Santa Cruz County

Children & Families Commission

Investing In Our Children

Strategic Plan
December 2000

Acknowledgements

Many individuals and organizations contributed greatly to the development of the first Strategic Plan for the Santa Cruz County Children and Families Commission.

First and foremost, we wish to acknowledge the thousands of parents and families from diverse communities throughout the county who willingly and passionately contributed their time and ideas at every stage of the plan's development. It is heartening to see so many people demonstrate such commitment to investing in the lives of young children and their families.

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SECTION ONE

Who we are

Santa Cruz County
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Who we are...

Proposition 10 Summary

In November 1998, the voters of California passed Proposition 10 establishing The California Children and Families Act. The statewide ballot initiative added a 50-cents-per-pack tax on cigarettes and tobacco products. The revenue must be used to fund education, health and child care programs that promote early childhood development from the prenatal period to age five. Proposition 10 created independent commissions in each California county to distribute funding to local community programs. Proposition 10 is expected to generate statewide $700 million annually, which is distributed to each county based on the number of live births.

State Commission

The California Children and Families Commission is responsible for state-level administration including developing program guidelines, reviewing county plans, and conducting annual program review and evaluation. The seven-member commission also spends twenty percent of the available revenues annually on mass media communications, parent and provider education, childcare, research and administration.

County Commissions

Eighty percent of the available revenues are allocated annually to county commissions. Each five to nine member commission is responsible for developing a strategic plan to guide the expenditure of local Proposition 10 funds. Local planning efforts must be consistent with state guidelines and programs must be reviewed and evaluated annually.

Our Commission

The Santa Cruz County Children and Families Commission was established by the Santa Cruz County Board of Supervisors on December 8, 1998 by urgency ordinance. The Board appointed nine Commission members between January and November 1999. Since then, the Commission has been engaged in an intensive planning process including dozens of community discussions, focus groups, task forces, surveys, analysis of existing data and review of literature on best and promising practices. This Strategic Plan reflects the Commission's commitment to involve community members as well as professionals working with young children and their families.

Santa Cruz County
Children & Families Commission

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Our Vision

The Santa Cruz County Children and Families Commission...

Welcomes Ever Child,

Empowers Families,

Cultivates Community.

Our Mission

To ensure that family-friendly services and education are available so that each child reaches the fifth year of life healthy, ready and able to learn, and emotionally well developed.

Our Values

The Santa Cruz County Children and Families Commission believes that every child is important and unique; families have primary responsibility for their child's healthy growth; the neighborhood and community are partners in supporting families; support must be available, accessible, and diverse; and solutions must be creative and innovative.

The Santa Cruz County Children and Families Commission is guided by the following principles: actions informed by strategic, community-based planning; maximize integration and use of successful resources; emphasis on measurable long-term benefits; and accountability.

Our Challenge

Current research indicates that the social, emotional, physical and intellectual environment that a child experiences during prenatal to five years of age profoundly influences how a child will function in school and later in life. Integrated services, including, but not limited to, health care, quality childcare, parent education and effective programs to prevent abuse and neglect to children at risk, will provide parents and caregivers with the tools necessary to foster secure, healthy, and nurturing environments. The Commission will develop accountability and performance measurements to ensure that the desired outcomes for early childhood are achieved.

Our Community Goals

Healthy Children

Children who are healthy in mind, body and spirit grow up confident in their ability to live a fulfilling, productive life. Healthy children have sufficient nutrition, health care, nurturing and guidance, mental stimulation and they live in communities that value them. The research on child development and the impact of the early years emphasizes the importance of children beginning life with healthy nutrition and healthy environments.

Strong Families

Successful and strong families are those that are able to provide for the physical, mental and emotional development of their children. Young children are entirely dependent upon caregivers for survival and nurturing. It is the interaction of the parent or primary caregiver with the child that shapes the child's self-view as an individual capable of interacting with the world and achieving desired outcomes from that interaction. Parents and caregivers provide the foundation for a child's ability to create successful relationships, solve problems and carry out responsibilities. Children who are encouraged to develop a strong self-concept from an early age are more likely to achieve a productive and fulfilling life.

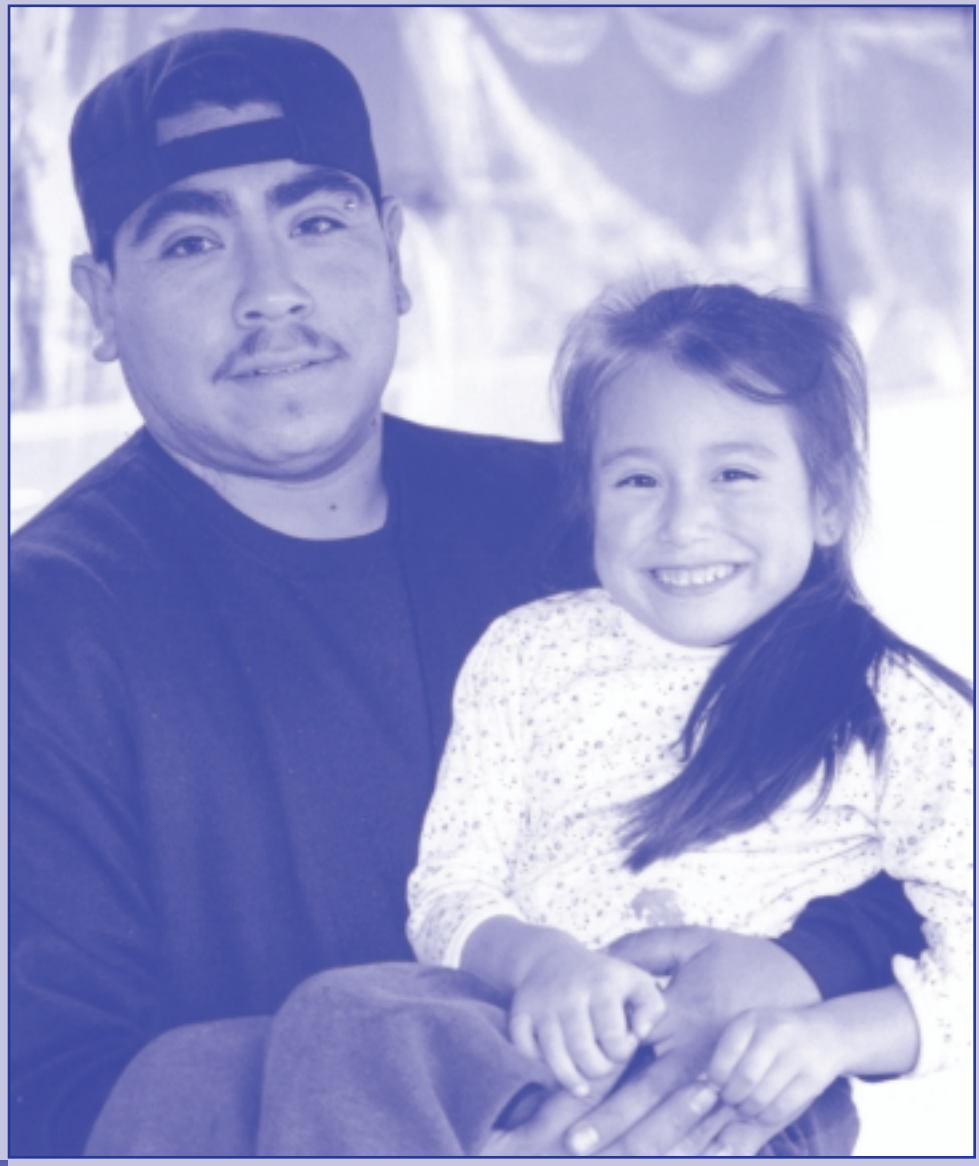
School Ready Children

The importance of preparing children to succeed in school is critical. The role of education is vital to a child's later ability to create a healthy, fulfilling life. Skills that allow a child to problem solve and think creatively are developed in early childhood education settings and nurtured through community and parental reinforcement. The National Association of Elementary School Principals has stated that "better childhoods" would be the single greatest contributor to improvement in school achievement.

These community goals are interrelated and the promising strategies, programs and services selected to achieve them should also be interrelated. The domains they encompass —prenatal care, child health, preschool education, child care, family support, parent education and community building—should form a coherent whole that can be sustained over time and will produce widely valued outcomes for young children and their families.

SECTION TWO

How we gathered the information and what we learned



Santa Cruz County
Children & Families Commission
Investing In Our Children

How we gathered the information and what we learned

Background

The Santa Cruz County Children and Families Commission is fortunate to have a wealth of current information sources and existing plans in place. The Commission is dedicated to building upon existing community efforts. Additionally, the Commission regularly invites community groups and projects to present their work to facilitate communication and avoid duplication of effort.

Children and Families: A Santa Cruz County Profile

Santa Cruz County is a mountainous central coast county on the Monterey Bay in California. Geographically, it is the second smallest county in the state, covering 440 square miles. With an estimated total population of 251,475, there are 21,745 children under the age of six. Of these children, 10,353 are white and 10,423 are Latino. Twenty two percent of the children ages 4 and younger live in poverty.

Although most county residents are white (approximately 75%), the largest and fastest growing ethnic group is Latino, representing 23% of the population. While the majority of Latinos live in Watsonville, there are smaller pockets of Latino neighborhoods, including the Beach Flats area of Santa Cruz City, the Live Oak area in the unincorporated area of central Santa Cruz County, the agricultural area along the north coast and in the town of Davenport. While families of Latino origin make up 23% of the population, they comprise about 36% of those living at or below the poverty level. Of the 24,400 people who received services from the local food bank system last year, over half were Latinos. Many Latino parents are employed as farm workers (estimated at more than 15,000), who work long hours, and receive low pay and minimal or no health benefits during the picking season. During the off season, workers must either compete for other low paying jobs, apply for unemployment (many of whom are not eligible because of residency status), or temporarily leave the area in search of field work in other counties or states.

The two major cities are Santa Cruz in the north, a popular seaside resort that attracts thousands of tourists every year, and Watsonville in the southernmost area of the county, which is the center of the county's agricultural economy. Other incorporated areas include the cities of Scotts Valley and Capitola. Unincorporated areas under the jurisdiction of the County include: the mid-county cities and outlying communities, the northern coastal area, including the town of Davenport, and the small, rural towns of the wooded and mountainous San Lorenzo Valley.

The principal industries are agriculture and tourism. Residents are also employed in the service sector and the computer/electronic industries. As many as 25,000 of the higher income residents of the county commute over the Santa Cruz Mountains to Silicon Valley to work. The county's unemployment rate is higher than the statewide average of 5.9%. The city of Santa Cruz's rate is 5.5%, while Watsonville in the Pajaro Valley in South County is considerably higher at 13.2%. Of the 10 least affordable housing areas in the nation, Santa Cruz County ranks as the second least affordable area of the country. Rent for a two-bedroom unit is about $1,000 to $1200 a month, more than a single mother with two children can receive through TANF (formerly AFDC/Welfare). Although there were about 5,850 government financed and non-profit assisted housing units filled in 1999, there was and continues to be a long waiting list of applicants for these programs.

Although the extent of homelessness in the county is not really known, almost 4% of county residents stated that they had been homeless, staying at a shelter or living on the streets within the last five years, based on the 1999 random telephone survey of the Community Assessment Project of 558 respondents. Last year, the County's Homeless Persons Health Project served over 600 women of childbearing age, children and teens. Homeless women and children are the most vulnerable in terms of health and mental health, hunger, and economic and social stability, and have a difficult time connecting with needed services.

Infant mortality rates and low birth weight rates are very low in Santa Cruz County and have consistently remained at or below the average in the state for many years. They reach or surpass The Healthy People 2000 goals. Continued surveillance and publication of these indicators are important to ensure discovery of any disparities among mother's age, ethnicity, or source of payment for care, as currently these factors do not show disparities in low birth weights. The 1998 birth certificate analysis shows entry to prenatal care is quite high in Santa Cruz county (84%), but it still does not meet Year 2000 goal of 90%. This indicator shows disparities for teens (73.8%), Latinas (77%), and for the Medi-Cal funded births (73%). Trends in this indicator show improvement over the past four years. Reporting of "No prenatal care obtained" also remains very low in 1998 (under 1% of births), and the ability to study these few births individually if needed remains quite possible. Of the women who reported having no prenatal care, most lived in Watsonville. This is a significant disparity to be monitored closely.

The breastfeeding rate at hospital discharge in 1997 was 62% in Santa Cruz County, according to data from State data sources. This does not meet the 75% goal, nor are the rates for 6 months post-partum available. This health indicator needs updated data and local attention. Santa Cruz County has a strong and visible Nursing Mother's Council and La Leche League. Together with County Health Services, the Well Infants and

Children Program, the Central Coast Alliance for Health and other health professionals and advocates, they have established a Breastfeeding Coalition. First steps have been taken by the coalition to study this indicator and survey new mothers from 4 weeks to 6 months post-partum, then plan and recommend promotional activities, according to the need. In a 1999 study by the Santa Cruz County Breastfeeding Coalition, Hispanic mothers reported significantly lower breast feeding initiation rates than Caucasian mothers (50% compared to 80%). By six months post-partum, close to 75% of Hispanic mothers surveyed had discontinued breastfeeding. While more data is needed, breast feeding advocates agree that a large number of pregnant and postpartum mothers in Santa Cruz County are not getting the information and support needed to breastfeed their infants successfully.

Dental disease, especially for the low-income population, is thought to be the number one health problem for children in Santa Cruz County by all anecdotal sources. However, finding hard facts and reliable data to support this claim is no easy matter. CHDP PM 160 data show increasing numbers of dental conditions identified over the past several years, but the small 6% of children identified by CHDP providers as needing a referral for care is not representative of the problem among this population. Other data sources, such as the Dientes! Community Clinic sampling screening of 500 students at a south county elementary school, revealed 60% of the children needing some kind of dental care (10% of these were urgent, with abscessed teeth and 30% were moderate problems, such as large cavities). This shows the most severe picture of the problem. Only 72% of Community Assessment Project (CAP) respondents indicated that they had a regular source of dental care. The picture is further enhanced by the fact that inadequate resources for care for low-income children (with or without Medi-Cal) exist in the county.

In terms of immunizations, Santa Cruz County has one of the highest rates in the state for personal belief exemption for immunizations (IZ's) at school entry. In 1998, the county also had one of the highest rates of Pertussis disease reported in the state. The age two years up-to-date on IZ's rate was 63% in 1998, and although the rate has been gradually improving over the last five years, this problem needs constant and energetic attention. As the numbers and types of IZ's recommended and required increases, so does the public and providers' confusion and omission rate.

The extent and severity of child abuse and neglect in Santa Cruz County is not clear. A change in the way the calls are counted from 1996 to 1997 made comparison by year difficult. But the fact that 2332 cases were reported in 1997 gives this community enough concern to invest in multiple prevention efforts. The community has a low tolerance for this problem, and has joined in collaborative efforts at treatment and prevention. The data sets and benchmarks are high on the list for clarification and revision.

Childhood nutrition practices (including breastfeeding) have come to public attention through the Community Assessment Project publication of obesity and anemia data from the "Pediatric Nutrition Surveillance." The data is not easily analyzed, yet points out the need to focus attention in this area. Certainly, continued surveillance and increased education efforts can be placed on this issue through the many existing and emerging early intervention and parenting programs. Childhood injury and death rates in Santa Cruz County are very low and represent very small numbers. Case by case monitoring via the Child Death Review Team meetings ensure appropriate attention to control and prevention of these problems.

Although birth certificate data shows the overall county rate of births to teens to be below the average in the state, there continues to be areas in Watsonville where teen births are relatively high. In 1998, the overall percentage of births to teens in the county was at 10.8 % of the total births, but Watsonville had a 16% rate. Surveillance over the years shows decreasing trends countywide since 1995, but constant attention in Watsonville needs to be maintained.

Data Gathering and Review of Existing Plans

The strategic planning process included the following key elements.

Review of Best Practices and Existing Planning Efforts

The Commission gathered information about programs, services and resources currently available. The Commission built on existing community efforts, including the United Way's Community Assessment Project which annually measures the quality of life in Santa Cruz County, Success By Six planning efforts, the Santa Cruz County Child Care Planning Council's Needs Assessment, Investing in Children and Families: What Works! and other projects.

Additionally, the Commission adopted the *Investing in Children and Families: What Works!* Model of Common Definitions to be part of a countywide effort to use consistent definitions in human services. The goal of *What Works!* is to identify and support effective strategies, services and activities for keeping children safe in their families and communities, in order to improve the health and well being of children in Santa Cruz County. What Works! is using a results based accountability model. They are agreeing on common definitions, identifying community wide indicators of children's safety, and working with funders, service providers, and the overall community to understand how to identify what works and how to measure its impact.

Community Needs and Resources Review

The Commission thoroughly reviewed the Success By Six Plan which is focused on increasing community services and incorporating a cross-disciplinary approach for all children 0 to 6 years old. The Success By Six Planning Committee coordinated with other existing collaborations dedicated to achieving healthy outcomes for children and families including The Santa Cruz County Children's Network, Santa Cruz County Child Care Planning Council, Family Resource Center Network and the Children's Commission. The Commission adopted the work contained in the Success By Six Plan as the foundation for the strategic plan as it identified the needs, current assets and resources for young children and their families.

Specialized Task Forces

The Commission convened task forces in the following three subject areas:

- Family and Child Health
- Family Supportive Services
- Child Care and School Readiness

Professionals in each of the three task forces were charged with the following three tasks.

- Review existing strategies, programs and services
- Identify unmet needs in the community
- Identify promising strategies, programs, services and activities to meet unmet needs

(The results of the Task Forces findings are included in Appendix A)

Community Outreach and Involvement

The Commission was one of eight counties in the state of California to participate in a pilot project known as the Civic Engagement Project. The Civic Engagement Project is a collaboration of six foundation sponsors interested in supporting strategies to engage a diverse public with the issues facing young children and their families. The project encourages a civic dialogue at the local level that impacts public policy decisions made by the Commission in a tangible and timely way.

The Civic Engagement Project complemented the Commission's activities by broadening the reach of public input, stimulating participation from people who would not typically be involved, and linking different people and perspectives for ongoing support of young children and their families.

Over 2000 community members representing diverse ethnic, gender, age, socio-economic and professional characteristics, life experiences and interests participated in this initial strategic planning process. The Commission is committed to continuing open communication with the community to ensure their participation, feedback, and suggestions for creating family-friendly and responsive service systems.

There were a variety of opportunities for involvement as follows:

- A twenty member Civic Engagement Committee of community members
- Telephone surveys to 400 households in Santa Cruz County
- The public comment process at meetings of the Commission
- Intensive grass roots outreach to isolated communities and populations
- Ten regional community forums throughout the county
- Parent/guardian community surveys conducted with nearly 2,400 parents
- Intercept interviews/face-to-face information sharing with community outreach workers
- Community presentations with varied interest groups

(A summary of the parent/guardian survey is included in Appendix B)

SECTION THREE

What we are going to do

Santa Cruz County
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What we are going to do

Strategic Results and an Accountability Framework

All of the data gathering, review of existing planning efforts, commnity needs and resources review, specialized task forces, and community outreach and involvement provided the foundation for defining the community level indicators, measurable client outcomes, and promising strategies.

The community goals, indicators, outcomes and strategies have been developed in response to the needs of young children and their families identified though the participation of parents and guardians, families, as well as professionals working with children and families throughout Santa Cruz County.

The Santa Cruz County Children and Families Commission has selected specific community level indicators in each of the three major focus areas: Healthy Children, Strong Families, and School Ready Children. While there are numerous individual strategies designed to achieve the outcomes and meet the community goals, the over-arching concept is to develop an integrated, coordinated, family-friendly system of health, family support and early education services.

Such services will augment, not supplant existing programs. Investments will be made to develop an effective system for analyzing program results that are supported by verifiable outcome data. The strategies presented include a commitment to performance measurement and program evaluation. The Commission is committed to working with the community to provide training and technical assistance to grantees.

The following are the common definitions adopted by the Commission and other funders in Santa Cruz County in working towards a results based accountability framework.

Common Definitions

Term	Definition	Examples
Community Goal	A condition of well-being	Children 0-5 are healthy
Community Indicator	A measure that helps to quantify the achievement of the goal	Percent of early and adequate prenatal care Percent of children enrolled in health and dental insurance Teen birth rate
Strategy	A general approach to achieve the goal	Client-centered Home-based Center-based School-based
Program	An organization or a defined part of an organization that implements one or more strategies through its services/activities	XYZ Parent Center XYZ Healthy Start XYZ Community Clinic
Service/Activity	A specific tactic used by a program in partial implementation of a strategy. Many programs use multiple services/strategies.	Intensive case management Home visiting
Client Outcome Objectives	A specific, measurable statement of the service's intended effect on a client's knowledge, attitude, condition and behavior.	Improvement in parent functioning Teens will show increased knowledge around family planning/birth control
Method of Measurement	A specific, identified data source that measures the indicator or the program outcome objective	Pre and post assessment of parent skills County health department live birth statistics

Healthy Children

Community Goal and Community Level Indicators	Desired Child (Client) Outcome	Promising Strategies, Programs and Services
Children are born healthy ✷ Percent of women receiving early and adequate prenatal care ✷ Rate of alcohol and drug exposed infants at birth ✷ Teen birth rate **Children remain healthy** ✷ Percent of children who have healthcare coverage ✷ Percent of children who have ongoing source of comprehensive care/a medical home and utilize this care ✷ Percent of two year old children who are fully immunized ✷ Percent of children who have dental care coverage ✷ Percent of children who have an ongoing source of comprehensive dental care and utilize this care ✷ Percent of children with anemia (nutritious diet) ✷ Rate of children hospitalized for asthma ✷ Rate of emergency and urgent care utilization for children for non-injury related illnesses ✷ Rate of obese children ✷ Percent of children exposed to second hand smoke ✷ Percent of women who initiated breast feeding at birth and continued at 6 and 12 months ✷ Percent of children accessing needed mental health and developmental supports	Increased numbers of children will have a medical home and early detection screening	**Integrated Systems and Comprehensive Care** ✷ A health and social services care management system for children and a clearinghouse for their families and health care provider
	Increased access to primary health care (prenatal, natal, post natal care) for children including mental health and developmental supports	**Benefits Outreach and Advocacy** ✷ Benefits advocacy in every community clinic and access to benefits advocacy for private care providers ✷ Outreach and streamlined enrollment and re-enrollment in Healthy Families, MediCal, CCS and other insurance programs
	Increased number of children under age 2 who are fully immunized on time	**Immunization Registry** ✷ Immunization registry with capacity for referrals to multiple providers ✷ Free or low cost immunizations, with information link back to primary care/multiple providers
	Improved parents access to health information Improved health status for high-risk infants	**Home Visitation** ✷ Para-professional home visiting program and multi-disciplinary team consultation ✷ In-home Nursing Support Program for high risk infants ✷ Early detection screening program
	Improved dental status for children	**Comprehensive Dental Care** ✷ Comprehensive dental treatment services ✷ Funded premiums for dental insurance ✷ Parent and child education regarding dental care ✷ Water fluoridation
	Increased number of children living in homes free of alcohol and drug abuse	**Drug and Alcohol Screening** ✷ Expanded drug and alcohol treatment for parents/guardians of children 0-5
	Improved physical fitness for children	**Physical Fitness** ✷ Physical fitness and nutrition activities related to obesity
	Increased number of well nourished infants and children	**Nutrition** ✷ Breastfeeding promotion, education and training for families, health providers and workplaces
	Increased number of children living in smoke free homes	**Smoking Cessation** ✷ Support and promotion of smoking cessation and secondhand smoke programs

School Ready Children

Community Goal and Community Level Indicators

Children Have Accessible and High Quality Child Care

- Percent of child care providers who receive adequate training and technical support to provide high quality care for children
- Percent of preschool and child care slots available
- Percent of children 0-2 years of age enrolled in high quality preschool and child care programs
- Percent of children 2-5 years of age enrolled in high quality preschool and child care programs
- Percent of children who are adequately screened on a periodic basis for developmental delays or behavioral/emotional disorders and who receive required treatment and supports
- Percent of parents/families reading to their children on a regular basis
- Percent of children demonstrating early literacy skills
- Kindergarten attendance rate
- Percent of children who are not promoted to the first grade
- Average number of hours per week of television watched by children

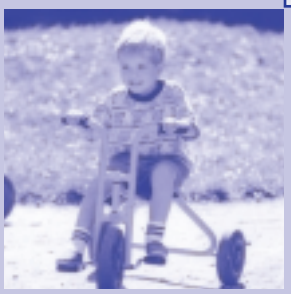
Desired Child (Client) Outcome	Promising Strategies, Programs and Services
Increased number of children experience high quality child care	**Highly Qualified Child Development Workforce** ✷ Menu of financial incentives such as stipends, scholarships, health insurance or retirement benefits for child care providers to retain and enhance a quality workforce ✷ On-site training, mentoring and technical assistance to child care providers ✷ Professional substitute pool available to child care providers ✷ Menu of financial incentives for child care providers who increase and maintain the number of infants and toddler spaces
Increased number of children arriving at Kindergarten having developed a broad range of literacy skills	**Literacy** ✷ Comprehensive literacy development programs in association with libraries ✷ Language arts training program offered to all child care providers ✷ Teacher training and appropriate materials to teach literacy skills to preschool children ✷ Book distribution system and parent education program in locations where parents take their children, such as clinics ✷ Revolving book and educational toy delivery system ✷ Activities/programs to transition preschoolers to kindergarten
Increased number of parents who are seeking child care, and those who are eligible for subsidies, will be aware of the full range of options available to them and will understand how to successfully access the subsidies	**Parent Outreach** ✷ Marketing and outreach strategies to inform parents of program/service availability with respect to childcare ✷ Streamlined application process
Improved functioning of children with emotional and behavioral problems	**Mobile Development Screening/Mental Health Teams** ✷ Mobile mental health teams that can conduct on-site assessments and screenings
Increased number of children in informal childcare receiving high quality and safe care	**Expanded Licensed Child Care and Kinship Care Support** ✷ Services to support informal child care providers and kinship care situations ✷ Encourage unlicensed care providers to become licensed ✷ Training opportunities and classes for informal child care providers
Increased number of parents becoming successful advocates for their children's education Increased access to and subsidies for child care for low income/working families	**Parent Education** ✷ Training and education to parents so that they advocate effectively on their children's behalf ✷ Parent support, programs, information and advocacy for parent groups

Strong Families

Community Goal and Community Level Indicators	Desired Child (Client) Outcome	Promising Strategies, Programs and Services
Children Live in Safe and Supportive Environments ✷ Percent of children living at 250% of poverty level by age six ✷ Percent of child support paid ✷ Rate of children with petitions filed by court for child abuse and neglect ✷ Rate of hospitalizations due to unintentional and intentional injuries ✷ Percent of parents of children enrolled in parenting programs/classes ✷ Rate of exposure to alcohol and drug abuse ✷ Rate of exposure to domestic violence	Increased number of parents will have information about programs and services for their children and families Improved functioning of children with emotional and behavioral problems	**Family Resource Centers** ✷ Family resource centers with mobile services ✷ Countywide, coordinated information and referral services ✷ Parenting support and education programs ✷ Web based access to information related to family needs ✷ "Welcome Baby Kits" for all newborns and their families **Mobile Development Screening/ Memtal Health Teams** ✷ Mobile mental health teams that can conduct on-site assessments and screenings
	Increased number of parents with English language literacy Increased number of families with higher income	**Literacy** ✷ English literacy programs linked to child care settings and family resource centers
	Increased number of parents with better parenting skills	**Home Visitation and Parent Education** ✷ Para-professional home visiting program ✷ Parenting support groups and education programs
	Increased number of children with special needs will have access to the services they are entitled to by law	**Parent Support Groups** ✷ Parent information, advocacy and support groups for special needs children
	Increased number of children in out-of-home placement will live in high quality foster care homes	**Foster Parent Training** ✷ Foster parent training and supportive services
	Increased number of children living in violence free homes	**Domestic Violence Parenting Education** ✷ Parenting education for all family members ✷ Family counseling programs
	Increased number of children receiving their court ordered child support	**Child Support Programs** ✷ Programs to receive court ordered child support

SECTION FOUR

How the funds will be spent



Santa Cruz County
Children & Families Commission
Investing In Our Children

How the funds will be spent

Introduction

The Santa Cruz County Children and Families Commission will receive an estimated $3.7 million annually from revenues generated by Proposition 10. The tax on tobacco products took effect on January 1, 1999 and revenues have been accruing since that time.

Proposition 10 funding presents the community with a unique opportunity for improving the well-being of children, prenatal to five years of age, and their families.

The community goals, indicators, outcomes and strategies have been developed in response to needs of young children and their families identified though the participation of parents/ guardians, families, as well as professionals working with children and families throughout Santa Cruz County.

The Commission recognizes, however, that the funds provided by Proposition 10 are not sufficient to fund every program described in this Strategic Plan. They constitute an ambitious agenda among which priorities must be determined and invested within the community in order to have the greatest impact on children and their families.

Funding Principles

As required by the initiative passed by the voters of California, Proposition 10 funding will not be used to supplant current expenditures. Rather, funding will be used to supplement, enhance or fund new programs, services and infrastructure needed to create a family-friendly, comprehensive and integrated system of early childhood development programs. To the maximum extent possible, Proposition 10 funding will be used to leverage local, state, federal and private funding to meet the goals of the strategic plan. The Commission's funding decisions will also be guided by the following principles:

CREATE STRATEGIC IMPACT by funding programs and activities that support the goals in the strategic plan, show evidence of effectiveness, and need Proposition funding in order to meet those goals.

PROMOTE INCLUSION by funding programs and activities that are responsive to, and reflective of, the needs of our diverse community and have been shaped by community participation and collaborative efforts.

LEVERAGE RESOURCES by funding programs and activities that broaden the number and range of funding opportunities for children prenatal to age five and their families.

MOVE TOWARD SERVICE INTEGRATION by funding programs and activities that reduce fragmentation of existing services, make services more accessible and comprehensive, and support shared decision-making and resources among partners who need each other to succeed.

BUILD ON STRENGTHS AND BUILD CAPACITY by funding programs and activities that identify and enhance existing community strengths.

Guidelines for Distribution

The Commission will achieve its goals through a variety of funding mechanisms including a Request for Applications (RFA), mini-grants, and contracts for products and services.

- Funding will be reflective of the needs identified in the strategic plan.
- Funding in each of the three community goal areas of Healthy Children, Strong Families and School Ready Children will be equally considered.
- Request for Applications (RFA) will provide a competitive granting process that strongly encourages service integration, outcomes measurement and clearly defines the services to be provided to children prenatal to age five and their families.

Allocation of Resources

The Commission will allocate approximately the same amount each year that it receives in that twelve-month period (approximately $3,700,000 a year). All funding decisions will be made by the Commission, the final decision making body.

The Commission will allocate approximately one million dollars in each of the three major goal areas: Healthy Children, Strong Families, and School Ready Children. The majority of Proposition 10 funding will be distributed within these respective areas. Further, the Commission recognizes the need to invest in training and outcome measurement assistance to grantees, integrated service systems for families, community participation activities, special/one-time-only projects, capital improvements, and Commission operations. Overall, the Commission recognizes the need to be flexible in both its grant making and its resource allocation to best meet the needs of the community.

Allocation of Resources

Estimated Total Revenue through March 31, 2001	**$ 8,228,000**
Estimated Total Expenses through March 31, 2001	**$ 317,000**

Annual Allocation of Resources

Twelve Month Period Beginning April 1, 2001

GRANTS

Healthy Children		
Grants over $10,000	$	970,000
Mini-Grants ($100-$10,000)	$	30,000
	$	**1,000,000**
Strong Families		
Grants over $10,000	$	970,000
Mini-Grants ($100-$10,000)	$	30,000
	$	**1,000,000**
Children Learning and Ready For School		
Grants over $10,000	$	970,000
Mini-Grants ($100-$10,000)	$	30,000
	$	**1,000,000**

Training and Outcome Measurement Assistance to Grantees	$	100,000
Integrated Systems for Families	$	281,000
Community Participation (Civic Engagement)	$	28,000
Commission Operations	$	302,000
	$	**3,711,000**

Special Project and Capital Improvements Funding	$1,500,000
Available for Future Grant Making and Commission Operations from Revenues Accumulated through March 31, 2001	$2,700,000

SECTION FIVE

How we will know if we have met our community goals

Santa Cruz County
Children & Families Commission
Investing In Our Children

How we will know if we have met our community goals

Community Goals and Community Level Indicators

The Santa Cruz County Children and Families Commission has selected three community goals: healthy children, strong families and school-ready children. The Commission has further identified thirty-one community level indicators to chart progress over time in the achievement of these three community goals.

The Commission will collaborate with the Community Assessment Project (CAP) of Santa Cruz County for the annual measurement of progress toward the community indicators selected by the Commission. The CAP has annually measured community indicators and community goal achievement for the past six years.

The Commission will publish an annual Children's Report Card which will record the progress over time of the selected community indicators of child health and well-being, as well as other related child and family indicators that are currently being monitored by the CAP.

Client Outcomes

Each of the grantees receiving Children and Families Commission funding will identify and measure the client outcomes their program is seeking to achieve. A client outcome is defined as the service's intended effect on the client's knowledge, attitude, condition or behavior. Grantees will receive, at no cost, training and technical assistance in identifying and measuring their client outcomes. The Commission, in collaboration with other funders of health and human services in Santa Cruz County, will provide ongoing resources for the grantees' program evaluation, using the Results Based Accountability framework.

Improvements Over Time

Both the community level indicators and the client outcome results will be valuable sources of information to the Commission in evaluating the impact of its investments over time and will inform the Commission for future years' strategic planning and grantmaking.

SECTION SIX

Appendix A Task — Force Reports

Santa Cruz County
Children & Families Commission
Investing In Our Children

Appendix

A

Task Force Reports

Report to the Santa Cruz County Children and Families Commission

from the Family and Child Health Task Force
September 2000

Introduction

The Family and Child Health Task Force met four times in May and June 2000.

The Task Force engaged in presentations and discussions on the following health issues: immunizations, nutrition, substance abuse prevention and treatment, children with special health needs, mental health, dental health, health insurance, pediatric care, peri-natal care and smoking cessation.

Participant Members

Members of the Task Forces were Christine Albecht, Nursing Mother's Council; Norene Bailey, HSA-Child Health & Disability Prevention Program; Jay Balzar, Dientes Community Dental Clinic; Celia Barry, Tobacco Education Coalition; Cathy Cavanaugh, Food and Nutrition Services Inc., WIC Program; Dane Cervine, HSA-Children's Mental Health; Karen Ehlrich, Santa Cruz Midwives; Willy Elliot McCrea, Second Harvest Food Bank; Lee Fitzsimmons, All Kids By Two; Donna Hancock, Santa Cruz Montessori School; Linda Kerner, All Kids By Two; Bill Manov, HSA-Drug and Alcohol Program; Laura Maxson, Birth Network; Betsy McCarty, HSA-Public Health; Lynn McKibbin, HSA; Charles Moody, Community Volunteer; Sister Michaella Siplak, Dominican Hospital; Molly Savitz, Nurse Practitioner-Dominican Hospital; Teri Smith, Food and Nutrition Services, Inc., WIC Program; and Deborah Wechsler, Special Parents Information Network.

Process

The Task Force reviewed existing plans, reports and research; they identified unmet needs and recommended promising strategies, programs, services and activities to meet the unmet needs. Their recommendations for the Santa Cruz County Children and Families Commission's consideration in developing the Strategic Plan and funding priorities for the Proposition 10 tobacco tax funds are listed in this report. These recommendations represent a consensus of all participating members. The recommendations are not in priority order; the Task Force did not engage in a priority setting process.

I. Childhood Immunization Rates in Santa Cruz County

In Santa Cruz County, only 68% of children under two years of age are up-to-date with their childhood immunizations and fully protected against several serious childhood illnesses. Children under two are the most vulnerable to hospitalization and death from vaccine-preventable diseases. The following statistics show how these low immunization rates impact the county:

Vaccine Preventable Disease	Confirmed Cases 1998	Confirmed Cases 1999	Confirmed Cases May, 2000
Pertussis	76	54*	9
Measles		6	4***
Meningitis		1**	

* 1/3 of the Pertussis cases were in children under 5 years of age, not up-to-date with DTaP immunizations. Several infants were hospitalized.

** Caused by Haemophilus Influenza b. This was the first local case in 2 years. This was a common illness prior to introduction of Hib vaccine.

*** Santa Cruz County leads the state in the number of confirmed measles cases, reporting 50% of all measles cases reported in California so far this year.

These illnesses are preventable if children are current with their shots. The challenge is to "find" those children who are not up-to-date, identify barriers, and develop strategies to ensure that all Santa Cruz County children are fully protected against childhood vaccine preventable diseases.

Unmet Needs

There is limited access to immunization services for working parents. It is often difficult for parents to take time off work to bring their children to the doctor for childhood immunizations. Some providers have evening or Saturday office hours, but most do not.

There is a lack of knowledge about the availability of low cost immunization services. Although immunizations are available at no cost to families who cannot afford to pay for them, many parents do not know where low cost or no cost immunization services are provided in Santa Cruz County.

Additional Cost-Related Barriers

Insured families with office visit co-pays often experience additional charges for shots.

- There are families with health insurance who don't take their children to the doctor because they cannot afford the office visit co-payments required by their health plans. In addition, some families are charged a fee for each shot their child receives.

- There is an underenrollment of eligible families in the Healthy Families Program. Although Santa Cruz County has enrolled over 2,176 families in the Healthy Families Insurance Program; there are still many eligible families who are not enrolled and not accessing available health care services for their children.

Parent Education

More parent education related to childhood immunizations is needed to address the following issues:

- Many parents don't know how many shots their children need to be up-to-date

- Because immunizations have greatly decreased the incidence of vaccine preventable diseases, there is a degree of complacency about the need to "immunize – on time," "every time" and parents may not view childhood immunizations as a priority.

- Myths and misinformation about immunizations abound and there must be accurate information available to respond to unfounded statements about vaccine safety and, the risks versus benefits of childhood immunizations.

Immunization Registry

- Santa Cruz County has no centralized data source and computerized immunization tracking system for children's immunization records. Computerized tracking systems can automatically remind parents and providers when immunizations are due. Lack of access to immunization information results in "missed opportunities" which occur when parents bring their children to the doctor for minor illnesses and the child's immunization record is not reviewed to see if the child is due for another shot at that time. Lack of access to immunization information also leads to needless and costly duplicate immunizations.

Recommended Strategies, Services, Programs and Activities

- **Develop a Computerized Immunization Registry for Santa Cruz County.**
  The Centers for Disease Control and Prevention (CDC) strongly promotes registries as key to raising immunization coverage. In addition, Healthy People 2010 established a goal of enrolling 95% of children from birth through age 5 in a fully functioning immunization registry. Registries benefit children, parents, doctors and nurses, health plans, schools and communities. Experience in other parts of the United States has shown that immunization registries can raise immunization levels by 25%. Based on this information, if Santa Cruz County had an immunization registry, our county could exceed the national goal of 90% of all two year olds up-to-date with their immunizations.

Primary Functions of an Immunization Registry would include:

- Maintain accurate immunization histories of children.
- Provide rapid access to immunization data by providers.
- Determine when immunizations are due.
- Notify providers and parents when children are due for shots.
- Assess current levels of immunization coverage.

Benefits to Parents

- Readily available immunization records for childcare and school entry.
- Reminders to assist in keeping their children on schedule for shots.
- Reduced costs due to unnecessary duplicate immunizations.

Benefits to Children

- Avoid needless suffering by protecting them from vaccine preventable illnesses.

Benefits to Community

- Protecting the health of young children promotes healthier communities.

All Kids By Two Immunization Coalition plans to implement the following activities to address unmet needs related to childhood immunizations. These activities are supported by grant funds received by All Kids By Two Immunization Coalition:

Expand Access to Immunization Services

AKT plans to implement the following activities to expand/improve access to immunization services:

- School-based Immunization Clinics.
- Immunization Clinics at WIC sites.
- Weekend and evening hours community-based clinics.

Address Cost Barriers

- Coordinate immunization clinics with Healthy Families Insurance Assistors to enroll eligible families in the Healthy Families Program and improve access to health care for their children. Promote the availability of low cost immunization services available in the County.

Increase Parent and Provider Education

AKT Parent Education activities will include:

- Increase outreach efforts by participation in community events and health fairs to inform and educate parents about childhood immunizations.
- Distribute immunization parent education resources to programs in the county serving families with young children.
- Increase collaboration with programs serving families to promote childhood immunizations (i.e. CHDP, HRA Cal Works & Day Care Licensing, Child Development Resource Center, and the WIC Program.)

AKT Health Care Provider Education activities will include:

- Distribute Health Care Provider Resource Packets with tools and tips to providers to reduce "missed opportunities" in their practice.
- Assist providers in assessing their immunization practices by use of a "Self –Assessment Tool for Immunization".

II. Nutrition
Breastfeeding Support

Unmet Needs

According to a 1999 survey conducted by the Breastfeeding Coalition of Santa Cruz County, on "Infant Feeding Practices Among Postpartum Women in Santa Cruz County," women who delivered at Watsonville Community Hospital breastfed their babies for significantly less time than women who delivered at Sutter Maternity and Surgery Center or Dominican Hospital. It is significant that both Sutter Maternity Center and Dominican Hospital provides breastfeeding support services, whereas, there are no such services in south Santa Cruz County. Breast feeding support is vital for encouraging women to breastfeed.

The Breastfeeding Promotion Committee's Report to the California Department of Health Services "Importance of Breastfeeding" documents why breastfeeding is an important health issue for children:

Human milk is uniquely suited for human infants. Human milk is easy to digest and contains all the nutrients that babies need in the early months of life. Breast milk construct contains factors that helps infants grow and mature. Factors in breast milk protect infants from a wide variety of illnesses. Breast milk contains antibodies specific to illnesses encountered by each mother and baby. Fatty acids, unique to human milk, may play a role in infant brain and visual development. In several large studies, children who have been breastfed had a small advantage over those who have been artificially fed when given a variety of cognitive and neurological tests, including measures of IQ.

Breastfeeding saves lives. Lack of breastfeeding is a risk factor for Sudden Infant Death Syndrome (SIDS). Human milk may protect premature infants from life threatening gastrointestinal disease. Breastfeeding infants are healthier. Infants who are exclusively breastfed for at least 4 months are half as likely as artificially (milk or milk substitute other than mothers' milk) fed infants to have ear infections in the first year of life. Breastfeeding reduces the incidence and lessens the severity of bacterial infections such as meningitis, and lower respiratory infections in infants. Breastfeeding is protective against infant botulism. Evidence suggests that exclusive breastfeeding for at least two months protects susceptible children from Type 1 insulin dependent diabetes mellitus (IDDM). Breastfeeding may reduce the risk for subsequent inflammatory bowel disease and childhood lymphoma. Breastfed infants are less likely to have diarrhea. Women who were breastfed as a child are less likely to develop multiple sclerosis. Breastfeeding helps mothers recover from childbirth. Breastfeeding helps the uterus shrink to its pre-pregnancy state and reduced blood lost after delivery. Mothers who breast feed for at least three months may lose more weight than bottle-feeding mothers. Breastfeeding mothers usually resume their menstrual cycle 20 to 30 weeks later than bottle-feeding moms.

Breast feeding keeps women healthier throughout their lives. Breastfeeding can be an important factor in child spacing among women who do not use contraceptives. Breastfeeding reduces the risk of breast and ovarian cancer. Breastfeeding may reduce the risk of osteoporosis. During lactation, total cholesterol, LDL cholesterol, and triglyceride levels decline while the beneficial HDL cholesterol level remains high.

Breast feeding is economical. The cost of artificial milk has increased 150 percent since the 1980s. If no California infants were breastfed, the cost of artificial baby milk would exceed $400 million per year. Breastfeeding reduces health care costs.

Breast feeding is environmentally sound. Unlike artificial baby milk, breastfeeding requires no fossil fuels for its manufacturing or preparation. Breastfeeding reduces pollutants created as by-products during the manufacture of plastics and artificial baby milk. Breastfeeding reduces the burden on our landfills."

Recommended Strategies, Programs, Services, and Activities

- Incorporate breastfeeding education into childbirth preparation and other appropriate classes offered to members.
- Provide breastfeeding education and training, including resource materials, to perinatal pediatric and primary care providers to support the breastfeeding mother and child.
- Incorporate breastfeeding and lactation management into health assessment tools, protocols and practice guidelines.
- Include breastfeeding as part of individual, group and community needs assessments. Provide culturally appropriate breastfeeding education materials to health members, providers and contracting hospitals.
- Participate in community-wide breastfeeding education, promotion and outreach efforts, including local breastfeeding coalitions.
- Incorporate breastfeeding education into health advice, referral and/or hotlines in appropriate languages.
- Develop methods to evaluate the number of mothers initiating breastfeeding at delivery and continuing for six months.
- Support the Baby Friendly Hospital Initiative by promoting early postpartum breastfeeding practices.

Child Obesity Prevention and Treatment

There is a pressing need for Santa Cruz County children to achieve healthful eating and physical activity patterns to prevent future health problems such as coronary heart disease, cancer, stroke, hypertension, diabetes, gallbladder disease, osteoarthritis, osteoporosis, as well as stress, poor body image, and low self-esteem.

During the past decade the number of overweight children in the US has more than doubled to approximately 11% and an additional 14% have a body mass index between the 85th and 95th percentiles.

14-16% of children measured >95th percentile as reported by the 1996-99 CHDP Pediatric Nutrition Surveillance.
25% of 3300 WIC children measured >90th percentile wt/ht in January 2000.
10% of 3300 WIC children measured >98th percentile wt/ht in January 2000.

Unmet Needs

Santa Cruz County Health Services Agency currently does not have a public health nutritionist, nor is there a public health nutritionist available at the many community medical clinics in this county. Public Health Nutritionists have the training and skills to: promote good nutrition and exercise programs; disseminate existing comprehensive health education programs; conduct effective nutrition education training programs for physicians, child nutrition personnel, and other health care providers; foster communication and partnerships across all health-related disciplines; develop and implement strategies for educating parents and caregivers; and, advocating for the need to increase nutrition programs.

Recommended Strategies, Programs, Services and Activities

Promising strategies may include any program or activity that provides the following services:

- Good nutrition conforming with current dietary recommendations.
- Physical activity.
- Family support in the development of healthy eating and activity behaviors.
- Behavior focused education programs in daycare and school settings.
- Healthy meals provided to children to promote healthful eating habits.
- Services that include the whole family, especially siblings and parents, who are so vital to modeling and providing for positive health habits at home.
- Consumer education for parents, childcare providers and teachers.
- Obesity prevention training for providers of service to preschool children, such as, child care workers, WIC Program staff, teen parenting program workers, and parents.
- Training for medical providers in assessment, treatment and referral services for childhood obesity.
- Screening of obesity in childcare and preschool settings.
- Media campaign to increase public awareness about childhood obesity prevention. Integration of obesity prevention into existing programs, such as childcare, WIC, Head Start, and primary care clinics.
- Multidisciplinary child obesity treatment program that includes physicians, nutritionists, family therapists or psychologists, occupational therapists, home visitors, and educators.
- Multidisciplinary programs provided in a variety of settings including hospitals, community medical clinics, family resource centers, community centers, WIC sites, home day care, preschools, schools, parks and recreation centers.
- Access to programs by providing services at little or no financial cost to low-income families.
- Recruitment of Public Health Nutritionists to provide child obesity prevention services.

Hunger

Unmet Needs

The greatest rate of increase in poverty is among young children; 33% since 1980. 63% of young children living in poverty have at least one working parent. Hunger is a serious problem. Children living in poverty are food insecure because there is not enough money for rent, medical care, food and other basic necessities. Periods of inadequate nutrition permanently harms cognitive and physical development. The 1997 local Hunger Study collected data from 80 Food Bank Member agencies documenting a local Hunger gap of 2.5 million pounds of food needed to meet client requirements.

Promising Strategies, Services, Programs and Activities

Partner with organizations to identify and enroll low-income children and their families to receive monthly Food For Children boxes. The food alleviates hunger and malnutrition. The challenge is to find ways to identify and enroll children and families in food programs and to fund the distribution of nutritious food to those in need. For example, partner with Watsonville Community Hospital to enroll low-income women giving birth in a year's worth of monthly Food For Children boxes. Partner with Head Start to enroll low-income children and their families. Partner with WIC to identify and enroll low-income children and their families. Identify other potential partners.

Provide transportation, storage and financial support to existing network of neighborhood Food Pantries serving young children and their families. Increase nutrition education to encourage increased consumption of fresh fruits and vegetables, grains and legumes and decrease consumption of fats and sugars. This is good nutrition practice in general and in particular it makes best use of surplus donated foods, which are in greatest abundance. It also helps low-income families stretch their food dollars. Increase understanding and awareness by low-income families of the dangers of under-nutrition to their children so that they will access available services rather than do without.

Actively expand referrals and collaboration between all food programs including food stamps, WIC, emergency food, school breakfast and lunch, summer lunch and childcare feeding programs.

III. Substance Abuse Prevention and Treatment

Alcohol and Drug-Related Needs and Proposed Services for Children Age 0 to 5 and Their Families

Alcohol and drug abuse have a tremendous impact on the healthy development of young children, ranging from birth defects caused by intrauterine exposure to alcohol and drugs; dysfunctional parenting, child abuse and neglect; increased risk of unintentional injuries; and developmental problems and school difficulties. Parental abuse of alcohol and drugs is one of the best single predictors of later alcohol and drug abuse among their children.

Research consistently demonstrates that treatment of alcohol and drug abuse is cost-effective. Several promising approaches to meeting the recovery-related needs of parents of children age 0 to 5 can be implemented locally to address gaps in the existing service system.

Unmet Needs

Local and national data on the incidence of alcohol and drug abuse and its impact on children age 0 to 5 demonstrate the need for services in Santa Cruz County:

A 1992 Statewide study of random hospital urine screens of women at delivery showed that 5.2% of women giving birth tested positive for illicit drugs, and 6.7% tested positive for alcohol. The Santa Cruz/Central Coast region had rates higher than the Statewide average. Projections of the Statewide prevalence rates against the 3,776 live births in Santa Cruz County in 1999 result in annual estimates of 198 children born exposed to drugs, and 253 exposed to alcohol. These estimates are conservative owing to the fact that urinalysis only detects drugs used within 3 to 5 days of delivery (except marijuana) and alcohol used within 8 to 12 hours of delivery. Alcohol and drugs cause the most severe damage to the fetus when used during the first trimester of pregnancy.

Local projections of National Institute of Drug Abuse random household survey data indicate that there are conservatively estimated to be 13,809 adults age 18 and over in Santa Cruz County who need alcohol and drug treatment. The vast majority of these adults are in the prime child-bearing years of 18 to 35. Yet, due to funding constraints, only 1 in 4 of persons who need treatment are able to receive it. Long waiting lists and missed opportunities for recovery are a daily reality at local alcohol and drug treatment programs, including perinatal treatment programs.

Among the 1,843 clients in County-funded treatment programs during the 1998-99 fiscal year, 240 (13%) had open Child Protective Services (CPS) cases. CPS estimates that upwards of 80% of the cases handled annually by CPS involve alcohol and drug abuse.

Alcohol and drug treatment works! A Statewide study of publicly-funded alcohol and drug treatment programs demonstrates that every $1 invested in alcohol and drug treatment yields an average of $7 of benefits in terms of reduced criminal justice, healthcare and social welfare costs. These studies do not even begin to measure the down-stream impact of parents' recovery on their children's well-being and ability to become successful adults.

Recommended Strategies, Programs, Services and Activities

Substance abusing parents of young children are often ambivalent about seeking help, or do not know where to get help if they are motivated to seek it. Childcare providers are often aware that children under their care are demonstrating emotional or behavioral problems, but typically do not have the resources to determine whether these problems are a result of parental substance abuse. In addition, childcare workers who suspect parental substance abuse (e.g., mom shows up late to pick up her child and smells of alcohol) frequently do not know where or how to obtain assistance for the family.

Several programs designed specifically for pregnant and parenting women exist in Santa Cruz County, including residential treatment at Janus, Sunflower House and Fenix that allows children to live with their mothers. In addition, outpatient and day treatment services are provided respectively at Fenix and Janus that include childcare. However, waiting lists at these programs are extensive. In addition, there are not sufficient resources in existing treatment programs to provide needed supports for parents of young children who are attempting to deal simultaneously with their own personal recovery issues and the effects of their substance abuse on their young children.

Specific Service Recommendations Include:

- Development of multi-disciplinary teams that include alcohol and drug specialists to provide outreach, assessment, referral and comprehensive case management in settings such as child care centers, Head Start programs, and Child Protective Services where children who are experiencing problems as a result of their parents' alcohol and drug abuse can be identified and assisted.

- Expanded perinatal alcohol and drug treatment services for pregnant and parenting women that allow children to live with their mothers in residential treatment programs. Existing perinatal residential treatment providers currently have unused licensed service capacity that could be brought on-line quickly with additional funding.

- Provision of childcare, parenting classes, and specialized child developmental services for parents who are participating in outpatient and day treatment recovery services. Local service providers have developed a parenting curriculum designed specifically for parents in early recovery, and are implementing it at Janus and the Blaine Street Women's Jail. These parenting classes could easily be expanded if additional funding were available.

Development of clean and sober transitional housing for women with young children who have completed an initial course of alcohol and drug treatment and need a low-cost living environment that is supportive of their recovery. Local program models exist that include use of one-time start-up funds to establish houses that are subsequently supported by client rents, and programs that have ongoing funding to subsidize housing costs until the women can become self-supporting.

IV. Children with Special Needs

Families with special needs children must confront enormous challenges in raising a special needs child. Navigating through huge amounts of information and multiple agencies, constructing and maintaining a functional and cohesive family, coping with the strain on family resources, and achieving a sense of control, confidence and mastery of parenting are necessary goals that are often met with fragile success if at all.

Unmet Needs

In Santa Cruz county, some of the unmet needs by the families of special needs children to begin to meet the challenges above include.

- A lack of parent networking and advocacy. If there are well-informed, organized, and supported parents, many other needs will be easier to meet.
- A lack of support groups for parents to avoid the negative effects of isolation when parenting a special needs child.
- No information clearinghouse for parent education on various disabling conditions of young children, available resources and services in Santa Cruz county, etc.
- A need for mentoring/support to families learning to navigate the various agencies and available resources as well as more user-friendly agencies.
- The need for bilingual information and outreach to the Latino population with special needs children.

- Few opportunities for integration/inclusion of special needs children into existing community childcare facilities, preschools and other community programs.
- Little access to recreational activities in the community for special needs children in an integrated environment when desired.
- A lack of training and adequate pay for child care and respite providers to improve care and avoid constant provider turnover, which is disruptive to families.
- Inadequate health insurance coverage for some families and too many restrictions on needed services for those with coverage.
- Inadequate data collection regarding special needs children and their families, especially regarding domestic violence, substance abuse and neglect.

Recommended Strategies, Programs, Services and Activities

- A parent-to-parent advocacy group to provide information, networking, training, support, and out reach to families of special needs children, including the Latino population. It could also facilitate collaboration between various service-providers and parents, and assist in collecting needed statistical data on special needs families.
- Adequate paid training program for childcare and respite providers that will address the needs of special needs children, including various medical conditions, working with the culture of the family, and time commitment to a family to avoid turnover.
- A training program for recreational facilities, daycare providers, and preschools to facilitate the inclusion of special needs children into their programs, and to provide additional opportunities for inclusion.
- Additional insurance programs to provide coverage for families who have none, and fewer restrictions on needed services for those with limited coverage.
- Support groups for parents to avoid the negative effects of isolation when parenting a special needs child.
- An information clearinghouse for parent education on various disabling conditions of young children, and information on available resources and services in Santa Cruz County.
- Educational events for parents and professionals in regards to special needs children.
- Mentor support to families learning to navigate the various agencies and available resources as well as more user-friendly agencies.
- Increased “spirit” of collaboration among the various agencies and parents.
- The need for bilingual information and outreach to the Latino population with special needs children.
- Improved opportunities for integration/inclusion of special needs children into existing community childcare facilities, preschools and other community programs.
- Access to more recreational activities in the community for special needs children, in an integrated environment when desired.
- Better training and adequate pay for child care and respite providers to improve care and avoid constant provider turnover.
- Health insurance coverage for some families and fewer restrictions on needed services for those with coverage.
- Improved data collection regarding special needs children and their families.

High Risk Infants

- In 1999, there were 3776 total births in Santa Cruz County facilities and to county residents. Among those births: 198 or 5.2% were low birthweight (under 5.5 pounds), 342 or 9% were premature (under 37 weeks gestational age), 366 or 9.7% were born to teenagers (age 19 and under), 699 or 18.5% were born to women 35 years old or older, 1276 or 34% were born to women with 11 or fewer years of education, 1592 or 42% of the births were funded by Medi-Cal.

Multiple Risk Factors

- 144 were low birthweight and premature.

Poverty

- 147 were Medi-Cal funded and premature.
- 80 were Medi-Cal funded and low birthweight.
- 60 were Medi-Cal funded, low birthweight and premature.

Education

- 71 were low birthweight and a mom with 1-11 years of education.
- 167 were premature and a mom with 1-11 years of education.
- 48 were premature, low birthweight and a mom with 1-11 years of education.

Mother's Age

- Under 20: 32 were low birthweight, 45 were premature.
- 35 and older: 30 were low birthweight and 77 were premature.

These are the babies that are most at risk for child abuse and neglect, poor attachment between mother and infant, substance exposure, and compromised growth and development when given no special attention and intervention.

Unmet Needs

Only 40 of these infants can be followed each year through the Public Health Nurse High Risk Infant Program, and there is a need for approximately 150-200 infants per year.

There is a lack of a coordinated, universal screening and triage system at birth which would identify all infants at risk and enroll them in appropriate follow-up. There is a lack of universal outcome measurement tools that would allow a variety of programs across all agencies and disciplines to track and measure family/infant functioning progress and outcome. (There are two very promising tools currently being tested: The Family Matrix and the Monterey Life Skills Progress)

Recommended Strategies, Programs, Service and Activities

- Expand the County Health Services Agency High Risk Infant Program.

V. Mental Health

Unmet Needs

Mental health services are a key component of a comprehensive service delivery system for young children and their families. Unfortunately, at this time services are quite limited for children age 0-6—it comprises a tremendous "gap" in service capacity. However, at the same time there is tremendous opportunity to create a comprehensive system of care—as well as continuum of mental health services—for this target group given the possibilities of combining EPSDT Medi-Cal dollars with Proposition 10 and other local and state funds.

Promising Strategies, Programs, Services and Activities

A wide variety of creative, supportive services can be provided through mental health in a flexible, field-based, "wraparound" approach—and should be provided as part of collaborative teams with other organizations, such as Public Health, Human Resources Agency education, child development and child care centers, family resource centers, Healthy Start sites, and key community based organizations.

The County Mental Health Services can play a key role in helping to create a "Comprehensive System of Care for Young Children and their Families." These services should be available across a broad continuum of need—from prevention and early intervention, to multi-systemic intensive services for complex child/family needs.

To the extent that the Medi-Cal population is served, there is significant leveraging potential with EPSDT dollars to dramatically expand Proposition 10 funds. The following spectrum of services was outlined in the Success By Six Strategic Plan under "Services and Supports for Families At-Risk" on page 31. Each of these major strategies should incorporate key health, mental health and substance abuse personnel in a multi-disciplinary approach, along with other community providers. Mental Health can and should be a part of the following:

- Universal screening/needs assessment at hospital or home-births.
- Home visitation and welcome packet for every child born.
- Continuous risk re-assessment for at-risk families by multi-disciplinary teams as children age towards kindergarten.
- Family resource centers and school-based "one stop" centers as community based locations for health, mental health and substance abuse services for families with young children.
  Child/day care and therapeutic classrooms as sites for collaborative, multi-disciplinary teams providing health, mental health and substance abuse counseling to children, care providers, and families.
- School-based prevention and early intervention services (K-1) to ensure children enter school ready and able to learn.
- Flexible funding for wraparound expenditures for key family support needs not addressed by more traditional programs.

The interagency Revenue Enhancement Team (RET) should be utilized as a forum for strategic/technical planning for leveraging funds such as EPSDT to expand mental health service capacity, which can also help ensure that a coordinated System of Care emerges.

Following are some key examples of more specific inter-agency, collaborative efforts already being reviewed by the Revenue Enhancement Team (RET) that fit into the larger Proposition 10 goals of leveraging additional dollars to serve the 0-5 population:

- Planning with Human Resources agency and the Parent Center to better coordinate and expand our contracts through EPSDT funding, including better provision of services to the 0-5 population.
- Planning with the ABC Collaborative regarding sustainability of the Family Resource Center in Watsonville, including services to the 0-5 population.
- Beginning discussions with Head Start (under SCCCC) about provision of EPSDT services to preschool children and their families.
- Beginning discussions with organizations such as Salud Para La Gente and the Child Development Resource Center about possible EPSDT collaboration.

Additional examples of key projects that could be focused on under Proposition 10, using leveraged EPSDT and other funds, would be:

- Collaboration with the County Office of Education and other school districts about provision of health, mental health and substance abuse services to children and their families as a part of specialized
- Therapeutic Classrooms for at-risk pre-school children.
- Training, consultation and support to child care providers regarding early detection of mental health/behavioral issues and intervention strategies.
- Provide in-home behaviorally focused interventions for pre-schoolers, siblings, and other family members for at-risk families identified by other agencies.
- Provide training and support to respite care providers throughout the county.
- Provide support and training for foster home, kinship, and shelter care providers regarding infants and toddlers in their care.
- Help staff and support family resource centers and Healthy Start sites to serve families of young children in need: link to resources, provide support/outreach, serve children at risk of being kicked out of child care or pre-school, assist with school readiness issues involving family support.

- Assist with more comprehensive training, consultation, support for county-wide implementation of the Early Mental Health Initiative (EMHI) for K-1 children in every elementary school (Santa Cruz City Schools/Mental Health continues to operate EMHI—most districts have had the 3 year grant at some point over the last decade).
- Help fund, train and support family partnerships through parent to parent peer support programs.
- Proposition 10 funding can provide coverage for the non-MediCal population not eligible for EPSDT—to ensure a seamless service system not based on pay or sources.

VI. Dental Health

Assumptions

- Do not create a new program; utilize existing programs.
- Dental problems in the very young child are partly a result of deficient parenting practices; the child's dental problem is only a symptom.
- Prevention of dental disease is better than treatment.
- A child with untreated dental problems is not a healthy child.

Unmet Needs

Dental disease, especially for the low-income population, is thought to be the number one health problem for children in Santa Cruz County by all anecdotal sources. Harmful parenting practices (e.g, putting a child to bed with a bottle, unlimited access to candy) that promote dental disease and inadequate access to dental care due to lack of insurance, lack of providers, or lack of parent motivation are two factors that attribute to this problem. Other factors include lack of fluoridation of water supplies and a need for a greater role by childcare providers in promoting dental health.

However, finding hard facts and reliable data to support this claim is no easy matter. CHDP PM 160 data show increasing numbers of dental conditions identified over the past several years, but the small 6% of children identified by CHDP providers as needing a referral for care is grossly under representative of the extent of the problem among this population. Other data sources, such as the Dientes! Community Clinic sample screening of 500 students at a south county elementary school, revealed 60% of the children needing some kind of dental care (10% of these were urgent, with abscessed teeth and 30% were moderate problems, such as large cavities). This shows the most severe picture of the problem. Only 72% of CAP respondents indicate that they had a regular source of dental care. The picture is further enhanced by the fact that inadequate resources for care for low-income children (with or without Medi-Cal) exist in this county.

Promising Strategies, Programs, Services, and Activities

- Increase the number of new parents who obtain dental health education so they learn how to prevent their children from getting baby bottle tooth decay.
- Increase the number of young children who obtain preventative dental care (e.g., fluoride therapy) and urgent care (to treat abscess or toothaches).
- Educate county residents regarding the benefits of fluoridation, so that future attempts to implement fluoridation are more likely to succeed.

Other recommendations include

- Training of caregivers to promote the dental health of young children (education, screening, parent education, referral for treatment).
- Training of caregivers to understand how parenting practices affect dental health, including soon-to-be parents during the prenatal period.
- Better access to dental insurance through Medi-Cal and Healthy Families Insurance Program
- Improved outreach to soon-to-be parents during the prenatal period.
- Better access to dental insurance through Medi-Cal and Healthy Families Insurance Program.
- Improved outreach and payment of Healthy Family Insurance Program premiums.
- Additional treatment funds to pay for urgent cases that, left untreated, could result in systemic infection or expensive hospitalization (e.g., advanced dental infections, general anesthesia for uncooperative children)

VII. Health Insurance

Unmet Needs

There are between 5000 and 6000 uninsured children in Santa Cruz County. Based on results of the Medi-Cal Outreach Project Needs Assessment completed in December 1999, some of the identified barriers to Medi-Cal enrollment for low income residents of Santa Cruz County include: lack of knowledge regarding program benefits and eligibility requirements, lack of transportation, mistrust of government agencies, fear related to immigration, lack of appropriate language specific and/or low-literacy materials and the complicated enrollment process. It is necessary to reduce or eliminate enrollment barriers in order to be successful at achieving projected enrollment goals by providing outreach in isolated geographic areas of the county. This can be accomplished by building on trusted relationships that already exist with staff in community agencies that offer services to the targeted population. By utilizing bilingual, bicultural staff outreach workers as peer educators and client advocates, this will provide opportunities for families to learn about and enroll in Medi-Cal and Healthy Families. Outreach about immigration and other community services in specific languages easy to understand and using low literacy materials needs to occur where their children attend school and at community and cultural events.

Recommended Strategies, Programs, Services and Activities

- Provide health insurance for uninsured children, including mental health insurance; effectively connect these families to a source for primary care.
- Increase Medi-Cal and Healthy Families enrollment and retention by conducting outreach and enrollment activities that target low income families and their children within Santa Cruz County who may be eligible and who are not currently enrolled or who do not retain Medi-Cal and or Healthy Families benefits.

VIII. Alternatives in Pre-Natal Care and Maternity Care

Unmet Needs

Total births = 3798
Total out of hospital births = 86 (2.26% of all birth)
1998 Santa Cruz County - Success by Six November 1999

"Our analyses of the California data...do not support the claim by the obstetric profession that for the large majority of low-risk women hospital birth is safer with respect to perinatal mortality. The already apparent disadvantages of the obstetric approach are of such a large order of magnitude as to raise serious doubts concerning the appropriateness of conventional 'obstetric' treatment for low-risk childbirth." — The Safety of Alternative Approaches to Childbirth, Peter Schlenzka, Ph.D., MBA, MS, Stanford, 1999

"Current maternity and newborn practices that contribute to high costs and inferior outcomes include the inappropriate application of technology and routine procedures that are not based on scientific evidence"
"The midwifery model of care, which supports and protects the normal birth process, is the most appropriate for the majority of women during pregnancy and birth." — The Mother-Friendly Childbirth Initiative

Birth is a time of transition. During this transition, while a woman is most open to change, there is an opportunity to strengthen families. A woman can be made to feel that her body is working to full capacity to grow a baby, give birth and then nourish that baby through breastfeeding. She can develop a trust in her body and a confidence in herself.

The Coalition for Improving Maternity Services (CIMS) is a national organization, backed by 90,000 birthing professionals, and produced the Mother-Friendly Childbirth Initiative (MFCI) consisting of Ten Steps to Mother-Friendly Care. In these ten steps the MFCI gives us the gold standard for maternity care in the United States, that are research based and demonstrate excellent and cost effective outcomes as well as high parent satisfaction.

In a preliminary survey of the birthing options in Santa Cruz County (Watsonville Community Hospital, Sutter Maternity and Surgery Center and Dominican Hospital, and homebirth services) Birth Network found that the birthing option that most closely met the criteria set forth in the Ten Steps of the Mother-Friendly Childbirth Initiative was the homebirth option. Homebirth midwives offer 30-60+ minutes long appointments. Their care is low cost and low intervention with little dependence on technology unless specifically needed. Rates of infection are very low as is the threat of a baby mix-up or security failure. Breastfeeding rates are almost 100%. MFCI's goals are met with home-based midwifery care.

Midwifery care in the hospital offers a birth experience with a moderate dependence on technology. Obstetricians tend to have the most restrictions and highest rates of interventions. Obstetricians deal with high risk patients where high technology birth is expected. However even with low risk patients, an obstetrician's care is generally higher in interventions which often cascade one onto another until normal birth becomes high risk.

How can we tell if a woman is receiving the best possible maternity care? Goals of early access to prenatal care, low percentage of teen births and fewer low birth weight babies are currently used as indicators of quality maternity care. However we believe they should not be the only indicators used.

There are other important indicators. Among the most significant are:

- Amount of time spent in prenatal appointments with the person who will deliver the baby, providing solid education and continuity of care.
- Access to the full range of options for pregnancy, birth and nurturing her baby, and to accurate information on all available birthing sites, caregivers and practices.
- Satisfaction with the birth experience.
- Success with breastfeeding through the hospital stay and beyond.
- Drug free newborns born with (no exposure to IV, spinal or epidural pain medications in labor)
- Ability of a woman to choose her care provider based on published information listing frequency of cesarean section, episiotomy, epidural, induction and other interventions which MFCI research indicates is overused.

A successful birth experience is the starting point for optimum health and development in a family and in a society. When a woman and her family enter parenthood feeling empowered and are assisted in experiencing optimum bonding with their baby, the family and the community reap the benefits for life long health, beginning with increased breastfeeding success and higher confidence in parenting skills. Healthy relationships and healthy lifestyle choices, which are very cost effective, can begin with a successful birth and breastfeeding relationship. These mother-friendly practices will have long lasting effects on mothers, babies and families in dental health, child abuse, obesity, and many, many health related issues.

Recommended Strategies, Programs, Services and Activities

- Adopt the mother-friendly childbirth initiative (MFCI's) goals for this county.
- Encourage county-wide/agency-wide support of MFCI's goals, in part through funding Birth Network's publication of the Consumer's Guide to Birth in Santa Cruz County.
- Make midwifery care available at Watsonville Hospital.
- Provide every pregnant woman with the "Midwifery Model of Care" brochure.
- Recommend that area hospitals, birthing services, and prenatal care providers refuse free formula, advertising, gifts and/or funding from formula manufacturers, according to World Health Organizations (WHO) directives.
- Fund some of the development costs of a free standing birth center in South County, which would serve the Latina community and the general population. A free standing birth center is not a hospital and could be located in an existing office building or residential type property with improvements.
- Ensure financial support for women desiring out of hospital birth, especially those on public assistance. Unfortunately this least expensive birthing option is only available to those who can afford to pay out of pocket.
- Award grants to existing programs and nonprofit agencies that promote independent childbirth educators, birth doulas, and postpartum doulas.
- Expand postpartum doula care in Santa Cruz County, dovetailing with other in-home programs providing family support during the critical first few weeks and months of parenthood.
- Award grants to small nonprofits such as Nursing Mothers Counsel, La Leche League, Nurture, and Birth Network. These nonprofits provide major benefits to our community and deserve support.
- Support WIC's Drop-in Lactation Center in Watsonville and support the creation of a Santa Cruz WIC drop-in Lactation Center.
- Support efforts to bring continuing medical education to Santa Cruz County for family practice physicians, obstetricians, nurses, social workers, physician assistants, midwives, lactation consultants and counselors to learn successful management of breastfeeding for the first full year of a baby's life.
- Support and encourage efforts to create a breastfeeding friendly workplace. Including, providing breast pumps, designating space for the pumping and storing of breastmilk, flexible break times for pumping or breastfeeding a baby, and accepting and encouraging breastfeeding during appointments and meetings with breastfeeding clients.
- Create an independent health information center to include low cost space for childbirth education classes, lactation education, parent education and support groups, as well as housing birth related non profits. This could possibly be accomplished by expanding access to existing facilities.

IX. Smoking Cessation

Unmet Needs

Smoking and Young Children:

Children of mothers who smoke during pregnancy and young children in households where smokers are present are at higher risk of suffering from:

- Sudden Infant Death Syndrome
- Low birthweight
- Asthma
- Ear infections
- Respiratory infections including bronchitis and pneumonia
- Middle ear infections

Additionally, children of mothers who smoke are more likely to become smokers.

Cessation for pregnant women

- Encouraging and training more healthcare providers to counsel pregnant smokers to quit.
- Providing free smoking cessation services to pregnant women.
- Providing free pharmacological smoking cessation aids to pregnant women.
- Conducting home visits by nurses to pregnant smokers.
- Encouraging and training more healthcare providers to counsel family members of young children to quit smoking.
- Providing free smoking cessation services to family members and caregivers of young children.
- Providing free pharmacological smoking cessation aids to family members and caregivers of young children.
- Conducting home visits by nurses to post-partum smokers.

Smokefree environments for children 0 – 5

Recommended Strategies, Programs, Services and Activities

- Requiring agencies receiving funds from the Commission to not accept resources from the tobacco industry.
- Requiring agencies receiving funds from the Commission to periodically survey their pregnant and parenting clients to assess the exposure of young children to tobacco smoke.

Report to the Santa Cruz County Children and Families Commission

from the Family Supportive Services Task Force
September 2000

Introduction

The Family Supportive Services Task Force met four times in May and June 2000.

Members

The members of the Task Force were: Mary Balzer, SPIN-Special Parents Information Network; Debra Church, Early Decision Program; Elizabeth Demos, Kidpower; Pam Elders, Head Start; Carol Frankl, Parents Center; Seena Frost, Family Services Association of the Pajaro Valley; Yolanda Goda, Familia Center; Evelyn Hengeveld-Bidmon, Valley Resource Center; Rebecca Holland, ABC; Sandy Paiva, Teenage Parents Programs; Janet Parske, New Families; Michele Shippen, Human Resource Agency; Deborah Wechsler, SPIN-Special Parents Information Network.

The Task Force reviewed the following areas of family support: child abuse and neglect, domestic violence, mental health, support for families with children with special needs, adoption and alternative families, foster care, family counseling, postpartum depression, homeless children and work/family issues.

Process

The Task Force reviewed existing plans, reports and research; they identified unmet needs and recommended promising strategies, programs, services and activities to meet the unmet needs. Their recommendations for the Santa Cruz County Children and Families Commission's consideration in developing the Strategic Plan and funding priorities for the Proposition 10 tobacco tax funds are listed in this report. These recommendations represent a consensus of all participating members. The recommendations are not in priority order; the Task Force did not engage in a priority setting process.

I. Child Abuse and Neglect

Unmet Needs

Child abuse and neglect is found in all socioeconomic groups, and cuts across lines of ethnicity, culture and education. However, there are a number of factors that put the child at risk of abuse or neglect. Parental substance abuse and domestic violence are strong correlates. In Santa Cruz County, it is estimated that substance abuse is a problem in up to 90% of all child abuse and neglect cases. Other key factors are social isolation, family disorganization and parental stress. In up to 60% of cases, there is also intimate partner violence in the home. Poverty and housing problems are contributing factors. Parent risk factors are a lack of parenting skills and lack of knowledge about child development, younger parents (including teens), parental mental illness and a history of the parent having suffered child abuse or domestic violence as a child. Babies and children under 5, and children with chronic health issues or special needs are at increased risk for abuse.

In Santa Cruz County, there is a shortage of services and activities that can impact child abuse by reducing these risk factors. There is a need for services that protect against substance abuse, through prevention and treatment services, and by providing support systems that reduce stress and strengthen overall family functioning. Services that build family strengths are key, not only to reduce the risk of substance abuse, but also to reduce social isolation, develop parenting skills, and facilitate access to health and social services. There needs to be a focus on prevention, using a strength-based/assets approach model to services. Formal and informal family centered and parent education activities need to be available at the neighborhood level. These efforts need to include collaboration among many partners, including families, schools, public and non-profit agencies, churches, business and community members. Service delivery structures need to be encouraged which build an alliance between families and professionals, identifying and building on family assets and providing coordinated services to families to best meet their needs.

Recommended Strategies, Services, Programs and Activities

Substance Abuse Prevention & Treatment

Approaches that take the "whole family" into consideration are encouraged. For example, treatment services that involve other family members, that provide child care and that offer services in the evening and on weekends are desirable. Stationing substance abuse specialists within the everyday structure of family resource centers, on multi-disciplinary teams and at the One-Stop Centers can reduce barriers to individuals seeking and engaging in treatment; ensure that the issue of substance abuse is integrated into all aspects of case planning; strengthen the awareness and skills of other professionals in the area of substance abuse; and provide greatly increased opportunities for outreach and prevention education.

Family Resource Centers

Family Resource Centers (FRCs) are a key prevention strategy for addressing many of the challenges that face families. The goal of FRCs is healthy families in healthy communities. Evolving research and evaluation indicate that family resource centers are promising strategies for addressing issues such as child abuse and neglect, substance abuse, family violence, family instability, community unity, family isolation and educational outcomes. A family resource center serves as the hub of community services designed to improve family life, especially for isolated and overburdened families. A quality family resource center offers a blend of services, supports and opportunities—where family members and center staff work together in a mutually respectful environment. FRC staff help families identify and use their strengths and skills to problem solve and create opportunities for success.

In Santa Cruz County, the family resource center initiative is guided by the 9 "Principles of Family Support Practice" developed by the Family Resource Coalition of America. While having many features in common (such as family involvement in governance and co-located services) each FRC is designed to reflect the unique needs and interests of the community. Typical services include: information and referral, child development, home visiting, parenting education, health and nutrition service, substance abuse services, counseling, family fun activities and links to the One Stop Centers.

Home Visiting

Home visiting programs for families with young children are showing significant success locally and nationwide. It is important to encourage and support home visiting models that incorporate comprehensive services including a multi-disciplinary team, center-based parenting and child development classes and a therapeutic support team. Home visitors may be either para-professionals or professionals, but the most effective approaches will also include involvement of child development specialists, nurses and other specialists and will be closely linked with other family support services. The resources of co-located family resource centers enhance the healthy development of families and children participating in home visiting programs.

Skill Building Prevention Approaches

KIDPOWER programs are an example of skill building prevention and can be conducted in a variety of settings, not only with children, but also with parents, caregivers, and agency staff working with young children. KIDPOWER aims to achieve the following outcomes through the following strategies:

- Increasing the children's social, emotional and behavioral skills, including self-esteem. KIDPOWER provides young children with the knowledge, skills and values to stay safe, act wisely, and believe in themselves. Parents and teachers report that this training helps to raise self-esteem, self-confidence and age-appropriate competence in handling difficult situations. Educating children about the power they have to keep themselves safe is crucial to the emotional well-being they need to succeed in school and life.

- Increasing safe learning environments to meet the children's social and emotional needs. The ability of the early childhood education care giving system to successfully achieve its primary function—the imparting of social, emotional and behavioral skill necessary for successfully entering Kindergarten—is contingent upon performance of a secondary function, the provision of a suitable, safe and secure learning environment. KIDPOWER has been providing a child safety training for care givers including Head Start.

- Decreasing the effects of children's disabilities on their ability to reach their full potential. KID POWER provides workshops specifically tailored to those high-risk children facing special life

challenges such as being visually or hearing impaired and physically or developmentally disabled.

- Increasing children's health conditions. KIDPOWER take a proactive approach to the prevention of violence at all levels; therefore it serves as a powerful tool in the prevention of both short- and long-term health problems associated with abuse, abduction, or assault.

- Decreasing the harmful effects of substance abuse, including usage during the mother's pregnancy, on the children's living environment. It has been proven that pregnant women who are battered have significantly higher rates of smoking, and alcohol or drug use during pregnancy than non-battered pregnant women and or drug use during pregnancy than non-battered pregnant women and are between one-and-a-half and four times more likely to deliver a low-birthweight infant than non-battered women. KIDPOWER has developed a program, with a grant from the March of Dimes Birth Defects Foundation, to prevent such damaging outcomes during the time when women are also responsible for the safety and well being of their unborn babies, newborns and young infants.

- Increasing healthy emotional relationships between the children and family members. KIDPOWER is unique in providing a self protection program for young people that recognizes the primacy of parents and families as the children's most important and influential teachers. KIDPOWER provides families and caregivers with a common language and set of experiences that become a framework parents can build upon as they take a proactive role in fostering healthy, positive self-protection skills in their children. Joint parent/child classes specifically help strengthen or reinforce the parental role in dealing with children's self-esteem and violence prevention issues.

- Increasing parents and caregivers knowledge of parenting skills. KIDPOWER teaches work shops aimed at preparing the family or caregivers of children who have participated in the everyday safety skill trainings to support and reinforce the skills taught to the children in their care. KIDPOWER teaches positive and practical every day living skills that focus on building relationships while staying safe at the same time.

- Increasing protection against domestic and community violence, child abuse and neglect. KIDPOWER has helped young children of all walks of life and abilities as well as their educators and caregivers learn to be aware, take charge of their personal safety, and get help through success-based, hands-on practice. The skills practiced in KIDPOWER programs can help young children learn to set clear boundaries deal with difficult and sometimes dangerous situations with bullies, strangers, peers, and adults they know and trust, and stop or avoid most trouble before it starts.

- Increasing availability and accessibility of children's services KIDPOWER'S ongoing goal has been to ensure that its high quality, potentially life-changing self confidence, violence and abuse prevention and personal safety skill building services become widely and equitably available to as many young children as possible, especially those most in need. The latter include people with limited access due to financial, language or cultural barriers.

II. Domestic Violence

Unmet Needs

In 1996, the American Psychological Association expanded the definition of child abuse to include domestic violence with children present. While the exact number of children exposed to domestic violence is unknown, the American Bar Association estimates that 87% of children in homes where domestic violence occurs witness the abuse. As a result these children may exhibit a wide range of problems, including low self-esteem, aggression, depression, anxiety, learning difficulties, or post-traumatic stress disorder.

As with child abuse and neglect, domestic violence occurs in all socioeconomic groups, and cuts across lines of ethnicity, culture and education. Key risk factors are substance abuse, social isolation and a perpetrator or victim history of experiencing domestic violence as a child. The most important protective factors for domestic violence are social and financial independence, and the availability of an effective support system, including family, childcare and other resources.

A comprehensive coordinated system of services is needed, including more services for batterers; more culturally competent and Spanish language services; services for victims; and strategies that address substance abuse and social isolation.

Recommended Strategies, Services, Programs and Activities

Some of the most effective strategies include holding batterers more accountable and using jail time as an effective deterrent; a full Domestic Violence Court linked to services; cross-disciplinary collaborative training and response between law enforcement, advocates, and child welfare (such as the Family Violence Response Team—FVRT); and wrap around services—housing, education, job, health care.

Effective services and activities include crisis intervention and emergency shelters, legal advocacy including restraining orders, batterer intervention and treatment; effective consequences for batterers, anger management and conflict resolution training. Resources that engage and support the family at the community and neighborhood level are most effective, including opportunities for economic independence, housing, health and childcare.

III. Mental Health

Unmet Needs

Mental health services are a key component of a comprehensive service delivery system for young children and their families. Unfortunately, at this time services are quite limited for children age 0-6—it comprises a tremendous “gap” in service capacity. However, at the same time there is tremendous opportunity to create a comprehensive system of care—as well as continuum of mental health services—for this target group given the possibilities of combining EPSDT Medi-Cal dollars with Proposition 10 and other local and state funds.

Promising Strategies, Programs, Services and Activities

A wide variety of creative, supportive services can be provided through Mental Health in a flexible, field-based, "wraparound" approach—and should be provided as part of collaborative teams with other organizations, such as Public Health, Human Resources Agency education, child development and child care centers, family resource centers, Healthy Start sites, and key community based organizations. The County Mental Health Services can play a key role in helping to create a "Comprehensive System of Care for Young Children and their Families." These services should be available across a broad continuum of need—from prevention and early intervention, to multi-systemic intensive services for complex child/family needs.

To the extent that the Medi-Cal population is served, there is significant leveraging potential with EPSDT dollars to dramatically expand Proposition 10 funds. The following spectrum of services was outlined in the Success By Six Strategic Plan under "Services and Supports for Families At-Risk" on page 31. Each of these major strategies should incorporate key health, mental health and substance abuse personnel in a multi-disciplinary approach, along with other community providers. Mental Health can and should be a part of the following:

- Universal screening/needs assessment at hospital or home-births.
- Home visitation and welcome packet for every child born.
- Continuous risk re-assessment for at-risk families by multi-disciplinary teams as children age towards kindergarten.
- Family resource centers and school-based "one stop" centers as community based locations for health, mental health and substance abuse services for families with young children.
- Child/day care and therapeutic classrooms as sites for collaborative, multi-disciplinary teams providing health, mental health and substance abuse counseling to children, care providers, and families.
- School-based prevention and early intervention services (K-1) to ensure children enter school ready and able to learn.
- Flexible funding for wraparound expenditures for key family support needs not addressed by more traditional programs.

The Interagency Revenue Enhancement Team (RET) should be utilized as a forum for strategic/technical planning for leveraging funds such as EPSDT to expand mental health service capacity, which can also help ensure that a coordinated System of Care emerges. Following are some key examples of more specific inter-agency, collaborative efforts already being reviewed by the Revenue Enhancement Team (RET) that fit into the larger Proposition 10 goals of leveraging additional dollars to serve the 0-5 population:

- Planning with the Human Resources Agency and the Parent Center to better coordinate and expand our contracts through EPSDT funding, including better provision of services to the 0-5 population.
- Planning with the ABC Collaborative regarding sustainability of the Family Resource Center in Watsonville, including services to the 0-5 population.
- Beginning discussions with Head Start (under SCCCC) about provision of EPSDT services to pre-school children and their families.
- Beginning discussions with organizations such as Salud Para La Gente and the Child Development
- Resource Center about possible EPSDT collaboration.

Additional examples of key projects that could be focused on under Proposition 10, using leveraged EPSDT and other funds, would be:

- Collaboration with the County Office of Education and other school districts about provision of health, mental health and substance abuse services to children and their families as a part of specialized Therapeutic Classrooms for at-risk pre-school children.
- Training, consultation and support to child care providers regarding early detection of mental health/behavioral issues and intervention strategies.
- Provide in-home behaviorally focused interventions for pre-schoolers, siblings, and other family members for at-risk families identified by other agencies.
- Provide training and support to respite care providers throughout the county.
- Provide support and training for foster home, kinship, and shelter care providers regarding infants and toddlers in their care.
- Help staff and support family resource centers and Healthy Start sites to serve families of young children in need: link to resources, provide support/outreach, serve children at risk of being kicked out of child care or pre-school, assist with school readiness issues involving family support.
- Assist with more comprehensive training, consultation, support for county-wide implementation of the Early Mental Health Initiative (EMHI) for K-1 children in every elementary school (Santa Cruz City Schools/Mental Health continues to operate EMHI—most districts have had the 3 year grant at some point over the last decade).
- Help fund, train and support family partnerships through parent to parent peer support programs.
- Proposition 10 funding can provide coverage for the non-MediCal population not eligible for EPSDT—to ensure a seamless service system not based on pay or sources.

IV. Children with Special Needs

Families with special needs children must confront enormous challenges in raising a special needs child. Navigating through huge amounts of information and multiple agencies, constructing and maintaining a functional and cohesive family, coping with the strain on family resources, and achieving a sense of control, confidence and mastery of parenting are necessary goals that are often met with fragile success if at all.

Unmet Needs

In Santa Cruz county, some of the unmet needs by the families of special needs children to begin to meet the challenges above include.

- A lack of parent networking and advocacy. If there are well-informed, organized, and supported parents, many other needs will be easier to meet.
- A lack of support groups for parents to avoid the negative effects of isolation when parenting a special needs child.
- No information clearinghouse for parent education on various disabling conditions of young children, available resources and services in Santa Cruz county, etc.
- A need for mentoring/support to families learning to navigate the various agencies and available resources as well as more user-friendly agencies.
- The need for bilingual information and outreach to the Latino population with special needs children.

- Few opportunities for integration/inclusion of special needs children into existing community child care facilities, preschools and other community programs.
- Little access to recreational activities in the community for special needs children in an integrated environment when desired.
- A lack of training and adequate pay for child care and respite providers to improve care and avoid constant provider turnover, which is disruptive to families.
- Inadequate health insurance coverage for some families and too many restrictions on needed services for those with coverage.
- Inadequate data collection regarding special needs children and their families, especially regarding domestic violence, substance abuse and neglect.

Recommended Strategies, Programs, Services and Activities

- A parent-to-parent advocacy group to provide information, networking, training, support, and out reach to families of special needs children, including the Latino population. It could also facilitate collaboration between various service-providers and parents, and assist in collecting needed statistical data on special needs families.
- Adequate paid training program for childcare and respite providers that will address the needs of special needs children, including various medical conditions, working with the culture of the family, and time commitment to a family to avoid turnover.
- A training program for recreational facilities, daycare providers, and preschools to facilitate the inclusion of special needs children into their programs, and to provide additional opportunities for inclusion.
- Additional insurance programs to provide coverage for families who have none, and fewer restrictions on needed services for those with limited coverage.
- Support groups for parents to avoid the negative effects of isolation when parenting a special needs child.
- An information clearinghouse for parents education on various disabling conditions of young children, and information on available resources and services in Santa Cruz County.
- Educational events for parents and professionals in regards to special needs children.
- Mentor support to families learning to navigate the various agencies and available resources as well as more user friendly agencies.
- Increased “spirit” of collaboration among the various agencies and parents.
- The need for bilingual information and outreach to the Latino population with special needs children.
- Improved opportunities for integration/inclusion of special needs children into existing community childcare facilities, preschools and other community programs.
- Access to more recreational activities in the community for special needs children, in an integrated environment when desired.
- Better training and adequate pay for child care and respite providers to improve care and avoid constant provider turnover.
- Health insurance coverage for some families and fewer restrictions on needed services for those with coverage.
- Improved data collection regarding special needs children and their families.

V. Adoption and Alternative Families

The issue of adoption in American family life is vitally important to many children's sense of permanency and belonging. Concurrent planning is a key element of recent state and federal laws, which mandates planning for the reunification of the child to the parents at the same time planning for the relinquishment of the child for adoption in the event it is not safe to return the child to the parents. The Adoption and Safe Families Act of 1997, P.L. 105-89, which was signed into law by President Clinton on November 19, 1997, places the safety of children as the paramount concern in placement decision, supports concurrent planning for adoption, and provides financial incentives to states to increase adoption. California AB 1544, Chaptered October 9, 1997, requires that when out-of-home services are used and the goal is reunification, the case plan also describes services to be provided concurrently to achieve permanency if efforts to reunify fail.

Unmet Needs

The following unmet needs of adoptive families in Santa Cruz County were identified:

- Need for recruitment of concurrent planning homes.
- Need to educate the community about adoption in general.
- Need to increase permanency/stability for children.
- Need to decrease multiple placements for children.
- Need to free children for adoption as soon as possible.
- Need to find programs and policies to expedite adoption as required by law.
- Need for accessible parenting education directed toward adoptive parents.
- Need for support systems, such as support groups, for adoptive parents/families.
- Need to support kinship adoption, including developing a support system for relatives raising children in their families.
- Need for mental health services for adopted children with special emotional needs.
- Need to work with birth parents with services that could lead to expediting adoption.

Recommended Strategies, Services, Programs and Activities

- An effective recruitment plan to recruit concurrent planning homes,
- Media education about adoption to the public at large,
- Training programs to teach prospective concurrent planning parents about their role in the concurrent planning process,
- Support groups for adoptive and concurrent planning parents, as they go through the process of concurrent planning and after adoption occurs,
- Programs and services to support and coordinate services specifically for kinship families,
- Coordination of mental health services and adoptive families with children having special needs,
- Programs to assist the dependency court in making the hard decision to terminate birth parents' rights and free children for adoption,
- Programs to assist the birth parents to consider when adoption is in the best interest of their children,
- Respite services for adoptive parents, especially those having children with special needs.

In recent years the number of traditional nuclear families has declined, and the face of the American family is changing. The task discussed the types of alternative families that need to be considered when determining the needs of young children in Santa Cruz County. Alternative families can include single-parent families, gay and lesbian parented families, kinship families, stepfamilies, and blended families.

Unmet Needs

The following unmet needs of alternative families in Santa Cruz County were identified:

- Need for parenting education that relate to the specific circumstances of each alternative family.
- Need for support groups for parents and children of alternative families.
- Need for public education to increase awareness of alternative families and their particular needs.
- Need for identifying and accessing community/county resources for specific circumstances.

Recommended Strategies, Services, Programs and Activities

- Establishment of parenting education classes that relate to alternative families.
- Program that facilitates support groups for specific issues relating to alternative families.
- Development of a media campaign to educate the community about alternative families.
- Establishment of a program that would identify and coordinate existing services that could assist alternative families with their specific needs.

VI. Foster Care

"A half-million of our nation's children is in foster care. Many times victims of neglect and abuse, foster children are often caught in a system trying to balance the need to protect children with the policy of preserving families. Consequently, children find themselves in a system that is overburdened, undefended, fragmented, and often riddled with bureaucratic obstacles." — Consider Kids, May 1998.

Infants and young children are the fastest growing population in foster care. These children have special needs, and these needs have to be addressed in order for children in foster care to get the quality care they need and develop to their fullest potential.

Unmet Needs

The following unmet needs of children in foster care in Santa Cruz County were identified:

- Need for recruitment of concurrent planning foster/adopt homes.
- Need for education about concurrent planning and the foster parents' role during this process.
- Need for voucher money to subsidize day care and transportation for foster families.
- Need for quality supervised visitation.
- Need for ongoing therapy for young children in foster care.
- Need for Spanish-speaking professionals to do assessments and/or therapy with young children.
- Need for professional specializing in behavior therapy to work with special needs children.
- Need for male role models for boys in foster care.
- Need for respite/support for foster parents.
- Need for parenting education for foster parents.
- Need for shared homes (foster homes for the whole family).
- Need for on-going services for the families whose children are in out-of-home placement.

Recommended Strategies, Services, Programs and Activities

- An effective recruitment plan which will recruit and train concurrent planning homes.
- On-going training and support groups for concurrent planning foster parents.
- Subsidies for day care and transportation for foster parents.
- A visitation center for supervised visits which is both instructional for the birth parent and informative to the court.
- Subsidized therapy for young children in foster care which will assess and address attachment and bonding issues and deal with the traumas they have experienced.
- Provide Spanish-speaking professionals to assess and provide therapy with young children.
- Provide behavior therapy for special needs children.
- Recruit male role models for boys in foster care.
- Provide respite/support for foster parents.
- Provide on-going parent education which is developmentally appropriate for young children in foster care.
- Recruit and train foster parents to provide a home for the entire family to mentor a healthy family lifestyle.
- Program to provide counseling, parenting education, substance abuse treatment for parents whose children are in out-of-home placement, including Spanish-speaking services.

VII. Family Counseling

Recommended Strategies, Services, Programs and Activities

- Culturally appropriate mental health services/parenting classes should be available to families regardless of income and offered in a variety of ways and locales. For example: family support groups; sessions for parents and children which offer a meal and bring individuals families and family groups together for fun and instructional activities (FAST model, Family Wellness model which help families learn to be together); therapists who provide in-home services or will go to day care centers, schools, and other family-friendly places (Laundromats!); retreats; home visiting, etc. Support for families to make their attendance non-stressful is critical-e.g., food, child care.

- Prevention and early intervention are important. Child development centers offer excellent opportunities to identify children with challenging behaviors and to offer intervention services to children and families in a friendly setting.

- Drug and alcohol issues play a role in the health status of children and families.

- Family-friendly activities, which avoid stigma of being a “problem child” or a “dysfunctional” family, attract all families.

- Media presentations, which stress the importance of parenting and how it is a community responsibility/effort, reach all residents (the State commission is investing in a media campaign with their 20% cut of tobacco tax dollars).

- Self-defense and other programs which help children set realistic boundaries and to avoid the victim role are helpful.

- Getting fathers involved is essential. For example, providing instruction about how to hold their newborn; conduct special outreach to teen dads.

- Support to parents and children to help siblings to get along.

- When children witness violent events/domestic abuse, their emotional health is affected; such children are more likely to adopt violent solutions themselves.

- 3-15% of children in preschools have challenging behaviors; teachers need support to cope (education, additional staff, on-site therapy services).

VIII. Post Partum Depression

Postpartum Depression (PPD) is a very serious condition that threatens the health and well being of new mothers, their babies, and families. Postpartum depression is a name given to a wide range of emotional and physical reactions to childbirth. This condition invades every aspect of a new mother's life affecting her ability to parent, maintain relationships, attend to daily tasks of living, and function in careers. PPD usually occurs in the identified that 20% of new mothers will experience PPD.

Symptoms of PPD include, but are not limited to: Insomnia, uncontrollable crying, anxiety/panic attacks, irritability, feelings of despair or worthlessness, loss of appetite, lack of interest in the baby or over concern for baby, poor concentration, thoughts of hurting self or baby, irrational thoughts, and obsessive compulsive shortness of breath, palpitations, chest pain, dizziness, trembling, and feeling faint.

A woman suffering from PPD has little energy to give to her newborn. If she is experiencing irrational thoughts or thoughts of hurting herself or her baby, she is even less likely to attach or bond with her baby. These babies are at risk for attachment disorders, neglect, and/or abuse. Dr. Geraldine Dawson PH. D., and colleagues at the University of Washington, have found that mothers who are depressed throughout their child's first years, are less likely to respond sensitively to their child's cues and clues, thus having long lasting effects on their child's development. Further imparting this cycle of depression and anxiety is the social stigma attached to having a mood disorder or mental illness. Women who experience PPD feel guilty and ashamed of their condition and they tend to isolate themselves, thus preventing them from seeking help.

Unmet Needs

Postpartum depression exists in our community. Based on the above statistics it is estimated that of the 3,776 births that occurred in Santa Cruz County last year (1999), approximately 755 women suffered from PPD. Due to the lack of awareness of PPD in the community, lack of knowledge and misinformation regarding PPD by medical professionals, and lack of support, women who suffer from PPD have not been getting appropriate and timely treatment, thus extending the course of this condition up to two years or more. In an attempt to fulfill this unmet need, four professional women in Santa Cruz County who experienced PPD formed the Postpartum Distress Support Group. Aside from that group, there are no other agencies in Santa Cruz County that specifically address the multifaceted issues of PPD. There is a 24 hour telephone helpline that volunteers staff as volunteers facilitate a free bi-monthly support meeting. The group pro-

vides emotional support, advocacy, latest research, information on current treatment methods, outreach, and resources/referrals (i.e. therapists to women and their families). Many of the participants state this is the only place they can talk about what they are experiencing and get support, understanding, and current information on PPD. Unfortunately, due to the small volunteer staff, and lack of resources (all operating costs are paid out of pocket by volunteer staff), are reached annually 75 (10 percent) of the estimated 755 women who may be experiencing PPD annually. Research has identified support groups as an effective treatment modality, especially in conjunction with other types of treatment such as professional counseling and/or medication. With early identification and treatment for PPD, healthy family functioning is an achievable outcome.

Recommended Strategies, Services, Programs and Activities

Increase the number of women served by the helpline and support group to 200 the first year, expand existing services by providing support groups in south county and possibly San Lorenzo Valley, increase public awareness and decrease social stigma regarding PPD by providing outreach and education in our community through PSAs, feature articles in local papers, and outreach to helping agencies, increase knowledge base of health care providers by conducting staff inservices regarding PPD and providing current literature, and collaborate with existing agencies to ensure that women identified with PPD have access to timely and appropriate services.

IX. Homeless Children

Unmet Needs

Not so long ago, women and children were rare at rescue missions and shelters. Now times have changed. Today homeless women and children are more common than ever. Santa Cruz County will soon have detailed information on homeless families with children from the Homeless Survey and Needs Assessment 2000. In the meantime national trends indicate according to some estimates, that between 70% and 90% of homeless families in America are headed by women. Even more significant, the population of homeless families has increased by 35% since 1989.

One of the fastest growing segments of the homeless populations is families with children. Families with children constitute approximately 40% of people who become homeless (Shinn and Weitzman, 1996). A survey of 30 U. S. Cities found that in 1998, children accounted for 25% of the homeless population (U.S. Conference of Mayors, 1998). These populations are likely to be higher in rural areas; research indicates that families, single mothers and children make up the largest group of people who are homeless in rural areas (Vissing, 1996).

Recent evidence confirms that homelessness among families is increasing. Requests for emergency shelter by families with children in 30 U.S. cities increased by an average of 15% between 1997-1998 (U.S. Conference of Mayors, 1998). The same study found that 32% of requests for shelter by homeless families were denied in 1998 due to lack of resources. Moreover, 88% of cities surveyed expected an increase in the number of requests for emergency shelter by families with children in 1999.

Poverty and lack of affordable housing are the principal causes of family homelessness. Poverty is growing more common for children, especially those in female-headed and working families.

As a result of low wages and unstable employment, many families struggle to get medical care, food and housing. Many do not have health insurance, a recent study found that 675,000 people lost health insurance in 1997 as a result of the federal welfare reform legislation, including 4,000,000 children (Families USA, 1999). In addition, housing is rarely affordable for families earning low wages, yet subsidized housing is so limited that less than one in four TANF families nationwide lives in public housing or receives a housing voucher to help them rent a private unit.

The shrinking supply of affordable housing is another factor underlying the growth in family homelessness. The gap between the number of affordable housing units and the number of people needing them is currently the largest on record, estimated at 4.4 million units (Daskal, 1998). The affordable housing crisis has had a particularly severe impact on poor families with children. Families with children represent 40% of households with "worst case housing needs" – those renters with incomes below 50% the area median income who are involuntarily displaced, pay more than half of their income for rent and utilities, or live in substandard housing (U.S Department of Housing and Urban Development, 1998). With less income available for food and other necessities, these families are only an accident, illness or paycheck away from becoming homeless.

Locally, the strong economy has caused rents to soar, putting housing out of reach for the poorest families in Santa Cruz County. Rents increased faster than income for the 20% of households with the lowest incomes (U.S. Department of Housing and Urban Development, 1999). As a result, more families are in need of housing assistance. From 1996 to 1998, the time families spent on waiting lists for HUD housing assistance grew dramatically. The waiting list in Santa Cruz county is currently seven to eight years. Long waiting lists for public housing mean that families must remain in shelters or inadequate housing arrangements longer. Many women with very young children refuse to go to local shelters because they are afraid their children will not be safe.

Domestic violence also contributes to homelessness among families. When a woman leaves an abusive relationship, she often has nowhere to go. This is particularly true of women with few resources. Lack of housing can mean that many women are forced to choose between abuse and the streets. In a study of 777 homeless parents (the majority of whom were mothers) in ten U.S. cities, 22% said they had left their place of residence because of domestic violence (Homes for the Homeless, 1998). In addition, 46% of cities surveyed by the U.S. conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 1998).

Homelessness severely impacts the health and well being of all family members. Compared with housed poor children, homeless children experience worse health; more developmental delays; more anxiety; depression and behavioral problems; lower educational achievement (Shinn and Weitzman, 1996). Deep poverty and housing instability are especially harmful during the earliest years of childhood; alarmingly, it is estimated that almost half of children in shelter are under the age of five (Homes for the Homeless, 1998).

Parents also suffer the ill effects of homelessness and poverty. One study of homelessness and low-income housed families found that both groups experienced higher rates of depressive disorders than the overall female population, and that one-third of homeless mothers had made at least one suicide attempt.

Recommended Strategies, Services, Programs and Activities

Santa Cruz County is examining the necessity of "a living wage" as opposed to "the minimum wage". All sectors of the society must support strategies, which will enable families with young children to live and work and be housed in Santa Cruz County.

Close to home, San Mateo County operates a variant of a voucher program. This program uses a combination of TANF and general County funds, HOME funds and foundation grants. Vouchers are valid for one year and pay for privately owned rental housing at the local fair market rent. In addition to housing assistance, families receive case management services and life-skills training. Families at risk of homelessness who are eligible for, or are currently receiving TANF, have completed at least 75% of a job training program or are currently employed and are assessed as highly motivated and likely to be able to handle their own rent within one year are eligible. Families pay 50% of their own rent for the first six months, 75% for the second six months. The Human Investment Project, a non-profit housing development agency, administers the program in collaboration with the county human service agency. 28 of 37 families in the pilot program successfully completed their first year, earning an average of $13.00 per hour and experiencing significant boosts in self-confidence.

Connecticut and New Jersey have developed housing assistance programs from limited numbers of former TANF recipients who are now employed. Connecticut's program is specifically intended to help working families with low earnings when they reach the state's TANF time limit and lose benefits – families generally contribute at least 40% of income toward rent and assistance is limited to one year. New Jersey's program is targeted to those with particularly severe housing needs and incomes under 150% poverty line – family rental contributions are based on income and decrease each year for three years.

In 2000, Minnesota's Governor, has proposed that the State earned Income Tax credit acts as a match under the State's MOE. This would free up general appropriations to provide 39.5 million for rental housing at rents of $400 a month for TANF families and $15 million in revolving loan to Habitat for Humanity for home ownership for TANF families.

X. Work/Family Issues

Definition

Employer's efforts to acknowledge that work is done by human beings with important personal responsibilities and priorities, and to support workers in handling them. Work-life efforts include anything that supports people in achieving life balance or handling both personal and work responsibilities.

Unmet Needs

The Success By 6 Work Group identified the following needs related to Work/Family issues: easily accessible, easily identify information and resources for employees; easily identified information and resources for employers; employee surveys to assess work-life challenges, see what they really want, need and would use; and employer surveys, such as the Work & Family News Brief Survey on Evaluation of Work-Life Efforts.

A culture shift will be necessary to fully implement family-friendly workplace policies.

Recommended Strategies, Services, Programs and Activities

- Encourage employers to make policy changes such as paid family leave and increased employee control over work hours.

- Collect information to answer questions.
  - What does work-life mean to leading edge companies?
  - Why do they feel they can't afford not to have a comprehensive program?
  - What are leading edge companies doing in the areas of programs, policies, culture and work practices?
  - How are leading edge companies approaching the challenge of creating a comprehensive work-life effort?

- Expansion of the Family and Medical Leave Act.

Report to the Santa Cruz County Children and Families Commission

from the Child Care and School Readiness Task Force — September 2000

Introduction

The Child Care and School Readiness Task Force met four times in May and June 2000.

Members

The members of the Task Force were: Lise Bixler, UCSC Child Care Services; Julie Olson Edwards, Cabrillo College Early Childhood Education Program; Pam Elders, Head Start; Lynn Lerose, Family Childcare Provider (Blueberry Hill) and Representative of the Santa Cruz Family Child Care Association Board; Jim Marshall, Childrens Commission and Local Child Care Planning Council; Marcia Meyer, Child Development Resource Center and Local Child Care Planning Council; Denis McCoy, Child Development Resource Center and Cabrillo College Early Childhood Education Program; Jeanne O'Grady, Youth Services Outreach Librarian-Santa Cruz County Library; Trisha Pastor, Live Oak Child Development Programs-Live Oak School District; Kim Sakamoto, Pajaro Valley Unified School District Teacher and Cabrillo College Early Childhood Education Program.

The Task Force reviewed the following areas of child care and school readiness: quality of childcare and infrastructure, child care affordability, child care availability, children with special educational/

developmental needs, family access to childhood development programs and funding, family/child literacy, parent support and education.

Process

The Task Force reviewed existing plans, reports and research; they identified unmet needs and recommended promising strategies, programs, services and activities to meet the unmet needs. Their recommendations for the Santa Cruz County Children and Families Commission's consideration in developing the Strategic Plan and funding priorities for the Proposition 10 tobacco tax funds are listed in this report. These recommendations represent a consensus of all participating members. The recommendations are not in priority order; the Task Force did not engage in a priority setting process.

General Overview

The majority of children under five are spending all or part of their day in group-care settings. Most of these are understaffed, under-trained, and are operating under conditions which make it extremely difficult to provide much more than minimal physical care of young children.

The single most important factor in children's eventual school and life success is the quality of human interaction and bonding, particularly in the earliest years of life. high staff turnover, shifting staff within programs, poor adult/child ratios, and vying values and practices between families and caregivers, all function to disrupt healthy development in young children in every arena of their growth. Any discussion of school readiness must address these fundamental problems or it cannot succeed. The early education/child care industry is in crisis of the most severe proportions. Staff shortages at every level, from aides to directors, inability to find substitutes, unavailability or high cost of buildings, poor and inconsistent professional development training, have resulted in many programs operating below minimal licensing standards. Additionally, the high percentage of children at risk, families in crisis, have put early education/child care staffs in the position of having to provide highly sophisticated, difficult and complex services for which no one on the staff has been appropriately trained.

Families of young children are in the group most likely to be experiencing economic stress, housing problems, relationship problems. They are often without extended family nearby, and even when there are two parents in the household, increasingly, both must be employed. The early education/child care industry is in a unique position to support families as it is the only institution that sees parents on a daily basis, and that shares with families their most precious resource—their children.

The entire infrastructure of early education/child care is threatening to collapse, particularly in the high cost area of Santa Cruz County. Addressing these issues must be the first priority of any approaches to early education/child care. Providing more childcare, without addressing these issues, will simply compound the injury to children that is already occurring.

Proposals Summary

- Create a local version of CARES bill to address issues of compensation.
- Set up a regional health benefits package for Family Child Care Home Providers and for center based programs.
- Create a regional professional substitute pool, providing full time work with benefits for substitutes who can be contracted out to programs.
- Provide on-site and regional training programs, particularly in the high-crisis areas of infant/toddler care and in family support intervention.

- Develop a regional early education/child care facilities program which provides some combination of rent relief, modular buildings, construction loans, insurance packages for groups that rent to children's programs, etc.
- Provide grant-based support to staffs of children's programs that take part in professional development activities (courses, conferences, consultations, etc.) that improve their capacity to serve young children and their families.
- Develop a regional Social Worker service focused in families with young children that can be accessed by all early education/child care programs.
- Develop a regional pool of trained parent educators to work with families across centers.

I. Quality of Child Care and Infrastructure

Unmet Needs

- Attracting and maintaining qualified teachers
- Continuity of educational opportunities between educational services and programs of 0-5 year olds and kindergarten

Recommended Strategies, Services, Programs and Activities

- Increase teacher salaries and general compensation packages
- Link salary augmentation to longevity/years of service
- Link years of service to ongoing training compensation
- Local match to statewide CARES legislation
- Develop a Santa Cruz County based CARES program
- Create a substitute pool that includes benefits and a livable wage
- Create better linkages between pre-school and kindergarten
- Establish on-site universal screening for hearing, vision, and speech

II. Child Care Affordability

Unmet Needs

- Increased pool of resources for families

Recommended Strategies, Services, Programs and Activities

- Financial incentives for programs that collaborate to increase services to capacity
- Establish a child care endowment with the Community Foundation of Santa Cruz County to include matching funds, planned giving, and structure to distribute funds
- Develop a mechanism to subsidize the full and true costs of child care slots (e.g. State Department of Education funded slots)

III. Child Care Availability

Unmet Needs

- Regional early education/child care facilities program which provides some combination of rent relief, modular buildings, construction loans, insurance packages for groups that rent to children's programs, etc.

Recommended Strategies, Services, Programs and Activities

- One-stop resource for families and providers
- Increase capacity in underserved areas, high need areas, and where no services exist

IV. Children with Special Educational/Developmental Needs

Unmet Needs

- Regional social worker services focused on families with young children that can be accessed by all early education/child care programs.

Recommended Strategies, Services, Programs and Activities

- Increase pool of year round assistants
- Provide additional resources for teachers who work with children with challenging behaviors
- Provide funding for accessibility facilities remodeling

V. Family Access to Childhood Development Programs and Funding

Unmet Needs

- Coordination of child care information and resources for families regarding child care availability

Promising Strategies, Programs, Services and Activities

- "Resource Centers" that are integrated within established child care centers to serve as one-stop resources for families to access information and resources including the coordination of information and referral with churches and community groups.

VI. Family/Child Literacy

Unmet Needs

- Increased general literacy opportunities for all families throughout the county

Promising Strategies, Programs, Services and Activities

- Funding for 0-5 providers to purchase high quality reading materials and family literacy activities and referrals
- Funding for "Literacy Coaches" that provide home visits, on-site center visits, visits to families and neighborhoods as well as the necessary coordination to schedule activities and resources.

VII. Parent Support and Education

Unmet Needs

- Regional pool of trained parent educators to work with families across centers

Recommended Strategies, Services, Programs and Activities

- Integrate and maximize use of existing parent education programs and expand them so that they are community and site based, geographically accessible, and meet linguistic and cultural needs.
- Creation of a "warm line" for parents and providers.

SECTION SEVEN

Appendix B — Selected Findings Parent/Guardian Community Survey

Santa Cruz County
Children & Families Commission
Investing In Our Children

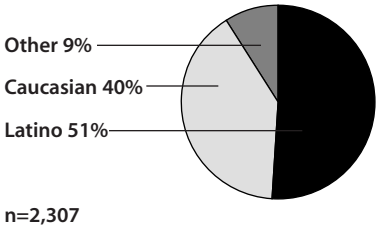
Appendix B

Selected Findings Parent/ Guardian Community Survey

Demographic Characteristics of Respondents

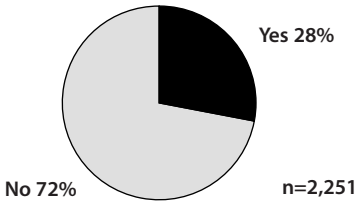
The respondents were mostly female (77.6%). Fifty-one percent of the respondents were Latino and low-income respondents (those with household income under $20,000) accounted for 48.7% of the totals. Most (57.1%) respondents were 35 years old or younger, and the most represented cohort was those aged 31 to 35 (23.4%). Over a fourth (27.8%) are a single parent or guardian, and a fifth (18.9%) when asked if their employer supports their needs indicated they are self-employed or unemployed. The largest group (43.3%) lives in Watsonville, with about a fourth (27.7%) in Santa Cruz, and 29.0% of the respondents were from sixteen other communities within the County.

Ethnicity of Respondents



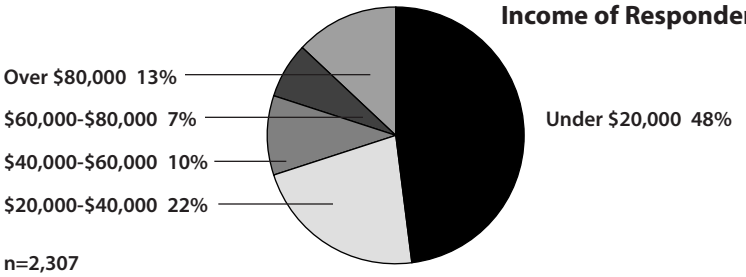
n=2,307

Single Parents



n=2,251

Income of Respondents



n=2,307

The sample of 2,398 respondents represents 3,458 children, an average of 1.4 children per respondent. (These numbers may include some double counts, since in many cases both parents of the same child were interviewed.) Of those respondents indicating they had children living with them: 1,593 had children 0-5 years of age, 1,151 had children 6-12 years of age, 546 had youth between the ages of 13-18, and 168 had young adults over 18. Most (72.0%) of the sample had children five years or younger, although half (52.0%) had children 6-12 and a third (32.3%) had youth 13 or older. There were 151 foster parents, the majority of whom were Latino and from the South County (This number is higher than official statistics, possibly because some respondents may consider themselves having the role of foster parents but do not meet the official definitions. There may also be a misunderstanding among the respondents as to the definition of foster parent). See appendix XIII for the language breakdown.

Childcare Arrangements

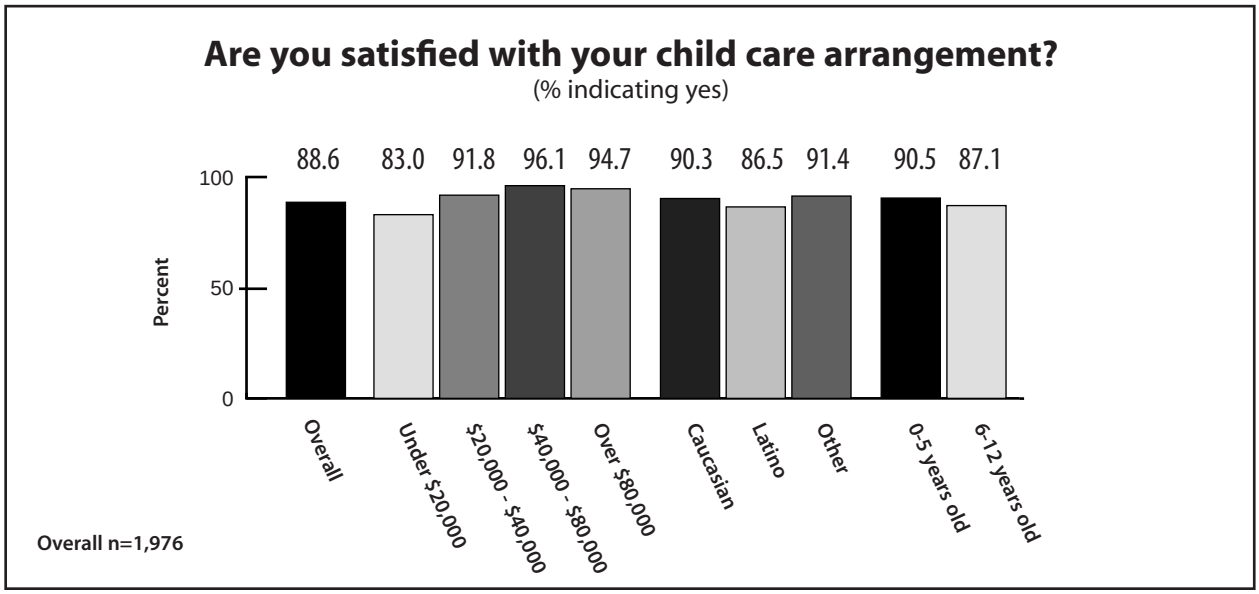
When asked why they chose their current child care arrangement, the most popular answers were because the child receives quality care (64.5%), followed by trust that the child will be safe and well cared for (61.5%, though only 55.8% of those with children 6-12) and convenience for family needs (43.5%). Latinos gave the same reasons though a fifth (20.5%) said they had no other choice. Although the same three reasons were cited by each income category, there were some differences across income categories: those with annual household income under $20,000 were more likely to say they have no other choice (24.1%) than those earning over $80,000 (2.6%), but less likely to say they chose their current arrangement because they could afford the cost (27.2% vs. 54.1%). Higher income respondents were also more likely to know where to get help in finding childcare (79.9% of those earning over $40,000 vs. only 61.6% of those earning under $20,000).

Table 1: "Why did you choose this childcare arrangement?"
Top 5 responses

Overall	%	Children 0-5 years old	%	Latino	%	Under $20,000	%
My child receives quality care.	64.5	My child receives quality care.	67.3	My child receives quality care.	52.5	My child receives quality care.	54.5
I trust that my child will be safe and well cared for.	61.5	I trust that my child will be. safe and well cared for.	66.4	I trust that my child will be safe and well cared for.	44.3	I trust that my child will be safe and well cared for.	44.2
It's convenient for my family needs.	43.5	It's convenient for my family needs.	45.6	It's convenient for my family needs.	34.0	It's convenient for my family needs.	38.1
Helps my child learn.	37.3	Helps my child learn.	42.1	Helps my child learn.	22.8	I can afford the cost.	27.2
The location is near work, home, or transportation.	35.1	The location is near work, home, or transportation.	38.1	I can afford the cost.	21.0	The location is near work, home, or transportation.	24.4

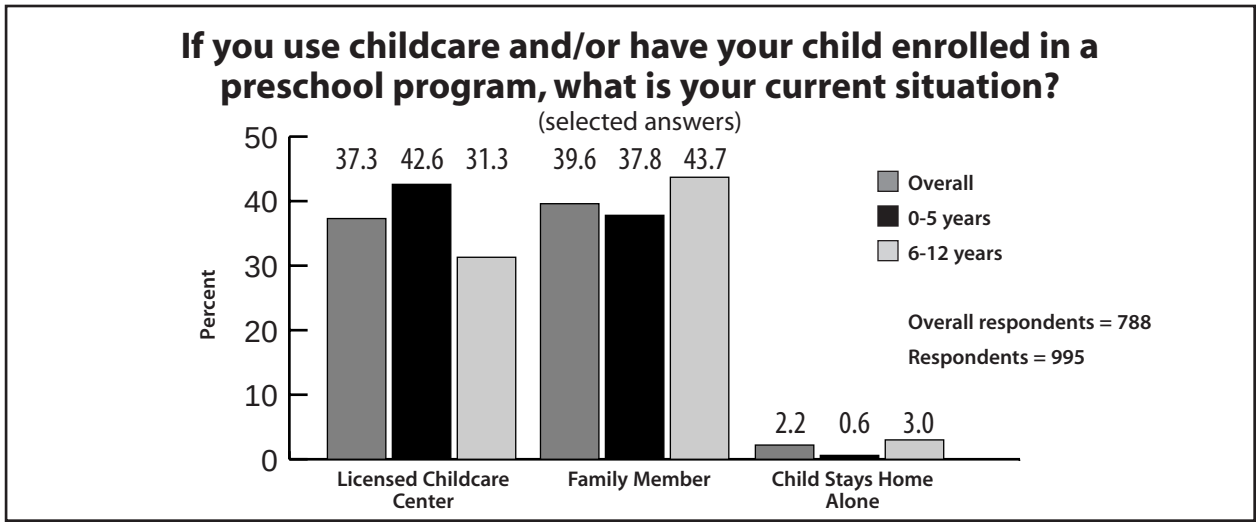
Most respondents say they are satisfied with their current child care arrangement (88.6%). Table 2 on the following page shows how satisfied the sub-groups are with their childcare. Nearly three-fourths of the respondents said they know where to get help in finding childcare (71.5% overall, and 61.5% of Latinos) and very few cannot communicate with their child care provider in their own language (6.2% overall, 8.9% of Latinos).

Table 2: Satisfaction with Child Care



Of those indicating they use childcare or have their child enrolled in a preschool program, nearly 40.0% indicated they have a family member caring for their children (30.2% in their own home, and 9.4% in the relative's home). Table 3 shows child care arrangements by the age of the child. About 2.2% indicated that their children stay home alone without adult supervision (3.0% of those with children 6-12).

Table 3: Child Care Situation

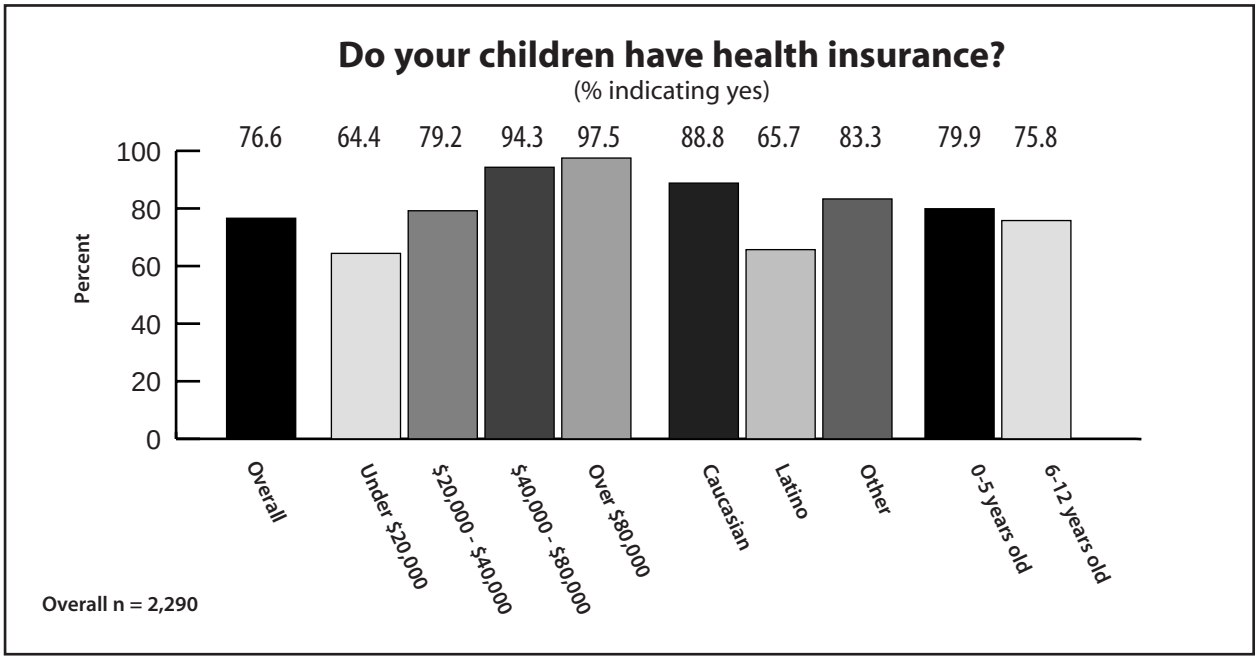


Health Issues

Three-fourths of the respondents indicated that they have health insurance or Medi-Cal (76.2% overall, 63.2% of Latinos) and 76.6% stated that their children have health insurance. Table 4 shows health coverage for children in selected sub-groups. South County children are less likely to have health insurance or have a physical examination every year.

However, a slightly higher percent of respondents said their children get a physical examination every year (83.4% overall, 81.8% of Latinos, 89.0% of those with children 0-5, 81.4% of those with children 6-12). Similarly, while less than two thirds (64.1% overall, 55.8% of Latinos, 67.9% of those with children 6-12) said their children have dental insurance or Denti-Cal, slightly more of the overall respondents (68.7%) say their children get a dental check up at least once per year.

Table 4: Health Insurance



Higher income respondents were more likely to have health insurance (97.1% vs. 66.2%), as were their children (97.5% vs. 64.4%), and their children were more likely to get an annual examination (88.8% vs. 79.8%). Overall, most (94.5%) said their children are up to date with their immunizations. Of those who said they weren't up to date on vaccinations, two thirds cited personal beliefs of one sort or another (66.7% overall, 65.0% of those with children 6-12). Nearly three quarters of the respondents with children 0-5 (72.9) cited personal beliefs. Very few don't know whether their children's vaccinations are up to date (1.1% overall, with no ethnic differences and only scant income differences).

The reasons for lack of healthcare are varied, limited office hours (19.7% suggesting problematic conflict with work schedules, having a hard time finding a doctor who accepts their insurance (15.4%), not knowing where to go for help in seeking health care (12.1%), and a language barrier (9.3%). Low income respondents were much more likely to say they have a hard time finding a doctor who accepts their insurance (21.2% of those under $20,000, compared to 8.1% of those making $40 to 80,000 and only 6.5% of those making over $80,000), to cite limited office hours (31.1%, vs. 5.6% and 3.2%, respectively), or to cite language problems (14.7%, vs. 3.5% and 2.5%, respectively).

Those with children five or younger were in the middle, with relatively high percentages citing insurance problems (15.7%), limited hours (17.4%), and language problems (8.1%). A Geographical System Information (GIS) map regionally displaying the survey question, "Do your children have health insurance," is available in Appendix VIX.

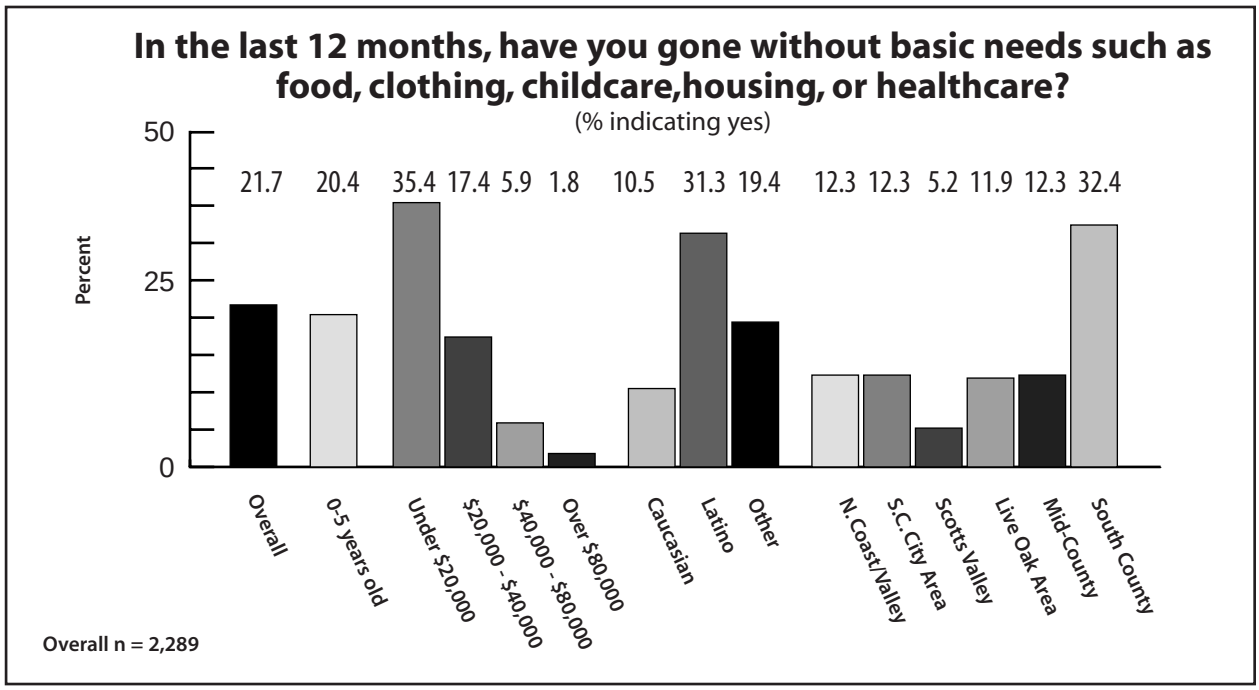
Someone smokes in a fourth of respondents' households (25.5% overall, 26.1% of Latinos, 22.2% of those with children five or younger but 26.7% of those with children 6-12), this is higher than the average in the state and the tri-county area. Only half say they know where to go if they want to quit smoking (54.1% overall, 40.6% of Latinos, 52.6% of those with children under five). Though ethnic differences were small, income differences were large: lower-income respondents smoke whereas higher-income respondents know where to get help to quit smoking. The frequency of someone in the household smoking drops in each successive income bracket, from a third (32.4%) of those earning under $20,000 to a fifteenth (6.8%) of those earning $80,000 or more. Regionally, someone smoking in the household is most common in South County

(33.0%) and least common in the Santa Cruz City area (15.0%). Meanwhile, knowing where to go for help in quitting increases across each successive income category, from less than half (44.9%) of those earning under $20,000 to more than three-fourths (78.8%) of those earning $80,000 or more.

Basic Needs

In the past year, a fifth or 21.7% of respondents have gone without basic needs such as food, clothing, childcare, housing, or healthcare. The figure in the 1999 Santa Cruz County Community Assessment Survey was only 9.7%, but that sample is "representative" of the County as a whole, whereas this sample is mostly lower income parents who may have more economic demands placed on them. (47.7% indicated that insufficient income was their biggest challenge). Table 5 indicates a lack of basic needs by sub-group.

Table 5: Basic Needs



Of those who have gone without such basic needs such as food, clothing childcare, housing or healthcare, the top needs mentioned were housing (44.0% overall), medical care (30.8%), and food (25.4%), with little difference for those with children five or younger (42.0%, 31.8%, and 23.9%, respectively). A fifth (17.3%) of the overall respondents indicated they have gone without childcare. (20.4% of those with children 0-5).

Basic needs are unmet most often in the South County (32.4%) and least often in Scotts Valley (5.2%). Which needs were unmet also varied by region: The most frequently cited unmet needs were medical care in the North County (58.3%), Mid-County (35.7%), and Santa Cruz City area (34.1%); housing in the South County (49.3%) and Scotts Valley (66.7%); and food in the Live Oak area (44.0%).

Only 0.3% indicated that they do not get important information for their children and family life. Important information or resources most often comes from friends and family members (73.5%), doctors/clinics (43.4%), and newspapers/magazines (34.5%), with little or no differences across ethnicity, regions, or income categories, or by age of children. The Internet provides important information for only a fifth (21.9%) of the respondents overall, although the percentage varies regionally (8.0% in the South County to 52.6% in Scotts Valley) and increases with each increase in income (from 7.4% of those earning under $20,000 to 54.2% of those earning over $80,000).

Challenges in Raising a Family

With respect to being a parent or guardian, respondents said they most liked loving, caring, and spending time with their children (26.0%). Less frequently given responses included teaching/supporting their children (10.0%) and participating in their activities (4.3%). Their biggest concerns about raising a family are public safety (19.6%, including gangs, crime, and violence), (22.0% of those with children 6-12), not enough money (14.5%), well being (health and security) of children in the future (12.5%), and drugs and alcohol (12.2%).

The most frequently cited desired major change in the community, for the purpose of improving the quality of life for their children, is more/better schools (15.8%), followed by more affordable housing (15.0%) and more parks, recreation centers, and sports facilities (14.3%).

Table 6: "What would you say is your biggest challenge as a parent or guardian of young children?" — Top 5 responses

Overall	%	Children 0-5 years old	%	Latino	%	Under $20,000	%
Balancing work and parenting	61.7	Balancing work and parenting	61.4	Balancing work and parenting	56.1	Sufficient income	59.3
Sufficient income	47.7	Sufficient income	47.8	Sufficient income	50.3	Balancing work and parenting	55.8
Education for your children	32.6	Education for your children	33.4	A place to live	40.3	A place to live	46.0
A place to live	28.6	Childcare	30.1	Education for your children	35.1	Childcare	31.6
Childcare	27.1	A place to live	27.8	Healthcare	30.2	Healthcare	29.9

The biggest challenge as a parent or a guardian is balancing work and parenting for two thirds (61.7%) of respondents, followed by sufficient income (47.7%) and education for their children (32.6%). This was true for each ethnic group. When asked "what they needed to become a better parent", 20.3% said if they had a better job and/or more money, parenting classes/more information (14.9%), and more time with their family (13.5%).

Over two thirds (65.7%) who are employed say their employer supports their needs as a parent (65.7% compared to 65.2% of those with children five or younger, and 66.3% of those with children 6-12).

Please visit our website for the comprehensive report.
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Santa Cruz County
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