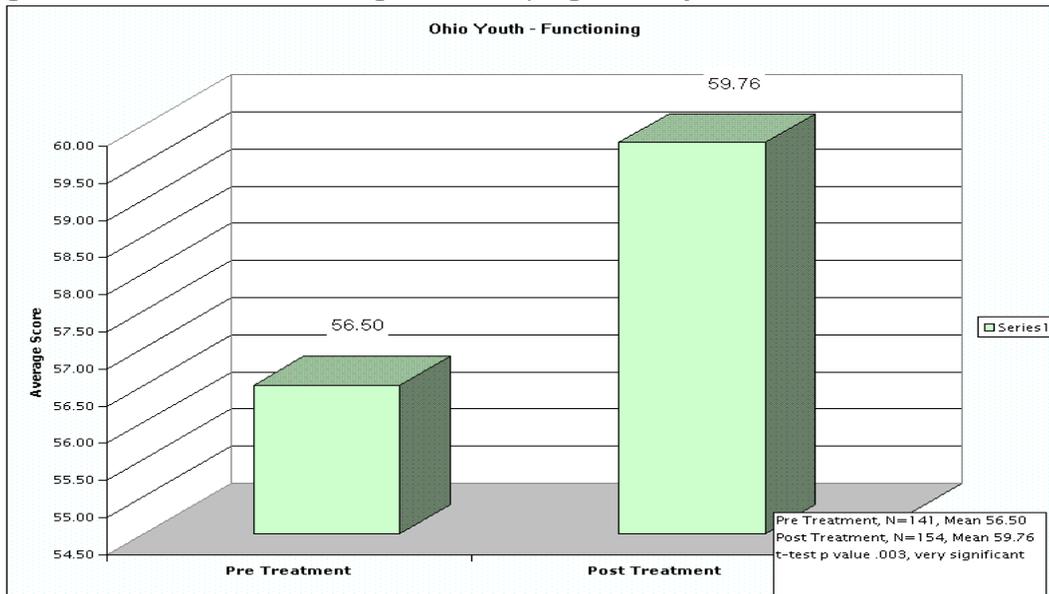


3. Youth Perspective

Ohio Scales - Youth Version

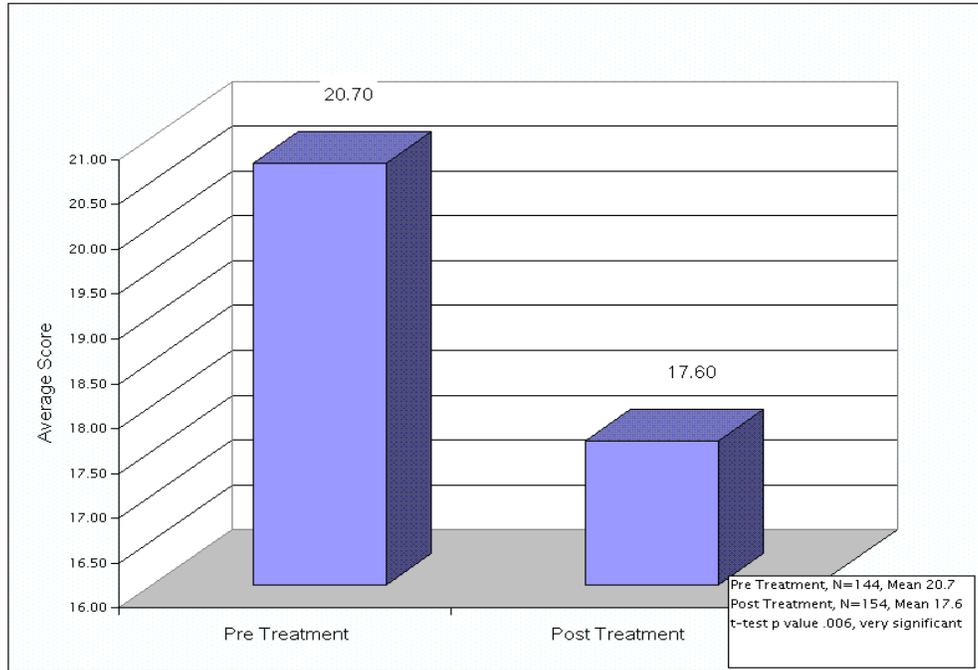
The Ohio Scales data below shows youth clinical outcomes *from the point of view of the youth*. The first graph indicates that youth see an **improvement in functioning** for themselves, for clients administered pre and post tests. In this case the statistics demonstrate a confidence that the changes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

Figure 23. Ohio Youth Functioning Scale, sampling from July 2004 - June 2006



graph 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 24. Ohio Youth Problem Severity Subscale, sampling from July 2004 - June 2006



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 2004 – June 2006

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Overall, I am satisfied with the services I received.	Youth	42%	50%	8%	1%	2%
	Family	57%	38%	3%	0%	1%
The people helping me stuck with me no matter what.	Youth	44%	42%	12%	2%	2%
	Family	51%	36%	4%	2%	2%
I participated in my own treatment.	Youth	33%	53%	11%	1%	2%
	Family	44%	46%	4%	2%	1%
The location of services was convenient.	Youth	38%	49%	10%	2%	1%
	Family	50%	43%	3%	3%	2%
Services were available at times that were convenient for me.	Youth	37%	50%	11%	4%	1%
	Family	50%	44%	3%	2%	1%
I got the help I wanted.	Youth	39%	47%	14%	2%	1%
	Family	46%	41%	8%	1%	2%
I got as much help as I needed.	Youth	34%	45%	17%	3%	1%
	Family	41%	37%	13%	4%	1%
Staff respected my family's religious/spiritual beliefs.	Youth	41%	42%	6%	0%	1%
	Family	52%	34%	2%	0%	1%
Staff spoke with me in a way that I understood.	Youth	46%	48%	5%	2%	1%
	Family	61%	37%	1%	0%	1%
Staff were sensitive to my cultural/ethnic background.	Youth	38%	38%	7%	1%	1%
	Family	45%	35%	2%	0%	1%
I am better at handling my life.	Youth	28%	47%	20%	3%	2%
	Family	28%	45%	19%	3%	2%
I get along better with family members.	Youth	25%	46%	20%	6%	2%
	Family	27%	46%	18%	3%	2%
Youth Surveys Total: 614						
Family Surveys Total: 624						

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

Historical View – Family and Youth Satisfaction Questionnaires

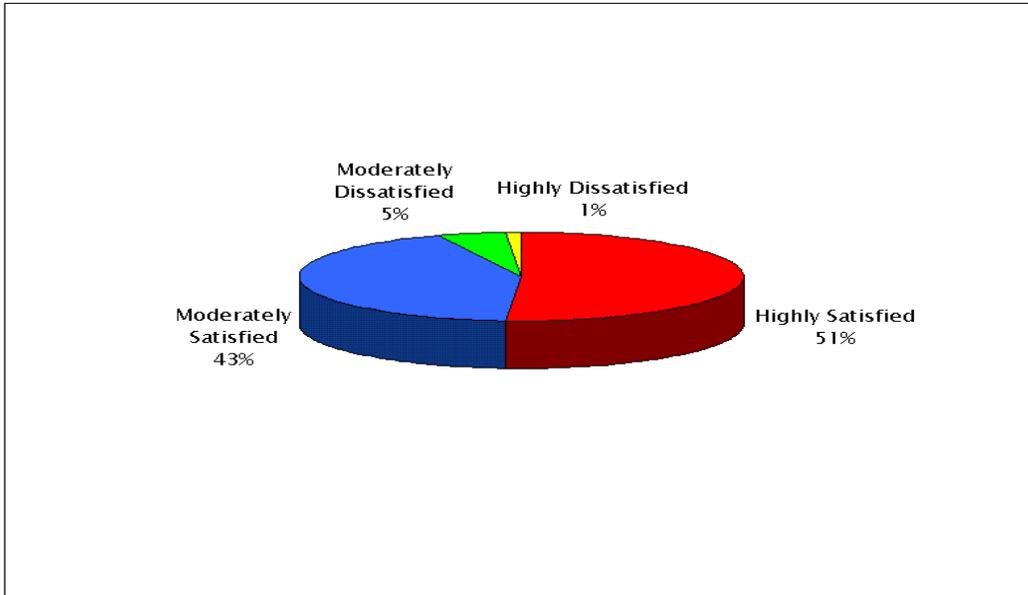
From 1995 through the beginning of 2004, the instruments used were the Family Satisfaction Questionnaire (CSQ-8) developed by Cliff Attkisson of the University of California San Francisco Child Research Service Group, and the Youth Satisfaction Questionnaire, developed by MACRO International as part of the CMHS National Evaluation of Systems of Care. Overall we collected 1,118 Family Satisfaction Questionnaires and 1,034 Youth Satisfaction Questionnaires.

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



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 offers peer support services to parents, caregivers and family members of children and youth with serious emotional disturbances. The program is operated by the Volunteer Centers of Santa Cruz, a non-profit agency, under contract with Santa Cruz County Children's Mental Health. Although Children Mental Health has had a long history of involving families in their children's care and treatment, the inception of the Family Partnership Program in 1995 gave parents and families a special voice and forum of their own within the Children's System of Care. The program provides home and field-based services to families throughout Santa Cruz County.

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. Staff members are family members with personal experience as parents, or parents/caregivers of children or family members with mental health issues and/or special education needs. 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's activities and accomplishments over the past two years have included:
- Providing ongoing support and 1-1 consultation to 40-50 families per year.
- Providing support and advocacy to 15-20 families per year as part of the collaborative, Wraparound Service Team for families with youth on probation.
- Collaborating in "Reclaiming Futures Project" system reform efforts, including hosting family engagement work groups, developing informational brochures on teen substance use for distribution to families, inviting and facilitating parents' participation in various trainings and workshops, and developing and pilot-testing satisfaction surveys for families of youth exiting residential treatment.
- Co-facilitating one 8-10 week "Cara y Corazon" family strengthening workshop series for 10-12 families per year.
- Hosting focus groups and distributing surveys to solicit parents' and youth input into Proposition 63 / Mental Health Service Act planning for Santa Cruz County.
- Representing family perspectives, needs and issues in various local, regional and statewide meetings and conference calls, including the Children's Steering Committee, the Greater Bay Area meetings, Reclaiming Futures Project management team meetings, the Wraparound Institute, and California Family Partnership Association (policy board for United Advocates for Children and Families).

Beginning in the spring of 2007, the Family Partnership Program will expand its outreach and advocacy activities with the addition of a new, MHSA-funded Family Advocacy Services component.

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:

- *Color of Fear*
- *Last Chance for Eden*
- *Co-Occurring Disorders: Mental Health and Substance Abuse*
- *Homelessness in Santa Cruz County*
- *Art of Ana Mendieta: Window into Acculturation & Trauma*
- *Substance Abuse Training in Pune, India*
- *Curando con Dignidad (Healing with Dignity)*
- *Encounters of the Three-Way Kind: How to be an Interpreter in a Mental Health Setting*
- *Lost in Translation? Found in Interpretation.*
- *Understanding the Oaxacan Culture*
- *Hearing Voices*
- *Hermanas Recovery – Panel Presentation*
- *Spirit Possession and Mental Health Among Vietnamese – American Spirit Mediums*
- *Addressing the Issues of Disparities*
- *Welcoming Diversity*
- *Triangle Speakers*
- *African American Cultural Explorations*
- *Jewish Heritage Panel Presentation*
- *Prevention of Sexual Harassment*
- *Disabled and Mislabeled: Living with disabilities ... visible or invisible*
- *The Racialization of a Debate: Charreada as Tradition or Torture?*
- *Culture of Poverty*
- *Sí Se Puede Panel Presentation*
- *Media Madness: Portrayals of Mental Illness in the Mass Media*
- *Biological, Social and Psychological Aspects of Aging*
- *Cultural Considerations in Assessment and Service of Immigrants and/or Latino Families*

- *Diversity/True Colors – Our Differences Are Not Necessarily What We Thought*
- *Performing Mexicanidades*
- *Latino Parents and Adolescent Sexuality: Breaking the Silences*
- *Cultural Considerations in Addiction Treatment*
- *MHCAN Consumer Culture Panel Presentation*
- *Unlearning Our Isms*
- *Understanding the Oaxacan Culture*
- *LBHI: A Decade of Progress, A Legacy of Changes, A Vision for the Future*
- *Latino Behavioral Health Institute Conference*
- *Cultural Competence & Mental Health Summit XII A Renewed Vision of Culture*
- *Cultural Competence & Mental Health Summit XIII*

The chart below illustrates a significant rise in our department’s overall **cultural competency training attendance from 36% in 2003, to 84% - 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 Comparison Charts								
	2003		2004		2005		2006	
Attended	91	36%	194	88%	193	92%	203	84%
<i>7+ hours</i>	53	21%	88	40%	120	57%	96	40%
<i>Less than 7 hours</i>	38	15%	106	48%	73	35%	107	44%
Did Not Attend	160	64%	26	12%	16	8%	38	16%
Total Employees	251	100%	220	100%	209	100%	241	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, including participation in the Local Mental Health Board, various Mental Health Services Act committees/groups, Quality Improvement Steering Committee, and Children's System of Care Steering Committee. Our interagency partners are also committed to this consumer/community process through Robert Wood Johnson *Reclaiming Futures* and the Child Welfare System *Improvement Planning* projects.

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, some of which were included in the Santa Cruz County High School Poetry Contest's annual chapbook:

HIDING, WAITING

I hide behind the shadows that protect me,
waiting for the storm of footsteps to pass.
Every scar on my body is a danger I had to live.
Even the memory that hunts me in my sleep scars me.
In every little kid I see my reflection.
I hide my secrets like I hide my scars –
so I won't be laughed at, or scare anybody.
I can count every bone in my body
and it feels like the weather is sucking the life out of me.
I wish I was in heaven smelling the sweet air, or
I wish I was a king, in a fairytale, or a lovely story.

-- Juan

RAIN

The rain came down like splinters.
It hit my hand. Now, as I walk
against the wind, I do not worry
about the silence night brings.

-- Nick

NEW FENCE

My charges pile up like dirty laundry.
Problems, like ghosts,
come back to haunt me.
The lies line up for miles.
My life's a file of mysteries.
No past, or history.
Think what you want,
but it's dust to me.
My new beginning knocked down
the old wall. I've got a new fence
to protect me.

-- Brett

BROKEN WINDOW

The broken window is a signal that the party's over.
A photo of the family now hangs crooked.
The new black couch is covered in chalk.
The stairs are stained from spilt drinks.
The refrigerator no longer stands on its end.
A beautiful home now the terrain of a battlefield.

-- Jackson

NO ONE KNOWS

No one knows what to name
the fear, the fear
that lies in the darkness.
It's so powerful it needs a friend
so it can be shared.
Even if you're a slave who praises it
to make it go away,
the fear stays in the darkness.
You still won't know how
to name your fear.

-- Uriel

The following poem was written by one of our foster youth, who reports she is doing well these days, and for whom poetry has been an important outlet:

PAINTING

See the beauty in the young girl
Painted up with life
She stands alone with secrets kept
Painting with a knife

See the pain in the young girl's eyes
Crying underneath
She holds it in and keeps it shut
Crying as she bleeds

See the sorrow in the young girl's life
Screaming to be heard
She hides behind herself in terror
Screaming at the world

Look beyond the pretty face
See into her dreams
Look past the pretty smile
See what lies beneath

See the beauty in the young girl
Painted up with tears
She stands alone with secrets kept
Painting with her fears

-- Michaela

APPENDIX

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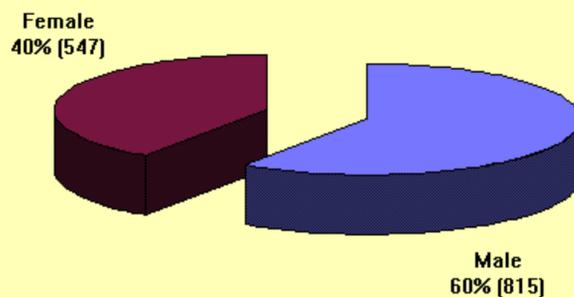
Year Sixteen of System of Care - Demographics

July 1, 2004 - June 30, 2005

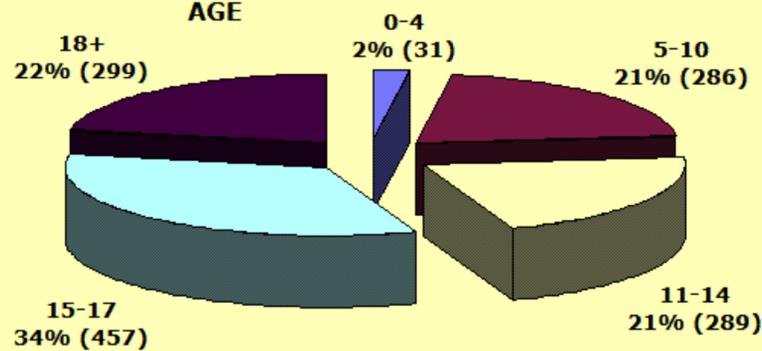
FY 04/05 ALL Children's Clients

Total Unduplicated Clients: 1,362
 Admissions: 2,251
 Discharges: 2,129
 Episodes Open as of June 30, 2005: 528

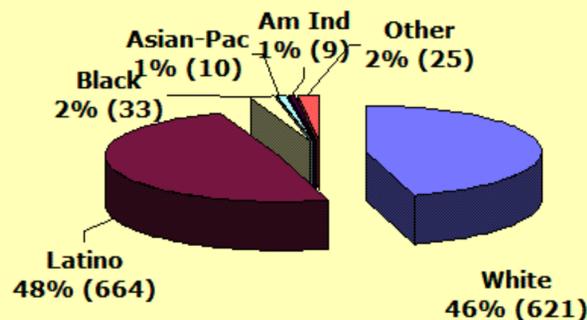
GENDER



AGE



ETHNICITY



Child Welfare Clients

Total Clients: 337
 Admissions: 516
 Discharges: 470
 Episodes Open as of June 30, 2005: 177

Ethnicity	Age
White: 55% (184)	0-4: 20
Latino: 41% (138)	5-10: 118
Black: 2% (6)	11-14: 78
Other: 2% (9)	15-17: 73
	18+: 48

Includes: CFDOPN, ILSIP, PARCTN, PARCTS, THPP, YSCPS, HRA

Probation Clients

Total Clients: 316
 Admissions: 621
 Discharges: 614
 Episodes Open as of June 30, 2005: 91

Ethnicity	Age
White: 40% (127)	0-4: 0
Latino: 53% (167)	5-10: 0
Black: 3% (8)	11-14: 10
Other: 4% (14)	15-17: 166
	18+: 140

Includes: HALL, LUNAEC, WRAP, PROB, STOP, UCCS, YSVSN

Special Education Clients

Total Clients: 137
 Admissions: 141
 Discharges: 90
 Episodes Open as of June 30, 2005: 89

Ethnicity	Age
White: 75% (102)	0-4: 0
Latino: 17% (23)	5-10: 32
Black: 4% (6)	11-14: 54
Other: 4% (6)	15-17: 35
	18+: 16

Includes: SCHOOL

Crisis Stabilization Clients

Total Clients: 165
 Admissions: 221
 Discharges: 219
 Episodes Open as of June 30, 2005: 23

Ethnicity	Age
White: 58% (96)	0-4: 0
Latino: 33% (54)	5-10: 8
Black: 3% (5)	11-14: 39
Other: 6% (10)	15-17: 91
	18+: 27

Includes: FAMSUP, MERT

EPSDT Contract Services Clients

Total Clients: 601
 Admissions: 673
 Discharges: 660
 Episodes Open as of June 30, 2005: 188

Ethnicity	Age
White: 32% (194)	0-4: 11
Latino: 64% (386)	5-10: 143
Black: 2% (11)	11-14: 151
Other: 2% (10)	15-17: 187
	18+: 109

Includes: EDGEDT, EDGEOP, CMCNFP, FSANC, FSASC, MILHOP, HILHDT, PVP, PVPSA, HRBRVW, YSALT, YSYES, YSOPS, YSFIT

Community / Other SED Clients

Total Clients: 73
 Admissions: 79
 Discharges: 76
 Episodes Open as of June 30, 2005: 23

Ethnicity	Age
White: 48% (35)	0-4: 0
Latino: 48% (35)	5-10: 8
Black: 1% (1)	11-14: 7
Other: 3% (2)	15-17: 34
	18+: 24

Includes: OTHSED, YSTYLR, UCTBS

NOTE: Under "All Children's Clients" client counts are unduplicated. All other groupings may count clients open to multiple reporting units.

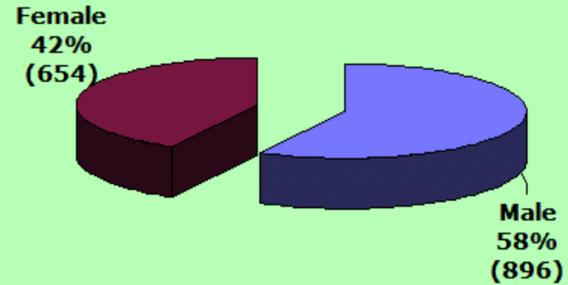
Year Seventeen of System of Care - Demographics

July 1, 2005 - June 30, 2006

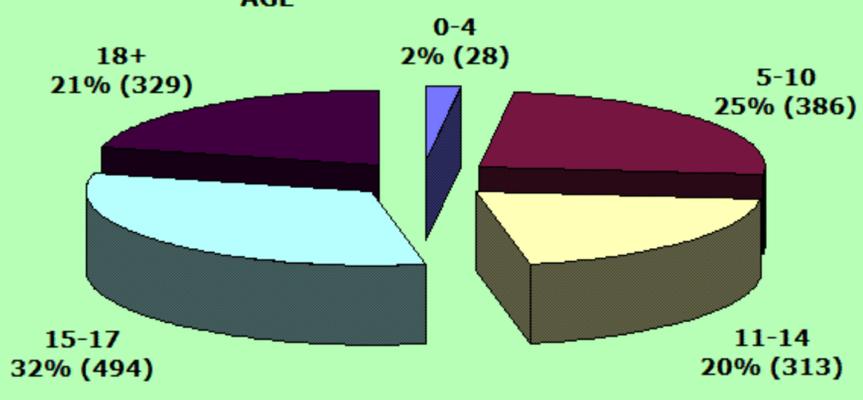
FY 05/06 ALL Children's Clients

Total Unduplicated Clients: 1,550
Admissions: 2,670
Discharges: 2,269
Episodes Open as of June 30, 2006: 752

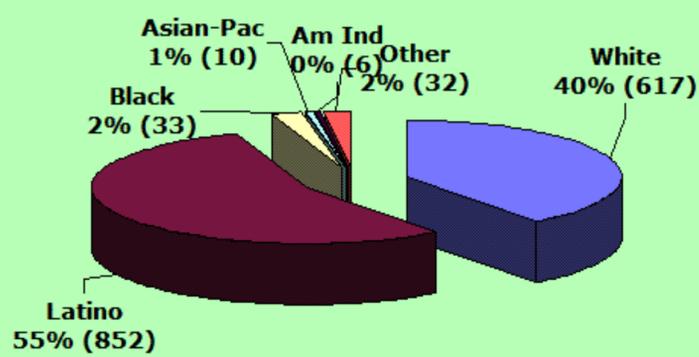
GENDER



AGE



ETHNICITY



Child Welfare Clients

Total Clients: 350
Admissions: 559
Discharges: 441
Episodes Open as of June 30, 2006: 187

Ethnicity	Age
White: 49% (171)	0-4: 14
Latino: 45% (158)	5-10: 117
Black: 3% (9)	11-14: 80
Other: 3% (12)	15-17: 78
	18+: 61

Includes: CFDOPN, ILSP, PARCTN, PARCTS, THPP, YSCPS, HRA

Probation Clients

Total Clients: 301
Admissions: 724
Discharges: 687
Episodes Open as of June 30, 2006: 93

Ethnicity	Age
White: 40% (122)	0-4: 0
Latino: 54% (162)	5-10: 1
Black: 3% (8)	11-14: 12
Other: 3% (9)	15-17: 166
	18+: 122

Includes: HALL, LUNAEC, WRAP, PROB, STOP, UCCS, YSVSN

Special Education Clients

Total Clients: 141
Admissions: 147
Discharges: 62
Episodes Open as of June 30, 2006: 106

Ethnicity	Age
White: 72% (101)	0-4: 0
Latino: 22% (31)	5-10: 38
Black: 3% (5)	11-14: 42
Other: 3% (4)	15-17: 42
	18+: 19

Includes: SCHOOL

Crisis Stabilization Clients

Total Clients: 157
Admissions: 191
Discharges: 185
Episodes Open as of June 30, 2005: 14

Ethnicity	Age
White: 60% (94)	0-4: 1
Latino: 33% (51)	5-10: 10
Black: 3% (5)	11-14: 32
Other: 4% (7)	15-17: 78

Includes: FAMSUP, MERT

EPSDT Contract Services Clients

Total Clients: 866
Admissions: 982
Discharges: 847
Episodes Open as of June 30, 2006: 409

Ethnicity	Age
White: 28% (246)	0-4: 14
Latino: 67% (583)	5-10: 246
Black: 2% (15)	11-14: 193
Other: 3% (22)	15-17: 269
	18+: 144

Includes: EDGEDT, EDGEOP, CMCNFP, FSANC, FSASC, MILHOP, HILHDT, PVP, PVPSA, HRBRVW, YSALT, YSYES, YSOPS, YSFIT

Community / Other SED Clients

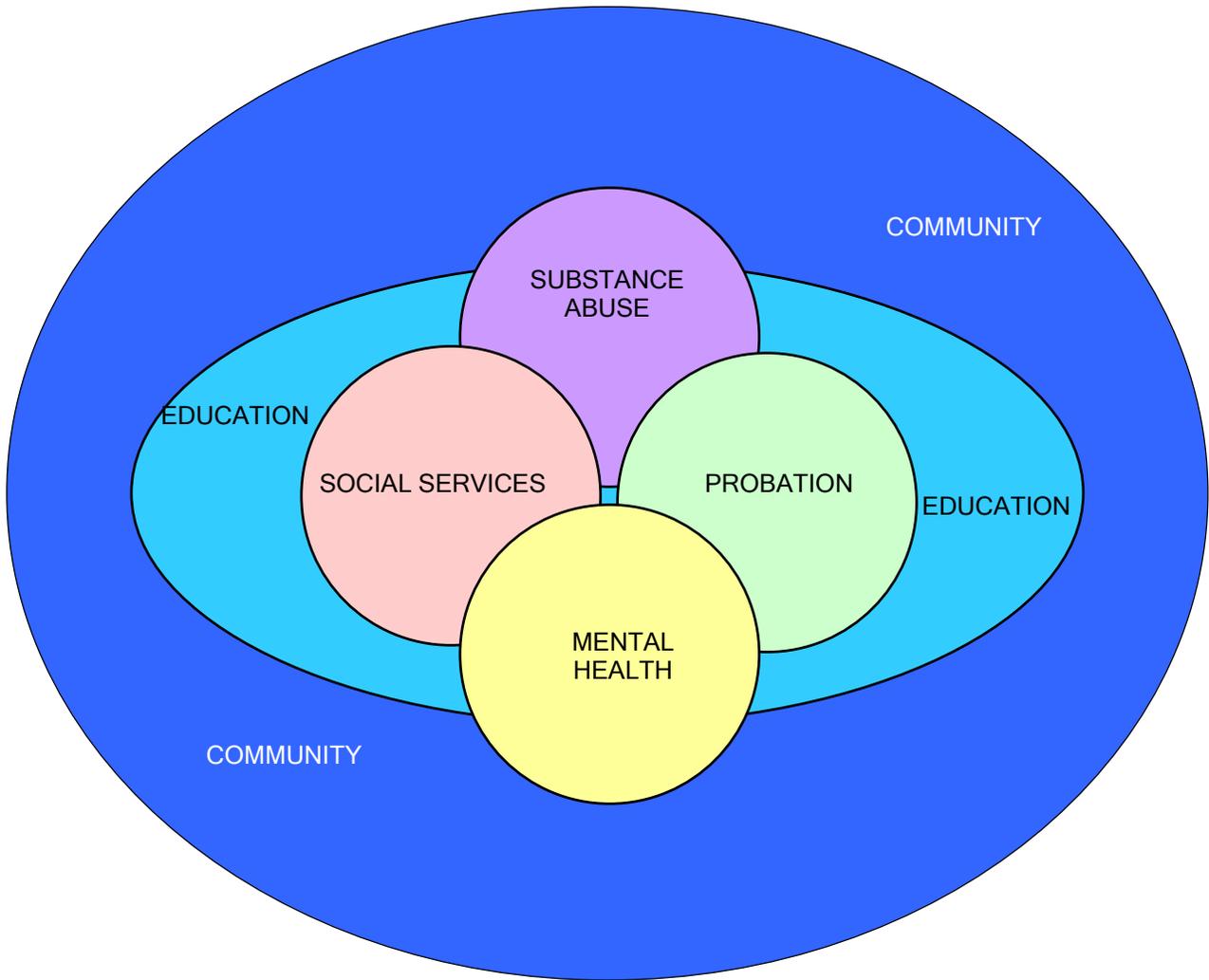
Total Clients: 61
Admissions: 67
Discharges: 51
Episodes Open as of June 30, 2006: 27

Ethnicity	Age
White: 43% (26)	0-4: 0
Latino: 54% (33)	5-10: 2
Black: 0% (0)	11-14: 10
Other: 3% (2)	15-17: 31
	18+: 18

Includes: OTHSED, YSTYLR, UCTBS

NOTE: Under "All Children's Clients" client counts are unduplicated. All other groupings may count clients open to multiple reporting units.

System of Care COMMUNITY AND INTERAGENCY COLLABORATION



CHILD / ADOLESCENT WITH SERIOUS
EMOTIONAL DISTURBANCES

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



***Reclaiming Futures Santa Cruz County** is engaged in a national effort to change the way our communities respond to teenagers involved with drugs, alcohol, and crime. The Santa Cruz County Juvenile Probation Department is partnering with the courts, alcohol and drug treatment providers, community organizations, and youth and their families to meet the urgent needs of these young people in our juvenile justice system.

Alcohol and drug use among teenagers in Santa Cruz County is higher in than national averages. In 2000, 67 percent of Santa Cruz County's juvenile offenses involved young people with alcohol or other drug dependency problems. A 1999 study of found that local youth who were heavily involved with alcohol and drugs were five times more likely than other participants to break the law again within six months of finishing the program.

At Reclaiming Futures Santa Cruz County we are working to improve the quality and effectiveness of alcohol and drug treatment services available to youth in our juvenile justice system. We plan to do the following:

- Identify up to 150 young people each year who are repeat offenders within the juvenile justice system with substance abuse and mental health issues
- Improve and increase the treatment and support services available to these youth and their families, with emphasis on programs proven most effective with adolescents
- Help these young people transition back to the community by engaging their families, other natural helpers and the excellent system of care this community has developed over the last decade
- Ensure that the courts and other juvenile justice system partners are able to recognize and incorporate these systemic changes into their responses to youth

Our core partners

Santa Cruz County:
Juvenile Court
Juvenile Probation
District Attorney
Public Defender
Alcohol and Drug Programs
Children's Mental Health
Office of Education Alternative Schools
Family Partnerships Program
Criminal Justice Council of Santa Cruz
Pajaro Valley Prevention and Student Assistance
Santa Cruz Barrios Unidos
Community Action Board, YCORP Youth Services
UCSF Child Services Research Group

* From Reclaiming Futures website, www.reclaimingfutures.org

Child Welfare: Keeping Children Safe

Local Performance Review



A new aspect of helping to keep our children safely at home, and in good foster and adoptive homes, is to be found in the Federal and State Child Welfare System Improvement processes. The Federal Child and Family Services Review (CFSR) focuses on improving *safety, permanence, and well being* for children in the Child Welfare System (CWS). California’s response is embodied in the Child Welfare Systems Improvement and Accountability Act (AB 636), which required counties to undergo a self-assessment and develop a system improvement plan.

Santa Cruz County Child Welfare System Data

- **Safety:**
 - Emergency response timeliness
 - Recurrence of maltreatment
- **Permanency:**
 - Timely reunification
 - Re-entry into foster care
 - Adoption timeliness
- **Child Well Being:**
 - Children placed with siblings
 - Children placed with relatives

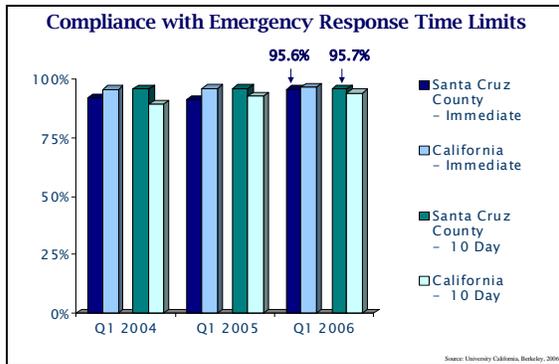
CWS reform is an important part of our local System of Care development, and is supported by the spectrum of mental health and community-based services provided to foster children and their families and caregivers.

AB 636 requires a series of indicators for key outcomes and processes. This outcome framework is organized by the three areas identified before: safety, permanency and well-being.

In order to provide a context for our local performance, comparison to the overall state performance will be made. However we must be mindful in making comparisons. At this time there are significant differences in data collection practices and polices among counties. In addition, all of our communities are different demographics and complexities and therefore need to be understood in their own context.

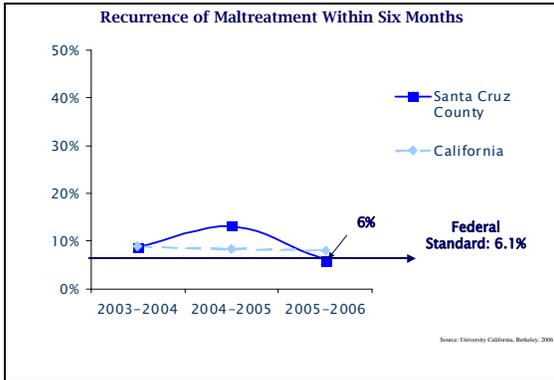
Safety is a crucial outcome of all our work. The following data begins with a review of several measures of this critical aspect of the child welfare system.

Safety Outcomes

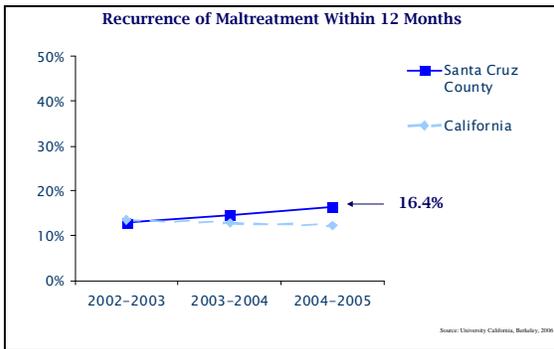


One way to ensure safety is to respond quickly to children in danger. The chart to the left displays the percent of cases in which face to face contact with a child occurs within the regulatory time frames in those situations in which a determination is made that the allegations indicate significant danger to the child. This information is reported by quarter and the most recent time quarter available is the first quarter of 2006. In order to provide you with a trend we also displayed data for the first quarters of 2005 and 2004.

The blue columns show cases that warranted an immediate response and the green columns display data for cases indicating a 10 day response time frame. This chart shows that overall the county had a high percentage of cases that were responded to within the required regulatory time frames and that the county performed slightly better than the state percentages for compliance with 10 day time frames.



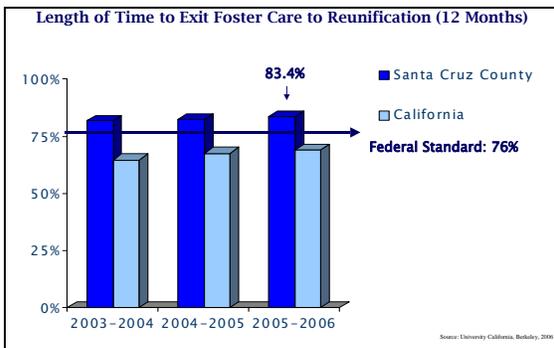
This measure reflects the percent of children who were victims of child abuse and/or neglect with a **subsequent substantiated report of abuse and/or neglect** within six-month and twelve-month time frames (see chart to the left and the one below it). The year time periods used are based on the most recent 12 month period available, which is April 2005 to March 2006. Data for this time period is displayed for the past 3 years.



Santa Cruz County data is reflected by the darker blue solid line. In the last 12 month period, of all children with a substantiated allegation, 6% had another substantiated allegation within 6 months. **This is a 7.2% decrease from the previous period, which was 13.2% in 2004-2005 and 2.6% decrease from 2003-2004.** Also of note is the fact the most recent percentage of recurrence is almost in alignment with the federal standard which is 6.1%.

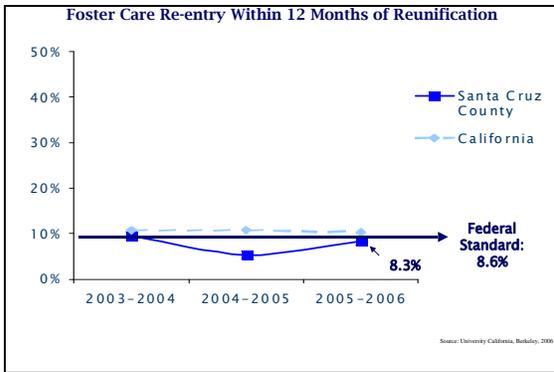
Local analysis suggests that, in part, this data may show somewhat higher than “normal” recurrence rates, but could also be due to a very active Domestic Violence community intervention approach that reports to Child Welfare the impact on children of adult domestic violence when law enforcement intervenes.

Permanency Outcomes

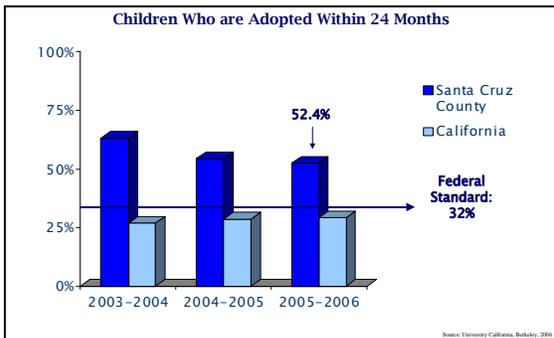


The permanency outcomes (see figure to left) reflect a process measure that shows the percent of children reunified who were **reunified within 12 months of a removal from the home.** Again, the chart reflects the most recent data available, showing comparisons over the past three years.

The trend shows that Santa Cruz County has been consistently better than the state percentage (this is both a state and federal measure).



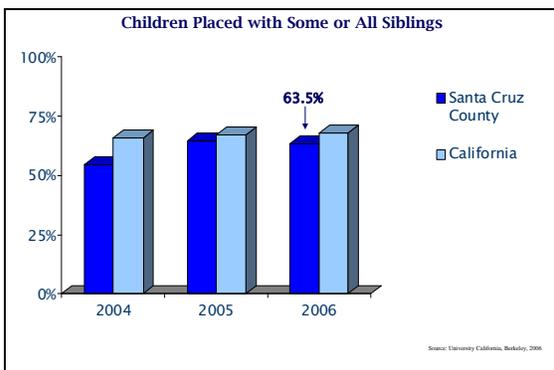
This measure (see chart at left) shows the percent of children who **re-enter foster care subsequent to reunification or guardianship**. In the most recent period, for all children who entered CWS supervised foster care in *Santa Cruz County*, **8.3% had a subsequent entry into foster care within 12 months of a prior exit. This is slightly under the federal standard of 8.6% and below the state percentage for that time period, which was 10.3%**



The figure at left shows the percent of the total children adopted that were **adopted within 24 months**. Half of the children who were adopted in the most recent time period were adopted within 24 months; this 52% represents 23 children. All but one of these children was 5 or younger. Of the 22 children under five, slightly more than half were under 2.

As you can see, in the last three 12-month time periods listed, Santa Cruz County was consistently higher than the federal standard of 32%, as well as consistently higher than the state percentage.

Child Well Being Outcomes



The figure at left illustrates the percent of foster care children in **placement with some or all of their siblings**.

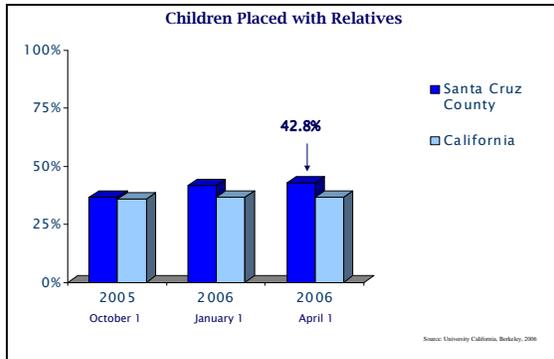
This information is collected at a point in time, April 1 in the years of 2004 – 2006. At this point in time in 2006, 64% of foster children were placed with some or all of their siblings. This is a small decrease from 2005 when 67% of foster care children were placed with some or all of their siblings. **However both 2005 and 2006 show an increase from 2004 when**

55% of foster care children were placed with some or all of their siblings.

Out of the children that were placed with some or all of their siblings on April 1 2006, 50% were groups of two, 30% were groups of 3, 16% were groups of 4 and 4% were groups of 6 or more.

Santa Cruz County is slightly below the state percentage. One contributing factor is the high cost of living, which makes housing and multiple bedrooms more expensive. In 2006, at this

point in time (April 1 2006) 68% of foster children statewide were placed with some or all of their siblings, so we're moving in the right direction.



The figure at left displays the percent of children **placed in foster care with relatives** at the identified points in time. The most recent data was collected on April 1, 2006 showing 43% of children who had been in care at least 5 days had been placed with relatives. In the last two times these data were collected, January 1 and April 1 2006, *Santa Cruz County was higher on this measure than the state*. Statewide data on April 1 2006 shows 35% of foster care children were in relative placement.

Local Data Summary

- **Recurrence of child maltreatment within 6 months:**
 - In alignment with the federal standard
 - Lower than the state percentage
- **Foster care re-entry:**
 - In alignment with the federal standard
 - Lower than the state percentage
- **Adoption timeliness:**
 - Higher than the federal standard
 - Higher than the state percentage
- **Placement with siblings:**
 - Under the state percentage
- **Placement with relatives:**
 - Higher than the state percentage

The figure at left provides a brief summary of each of the measures, and where our 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). Important to note again that 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 the measurement and ourselves.

On the majority of these measures, Santa Cruz County exceeds or is in alignment with the federal standard and are better than the statewide performance. However, there are outcome measures that need improvement, for example the placement of foster children with

their own siblings, and reducing rates of maltreatment recurrence even lower.

The California Endowment Healthy Returns Initiative (HRI)

What HRI is: The Healthy Returns Initiative is funded by the California Endowment to improve physical and mental health outcomes for youth in the juvenile justice system. We are one of 5 counties in the state to be chosen to receive these funds. Every youth who spends longer than 4 hours in the juvenile hall is eligible for services under HRI.

Who We Are:

Probation Officer: Cynthia Chase 454-3876
Health Educator: Kathleen Hofvendahl-Clark 454-3867
Certified Application Assistant: Krystal Guzman 454-7432
724-2997 ext. 208 (La Manzana Community Resources
521 Main St. Suite Y, Watsonville Ca 95076
(Management Contacts: Toni Spencer 454-3854, Laura Garnette 454-3866)

What We Do: Together, the HRI team listed above is creating system change resulting in smoother physical and mental health service transitions from the juvenile hall to the community. A record of the team's work is kept in a database, developed for that purpose.

The team of Krystal, Kathleen and Cynthia occupy the "breezeway" offices behind the medical wing of the juvenile hall. Juvenile Hall clinicians Urmila Schmit-Cohen and Mary Caston also play important roles in the initiative.

Probation Officer (Cynthia) - Oversees and contributes to the HRI database, serves as PO for court committed youth, coordinates the completion of case plans for in-custody youth, collects Youth Re-entry Team (YRT) surveys and forwards them to local service providers, assists in preparing reports to the California Endowment.

Certified Application Assistant - CAA (Krystal) - Krystal works through La Manzana, a community base organization located in Watsonville. She maintains an office there and in the Juvenile Hall. Her primary responsibility is to screen youth for health benefits. She will assist with insurance applications to enroll or renew: Medical, Healthy Families, Healthy Kids. She also will provide information and referrals and assist with other applications such as: food stamps, cash-aid, housing, childcare, job applications and SSI.

Health Educator (Kathleen): Provides continuity of care for youth when they leave detention and offers youth in detention and on probation a variety of presentations and classes that enhance their health - mental, emotional and physical.

Kathleen gets referrals from a variety of sources including: Juvenile Hall RNs; other Juvenile Hall Staff; Probation Officers; Children's Mental Health staff; Parents; Youth; helping and Youth Reentry Team surveys. Some of her services have included: making

appointments (dental, eye doctor, primary care, Planned Parenthood, tattoo removal), following up by reminding parents or driving to the appointments, sharing lists of doctors/dentists/specialists who take Medi-Cal or are nearest a youth's neighborhood, helping untangle Medi-Cal and other bureaucratic webs.

New Processes Due to HRI:

- The MAYSI-2 (Massachusetts Youth Survey Instrument) is a 52 item *intake* screen that identifies potential mental health problems in need of immediate attention on 7 scales (Alcohol/Drug Use, Angry-Irritable, Depressed-Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance and Traumatic Experiences)
- Youth Reentry (YRT) Survey: The survey, developed by members of the Youth Reentry Team, is given at *release*. The survey permits youth and their caregivers to identify their need for services by essentially self-referring to local providers. Upon receipt of referral, those local agencies have contact youth and families in 5 - 10 days.
- Technical Assistance: La Piana Associates has been working with the Probation Department and Children's Mental Health through a variety of retreat format to improve communication between the two agencies.