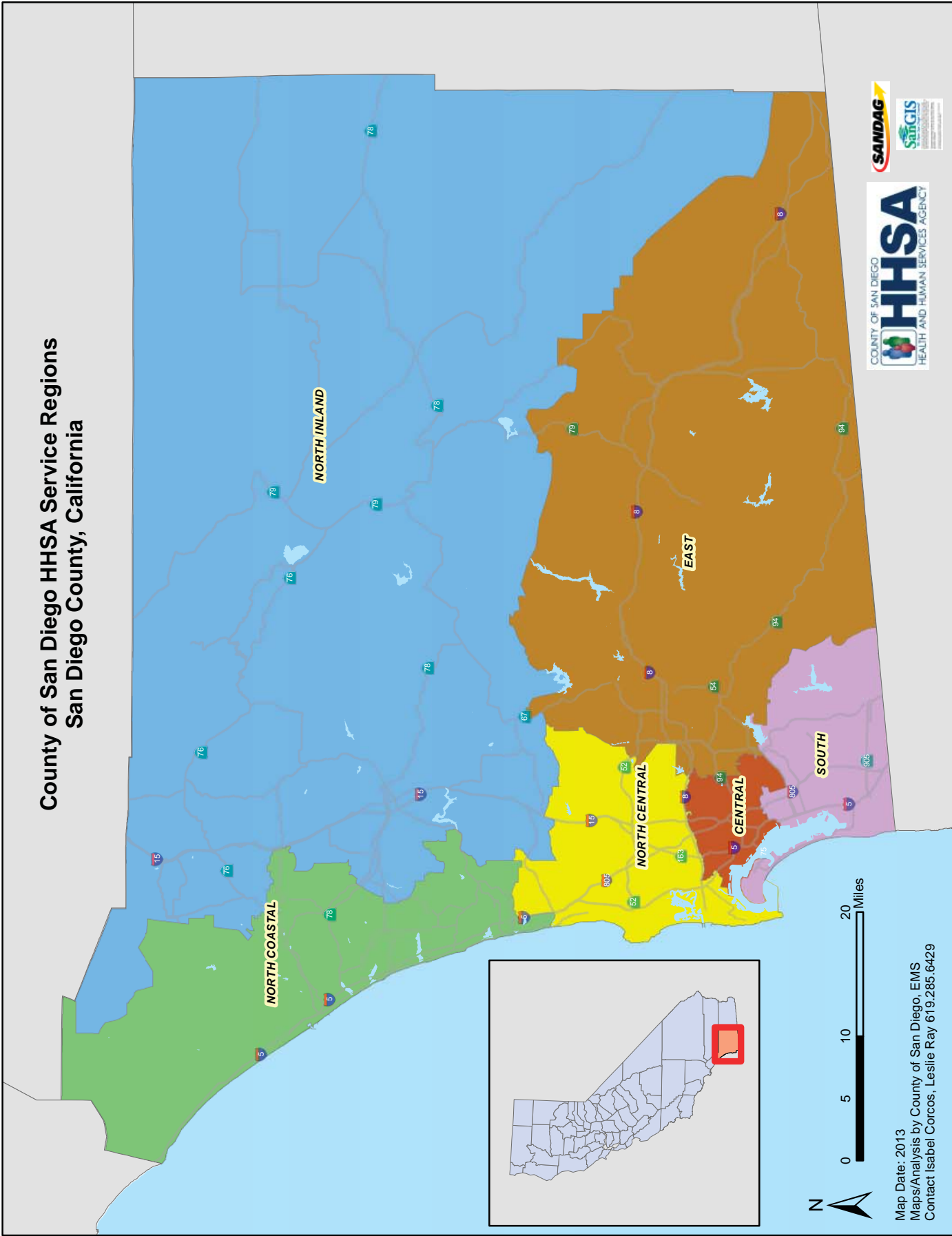


San Diego County Report Card on Children & Families 2015

County of San Diego HHSA Service Regions San Diego County, California



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Maps/Analysis by County of San Diego, EMS
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San Diego County Report Card on Children and Families

2015 Edition

Produced in partnership with the County of San Diego Board of Supervisors

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This *Report Card* is available in electronic format at www.thechildrensinitiative.org



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EXECUTIVE SUMMARY

The 2015 *San Diego County Report Card on Children and Families* continues to support and build on the vision of the County of San Diego *Live Well San Diego* to create a region that is “Building Better Health, Living Safely and Thriving.” The *San Diego County Report Card on Children and Families* is the tool for our region and for Live Well San Diego that documents the status of health, safety, and well-being of children and youth in San Diego County, California. To develop this *Report Card*, the Children’s Initiative worked with professionals in children’s services, government leaders, community organizations, schools, and foundations to drive a results-focused process. This process allows us not only to report data trends, but to highlight effective practices and make specific recommendations to “turn the curve” and through action to accelerate improvement in trends. The 2015 *San Diego County Report Card on Children and Families* is the continuation of a series of report cards that provides an overview of the overall health, safety, and well-being of our San Diego County children, youth, and families. This *Report Card* supports Live Well San Diego’s pursuit of healthy, safe, and thriving communities by reporting up-to-date data, emerging trends, national best practices, and local recommendations, working to ensure that all children, families, and communities are healthy, safe, and thriving.

The *Report Card* is produced biennially by the Children’s Initiative, a nonprofit child advocacy agency in San Diego. Supported through public and private partnerships and funding, the Children’s Initiative has continued to spearhead and advance a shared effort in the development and publication of this 2015 *Report Card*. The Children’s Initiative calls on and utilizes advice and expertise from a diverse group of stakeholders including subject matter and data experts in juvenile justice, education, and health, as well as government executives, community-based organizations, parents, and youth. Funders include: County of San Diego Health and Human Services Agency, The California Endowment, The San Diego Foundation, and McCarthy Family Foundation. A robust and influential Leadership Advisory Committee comprised of national experts and local leaders in the fields of: health, education, child care, child welfare, juvenile justice, and injury and violence prevention guide the development of the *Report Card*. The Leadership Advisory is integral to the selection of indicators, content of feature boxes, identification of San Diego efforts, and development of recommendations. A Scientific Advisory Review Committee from these same fields of study serves to ensure validity, reliability, and quality of data used for all indicators and other information in the *Report Card*.

The 2015 *Report Card* continues the work of previous editions, using 25 indicators to measure the health, well-being, and safety of children and families in San Diego County. In line with the efforts of Live Well San Diego this edition continues to highlight five adult indicators to demonstrate the impact of health, safety, and thriving across the life-span and to illustrate the interaction between child and adult risks. Using nationally recognized criteria in results-based accountability, each indicator was studied to ensure that it met specific criteria: Are the data reliable and consistent? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? Does the indicator say something of importance about the desired outcome? The Children’s Initiative, with the Leadership and Scientific Review Committees, used this decision model to select indicators that reflect some of the most important aspects of the lives of children and families for which reliable data are available.

As in the past, the 2015 *Report Card* reports the current status of the indicators and trends in the last five to ten years. It also provides information on evidence-based and best practices for prevention and intervention, as well as recommendations for action specific to San Diego County. This edition of the *Report Card* includes changes to local recommendations, defining three recommendation categories: (1) Policy, (2) Programs and Services, and (3) Family and Community. These new categories will help all stakeholders—community residents, government leaders, agency staff, professionals who deliver services, funders, and community-based organizations—understand what they can do to help guide policy

development, target prevention and intervention efforts, and educate residents and families. This edition also includes informational boxes for each indicator, which highlight notable local facts and provide additional data for regional, gender, age, or other factors. This edition continues to include “feature boxes” that highlight emerging concerns for children, youth, and families in San Diego County for which local data are not currently collected.

Summary of Trends

Birth to Three (Infants and Toddlers)

Generally, San Diego County compares favorably to state and national rates, with majority of the indicators for birth to three (early prenatal care, low birthweight, and breastfeeding) maintaining. The trend in births to teen shows consistent positive improvement, similar to the state and the nation.

Ages 3 to 6 (Preschool)

To fully understand the issues for preschool age children, we need additional indicators. With only two reliable indicators for this age group, the challenge is to develop and/or collect more data to better measure their progress toward healthy development and school readiness. The early care and education trend is maintaining with half of our 3 and 4 year olds enrolled in preschool or other early education settings. While lack of year-to-year data make it difficult to plot a trend for immunization, San Diego remains slightly above the national objective.

Ages 6 to 12 (School Age)

Among school age children, there is some progress yet more is needed. The indicator of school attendance shows fluctuations over time, with no improvements for elementary grades. The first year of reporting on common core testing results showed school achievement in English-language arts/literacy at 46% among 3rd graders. The trend in oral health and obesity are improving, yet remain below optimal levels.

Ages 13 to 18 (Adolescence)

While improvements are shown across most of the indicators for this age group, continued efforts are needed to protect youth from risks such as substance use, suicide, DUI, delinquency, and other threats to their lives and well-being.

Community and Family (Cross Age)

The majority of our community and family indicators are improving. Of concern is the economic situation many of our families are faced with, with more children and families living in poverty throughout San Diego County. The good news is that services and support for low-income families (e.g. nutrition assistance, health coverage) show positive trends.

Using the Life Course Framework and Adult Indicators

Health and well-being are intergenerational issues. Across the country researchers, agencies, and policy makers have gained new understandings of the interaction of factors that influence health and well-being across the life course. The life course theory is a conceptual framework that demonstrates how health, exposures, and experiences affect one's life from childhood to adulthood, as well as across populations and generations. Looking at risk and protective factors across the life-span gives new understanding to the drivers behind many health disparities, particularly those related to income and racial/ethnic inequality.

For the 2015 *Report Card* we are continuing to use select indicators that reflect factors affecting life course trajectories and intergenerational impact, which is the foundation of *Live Well San Diego*. This *Report Card* discusses life course implications through five distinct and powerful indicators: Oral Health, Obesity, Smoking, Poverty, and Lack of Health Coverage. These indicators illustrate how childhood factors can have lifelong impact on health and well-being, as well as how what parents do or do not do directly affects their children's life course trajectories.

These adult indicators align with *Live Well San Diego* representing measurable areas where change is needed to achieve the vision for healthy, safe, and thriving communities. For example, parental smoking directly affects child health through exposure to secondhand smoke and indirectly affects the health prospects of children by increasing the chances that a youth will become a smoker. Parent's views and practices on oral health have direct effects on children's oral health, and having diseased teeth as a child affects lifelong health. Similarly, childhood obesity increases the chances of lifelong overweight or obesity and parental weight is correlated with children's weight. The risks of childhood poverty are inextricably related to parents' ability to find a job with a living wage, secure affordable housing, reside in a safe neighborhood, and pay for health, child care, and educational expenses.

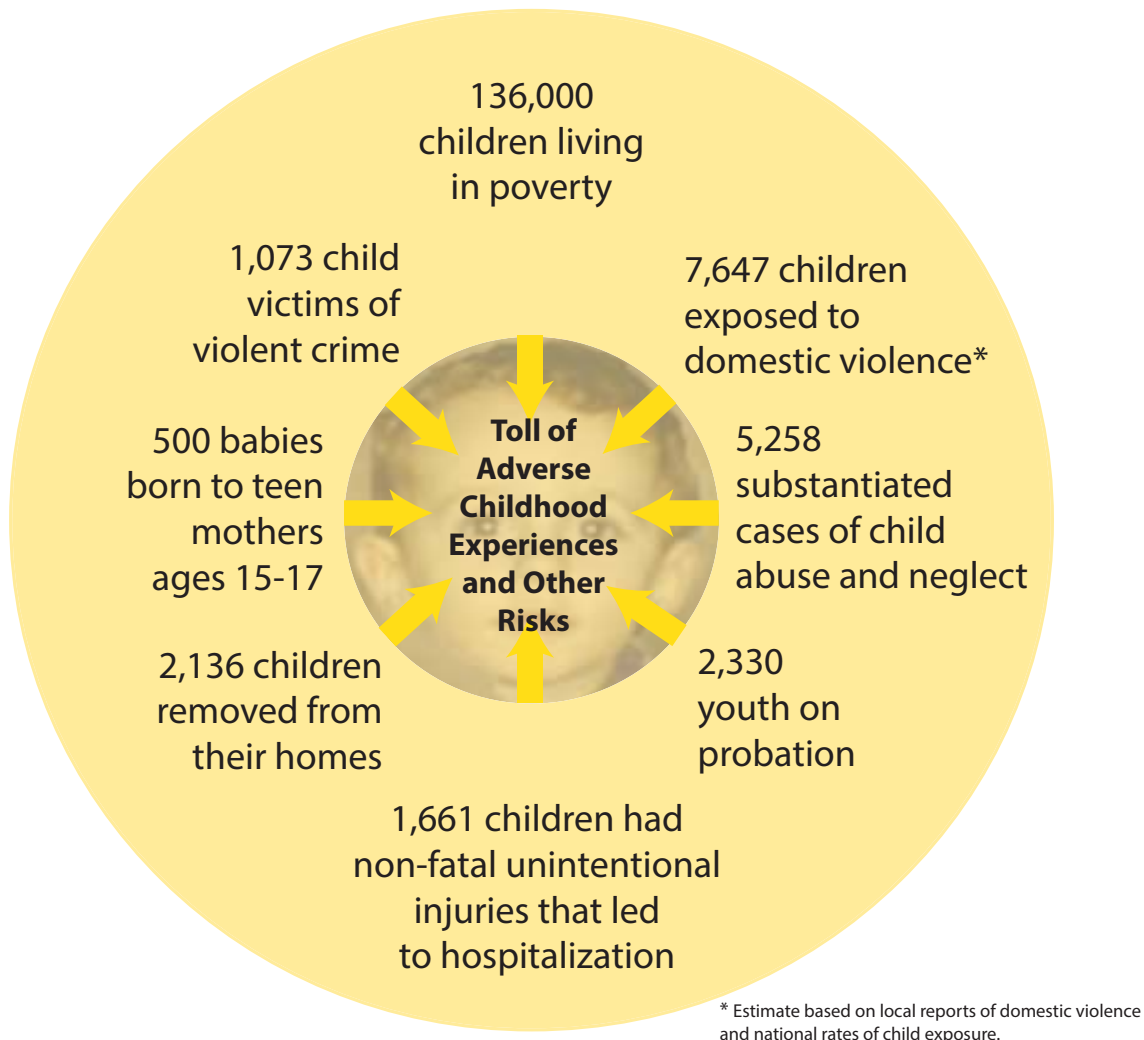
Figure 1 shows the prevalence of adverse childhood experiences (ACEs) and other serious risks and trauma among children and youth in San Diego. It illustrates how adult and child factors interact across the life-span. ACEs include experiencing child abuse and neglect (emotional, physical or sexual), experiencing divorce or separation of parents, witnessing domestic violence, living with a parent/caregiver who is abusing substances, has mental illness, or is incarcerated. Studies also include experiencing severe poverty or economic hardship and institutional racism (being unfairly treated or judged based on race/ethnicity). More than one in five US children experience two or more of these adverse childhood experiences. While we cannot measure all of these risks for San Diego County children, we do know some of the risks they face. These and other risk factors are shown in Figure 1.

The toll of ACEs begins in childhood and shows up prominently in adolescence, with a strong relationship to early initiation of smoking, sexual activity, illicit drug use, adolescent pregnancies, and suicide attempts. Lead ACE study researcher and chief of Kaiser Permanente's Department of Preventive Medicine in San Diego, Dr. Vincent Felitti, describes it this way: "*The ACE Study reveals a powerful relationship between our emotional experiences as children and our physical and mental health as adults, as well as the major causes of adult mortality in the United States. . . . How does this happen, this reverse alchemy, turning the gold of a newborn infant into the lead of a depressed, diseased adult?*"

Healthy development also depends on the interaction of personal and societal factors in health and well-being. What is increasingly understood is that epigenetics is an important force. Children's development and lifelong well-being is shaped by both innate characteristics present at birth (e.g., hereditary conditions and genetic make up) and experiences throughout childhood (e.g., factors related to parental, community, or societal influences). (See feature box.)

The role of social determinants of health is equally important. *Live Well San Diego* documents the role of social determinants of health, and they are reflected in the indicators of this report. The five adult indicators were selected based on the same criteria used for our childhood indicators. In addition, we considered the value of the adult indicators to reflect the life course trajectory, both the impact of child conditions on adult health and well-being and the impact of adult (parent) conditions on childhood.

Figure 1. Adverse Childhood Experiences and Other Risks Among San Diego Children and Families



The four major strategies of Live Well San Diego can also help to change the life course trajectory for families.

1. Building a better service delivery system by improving the quality and efficiency of County services to contribute to better outcomes for individuals and results for communities.
2. Supporting positive choices with information and resources to support residents to live healthy lives.
3. Pursuing policy and environmental changes by creating environments and adopting policies that make it easier to live well. This includes reducing barriers in social and physical environments that affect health.
4. Improving the culture within. County employees and providers work to live well, and they have a role in helping county residents live well and in helping children and families thrive.

The *Report Card* includes recommendations to improve the policies, programs, and community conditions and thereby offers greater opportunity for equity in life conditions, health, and well-being for our populations. By starting early in children's lives, we can maximize and optimize the potential of each child to grow and develop into a healthy, productive, and thriving adult.

Unlocking the Secrets of the Genome: The Epigenetics of Traumatic Stress

Scientists have long debated whether “nature” or “nurture” explains a child’s development and behavior. Current research has weighed in on this historic debate. Children’s development is shaped by both innate characteristics present at birth and personal experiences throughout childhood. The benefits of sensitive and supportive parenting and a stable, secure, and safe environment have long been credited with healthy child development. The relationship between adversity and child development is also now better understood.

The ACE study series linked early stress from abuse, violence, and family dysfunction in childhood to a host of negative long-term physical health, mental health, and social outcomes. The evidence is clear that childhood toxic stress often has devastating impacts on children that can last a lifetime. Now the science is turning to the mechanisms by which exposure to highly stressful traumatic events in childhood changes how the human brain develops and manages the stress of its environment. At the center of this interest is the science of epigenetics. In short, epigenetics is the study of how gene expression within the DNA is influenced by the environment. In children, this can lead to changes in how the individual genes are read at the cellular level, which in turn, can have a profound effect on the child’s life course.


Advances in neuroscience have demonstrated how early and chronic activation of stress hormones can have a dramatic impact on neurodevelopment and the body’s long-term ability to regulate stress responses. With epigenetics, we can begin to grasp how these stress hormones turn on and off selected genes affecting the developing brain in areas that influence learning, emotional regulation, and decision making, which are then linked to the ability to learn, make prudent lifestyle choices, form and maintain relationships, and even influence the body’s ability to fight off infection.


Understanding how stressful environments in childhood can alter the expression of genes and change the trajectory of a child’s development is an important step. The real promise of epigenetics for children is in the potential to use that knowledge to help alleviate the effects of toxic stress. In the future we may find that with epigenetics, we can tailor interventions to match the unique genetic profile of individual children, allowing us to better target evidence-based treatments to more effectively counteract the negative effects of past stressful environments. In years to come, pharmaceutical and/or behavioral interventions may be available to influence gene expression to reverse some of the adverse biological effects of toxic stress. In the end, epigenetics may facilitate our efforts to improve the life course trajectories of children who have been abused, neglected, or exposed to the toxic effects of adverse childhood experiences. In San Diego, Rady Children’s Hospital is at the forefront of this effort with its expertise in trauma management and with the new Rady Pediatric Genomic and Systems Medicine Institute.

San Diego County Report Card on Children and Families, 2015










REPORT CARD SUMMARY TABLE County, State, and National Comparisons

Key to table symbols:

 Trend is improving.

 Trend is maintaining.

 Trend is moving in wrong direction.

Indicator		San Diego County	California	United States
Birth to Age 3 (Infants and Toddlers)				
Percentage of mothers receiving early prenatal care		84.8 ¹	83.6 ¹	NA
Percentage of infants born at low birthweight		6.5 ¹	6.8 ¹	8.0 ¹
Percentage of mothers who initiate breastfeeding in hospital		95.7 ¹	93.0 ¹	NA
Birth rate per 1,000 teens ages 15-17 years		8.9 ¹	11.0 ¹	12.3 ¹
Ages 3-6 (Preschool)				
Percentage of young children (ages 19-36 months) who completed the basic immunization series	NA	81.8 ¹	71.3	74.9
Percentage of children ages 3-4 enrolled in early care and education		50.4	47.8	47.1
Ages 6-12 (School Age)				
Percentage of children ages 2-11 who have never visited a dentist		13.3	17.7	NA
Percentage of adults ages 18 and older who had not visited a dentist within prior 12 months		25.9	31.0	NA
Percentage of elementary school (K-5) students who did not attend school at least 95 percent of school days		29.1	NA	NA
Percentage of students in grade 3 who met or exceeded standard in English–language arts/literacy	NA	46.0	NA	NA
Percentage of students not in the Healthy Fitness Zone and at risk (obese)				
Grade 5	NA	17.3	NA	NA
Grade 7	NA	16.2	NA	NA
Grade 9	NA	14.1	NA	NA
Percentage of adults ages 18 and older that are obese		24.8	27.0	NA

Indicator		San Diego County	California	United States
Ages 13-18 (Adolescence)				
Percentage of middle and high school students (grades 6-12) who did not attend school at least 90 percent of school days	↑	7.3	NA	NA
Percentage of students who met or exceeded standard in English–language arts/literacy				
Grade 8	NA	50.0	NA	NA
Grade 11	NA	58.0	NA	NA
Percentage of students who report using cigarettes in past 30 days				
Grade 7	↑	1.9	NA	NA
Grade 9	↑	4.0	NA	NA
Grade 11	↑	7.1	NA	NA
Percentage of students who report using alcohol in past 30 days				
Grade 7	↑	5.8	NA	NA
Grade 9	↑	14.6	NA	NA
Grade 11	↑	23.9	NA	NA
Percentage of students who report using marijuana in past 30 days				
Grade 7	↑	3.3	NA	NA
Grade 9	↑	10.4	NA	NA
Grade 11	↓	17.4	NA	NA
Percentage of adults ages 18 and older who report smoking	↑	9.7	11.6	NA
Percentage of male students (grades 9-12) who report they attempted suicide in previous 12 months	→	6.9	NA	4.6
Percentage of female students (grades 9-12) who report they attempted suicide in previous 12 months	→	11.0	NA	8.1
Number of arrests for misdemeanor and felony crimes among youth ages 10-17	↑	6,351	NA	NA
Number of sustained petitions (true finds) in Juvenile Court among youth ages 10-17	↑	2,330	NA	NA
Number of DUI arrests among youth under age 21	↑	780 ¹	1,262	NA
Rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population	↑	68.9 ²	NA	NA

Indicator		San Diego County	California	United States
Community and Family (Cross Age)				
Percentage of children ages 0-17 living in poverty	↓	18.9	22.7	22.2
Percentage of adults ages 18-64 living in poverty	↓	14.2	15.3	14.6
Number of children ages 0-18 receiving Food Stamps	↑	144,014 ³	NA	NA
Number of adults receiving Food Stamps	↑	155,663 ³	NA	NA
Percentage of children ages 0-17 without health coverage	↑	6.4	3.6	NA
Percentage of adults ages 18-64 without health coverage	↑	15.7	17.2	NA
Rate of domestic violence reports per 1,000 households	↑	15.4	12.2	NA
Rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17	↑	7.2	8.7	NA
Rate of violent crime victimization per 10,000 children or youth	↑	14.5	NA	NA
Rate of fatal and non-fatal unintentional injuries resulting in hospitalization per 100,000 children ages 0-18	↑	177.6 ¹	219.9 ¹	NA
Infant mortality rate per 1,000 live births	↑	4.6 ¹	4.7 ¹	5.98 ²
Rate of mortality per 100,000 children				
Ages 1-4	→	24.6 ¹	NA	NA
Ages 5-14	↑	9.0 ¹	NA	NA
Ages 15-17	↑	18.2 ¹	NA	NA

Table notes: Unless otherwise noted all data are for year 2014, school year 2014-15, or California Health Interview Survey combined years 2013-14.

¹ Data from 2013

² Data from 2012

³ Data from 2015

SAN DIEGO COUNTY REPORT CARD ON CHILDREN AND FAMILIES, 2015

Introduction

This *2015 San Diego Report Card on Children and Families* supports and builds on the County of San Diego *Live Well San Diego* vision, to create a region that is “Building Better Health, Living Safely and Thriving.” The *San Diego County Report Card on Children and Families* is the tool for our region and for *Live Well San Diego* to identify and document the health, safety, and well-being of children, youth, and families in San Diego County, California. Generally, report cards monitor trends and can point to positive results or troublesome trends, as well as indicate the need for change or continued support of policies and programs.

Results (or outcomes) are conditions of well-being for children, adults, families, and communities. Results are what we aim to achieve as a society including: children who are healthy, ready for, and succeeding in school, avoiding risky behaviors, and safe in their homes, schools, and communities. Across the country, report cards use indicators as benchmark measures for monitoring progress toward desired results.

The *2015 Report Card* continues to use 25 selected child indicators to measure the health, safety, and well-being of infants and toddlers, preschoolers, school age children, adolescents, families, and communities. Supporting *Live Well San Diego*, this edition continues to include five indicators of adult well-being that are related to our child measures, have intergenerational importance, and reflect the life course trajectory. Using nationally recognized criteria in results-based accountability, each indicator was assessed to ensure that it met specific criteria: Are the data reliable and consistent? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? Does the indicator say something of importance about the desired outcome?

Research tells us much about what strategies have proven effective in improving the conditions of children and families. An up-to-date list of “strategies that can make a difference” is included for each indicator. These lists are compilations of evidence-based and best practices from across the United States, as reported in professional journals, federal websites, and other authoritative sources. Key sources and references from our extensive literature reviews can be found online. (Visit www.thechildrensinitiative.org.)

The *2015 Report Card* continues to support and document the success of *Live Well San Diego*, showing trends for indicators that reflect the health, safety, and well-being of children, youth, and adults. The indicators for the *2015 Report Card* are the foundation, beginning from birth, for the *Live Well San Diego* areas of influence:

1. Health—Enjoying good health and expecting a full life
2. Knowledge—Learning throughout the lifespan
3. Standard of living—Having enough resources for a quality life
4. Community—Living in a clean and safe neighborhood
5. Social—Helping each other live well

This edition also includes changes in how we focus local recommendations, defining three categories of recommendations: (1) policy, (2) programs and services, and (3) family and community. These new categories will help all stakeholders—community residents, government leaders, agency staff, professionals who deliver services, funders, and community-based organizations—understand what they can do to help

guide policy development, target prevention and intervention efforts, and educate residents and families. This edition also includes informational boxes for each indicator, which highlight notable local facts and provide additional data for regional, gender, age, or other factors. For many of these informational boxes, the number behind the trend data is presented. This edition continues to include special “feature boxes” that highlight emerging concerns for children, youth, and families in San Diego County for which local data are not currently available but are relevant to the health, safety, and well-being of San Diego’s children and youth.

The Report Card Development Process

The Children’s Initiative *Report Card* series is based on a unique approach that engages a broad array of stakeholders in a results-focused process and reports not only on data trends but also on effective practices and specific recommendations to “turn the curve” or accelerate progress on our indicator trends. It builds upon and has become a nationally recognized report card model.

Beginning in 1997-98, the San Diego County Health and Human Services Agency undertook the development and publication of the *Report Card on San Diego County Child and Family Health and Well-Being*. The last edition of that report was issued for the year 2005. In January 2006, the San Diego County Board of Supervisors approved the transfer of ownership and responsibility for the County Report Card to the Children’s Initiative, a local nonprofit agency that serves as an advocate and custodian for effective policies, programs, and services that support children, youth, and families. The first version of the report in its new format was published by the Children’s Initiative in January 2008, and this is the fifth edition.

This *2015 Report Card* was developed and published as a public-private partnership, continuing to align with the County of San Diego *Live Well San Diego*. To develop this *Report Card*, the Children’s Initiative worked with professionals in children’s services, government leaders, community organizations, and foundations to drive a results-focused process. This process allows us not only to report data trends, but to highlight effective practices and to make specific recommendations to “turn the curve” and accelerate progress on indicator trends. The Children’s Initiative calls on and utilizes advice and expertise from a diverse group of stakeholders including subject matter and data experts in the areas of juvenile justice, education, and health, as well as government executives, community-based organizations, parents, and youth.

A robust and influential Leadership Advisory Committee comprised of national experts and local leaders in the fields of health, education, child care, child welfare, juvenile justice, and injury and violence prevention guide the development of the *Report Card*. The Leadership Advisory is integral to the selection of indicators, content of feature boxes, and development of specific recommendations.

The research and analysis have been overseen by a Scientific Advisory Review Committee, including statisticians, epidemiologists, and program data managers from these same fields of study. Whenever possible, county agency staff with responsibility for data presented are directly involved in the preparation of the *Report Card*. This group has knowledge of particular methods for program-specific data, as well as broad understanding of the trends in their fields. They review data files, graphs, graph analysis, and the content of informational and feature boxes.

The document also reflects the advice and expertise of a broad array of San Diego County stakeholders concerned with the well-being of children and youth, including: public agency and government officials; subject matter experts in education, health, and other fields; providers and community-based organizations; and parents and youth. The Children’s Initiative staff and consultants meet regularly with educators, physicians, law enforcement, family advocates, and others to discuss the data, the trends, and what works.

Public and private funders for this 2015 *Report Card* include: County of San Diego Health and Human Services Agency, The California Endowment, The San Diego Foundation, and McCarthy Family Foundation.

Understanding Data in this Report Card

Readers of the Children’s Initiative *Report Card* will want to know how the data are presented and what they represent. The most recent data available at the time of production are used. Depending on the type and source of information, the most recent data available for this edition may be for 2013, 2014, or 2015. School related data is generally provided for school year 2014-15.

Trend graphs are presented to illustrate the status of an indicator over time. No tests have been done to determine the statistical significance of changes; we are only observing whether the trends are improving, maintaining, or worsening. Notably, a one-year change in a specific rate may be the result of a temporary environmental change, a change in data sample, or some other extraneous influence, and may not represent a true change in the trend. When possible, comparison data are presented to assist in understanding how our county is doing compared to California or United States averages, as well as to the federal Healthy People 2010 and 2020 Objectives set by the U.S. Department of Health and Human Services. Notably, in some cases the 2020 Objectives has set a less rigorous target for the nation.

When possible, data are presented in percentages and rates, reflecting the norms and standards for a particular data source. Using these standardized measures makes it easier and more accurate to look at trends or make comparisons. A percentage is the most easily understood comparison and is used whenever appropriate. Rates per 1,000, 10,000, or 100,000 people are used when the incidence of a condition is low. When reliable population denominators are not available, graphs show the number of events. For example, we report the number of youth DUI arrests and the number of individuals receiving nutrition assistance through CalFresh.

Most graphs use calendar years as a measure for trends. For education data, the trends are shown in school years (e.g., 2014-15).

Graphs generally show data on a scale of 0 to 100, 0 to 50, or 0 to 25, depending on the level of the trend. For some, however, the scale has been modified to better show year-to-year variations. When that occurs, the chart is marked with the words “note scale.”

The Children’s Initiative staff and advisory committees specifically selected the indicators in this report to have strong data and communication power, and to reflect broadly on a given topic. The adult indicators were selected based on these same criteria, plus the value of the measure to reflect the life course trajectory, which reflects both the impact of child conditions on adulthood and the impact of adult (parent) conditions on childhood. The total group of 25 child and 5 adult indicators reflects a broad array of concerns, but not all the results that are important to families. For example, we do not report on housing, employment, or recreation.

Best practices were identified from respected sources such as professional journal publications, government agencies, and university or other research organizations. Extensive literature and content reviews are conducted for each edition of the *Report Card*, using information from the latest data and publications. An effort has been made to offer comprehensive lists of evidence-based and best practices. These sections are not, however, intended to be exhaustive or complete lists of possibilities. (Selected references available online at www.thechildrensinitiative.org.)

The recommendations for action are based on a survey of community leaders and providers, advisory committee members, subject matter experts, and national consultants. For this edition of the *Report Card*, local recommendations are presented in three categories: (1) policy, (2) programs and services, and (3) family and community.

Notes on Geographic and Racial/Ethnic Data

San Diego is a large county, stretching 65 miles from north to south and 86 miles from east to west, covering 4,261 square miles—slightly smaller than the state of Connecticut. It borders Orange and Riverside Counties to the north; the agricultural communities of Imperial County to the east; the Pacific Ocean to the west; and the state of Baja California, Mexico, to the south. With an elevation that goes from sea level to 6,500 feet, our county includes beaches, deserts, and mountains. Our communities incorporate urban, suburban, and rural neighborhoods. San Diego County comprises 18 incorporated cities and 17 unincorporated communities, and even these are divided into locally identified communities and neighborhoods. The County of San Diego Health and Human Services Agency prepared geocoded maps for this 2015 *Report Card* that illustrate the occurrence of selected indicators according to more precise and easily understood community boundaries (e.g., zip code areas).

The San Diego Association of Governments (SANDAG) reports on population estimates, and SANDAG data are used here. The county's total population was estimated at 3,227,496 for 2015, and it is the second most populous county in the state, after Los Angeles County. Children under age 18 represent 23% of our population (SANDAG estimate 2015).

The region's population under 18 is distributed throughout urban, suburban, and rural areas, notably in inland communities. Areas with the highest concentrations of population—representing close to one-third of the population of children under age 18—are in Oceanside, Escondido, Vista, and Chula Vista. The areas with lower proportions of child residents tend to be those adjacent to the coastline, such as Coronado, Solana Beach, and Del Mar.

San Diego County is an ethnically diverse community. According to the 2015 SANDAG estimates, the overall population consists of: 47% non-Hispanic white; 33% Hispanic; 12% Asian, Hawaiian, or other Pacific Islander; 4% African-American; 3% other; and less than 1% Native American or Alaskan Native. The population of children is predominantly Hispanic (45%) and non-Hispanic white (35%) with the remainder similarly distributed to the overall population breakdown. San Diego County has 18 American Indian/Native American reservations, more than any other county in the United States, representing four tribal groups. Data on race and ethnicity are not uniformly available for indicators and are shown only in select informational boxes.

Birth to Age 3 (Infants and Toddlers): EARLY PRENATAL CARE

Why is this important?

Prenatal care that starts early is associated with a lower risk of premature births, better birthweight, and healthier babies. Prenatal care from a qualified health professional helps to ensure the health of a woman and her baby. Optimal, quality care includes comprehensive medical services and health promotion and education, with psychosocial supports as needed. Starting even earlier, prior to pregnancy, with preconception care is recommended to reduce health risks to both mother and baby. Inadequate prenatal care (starting late or too few visits) is associated with increased risk of being born too soon or too small.

What is the indicator?

This indicator—the percentage of mothers receiving early prenatal care—reflects the proportion of women who receive prenatal care beginning in the first three months (referred to as the first trimester) of pregnancy. Prenatal care information is recorded on the birth certificate and reported as part of local, state, and federal vital statistics.

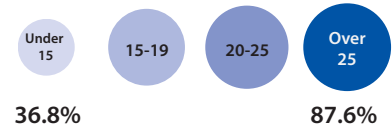
What is the trend?

The trend is maintaining. San Diego County has made only small improvement toward ensuring that all women begin prenatal care early, in the first three months of pregnancy. The national objective was made easier to achieve for the decade 2010-2020.

Number of babies born in San Diego County in 2013

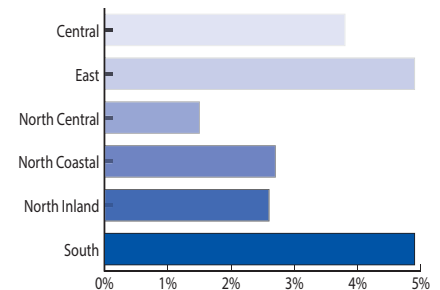
43,582

Teen moms are least likely to receive early prenatal care



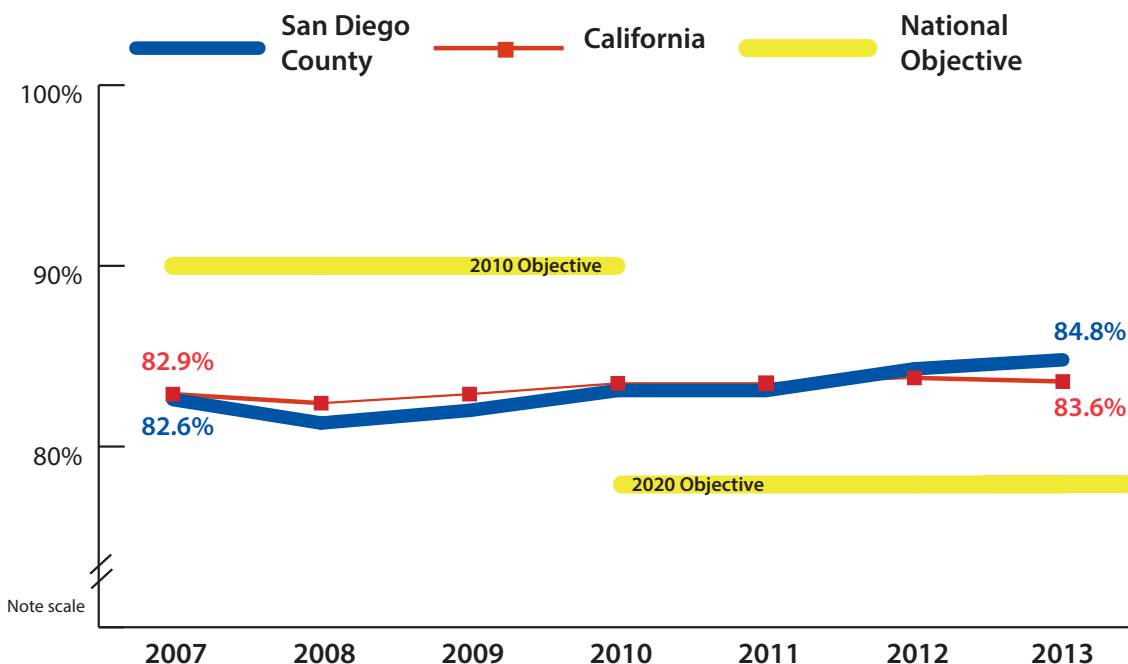
Source: Ratio of Early Prenatal Care, By Age of Mother, San Diego County, 2013

MORE THAN 1,000 MOTHERS RECEIVE LATE OR NO PRENATAL CARE, PLACING THEM AND THEIR BABIES AT RISK. THE RATES FOR LATE OR NO CARE VARY BY REGION.



Source: Percentage of Infants Born to Mothers Who Received Late or No Prenatal Care, By Region, San Diego County, 2013

Percentage of Mothers Receiving Early Prenatal Care, San Diego County and California Compared to National Objective, 2007-2013



What strategies can make a difference?

Women's use of prenatal care is affected by financial barriers (e.g., lack of health insurance), the context of care (e.g., lack of cultural competence, biased treatment by health providers), and the access to care (e.g., transportation, difficulties obtaining an appointment, inconvenient hours). In addition, personal attitudes and behaviors (e.g., lack of understanding about the importance of prenatal care, ambivalence about a pregnancy) may be barriers to early prenatal care. What works best is early, continuous, and high quality care that is appropriate for a woman's risks, needs, and culture.

The following strategies have been used to increase use of prenatal care:

- Ensure affordable health coverage (e.g., Affordable Care Act Exchange plans, Medi-Cal, and private plans with maternity coverage).
- Expedite health coverage for uninsured women who become pregnant.
- Include benefits coverage for comprehensive care (e.g., the California Comprehensive Perinatal Care Services package), which incorporates health education and risk counseling along with medical care.
- Assure that prenatal care services are available and accessible (e.g., accessible by public transportation, flexible service hours).
- Use safety-net providers such as community clinics and Federally Qualified Health Centers to provide prenatal care.
- Provide outreach to get women enrolled in health coverage, connected with a prenatal provider, and into early and continuous care.
- Provide prenatal services that are culturally and linguistically appropriate.
- Begin evidence-based home visiting programs in the prenatal period, particularly for high-risk pregnant women.
- Use trained and certified doulas and community health workers to provide health education, coaching, and support to pregnant women.
- Use evidence-based group-care approaches such as "Centering Pregnancy" to reduce costs and enhance the content of care.
- Offer transportation assistance such as vouchers for public transportation or taxis.

How can we improve the trend in San Diego County?

Based on what is underway and what works, the priorities for action are:

- | Policy | Programs & Services | Family & Community |
|--|--|--|
| <ul style="list-style-type: none">• Expand the availability of community health workers and doulas through public funding.• Support increased reimbursement rates for prenatal providers who offer Comprehensive Perinatal Care Services. | <ul style="list-style-type: none">• Prioritize outreach for health care enrollment in areas with high concentrations of low-income families.• Support translation and culturally and linguistically appropriate services for immigrant and refugee populations, beginning with prenatal visits and care coordination. | <ul style="list-style-type: none">• Work with community clinics and doctors to provide flexible service hours including evenings and weekends.• Organize community-based networks of transportation for pregnant women to attend medical appointments and other necessary services. |

Birth to Age 3 (Infants and Toddlers): LOW BIRTHWEIGHT

Why is this important?

Low birthweight babies face 20 times the risk of dying in their first year, compared to normal weight babies. Preterm (premature) birth (prior to 37 weeks gestation) is a primary factor contributing to low birthweight rates, and together these two conditions are the leading cause of infant mortality. Given neonatal intensive care, many infants born at low birthweight or preterm survive but experience short and long-term effects such as learning disabilities, vision, and hearing deficits. Individuals born at low birthweight also have higher risk for conditions such as high blood pressure, heart disease, and diabetes as adults.

What is the indicator?

This indicator—the percentage of infants born at low birthweight—is defined as weighing less than 2500 grams (5.5 lbs), and very low birthweight is defined as weighing less than 1500 grams (3.3 lbs) at birth. Both are included in this measure. These data are recorded on birth certificates and reported as part of local, state, and federal vital statistics.

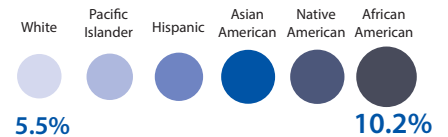
What is the trend?

The trend is maintaining. The percentage of low-birthweight births is not improving. San Diego County is close to the state level. The national objective was made easier to achieve for the decade 2010–2020.

Number of babies born at low birthweight in San Diego County in 2013

2,841

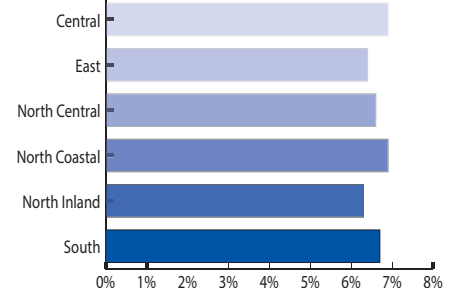
African American babies most likely to have low birthweight.



Percentage Born at Low Birthweight By Race/Ethnicity of Mother, San Diego County, Three-Year Average 2011-2013

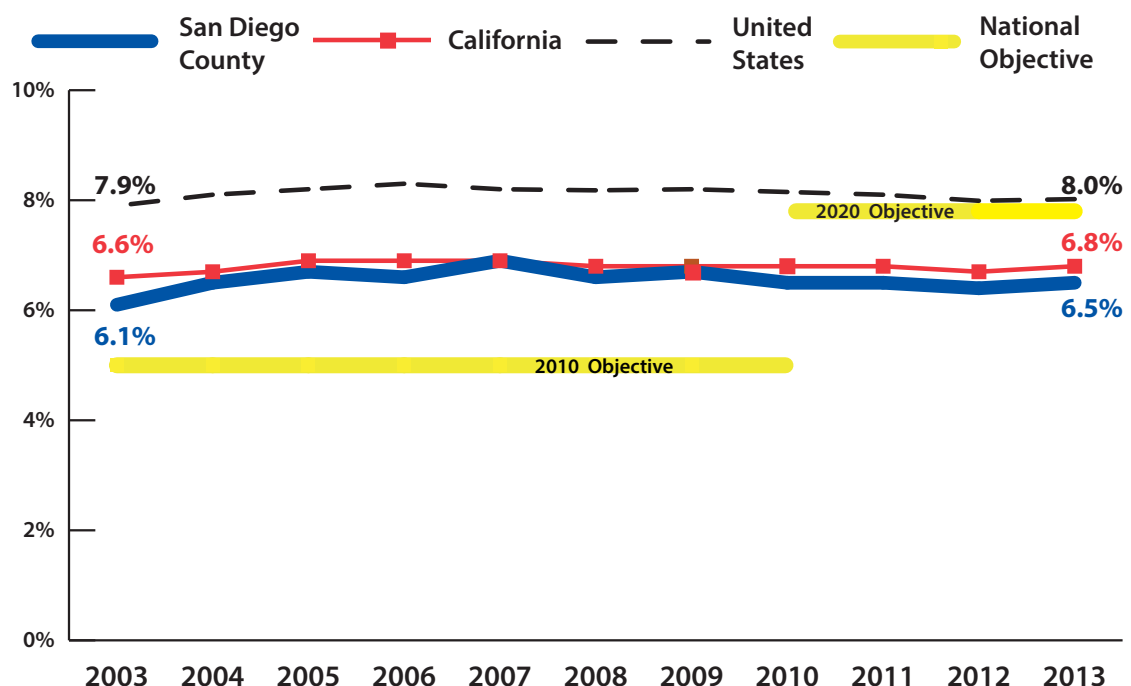
APPROXIMATELY 1 OUT OF EVERY 15 BABIES ARE BORN AT LOW BIRTHWEIGHT.

BABIES ARE AT RISK IN EVERY REGION OF OUR COUNTY.



Percentage of Infants Born at Low Birthweight, By Region, San Diego County, Three-Year Average 2011-2013

Percentage of Infants Born at Low Birthweight, San Diego County, California, and United States Compared to National Objective, 2003-2013



What strategies can make a difference?

All of the causes of low birthweight and preterm birth are not fully understood; however, we know how to reduce some risks. Preventing unintended pregnancies is an important step. Smoking and heavy drinking while pregnant are two important behavioral factors associated with low birthweight and preterm birth. Very young teen mothers (under age 15) and women who have multiple births (twins, triplets, etc.) are more likely to have babies born at low birthweight or preterm. Women who receive late or no prenatal care and those who experience extreme stress and violence face higher risks. Quality prenatal care and appropriate care at the time of birth, such as regional perinatal care and neonatal intensive care, is critical to the health and survival of mothers and infants. For women who have a low birthweight or preterm birth, “interconception care” can reduce risks prior to any subsequent pregnancy they may chose to have.

The following strategies have been used to reduce low birthweight and preterm births:

- Increase use of early and comprehensive prenatal care to screen for and address risk factors.
- Educate women about the dangers of alcohol and drugs, tobacco, prescription drugs, sexually transmitted diseases, hypertension, obesity, and diabetes.
- Promote family planning and pregnancy spacing.
- Inform women how to recognize the signs and seek help for early labor and other complications.
- Educate women about the importance of continuing pregnancy for 39-40 weeks gestation and eliminate elective deliveries prior to 39 weeks gestation (i.e., early elective deliveries).
- Implement quality improvement programs and measures for providers.
- Promote proper nutrition, exercise, and healthy weight before and during pregnancy.
- Finance smoking cessation services (including mandatory Medi-Cal prenatal smoking cessation benefits) and eliminate exposure to secondhand smoke during pregnancy.
- Eliminate pregnancies among younger teens.
- Reduce stress and exposure to violence at home and in the community, including racism.
- Provide expedited housing assistance to pregnant women to reduce housing insecurity.
- Use intensive, evidence-based home visiting for high-risk pregnant women.
- Avoid multiple births that may result from assistive reproductive technology.
- Promote health and reduce risks before pregnancy with preconception care.
- Offer interconception care to provide augmented services post-pregnancy to the highest-risk, lowest income women

How can we improve the trend in San Diego County?

Based on what is underway and what works, the priorities for action are as follows:

Policy	Programs & Services	Family & Community
<ul style="list-style-type: none">• Increase funding for substance abuse prevention and treatment services during pregnancy.• Advocate for regular monitoring of the quality improvement measures for the Healthcare Effectiveness Data Information Set with Medi-Cal providers.	<ul style="list-style-type: none">• Increase use of evidence based home visiting programs for pregnant women in substance abuse treatment programs.• Expand smoking cessation programs to all areas of San Diego County.	<ul style="list-style-type: none">• Develop community led support groups for pregnant women to encourage use of prenatal care, good nutrition and exercise.• Develop community campaigns to educate women about risks during pregnancy, the signs of early labor and the importance of 39-40 weeks of pregnancy.

Birth to Age 3 (Infants and Toddlers): BREASTFEEDING

Why is this important?

As one of the most effective and cost-effective preventive health practices, breastfeeding is recommended for almost every baby. For children, it enhances immunity to disease and decreases the rate and severity of infections. Breastfeeding is associated with improved development and reduced risk of childhood obesity. It reduces lifelong risks for chronic health problems such as cardiovascular disease. Benefits for the mother include: reduced risk of breast, ovarian, and uterine cancer; quicker recovery; and less work missed due to child illness.

What is the indicator?

This indicator—the percentage of mothers who initiate breastfeeding before leaving hospital—estimates what proportion of infants receive any breast milk. Recommendations call for 6 to 12 months of breastfeeding, but data on continuation rates are not available. These data are collected on newborn screening forms and reported by the California Department of Health Services, including virtually all births in California (military hospitals and home births are excluded).

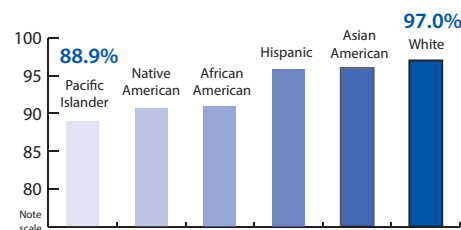
What is the trend?

The trend is maintaining. The percentage for San Diego was consistently better than the state average and the national objective.

Number of mothers initiating breastfeeding in San Diego County in 2014

32,772

Breastfeeding varies by mother's race-ethnicity.



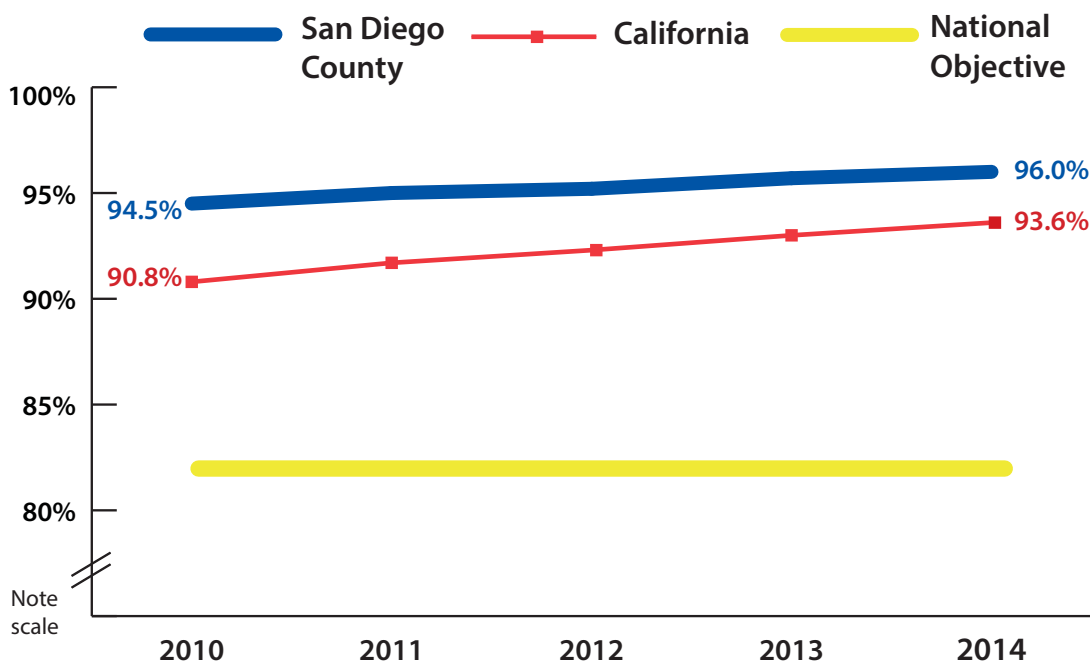
Percent of Mother's Initiating Breastfeeding in Hospital, By Race/Ethnicity of Mother, San Diego County, 2014. Multiple and other races not shown.

BREASTFEEDING BENEFITS BOTH MOTHERS AND CHILDREN. THE TOP BENEFITS OF BREASTFEEDING INCLUDE:

- Breast milk provides nearly perfect nutrition for infants, with antibodies to protect against infections.
- For children, breastfeeding has longterm positive health effects and promotes healthy weight.
- For mothers, breastfeeding helps to reduce the risk of breast and ovarian cancers.

Sources: Centers for Disease Control and Prevention; National Institute of Child Health and Human Development; MedLine; and Office of the U.S. Surgeon General.

Percentage of Mothers Who Initiated Breastfeeding of Newborn in Hospital, San Diego County and California Compared to National Objective, 2010-2014



What strategies can make a difference?

Across the nation, public and private leaders have worked to increase public awareness of the importance of breastfeeding. Education is important, but not enough. Women need knowledge before giving birth and support, training, and equipment following birth. Hospital practices have a significant impact on women's ability to initiate breastfeeding and exclusively breastfeed (e.g., use no formula). Mothers who receive in-hospital support are more likely to continue breastfeeding at home. Lack of workplace support and public accommodations (space) for breastfeeding remain as major barriers to continuation of breastfeeding beyond the initial weeks of infant life. While exclusive breastfeeding is recommended for first months, any breastfeeding can be advantageous.

The following strategies have been used to increase breastfeeding:

- Assure that all birthing hospitals and centers encourage breastfeeding through programs such as the evidence-based “Baby-Friendly” hospital policies, which support mothers in learning how to breastfeed and promotes exclusive use of breast milk.
- Ensure breastfeeding promotion and education both before and following birth (e.g., add lactation consultants to prenatal clinic staff as well as hospitals).
- Provide ongoing breastfeeding support and lactation education, particularly from trained and experienced lactation consultants, home visitors, and equipment such as breast milk pumps.
- Eliminate provider bias and unequal treatment by race-ethnicity and income in breastfeeding promotion and education.
- Implement federal laws that protect breastfeeding in public and require workplace supports, including requirements for employers to provide reasonable, though unpaid, break time for a mother to express milk and a clean and private place, other than a restroom, to express her milk.
- Offer other workplace support (e.g., paid breaks and ways to safely store breast milk).
- Enroll eligible families in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which offers incentives, education, and support for breastfeeding.
- Provide culturally and linguistically appropriate consumer information for mothers, with increased outreach and education for women of color.
- Use the *Business Case for Breastfeeding* “toolkit,” of the U.S. Department of Health and Human Services.
- Limit the marketing of breast milk substitutes (i.e., formula).

How can we improve the trend in San Diego County?

Based on what is underway and what works, the priorities for action are:

- | Policy | Programs & Services | Family & Community |
|---|---|---|
| <ul style="list-style-type: none">• Ensure that all government and public education workplaces implement the federal law that requires appropriate and adequate space and break time for breastfeeding.• Make WIC enrollment available online. | <ul style="list-style-type: none">• Develop culturally and linguistically competent Medi-Cal consumer information materials related to breastfeeding (e.g., coverage for lactation consultants, breast pumps, and other services).• Ensure that all eligible pregnant women are enrolled in WIC as part of their first prenatal visit. | <ul style="list-style-type: none">• Educate women about the considerable benefits of WIC, the eligibility requirements, and the procedures of enrolling.• Provide culturally and linguistically appropriate information on the benefits of breastfeeding for pregnant women and new mothers. |

Birth to Age 3 (Infants and Toddlers):

BIRTHS TO TEENS

Number of babies born to girls age 15-17 in San Diego County in 2013

558

Why is this important?

Teen pregnancy continues to be an issue of concern in the United States, which has the highest rate among industrialized countries. Girls and boys are unprepared for the responsibility of pregnancy and parenting. They are less likely to obtain prenatal care and more likely to continue unhealthy behaviors, placing the baby at risk for developmental and health problems. The children of teen parents are at greater risk for maltreatment, developmental delays, and poor academic achievement. Teen mothers and fathers are less likely to complete school and become economically self-sufficient. Teen parenthood places two generations at risk.

What is the indicator?

This indicator—the birth rate per 1,000 teens ages 15-17 years—monitors trends in births for teens ages 15-17. Reliable data are available annually from birth certificates and reported as part of local, state, and federal vital statistics. It is not possible to get reliable data on the number of teens who become pregnant or are sexually active.

What is the trend?

The trend is improving. The San Diego rate is consistently improving along with the state average and the national rate.

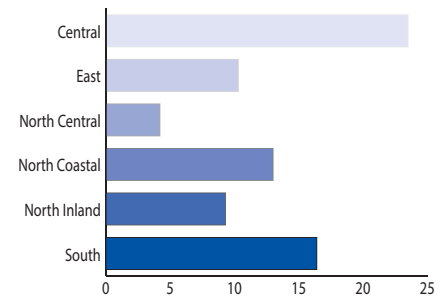
Teen mothers are less likely to complete their education.

* 50% OF TEEN MOTHERS DO NOT COMPLETE HIGH SCHOOL.

* LESS THAN 2% OF TEEN MOTHERS FINISH COLLEGE.

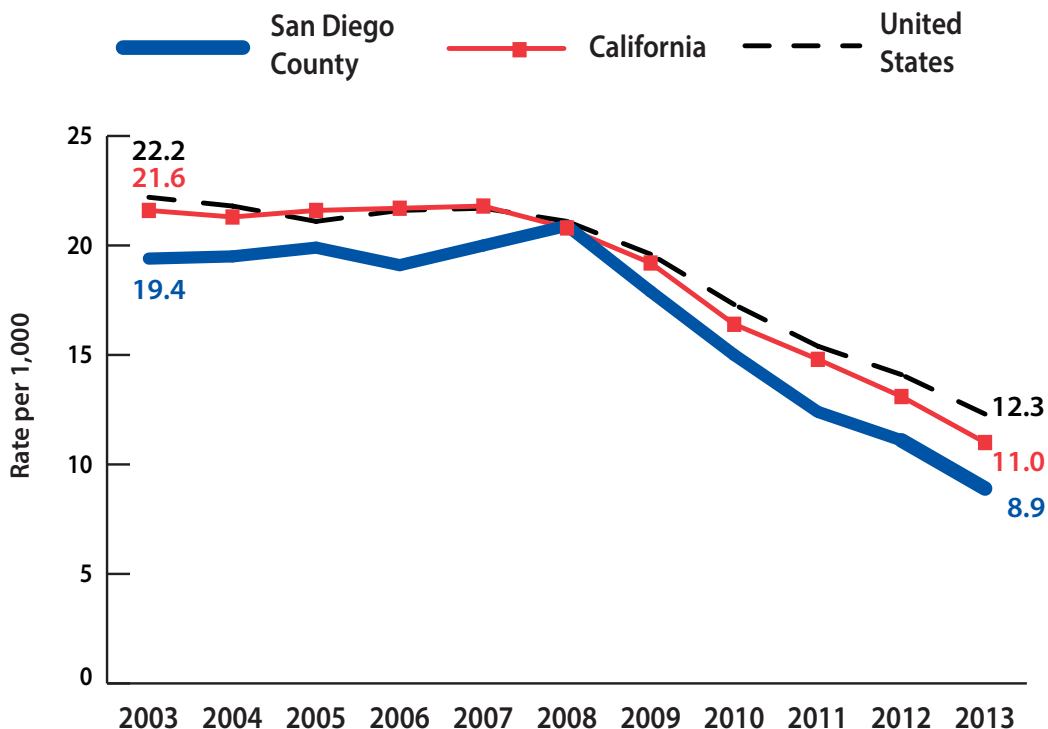
Source: National Campaign to Prevent Teen and Unplanned Pregnancy.

BIRTH RATES PER 1,000 AMONG GIRLS AGES 15-17 VARY BY REGION AND COMMUNITY.



Source: Birth Rate per 1,000 Teens Ages 15-17, By Region, San Diego County, Three-Year Average, 2010-2013

Birth Rate per 1,000 Females Ages 15-17, San Diego County, California, and United States, 2003-2013



What strategies can make a difference?

While there is no one preventive intervention that is singularly effective in reducing teen pregnancy, a combination of supports and services are essential. Best practices must be broad based and across systems that include: comprehensive life skills and reproductive health education, early prevention services and activities, and support for teen and family engagement and communication.

The following strategies have been used to decrease teen births:

- Teach comprehensive life skills and reproductive health education in schools through use of tailored and evidence-based curricula for sex and STD/HIV education programs.
- Promote strong positive family engagement. Engage parents and youth to promote positive communication and healthy relationships.
- Provide culturally relevant expanded learning programs, mentoring, and employment opportunities to engage teens after school and weekends, as well as programs to engage youth during the summer and school holidays.
- Involve teen males in discussion and education; one of the most significant factors in the reduction of teen pregnancy is increased education and information for males.
- Provide access to and financing of comprehensive and confidential adolescent health services, including education about contraceptive methods and family planning services on or near school campuses.
- Encourage screening for Adverse Childhood Experiences and trauma-informed services to intervene with youth who have experienced sexual abuse and other maltreatment or trauma.
- Provide access to evidence-based programs aimed at preventing second pregnancies (e.g., Adult Identity Mentoring 4 Teen Moms known as AIM4TM).
- Encourage teen parents to continue in school to help reduce subsequent pregnancies.
- Integrate and coordinate services such as school programs, reproductive health services, family life skills, social work, and health education interventions.

How can we improve the trend in San Diego County?

Based on what is underway and what works, the priorities for action are:

- | <i>Policy</i> | <i>Programs & Services</i> | <i>Family & Community</i> |
|---|--|---|
| <ul style="list-style-type: none">• Increase support for school-based pregnancy and prevention programs such as CalSafe and SANDAPP.• Co-locate adolescent health services on or near school campuses. | <ul style="list-style-type: none">• Increase middle and high school expanded learning programs to include summer and school holidays.• Provide internships and employment opportunities for high school students. | <ul style="list-style-type: none">• Host community events on weekends and evenings that engage parents and youth in positive communication and healthy relationships.• Develop peer-support networks among teen parents, both males and females. |

Ages 3–6 (Preschool): IMMUNIZATION

Why is this important?

Childhood immunizations save millions of lives each year. They are highly effective and cost-effective when children receive vaccines according to the recommended schedule. Vaccinations protect children from serious illness and complications of vaccine-preventable diseases, which can include paralysis, hearing loss, convulsions, and death. Children who are not adequately immunized put others at risk for illness and death. Access to safe, effective, and recommended childhood vaccines is vital for the health of our children. Timely, complete vaccinations are key to preventing disease.

What is the indicator?

This indicator—the percentage of young children (ages 19–36 months) who have received the basic recommended childhood immunization series (4:3:1:3:3:1)—monitors use of recommended vaccines in the first three years of life. While the basic series of vaccines are due by age 24 months, no data exist to track children precisely at that age. These data are collected from the Immunization Survey conducted every third year by the County of San Diego Health and Human Services Agency Immunization Branch.

What is the trend?

The trend cannot be determined because data are not available for recent years; however, the percentages in 2002 and 2013 are close to the same.

Percentage of young children completing basic series of vaccines in San Diego County in 2013

81.8%

TOP BENEFITS OF IMMUNIZATION

1. Immunizations save lives.
2. Vaccines are highly safe and effective.
3. Immunization protects others you care about such as the elderly or infants.
4. Vaccine-preventable diseases, such as measles and whooping cough, are still a threat.
5. Disease outbreaks happen when many parents fail to vaccinate their children.

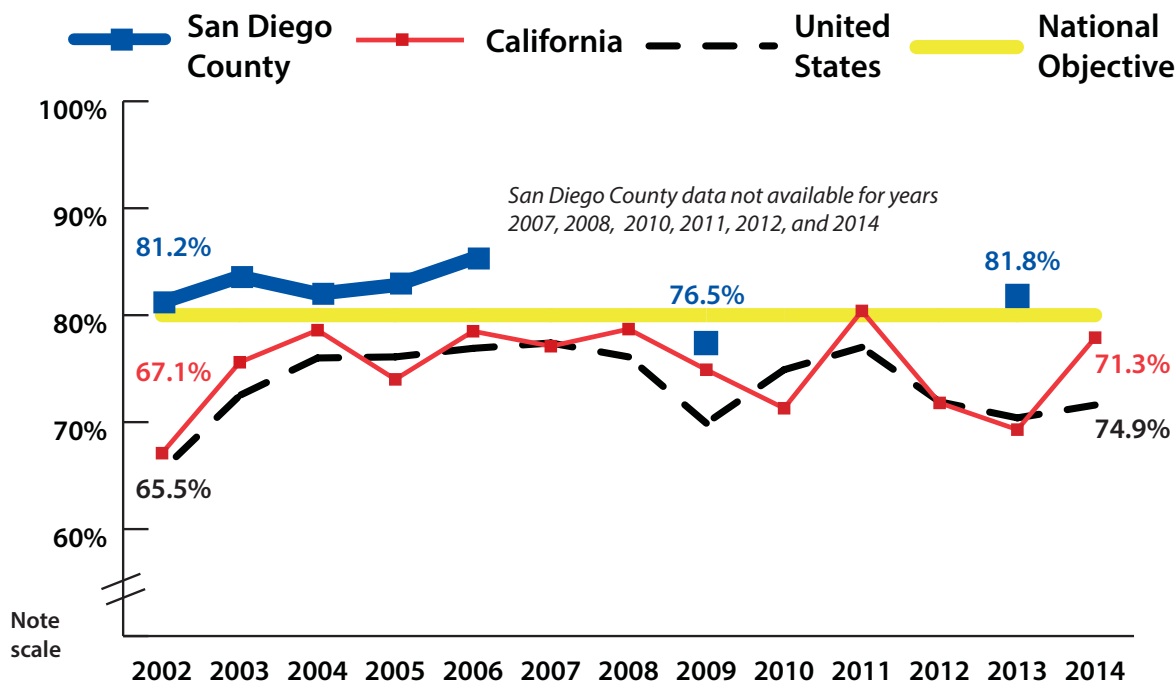
Sources: Centers for Disease Control and Prevention and National Vaccine Program Office, U.S. HHS.

Number of cases of pertussis (whooping cough) in San Diego County in 2014

2,105

Source: San Diego Health and Human Services Agency (HHSA), Immunization Program, December 2015. Measles, mumps, haemophilus, and hepatitis B cases also reported. Note no cases of diphtheria, tetanus, polio, rubella, congenital rubella reported for 2014.

Percentage of Young Children (Ages 19–36 months) Who Completed the Basic Immunization Series, San Diego County, California, and United States Compared to National Objective, 2002–2014



What strategies can make a difference?

High immunization rates are critical for the health of children, families, and communities. San Diego's progress in preventing disease has been affected by unimmunized and underimmunized children. Maintaining population-wide "herd" immunity is the key to preventing disease and protecting the more vulnerable (e.g., infants not yet immunized). Achieving high immunization rates for each new cohort of children requires ongoing awareness, acceptance, financing, and access. Success depends upon public-private partnerships involving health professionals who administer vaccines, policy makers, vaccine manufacturers, and, of course, families who voluntarily participate in immunization programs. Exemptions laws make a difference in rates. Provider attitudes and behaviors also have a significant affect on immunization coverage rates at the practice and community levels.

The following strategies have been used to increase immunization rates:

- Provide incentives for providers to use immunization registries.
- Regularly collect immunization data and conduct surveys to monitor who is up-to-date.
- Employ data and geographic mapping to identify clusters of underimmunized children and focus efforts on those areas.
- Contact and provide intensive support and information for families whose children are not up-to-date for recommended vaccines, including those who refuse and with less access.
- Educate parents about the importance and safety of childhood vaccines from birth to age 21.
- Develop and implement regulations limiting immunization exemptions laws.
- Implement community-wide and targeted campaigns and education to inform parents about the importance of immunizing "every child by two," the value of adolescent vaccines, and the risk of vaccine-preventable disease.
- Educate health providers about the importance and acceptability of giving vaccines, even if a child is mildly ill or at an office visit that is not a well-child visit.
- Provide access to vaccines through pediatricians, family physicians, local health departments, community clinics, pharmacies, and other locations.
- Engage health providers and health plans in quality improvement projects.
- Assure an adequate supply of affordable vaccines, including sufficient funding for the federal Vaccines for Children program.
- Protect vaccine providers from liability concerns by continuing the National Vaccine Injury Compensation Program.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- At the county government level, collect and report immunization survey data every other year.
- Implement and monitor new state policies on vaccine exemptions.

Programs & Services

- Engage pediatricians, family physicians, nurse practitioners, and other primary care providers to ensure children are fully immunized and on schedule.
- Incentivize all health providers to participate in the San Diego Immunization Registry.

Family & Community

- Provide information and education to parents about the safety and benefits of immunization in communities with a high percentage of children not fully immunized.
- Promote recommended vaccines among middle and high school students.

Ages 3–6 (Preschool):

EARLY CARE AND EDUCATION

Why is this important?

While parents are a child's first teacher, most children spend a large proportion of their early years in the care of others while their parents work. Early childhood care and education in a quality setting improves school readiness and development, as well as long-term education and employment outcomes. Quality early care and education from birth to 5 years also produces economic benefits to society that far exceed the initial investment, particularly investments in low-income children.

What is the indicator?

This indicator—the percentage of children ages 3-4 enrolled in early care and education—shows trends in early childhood care and education for our county's preschool age children who are regularly attending an out-of-home and non-relative early care and education setting. The setting about which parents report may be a child care center, family child care setting, preschool, nursery school, or Head Start program. The data are collected by the U.S. Census Bureau American Community Survey.

What is the trend?

The trend is maintaining. With new federal and state policies to promote early care and education, the percentage of children enrolled should increase in future years at the county, state, and national levels.

50%

of children ages 3 and 4 were enrolled in preschool or other early education settings in San Diego County in 2014

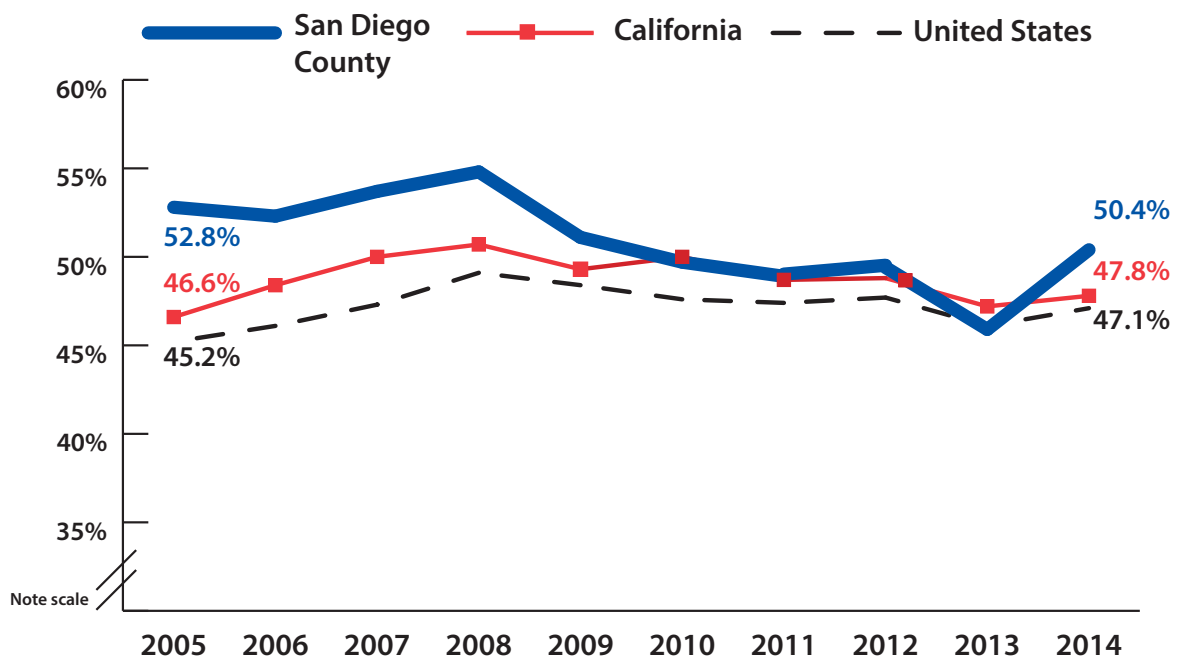
Child care slots are available for only 31% of San Diego County children who live in families with working parents.

Source: KidsData.org based on California Child Care Resource & Referral Network, California Child Care Portfolio (Nov. 2015)

MORE THAN 50,000 OF 3 AND 4 YEAR OLD CHILDREN ARE IN PRESCHOOL OR OTHER EARLY CARE AND EDUCATION. THE QUALITY AND TYPE OF SERVICES VARIES BY COMMUNITY, FAMILY INCOME, AND AGE OF CHILD. JUST OVER HALF ARE ENROLLED PUBLIC SCHOOL SETTINGS.

Source: Percentage of 3 and 4 Year Olds Enrolled in Preschool or Other Early Care and Education, San Diego County, 2014. American Community Survey estimates.

Percentage of Children Ages 3-4 Enrolled in Early Care and Education, San Diego County, California, and United States, 2005-2014



What strategies can make a difference?

While parents are the first and most important teachers, most young children in the United States spend time in groups in early care and education settings. Early care and education includes child care, preschool/pre-kindergarten (pre-K), and Head Start. Children in high quality early care and learning environments gain more advanced language, are ready for school, and develop better social skills. Low-quality early care and education can do more harm than good for low-income and higher risk children.

The following strategies have been used to increase access to quality early care and education:

- Ensure a comprehensive early childhood education system at the local level that offers parents varied, high quality options to meet families' needs.
- Increase access to quality preschool, Head Start, and pre-K programs. Combining programs into a "preschool for all" campaign helps to maximize resources.
- Provide appropriate reimbursement rates for early care and education providers.
- Target child care subsidies for low-income families to quality early care and education (i.e., with high quality rating or other demonstrated quality performance).
- Implement a state quality rating system to give families information to identify quality programs and provide incentives to providers that reach high standards.
- Provide inclusive child care to serve children with special health care needs and disabilities.
- Offer child care resource and referral lines or centers that assist families.
- Adopt teacher training and credentialing standards associated with quality.
- Increase the affordability, accessibility, and quality of infant and toddler care.
- Create career pathways for low-income mothers to train for jobs as assistants, teachers, and other staff in early care and education
- Train and deploy child care health and mental health consultants to provide supportive services to children in early care and education settings.
- Provide no-cost technical assistance and training to family day care homes/centers to ensure good quality care and financial sustainability.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

- | <i>Policy</i> | <i>Programs & Services</i> | <i>Family & Community</i> |
|---|---|--|
| <ul style="list-style-type: none">• Advocate for increased reimbursement rates for early care and education providers.• Financially support, to scale, the quality rating and improvement systems. | <ul style="list-style-type: none">• Expand no-cost professional in-person and online training for child care workers, including family child care home providers.• Increase use of early childhood mental health services in child care settings, including child care consultation to staff and families. | <ul style="list-style-type: none">• Develop and disseminate linguistically and culturally appropriate consumer information on how to choose quality child care.• Host community workshops and trainings on the benefits of and how to become a licensed family child care provider. |

Ages 6–12 (School Age):

ORAL HEALTH

Why is this important?

Oral health is essential for good overall health. Dental caries (the disease that causes cavities and tooth decay) is the single most common chronic disease of childhood. Untreated cavities can cause chronic pain, affecting school achievement, sleep, and nutrition. Even decayed “baby” teeth affect child health and adult teeth. Nearly one-quarter of U.S. children—mostly poor, minority, and/or with special health care needs—experience 80% of all tooth decay. While preventable, tooth decay is on the rise among young children. Nationally, 14% of preschool age children (3-5 years) and 17% of children ages 6-9 years already have untreated decay.

What is the indicator?

The indicator—the percentage of children ages 2-11 who have never visited a dentist—represents the most important years to prevent and treat dental disease and decay. National recommendations from dentists and pediatricians call for children to begin dental care at age 12 months and make at least annual visits. These data are routinely reported in the California Health Interview Survey.

What is the trend?

The trend is improving. The percentage of children ages 2-11 who have never had a dental visit has declined since 2003.

Estimated number of San Diego County children ages 2-11 who had never visited a dentist, average for 2011-2014

30,000

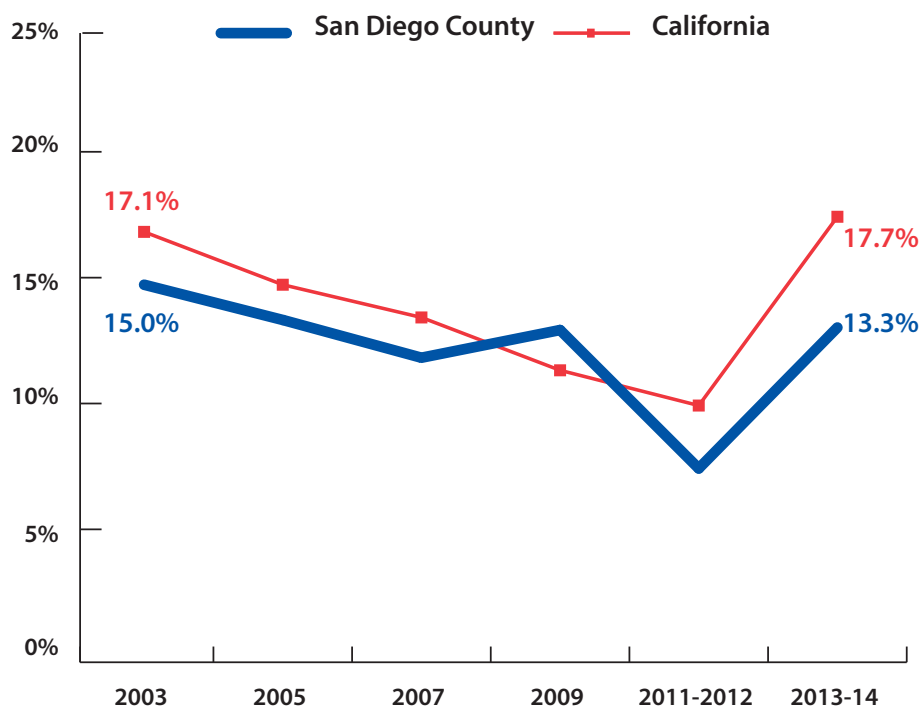
The estimated cost for treating preventable early childhood caries (cavities) for children younger than age 6 is \$7,200 per child.

Source: First 5 San Diego.

MORE THAN 150 DENTISTS IN SAN DIEGO COUNTY REPORT SERVING CHILDREN COVERED BY MEDI-CAL; however many of these do not accept new Medi-Cal patients, do not serve very young children, or cannot accommodate children with special needs and disabilities.

Source: Insure Kids Now, USHHS; and focus groups with San Diego County families.

Percentage of Children Ages 2-11 Who Had Never Visited a Dentist, San Diego County and California, Selected Years 2003 - 2013-14



Adult:

ORAL HEALTH

Why is this important?

Millions of U.S. adults do not receive needed dental care and suffer with untreated disease and tooth loss. Adult concerns include dental caries, cancers, and periodontal disease. Each year, mouth and throat cancers are diagnosed in approximately 30,000 people and about 8,000 adults die of these diseases. The life course perspective points to the importance of a two-generational approach to oral health. Among low-income families, limited use of dental care by parents often predicts and is related to inadequate oral hygiene and dental care for children. Lack of insurance, poverty, dental care experiences, and family misinformation are factors.

What is the indicator?

This indicator—the percentage of adults age 18 and older who had not visited a dentist within prior 12 months—represents the proportion of adults who did not have the recommended annual visit to prevent and treat dental disease and decay. These data are routinely reported in the California Health Interview Survey.

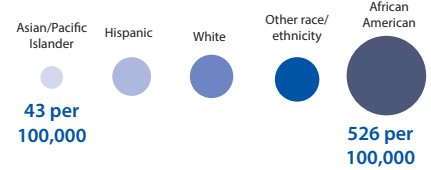
What is the trend?

The trend is improving. The percentage of adults who had not visited a dentist in the prior 12 months showed a small reduction between 2013 and 2014.

Estimated number of San Diego County adults age 18-65 who had not visited a dentist within prior 12 months, 2014

500,000

Visits to emergency departments for dental care are costly and vary by race/ethnicity.



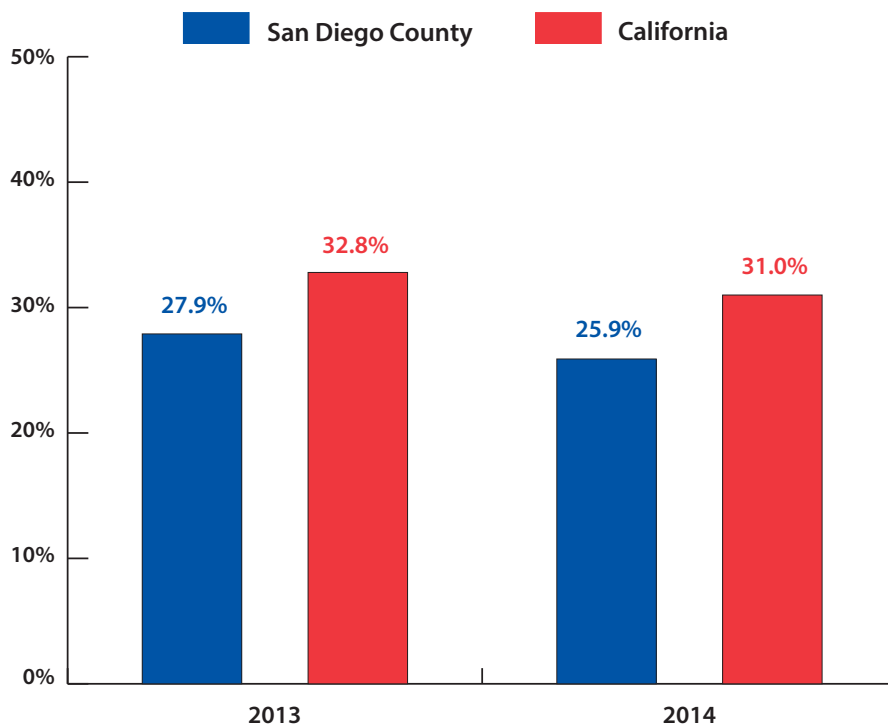
Source: Live Well San Diego, Data Portal. Data for dental emergency department discharges for 2013.

Among low-income pregnant women in San Diego County:

- * more than half had not seen dentist in prior year;
- * flossing and brushing differed significantly across racial/ethnic groups.

Source: Hunter and Yount. Oral health and oral health care practices among low-income pregnant women. *Journal of Midwifery and Womens Health*, 2011.

Percentage of Adult Ages 18–65 Who Had Not Visited a Dentist within Prior 12 Months, San Diego County and California, 2013 and 2014



What strategies can make a difference?

Good oral health habits and routine dental care “run in the family,” with adults' attitudes and habits reflected in what children learn and do throughout their lives. Preventing dental caries and promoting oral health are necessary for assuring good overall health among children and adults. The key elements for assuring optimal oral health, beginning in childhood and continuing throughout life, are: (1) sound nutrition, (2) effective “self-care” practices (e.g., brushing and flossing), and (3) access to dental prevention and treatment services through a “dental home” starting at age 1.

The following strategies have been used across the country to achieve success in improving the oral health status of children and adults:

- Implement health promotion campaigns that increase families' awareness of the importance of brushing and flossing (from infancy), as well as preventive dental visits.
- Promote and conduct oral health assessments through home visiting, Head Start, WIC, elementary schools, expanded learning programs, and other settings where children are served.
- Increase coverage for dental services, particularly through Medicaid/Medi-Cal and other publicly subsidized health plans.
- Increase effective use of primary health care providers (e.g., pediatricians, family physicians, nurse practitioners), early childhood education, and community-based organizations to educate parents about the importance of oral health and to screen children for oral health problems.
- Assure access to preventive services, including sealants and fluoride varnish, using dental providers, as well as preschools, elementary schools, and other community settings.
- Expand access to dental services in low-income and underserved communities (e.g., dental services in community clinics, mobile dental clinics).
- Increase the number of trained dental professionals, including dentists and dental hygienists. (This strategy includes increasing the number of training slots and offering loan repayment options in exchange for serving in low-income communities.)
- Assure community water fluoridation.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Ensure oral health assessments are being provided at kindergarten entry (California Education Code Section 494528).
- Support incentives for dental health providers to provide children with Medi-Cal coverage a dental health home.

Programs & Services

- Assure that community clinics offer dental care.
- Provide incentives both for dental providers to be the dental home for children in Medi-Cal and for primary care doctors to screen children for oral health problems.

Family & Community

- Conduct family engagement campaigns regarding the benefits and need for early oral health, particularly for children under age 5.
- Expand free dental screening opportunities at community events, schools, and other public areas.

Ages 6–12 (School Age):

SCHOOL ATTENDANCE

Why is this important?

One of the strongest predictors of school achievement is attendance. Whether children miss school as a result of illness, family vacations, or truancy, chronic absenteeism is an important “early warning sign” that a student is at risk for school failure and early dropout. Students in elementary school are learning basic reading, math, social, and study skills critical to success, and chronic absence as early as kindergarten can lead to deficits in achievement.

What is the indicator?

This indicator—the percent of elementary school (K-5) students who did not attend school at least 95% of school days—monitors school attendance based on 95% attendance on the Second Principal Apportionment (P2) reporting date of each district’s school year (not average daily attendance). It includes students who are absent approximately nine days per school year, for any reason. These school district data represent 98% of the student population in San Diego County.

What is the trend?

The trend is moving in the wrong direction. The percentage of students in grades K-5 who did not attend at least 95% of school days is fluctuating but is up overtime. Attendance varies by school and district (not shown).

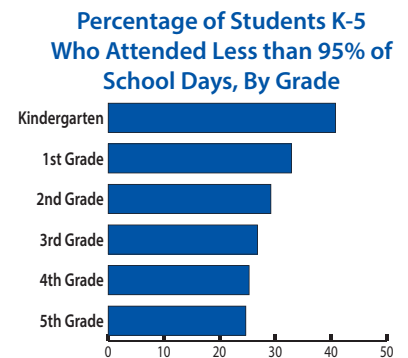
Number of students with enrollment reported in San Diego County, School Year 2014-15

K-5th Grade

167,539

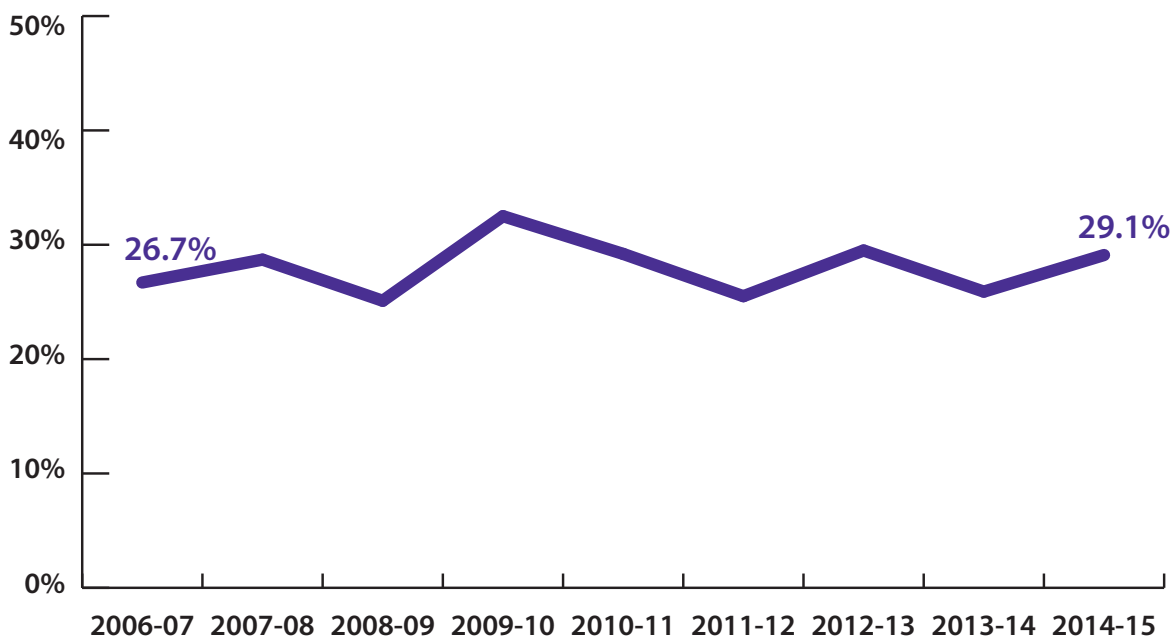
More than 50,000 students in grades K-5 attended less than 95% of school days in 2014-15.

Source: San Diego school district reporting on P2 data for 2014-15 school year.



Source: San Diego school district reporting on P2 data for 2014-15 school year.

Percentage of Elementary School Students (Grades K-5) Who Did Not Attend at Least 95% of School Days, San Diego County, School Years 2006-07 to 2014-15



What strategies can make a difference?

While school attendance may be affected by many factors, such as illness, transportation difficulties, child care, parent illness, or family dysfunction (e.g., poor supervision, parental substance abuse, neglect), focused and coordinated strategies can make a difference. To address frequent absences and truancies, schools, parents, community providers, and law enforcement must work together to develop policies, services, and programs that support students and their families.

The following strategies have been used across the country to improve attendance:

- Use evidence-informed practices and policies to engage and educate parents on the importance of regular attendance through education, outreach, and publicity (e.g., Attendance Works toolkit for engaging parents).
- Create a school climate and practices that promote parent and family involvement, orienting families regarding school policies.
- Develop accurate and daily monitoring of attendance, beginning in kindergarten, with feedback to parents (e.g., using multiple languages, the Internet, e-mail, and other forms of communication).
- Implement evidence-informed and well-communicated attendance policies and practices.
- Provide positive reinforcement and acknowledgement for even small improvements (e.g., attendance recognition events, commendation letters, front-of-line privileges at lunch, extra computer time at school).
- Target interventions for students with chronic attendance problems, including referrals to a trained professional (e.g., school counselor, social worker, health professional).
- Provide personalized early outreach and interventions that address the specific cause of absenteeism, involving families as partners (i.e., do not wait until absenteeism for a student reaches a serious or crisis level).
- Keep students safe and supported at school and on their way to and from—in particular, implementing evidence-based anti-bullying programs on a sustained basis.
- Make home visits to families whose children have chronic absenteeism in order to assess family needs and support parents.
- Link schools, parents, health and mental health professionals, and community supports in efforts to reduce absenteeism.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

- | Policy | Programs & Services | Family & Community |
|--|---|--|
| <ul style="list-style-type: none">• Develop and adopt a countywide framework for improving school attendance, grades K-3.• Implement monthly attendance tracking systems to monitor attendance, starting in kindergarten. | <ul style="list-style-type: none">• Increase the use of social workers on elementary school campuses with a focus on chronically absent students.• Implement proven attendance improvement strategies, such as positive reinforcement and family engagement. | <ul style="list-style-type: none">• Conduct community and school “meet and greets” and informal events to build strong parent and student connections to school.• Provide outreach to new kindergarten parents to educate them about the importance of consistent school attendance |

Ages 6–12 (School Age):

SCHOOL ACHIEVEMENT GRADE 3

Why is this important?

Assessments are important tools in elementary grades to measure students' academic strengths and areas for improvement, thus helping the student, teacher, and parents better understand the student's academic needs. Teachers can use results to better develop instruction based on the needs of their students. The data gathered from formal assessments provide teachers with information about individual students, as well as the class as a whole, which guides instruction in helping students gain proficiency across subject areas and assists them in being better prepared for future grades.

What is the indicator?

This indicator—the percentage of students in 3rd grade who have met or exceeded the state standards for English Language Arts/Literacy—reflects the first year of reporting these Common Core, Smarter Balance test results. This year's scores will be a baseline for student performance over time. These data will be reported annually by the California Department of Education.

What is the trend?

No trend is available because this is the first year of state reporting. The percentage of student who have met or exceeded the standards in the English language arts/literacy was 46% for 3rd grade.

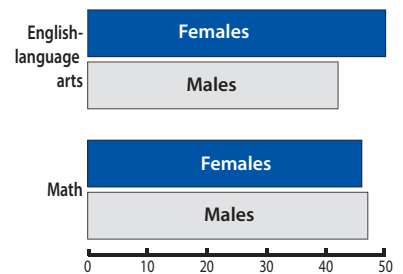
Number of 3rd grade students in San Diego County in 2014-15

39,453

54% of 3rd graders did not meet the achievement standard in English-language arts/literacy.

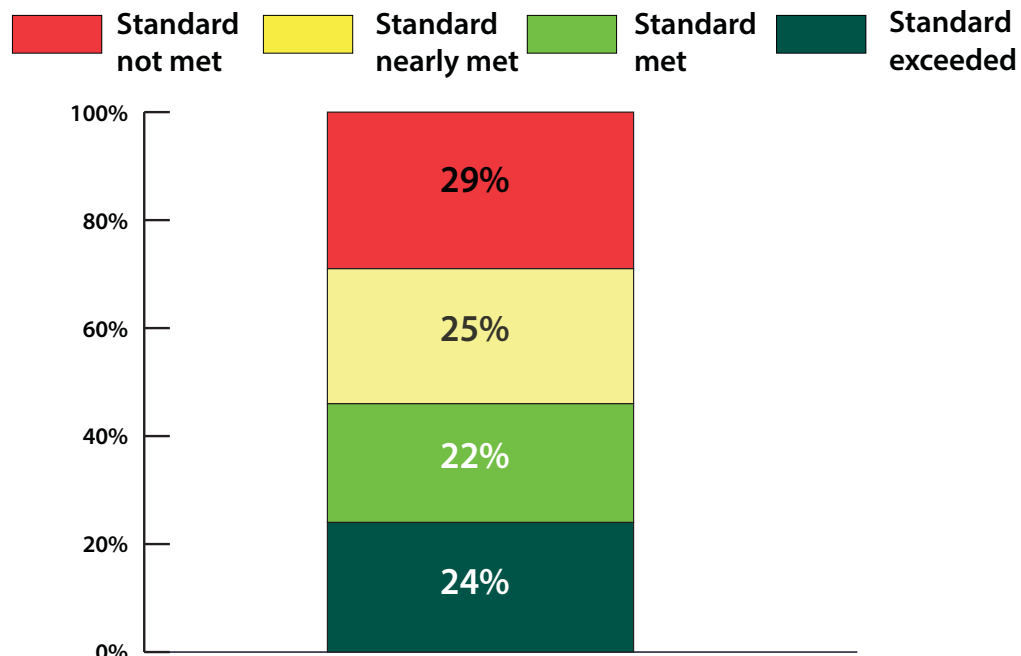
Source: California Smarter Balanced assessment system. Data for 2014-15 school year.

Percentage of 3rd Graders Who Met or Exceeded English-language Arts and Math Achievement Standard, By Gender



Source: California Smarter Balanced assessment system. Data for 2014-15 school year.

Percentage of Students in Grade 3 by Test Results in English-Language Arts/Literacy, San Diego County, School Year 2014-15



What strategies can make a difference?

Parents, early care and education providers, schools, and community programs all have a role to play in improving achievement in the early grades. Success in instilling language and reading skills begins with early language experiences and literacy skills incorporated into all areas of a child’s life. Building strong pre-reading and early reading skills, listening to stories, growing vocabulary in conversation with caregivers, and reading age-appropriate books all have value in the critical period from birth to third grade.

The following strategies have been used across the country to increase proficiency in language arts:

- Promote family reading and talking to infants and toddlers to grow vocabulary and other language arts skills.
- Limit “screen time,” including computers, television, and video games, ideally with no screen time for children under age 2.
- Ensure appropriate pre-reading and reading skills development in early care and education settings, including child care and preschool.
- Expand use of evidence-based programs that support early childhood and family literacy and make books available, such as Raising A Reader or Reach Out and Read.
- Offer intensive English-language arts instruction (particularly important in grades K, 1, and 2), including: phonics based instruction, word/language study, small group instruction, and use of interesting and relevant reading materials.
- Assess children in pre-K and at school entry to identify those with additional need for reading education and skills, and then provide services for children based on assessed needs.
- Use culturally and linguistically appropriate teaching strategies, including opportunities for students to share their cultural heritage and life experiences.
- Target services for parents of young children who do not speak English or who speak English as a second language.
- Provide Supplemental Educational Services to children who require special assistance.
- Develop appropriate intervention programs across settings where children are learning, including before and after school, summer, and in-school reading support.
- Promote independent reading and writing at home and at school.
- Encourage reading across the curriculum in schools (e.g., story problems in math).
- Ensure professional development for all teachers (e.g., Peer Assisted Learning Strategies).

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Prioritize Local Control Funding to support literacy tutoring in grades 1 and 2 in schools and Expanded Learning settings.
- Increase school support services during summer breaks to limit learning loss for grades 2 and 3.

Programs & Services

- Target and increase literacy support services such as one on one and small group tutoring for low level readers in grades 1-3 in schools and expanded learning settings.
- Expand programs that support early childhood and family literacy, such as Raising A Reader and Reach Out and Read.

Family & Community

- Host family reading nights at community centers, libraries, and local community settings.
- Provide book and reading material “give aways” at community clinics, libraries, neighborhood events, faith-based events, and local businesses.

Ages 6–12 (School Age):

CHILD OBESITY

Why is this important?

Healthy weight is important for children’s health and well-being throughout life. An estimated 80% of children who are overweight at ages 10-15 will become obese by the age of 25, as well as at increased risk for high blood pressure, high cholesterol, and Type 2 diabetes. One in three children will develop diabetes as a result of obesity and overweight. In addition to physical health risks, many overweight and obese children experience bullying, isolation, and discrimination.

What is the indicator?

This indicator—the percentage of students not in the Healthy Fitness Zone and at health risk in grades 5, 7, and 9—monitors obesity. The California Physical Fitness Test is given to students in grades 5, 7, and 9 each year. The criteria recently changed to better fit with federal criteria. This indicator uses parts of the test that measure body composition and body mass index (BMI) and reports on those who are at high risk (obese). These data are reported by the California Department of Education.

What is the trend?

At all three grade levels, nearly one third of students are not in the Healthy Fitness Zone and need improvement (i.e., overweight) or at health risk (i.e., obese) in school year 2014-15. (With changes in data collection criteria, no trend information is available.)

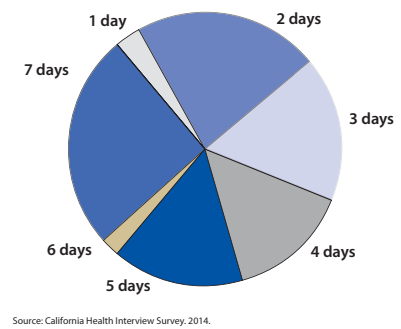
Estimated number of children under age 18 who were overweight for their age in San Diego County in 2014

66,000

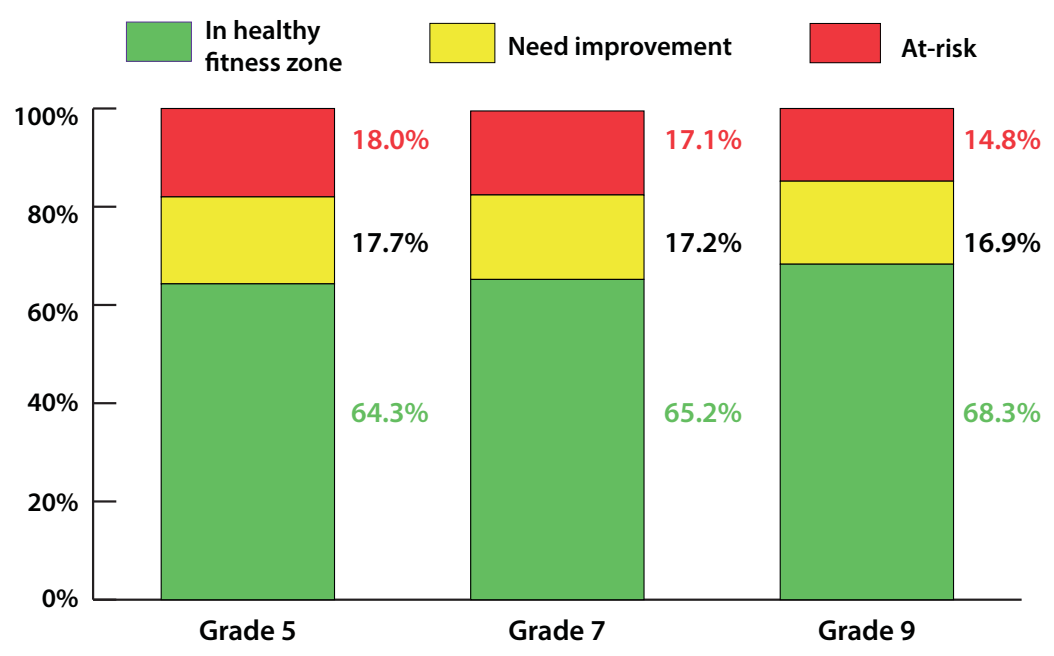
Obesity is declining more slowly among adolescents and girls ages 2-19 in Southern California.

Source: Koebernick et al. Secular Trends of Overweight and Obesity in Young Southern Californians 2008-2013. Pediatrics. December, 2015.

LESS THAN ONE-QUARTER OF SAN DIEGO COUNTY CHILDREN AGES 5-11 ENGAGE IN AT LEAST ONE HOUR OF PHYSICAL ACTIVITY OR EXERCISE DAILY (7 DAYS PER WEEK).



Percentage of Students Who Are in Healthy Fitness Zone, Need Improvement, or Are At Health Risk, Grades 5, 7, and 9, San Diego County, School Year 2014-15



Adult:

ADULT OBESITY

Why is this important?

More than one-third of U.S. adults are obese. Reflecting both genetic and behavioral factors, having obese parents places a child at increased risk for being overweight or obese throughout life. Obese children are at increased risk for adult chronic conditions including high blood pressure, heart disease, and Type 2 diabetes. Factors affecting this intergenerational, life course trajectory include: trauma and adverse childhood experiences, poor nutrition, and lack of exercise. Social determinants are also linked to obesity, including: poverty, parental education, residential location, access to nutritious food, access to health care, and availability of safe recreational areas.

What is the indicator?

The indicator—the percentage of adults ages 18 and older that are obese—measures those adults at highest risk for health conditions related to their weight and body mass index (BMI). These data are routinely reported in the California Health Interview Survey.

What is the trend?

The trend is moving in the wrong direction at the county and state levels, with more adults being obese. San Diego County and California are below, but approaching, the national objective.

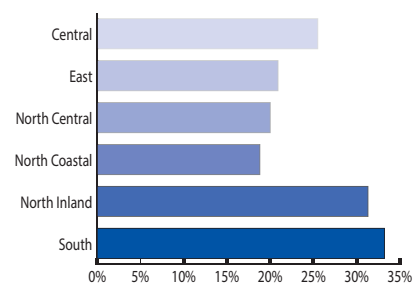
Estimated number of obese adults age 18 and older in San Diego County, 2014

500,000

Obese adults (with BMI of 30 or more) have a weight at least 20% heavier than the ideal for their height.

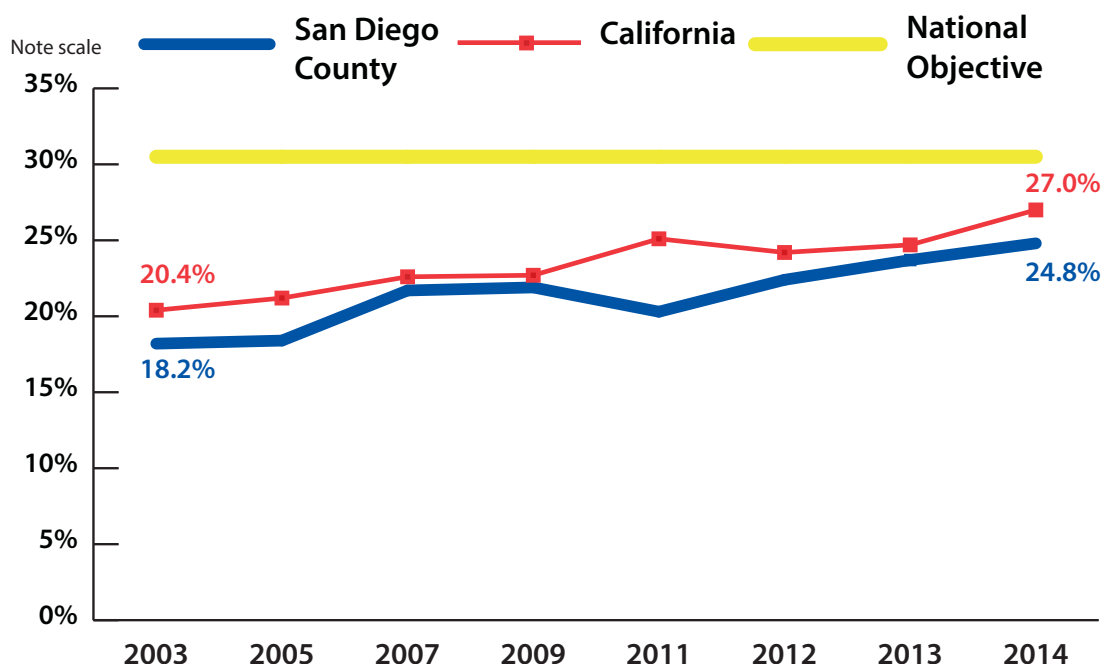
Source: San Diego County Health and Human Services Agency (HHSA). Obesity Fact Sheet, 2015.

OVERALL MORE THAN 1 OUT OF EVERY 4 ADULTS IN SAN DIEGO COUNTY ARE OBESE. WHILE THERE IS REGIONAL VARIATION, OBESITY IS TOO COMMON IN EVERY PART OF OUR COUNTY.



Source: California Health Interview Survey (CHIS), 2014.

Percentage of Adults Ages 18 and Older that are Obese, San Diego County and California Compared to National Objective, Select Years 2003-2014



What strategies can make a difference?

Promoting healthy weight and physical fitness among children is a nationwide priority. From the White House to the community level, efforts are underway to promote healthy weight among more children. Most programs and interventions aim to increase access to nutritious food, physical activity, healthy lifestyle choices, and access to safe recreation areas. For adults, combinations of interventions to modify diet and lifestyle have been shown to be most effective.

The following strategies have been used across the country to address weight and obesity issues:

- Increase nutrition education (including advice on shopping and cooking) through community-based programs.
- Expand levels of physical activity for all children and parents in school and community settings.
- Encourage eligible families to participate in WIC, which now offers healthier food packages.
- Use fitness, weight, and health assessments in communities and in schools starting at kindergarten, with interventions and referrals provided as needed.
- Increase the availability and affordability of fresh fruits and vegetables for homes and schools.
- Make drinking water more readily available at school, especially during lunch period.
- Reduce access to soft drinks, candy, and other foods and drinks high in sugar and calories, while low in nutrition, including requirements for public vending machines.
- Encourage smaller portion size options in schools and other public settings.
- Promote tax credits and incentives to develop and expand the availability of farmer's markets, farm-to-school programs, community gardens, and similar projects in low-income communities.
- Support student capacity to walk to and from school, using models such as walking school bus or safe passages.
- Provide education and support to increase breastfeeding.
- Provide extended hours and nighttime lights and security at public parks, sporting complexes, school fields, and community recreation centers.
- Encourage eligible families to participate in the Supplemental Nutrition Assistance Program (SNAP, known as CalFresh in California) in order to secure and use Food Stamps.
- Encourage businesses to sponsor health education, healthy weight interventions, fitness clubs, and subsidized health club memberships.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Implement supportive policies, such as tax credits and incentives to increase community gardens.
- Increase lighting, maintenance, and beautification of public parks, recreation centers, and school fields for increased community use.

Programs & Services

- Develop school and community partnerships to co-host farmer's markets and school gardens.
- Increase businesses' commitments to sponsor fitness clubs such as walking groups, health memberships, sporting leagues and events, and low cost exercise equipment.

Family & Community

- Develop community exercise and nutrition events such as cooking lessons, neighborhood walks and hikes, and health screenings.
- Conduct community health fairs with the Health and Human Services Agency, health care providers, community-based organizations, and schools to educate the community about healthy lifestyle choices.

Ages 13–18 (Adolescence): SCHOOL ATTENDANCE

Why is this important?

Poor attendance is an important warning sign that is associated with lower achievement, literacy problems, reduced high school completion, and delinquent behavior. Students who regularly attend school have a much greater chance of academic success and high school graduation, which are strongly correlated with better employment and lifelong earnings. Poor attendance is not just truancy-related. Whether students miss school as a result of illness, family vacations, or delinquent behaviors, missing too many days of school directly affects learning and life.

What is the indicator?

This indicator—the percent of middle and high school students who did not attend school at least 90 percent of school days—monitors school attendance based on 90 percent attendance on the Second Principal Apportionment (P2) reporting date of each district’s school year. This is not average daily attendance and represents approximately 18 absences in a school year. The data represent 96% of middle and high school students.

What is the trend?

The trend is improving. The percentage of San Diego County students in grades 6-12 who did not attend at least 90% of school days is declining. Attendance varies by school and district (data not shown).

Number of students with enrollment reported in San Diego County, School Year 2014-15

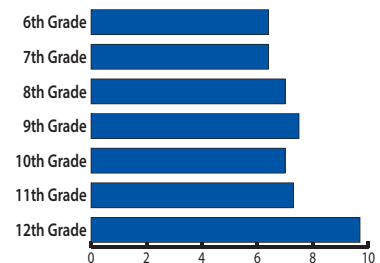
6th-12th Grade

223,130

Nearly 10,000 high school students attended less than 90% of school days in 2014-15.

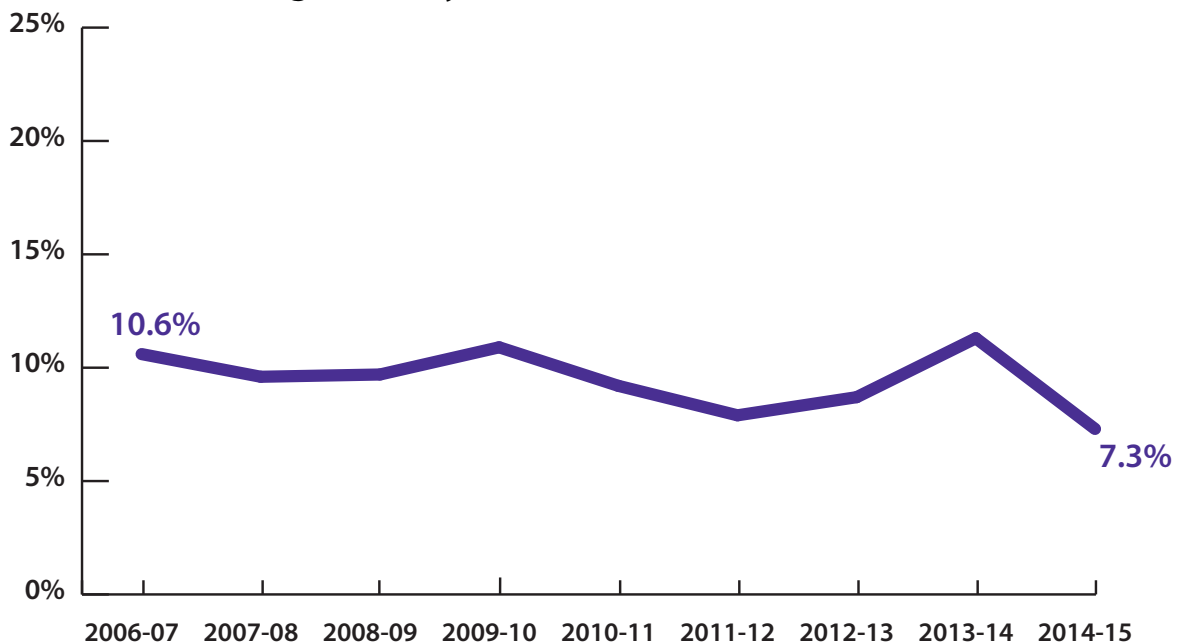
Source: San Diego school district reporting on P2 data for 2014-15 school year.

Percentage of Students Who Attended Less than 90% of School Days, By Grade



Source: San Diego school district reporting on P2 data for 2014-15 school year.

Percentage of Middle and High School Students (Grades 6-12) Who Did Not Attend at Least 90% of School Days, San Diego County, School Years 2006-07 to 2014-15



What strategies can make a difference?

A coordinated and multifaceted set of strategies is needed to reduce poor attendance patterns at the individual and school level. To address attendance issues with middle and high school students we must bring together schools, parents, community providers, and law enforcement to develop policies, programs, and supports focused on both prevention and intervention services.

The following strategies have been used across the country to increase school attendance:

- Develop accurate monthly and daily monitoring for attendance, with feedback to parents (e.g., using multiple languages, the Internet, e-mail, and other forms of communication).
- Create a school climate that engage parents as partners in education.
- Train staff to identify the early signs of chronic absenteeism.
- Develop parent, community, and school partnerships addressing the importance of regular attendance and parent involvement.
- Adopt evidence-based attendance policies, with a strong communications strategy to engage parents and school staff in their implementation.
- Use early interventions and provide positive reinforcement (e.g., commendation letters, attendance recognition).
- Provide expanded learning programs, and workplace service learning opportunities to engage teens after school, in the evening, and on weekends.
- Use visits to the home to engage families and identify unmet needs.
- Support student success and engagement in learning through targeted interventions such as: career academies, service learning, school-to-work programs, and technical education programs.
- Keep students safe and supported at school and with social media—in particular, implementing evidence-based anti-bullying and anti-cyber-bullying strategies.
- Coordinate district calendars to operate schools on same days.
- Build linkages between schools, mental health providers, and law enforcement.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Implement monthly attendance tracking systems to monitor attendance in all grades through high school.
- Coordinate elementary, middle, and high school calendars to operate on same school, holiday, and vacation schedules.

Programs & Services

- Expand work-place and service learning opportunities, career exploration, and college and career education in middle and high school.
- Identify and train staff to conduct home visits to engage parents and students.

Family & Community

- Develop joint school and community events and partnerships to increase parent engagement.
- Develop community partnerships to offer supportive programs in the evening and weekends to engage middle school youth.

Ages 13–18 (Adolescence):

SCHOOL ACHIEVEMENT GRADES 8 & 11

Why is this important?

English-language arts (e.g., reading and writing) and math skills are top predictors of school achievement and success in life. Formal academic assessments measure students’ skills and mastery of subject matter. Assessments help gauge students’ progress and, in turn, help students, teachers, and parents understand strengths and areas for improvement. Teachers can use results to better develop instruction to help students gain proficiency and prepare for higher learning and a 21st century career.

What is the indicator?

This indicator—the percentage of students in 8th and 11th grades who have met or exceeded the State Standards for English Language Arts/Literacy—reflects the first year of reporting these Common Core, Smarter Balance test results. This year’s scores will be a baseline for student performance over time. These data will be reported annually by the California Department of Education.

How are we doing?

No trend is available because this is the first year of reporting. The percentage who have met or exceeded the State Standards for English Language Arts/Literacy was 50% for 8th grade and 58% for 11th grade.

Number of students in San Diego County, 2014-15

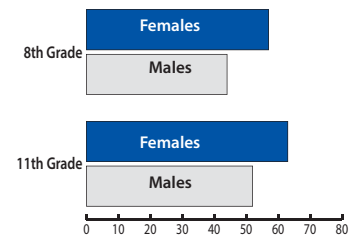
8th Grade
38,065

11th Grade
39,074

48% of 8th graders did not meet the achievement standard in English-language arts.

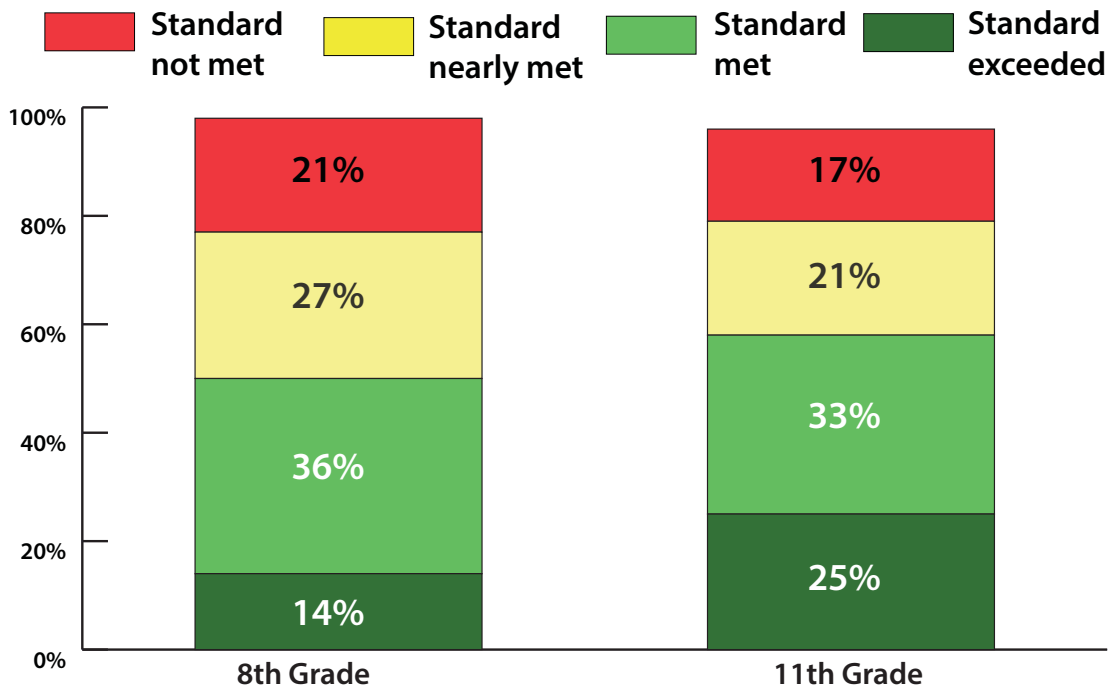
Source: California Smarter Balanced assessment system. Data for 2014-15 school year.

Percentage of Students Who Met or Exceeded English-Language Arts/Literacy Standard, By Gender



Source: California Smarter Balanced assessment system. Data for 2014-15 school year.

Percentage of Students in Grade 8 and 11 by Test Results Standard in English-Language Arts/Literacy, San Diego County, School Year 2014-15



Assessing Achievement in Grades 8 and 11 Using the Common Core State Standards

In recent years, states and school districts across the nation have adopted the same standards for English and math proficiency. These standards are called the Common Core State Standards. California is one of 45 states that have voluntarily adopted the State Standards. The Common Core State Standards reflect the knowledge and skills that students need to be successful in higher education and promising careers. These standards require that students gain knowledge and proficiency in problem solving and critical thinking across all subject matters.

In January 2014, California Education Code Section 60640 established the California Assessment of Student Performance and Progress (CAASPP) system of assessments to evaluate and measure whether or not students are meeting these new standards. These assessments are a combination of online and paper-pencil assessments for students, including those with different learning and language needs.

The online component used in California is the Smarter Balanced assessment. The Smarter Balanced assessment system has three components designed to support teaching and learning throughout the year: the Summative Assessments, the Interim Assessments, and the Digital Library.

Summative assessments are the comprehensive year end assessments of grade-level learning that measure progress toward college and career readiness. These are now administered in grades 3 through 8 as well as grade 11 for English-language arts/literacy and mathematics.

The Common Core State Standards for English Language Arts are part of a broad-based effort by states and schools to set high-quality educational performance standards. The standards set requirements not only for English-language arts but also for history/social studies, science, and technical subjects. The standards set expectations for performance in reading, writing, speaking, and listening. For older students, the English-language arts assessments include information about students' performance in the areas of reading, writing, listening, and research.

The Common Core State Standards for English Language Arts are only one area of measurement. Assessment of mathematics skills include: information about students' performance in problem solving, using concepts and procedures, communicating mathematical reasoning, and data analysis.

What strategies can make a difference?

Distinct from elementary students, older students need more intensive remediation and support when they are behind in English-language arts proficiency. As students enter middle and high school, feeling successful at and connected to school becomes increasingly important for staying in school and graduating. Identifying and intervening for learning and achievement problems are critical in upper grades.

The following strategies have been used across the country to increase proficiency in English-language arts among older students:

- Provide supports for the middle school to high school transition, particularly for underperforming students.
- Expand and target support services to underperforming students especially 8th and 9th graders (e.g., reading specialists, tutors, one-to-one instruction).
- Assess and address underlying issues of poor academic performance (e.g., substance abuse, mental health, safety concerns) in partnership with community and health partners.
- Increase focus on reading comprehension.
- Provide ongoing recognition for small improvements in reading and language arts skills.
- Adopt evidence-based and appropriate intervention programs, including before school, after school, and summer programming, and in-school reading support (e.g., Quantum Opportunity Program).
- Provide specialized reading trainings and instructional strategies for teachers and classroom support staff (e.g., Cognitively Guided Instruction).
- Develop smaller schools, schools within school models, and industry-specific academies.
- Promote and support reading and writing at school and at home.
- Create opportunities for reading achievement in the community (e.g., contests, awards, library programs).
- Improve students' and parents' feeling of connection to school.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Prioritize local control funding for grades 8 and 9 to provide supportive services such as tutoring and family engagement workers.
- Develop ongoing and sustaining partnerships with community and health care providers to provide mental health and substance support services.

Programs & Services

- Provide high school transition support programs for struggling middle school students.
- Develop summer, weekend, and evening programming, on and off campus, that includes both enrichment and academic support for low performing students.

Family & Community

- Conduct attendance and academic improvement events to support students.
- Provide informal teacher-parent “get togethers” to build trust, connections to education, and increased family engagement.

Ages 13–18 (Adolescence): SUBSTANCE USE

Why is this important?

Tobacco, alcohol, and drug use can stunt an adolescent’s physical and mental development. Studies show that prolonged use of alcohol and drugs can affect academic success, employment potential, and mental health. Use of the three reported substances represents only a share of the problem. Use of smokeless tobacco is a problem and is increasing. The prevalence of misuse of prescription drugs (e.g., OxyContin, Adderall, and Vicodin) is right behind marijuana use, can have serious consequences, and is likely to continue into adulthood.

What is the indicator?

This indicator—the percentage of students in grades 7, 9, and 11 who reported having used cigarettes, alcohol, or marijuana in the last 30 days—monitors a portion of substance use. These data are collected with the California Healthy Kids Survey, administered biennially to students in grades 7, 9, and 11. These questions mirror the questions in the Youth Risk Behavior Survey, a CDC-designed survey in use across the country.

How are we doing?

Substance use increases with each grade level. Data not shown indicate that for each grade level, the trends in cigarette smoking and drinking are improving but the same is not true for marijuana use.

Number of 7th, 9th & 11th grade students using e-cigarettes

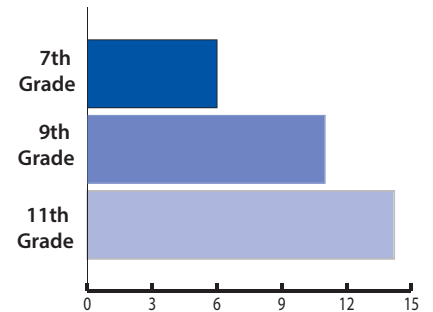
6,446

Some students report almost daily substance use.

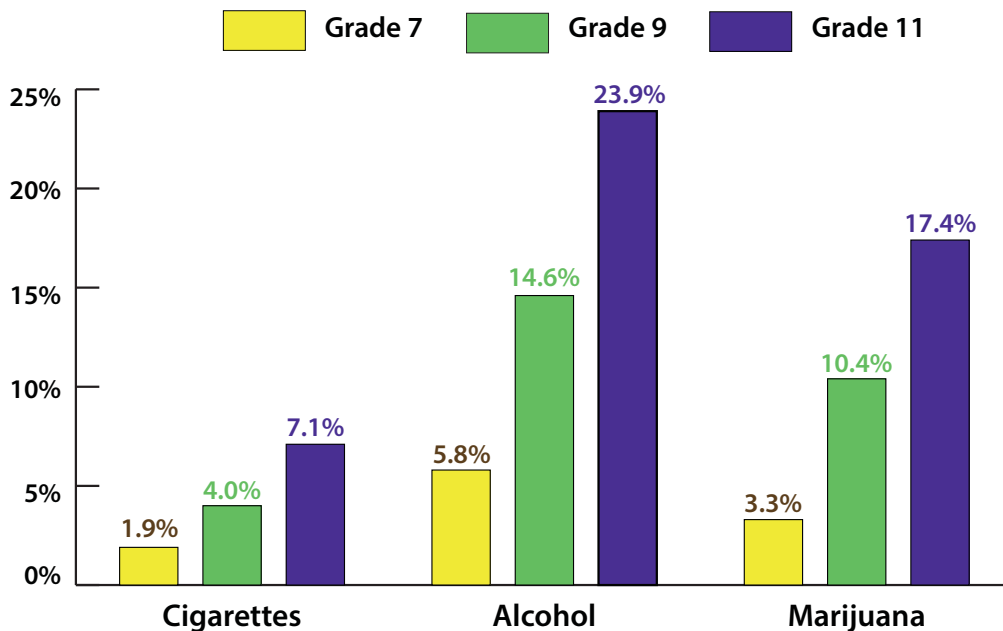
- 954 using alcohol
- 1,675 using marijuana

Source: San Diego County Office of Education. School year 2014-15.

Percentage of San Diego County Students Who Report Using E-cigarettes, By Grade



Percentage of Students Grades 7, 9, and 11 Who Reported Use of Cigarettes, Marijuana, or Alcohol in Prior 30 Days, San Diego County, School Year 2014-15



Adults: SUBSTANCE USE

Estimated number of adult smokers in San Diego County in 2014

237,000

Why is this important?

Smoking among adults has continuously declined in recent years but about 1 in 5 adults smokes tobacco. In 2014, about 17 of every 100 U.S. adults age 18 years or older were smokers. One quarter of poor adults are smokers. Cigarette smoking is the leading cause of preventable disease and death. Half of adults who continue to smoke will die from smoking-related causes. Millions more suffer with a smoking-related disease such as cancer or heart disease. Adult smoking affects the health of the next generation. Smoking contributes to preterm and low birthweight births. Infants exposed to cigarette smoke are more likely to die in the first year of life. Children exposed to secondhand smoke are more likely to have asthma. Parental smoking can promote smoking among adolescents.

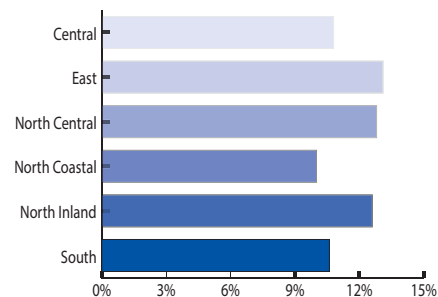
In 2014, 11.2% of males and 8.8% of females age 18 and older in San Diego County were smokers.

Source: California Health Interview Survey, 2014.

What is the indicator?

This indicator—the percentage of adults ages 18 and older who reported smoking—reflects one type of substance use. These data show current but not former smokers. These data are routinely collected in the California Health Interview Survey.

ADULT SMOKING VARIES BY REGION IN SAN DIEGO COUNTY, FROM 10.0% TO 13.1%.

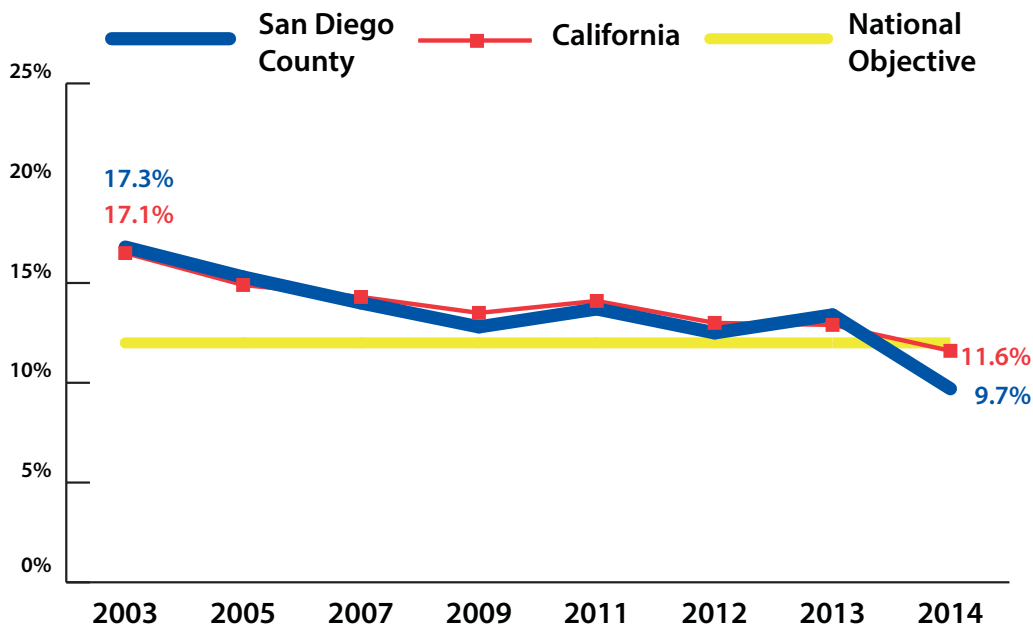


Source: California Health Interview Survey, 2014.

How are we doing?

The trend is improving. The percentage of adults smoking in San Diego County is lower than for both the state and national objective.

Percentage of Adults Ages 18 and Older Who Reported Smoking, San Diego County and California Compared to National Objective, Select Years 2003 -2014



What strategies can make a difference?

Reducing substance use requires both prevention and intervention policies, services, and programs. Services for individuals are most effective when they are available immediately, community based, and holistic. Education in schools, as well as community settings, is essential. Successful community-level prevention strategies rely on coalitions to select and implement preventive interventions that have proven effective.

The following strategies have been used to decrease young people's use of cigarettes, alcohol, and drugs:

- Use coalitions and partnerships to educate parents and other adults in the community about the dangers of substance use, the sources of substances, and the trends in use.
- Increase students' ability to resist social pressure to use tobacco, e-cigarettes, alcohol, illicit drugs, and nonprescribed medications through family, school, and community programs (e.g., LifeSkills Training, Child Development Project, Council on Prevention and Education: Substances, Inc.).
- Increase the availability of support groups for alcohol and substance users.
- Teach parents the skills they need to improve family communication and bonding through programs such as Guiding Good Choices.
- Work with parents, schools, community, and business to eliminate youth access to tobacco, alcohol, illicit drugs, and nonprescribed medications.
- Promote youth development and build resistance, resiliency, and problem-solving skills.
- Work with peers to reduce group supported substance use and/or reduce motivation to associate with networks of peers who use substances.
- Widely use culturally competent and effective substance abuse education.
- Use interactive games, and other technology-based approaches to reducing substance use.
- Increase the availability of community-based drug and alcohol treatment programs, both day treatment and residential, for youth and adults.
- Increase the availability of mental health services and counseling for youth and adults.
- Develop and enforce local ordinances prohibiting the sale of tobacco, e-cigarettes, and alcohol to minors, as well as over-the-counter substances that can be misused (e.g., bath salts, spice).
- Ensure substance abuse treatment is available to youth in custody, in foster care, and in transition from detention.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Develop and strengthen local government policies to reduce youth access to e-cigarettes and other smokeless tobaccos.
- Increase public funding for substance abuse treatment including day treatment and residential bed space for youth and adults in local communities.

Programs & Services

- Increase the availability of substance abuse treatment for adult and youth in community settings throughout San Diego County.
- Increase programs for youth development, resiliency, and problem-solving skills for youth.

Family & Community

- Work with local businesses to eliminate the promotion and access of tobacco, alcohol, and e-cigarettes to youth.
- Increase the availability of support groups for substance users at faith-based, community, and neighborhood locations.

Dangers of E-Cigarettes for Youth

The use of e-cigarettes is surging in the United States. This increased use is seen in children and adolescents, as well as in adults, and is especially concerning because of the increased risk for nicotine addiction. Researchers and policy experts are collecting and analyzing data about the use and harm of these electronic nicotine delivery devices, also known as vapes or vape pens. Contrary to what many people believe, the use of e-cigarettes is not a healthy alternative to smoking.

The Centers for Disease Control and Prevention reports that current e-cigarette use among middle and high school students tripled from 2013 to 2014. Among high school students nationally, the increase from 4.5 percent in 2013 to 13.4 percent in 2014 represents more than 2 million students. The Monitoring the Future study tracks annual trends in substance abuse nationwide among 8th, 10th, and 12th graders. Among its findings in 2015, a substantially higher percentage of adolescents used e-cigarettes in the past 30 days than had smoked traditional cigarettes—mistakenly believing they do not harm health. The same 2015 survey indicated that 9.5 percent of 8th graders, 14 percent of 10th graders, and 16.2 percent of 12th graders used e-cigarettes in the past 30 days.

Recent research revealed that almost three quarters of adolescents are exposed to advertisements for e-cigarettes, with many of these ads based on themes appealing to youth. Exposure to e-cigarette advertisements and their increased use means renormalizing smoking and unravelling of our healthier norm to make healthier choices and breathe clean air. A study published in August 2015 by Leventhal and colleagues showed that e-cigarette use among 14-year-old adolescents who have never tried combustible tobacco is associated with risk of starting to smoke cigarettes.

The chemicals found in e-cigarettes are not safe. One of these chemicals, nicotine, is highly addictive and has demonstrated negative effects on health. Other chemicals in e-cigarettes, including flavorings, have been linked to changes in lung function, damage to lungs, and cancer. At least 10 chemicals identified in e-cigarettes are on California's Proposition 65 (Safe Drinking Water and Toxic Enforcement Act of 1986) list of carcinogens and reproductive toxins. Additionally, the use of e-cigarettes has created a new hazard: nicotine poisoning. Poison control centers reported a 145% increase in calls involving e-cigarettes and liquid nicotine between 2013 and 2014. More than half of these calls were for exposure among children ages 5 and under.

These products are not currently regulated by the U.S. Food and Drug Administration. None of these products has been approved as a smoking cessation aid, and in fact, many studies have shown a continued dual-use of e-cigarettes and traditional cigarettes among individuals who are attempting to quit using tobacco.

California law prohibits the sale of e-cigarettes containing nicotine to children under 18 years old and many local jurisdictions in San Diego County have limits on e-cigarettes where traditional cigarettes have been banned. While further research information on the hazards of e-cigarettes is underway, public health officials currently recommend eliminating their use by youth, decreasing exposure to secondhand aerosols in public locations, and ensuring children and youth do not have access to any nicotine products.

Ages 13–18 (Adolescence): YOUTH SUICIDE

Why is this important?

Suicide is preventable. Support, guidance, and interventions can be provided to youth. Many youth who attempt suicide are injured or hospitalized as a result of attempts. Many other youth report suicide attempts and suicide ideation (contemplation). The most common methods among young people are firearms, suffocation, and poison/overdose. Beyond the tragedy of death, suicide has a lasting traumatic effect on the community and friends.

What is the indicator?

This indicator—the percentage of high school students who self-report having made a suicide attempt in the previous 12 months—reflects trends among a subset of youth. These data are collected and reported from the San Diego Unified School District’s Youth Risk Behavior Surveillance System (YRBSS). YRBSS is a national survey designed by the CDC and used by state, territorial, and local education and health agencies. The survey monitors health-risk behaviors among youth. San Diego Unified enrollment accounts for 26% of all county students.

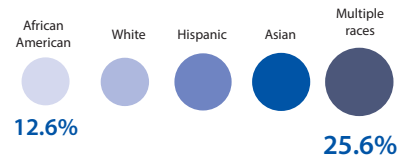
What is the trend?

The trend is maintaining. The percentage of high school students who report attempted suicide has remained constant since 2010-11.

Average number of youth suicides per year in San Diego County

10

Across race/ethnicity, students give different reports on whether they seriously considered attempting suicide.



Source: Youth Risk Behavior Survey, San Diego Unified School District, 2015.

Number of students reporting suicide attempts in the prior 12 months.

94

Source: Youth Risk Behavior Survey, San Diego Unified School District, 2015.

Percentage of Students Grades 9-12 Who Reported They Had Attempted Suicide in the Past 12 Months, By Gender, San Diego Unified School District, 2010–11, 2012–13, and 2014–15



What strategies can make a difference?

Youth typically do not seek assistance from mental health professionals when they are depressed. Peers, teachers, health professionals, and parents are the people most likely to have contact with a depressed youth, to identify warning signs, and thus in the best position to intervene early. Youth suicide prevention requires education of adults and youth, across a range of services.

The following strategies have been used to prevent youth suicide:

- Educate families, schools, and community leaders about the signs of depression and suicidal ideation (i.e., thinking or talking about dying or committing suicide).
- Educate peers and adult “gatekeepers” (e.g., teachers, school bus drivers, coaches) to recognize the warning signs and risk factors associated with depression and suicide—in particular, training peers to respond to suicidal statements as an emergency and to tell a trusted adult and use crisis hotlines.
- Train primary health care providers to screen for signs of depression and suicide ideation.
- Educate parents and others about eliminating access to lethal means, particularly firearms, which remain a major instrument used by youth who attempt suicide.
- Reduce access to prescription and other medications that may be used in attempting suicide.
- Expand school-based programs that promote help-seeking behaviors, teach problem-solving skills, and provide assessment and referrals (e.g., Cognitive Behavioral Intervention for Trauma in Schools).
- Reduce the stigma associated with seeking support and help for mental health problems.
- Increase access to mental health services appropriate for youth, including outpatient treatment and residential beds for youth.
- Use the federal Substance Abuse and Mental Health Services Administration (SAMHSA) *Preventing Suicide* toolkit for high schools.
- Provide interventions tailored to at-risk youth of various cultural and ethnic backgrounds.
- Improve data collection and reporting, particularly school-based child health surveys.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Increase public funding for mental health services including community based treatment and residential beds for youth.
- Expand school-based programs that provide assessments and referrals for depression, trauma, and mental health issues.

Programs & Services

- Educate primary health care providers, nurse practitioners, school personnel, and parents about the warning signs and risk factors of depression and suicide and appropriate action steps to take when signs are present.
- Provide culturally and linguistically appropriate mental health interventions and treatment at school settings and in the community.

Family & Community

- Work to eliminate the stigma associated with identifying and addressing mental health problems.
- Educate parents and others about eliminating access to lethal means of suicide, particularly firearms.

Ages 13–18 (Adolescence): JUVENILE CRIME

Why is this important?

Committing a crime and being arrested as a juvenile can have immediate and lifelong consequences for the youth and their families. It can have negative impact on communities. An arrest record and involvement with the juvenile justice system can affect young people’s educational attainment and relationships with their families and their communities. Depending on the type of crime, it can also hinder future employment opportunities and college acceptance. Crime also diminishes a sense of safety for families and communities and can be costly to victims.

What is the indicator?

This indicator—the number of arrests for misdemeanor and felony crimes among youth ages 10-17—reports on trends in crimes. Arrests for status offenses such as curfew violations or truancy are not included. Only the most serious charge is reported in each arrest. Data are collected by law enforcement, stored in the Automated Regional Justice Information System (ARJIS), and routinely reported by the San Diego Association of Governments (SANDAG).

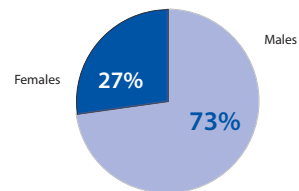
What is the trend?

The trend is improving. The number of arrests among youth has dropped by more than half between 2004 and 2014, parallel to a national decline.

Number of juvenile felony and misdemeanor arrests in San Diego County in 2014

6,351

Males represented nearly three quarters of juvenile arrests.



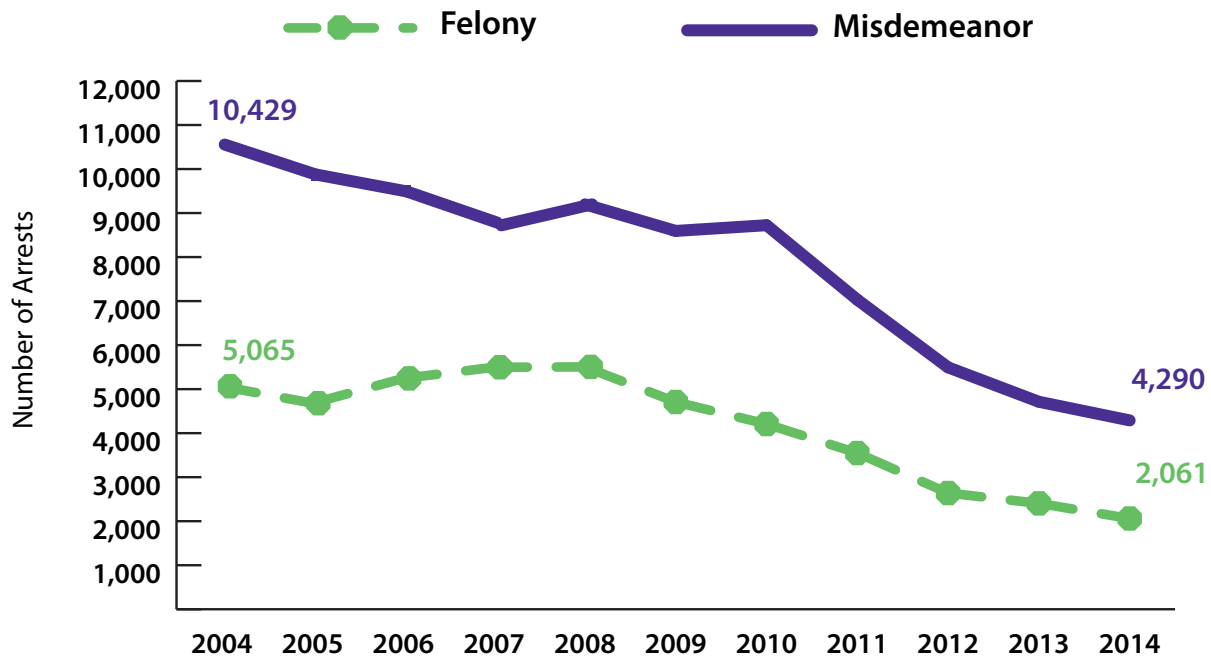
Source: SANDAG Annual Arrest Report, 2014.

788

Fewer juvenile arrests in San Diego County in 2014 than in 2013

Source: SANDAG Annual Arrest Report, 2014.

Number of Arrests for Felony and Misdemeanor Offenses, Youth Ages 10-17, San Diego County, 2004-2014



Ten Most Common Crimes Committed by Juveniles, Ages 10-17, San Diego County, 2014

Crime	Level	Number
Petty theft	Misdemeanor	839
Manslaughter/assault & battery	Misdemeanor	781
Drunk/liquor laws	Misdemeanor	535
Burglary	Felony	475
Aggravated assault	Felony	450
Weapons offenses	Felony	231
Drug law violations	Felony	209
Robbery	Felony	200
Vandalism	Misdemeanor	176
Larceny	Felony	100

Both misdemeanor and felony level crimes were among the top 10. The largest number of crimes committed by youth was in the category of petty theft, followed closely by manslaughter/assault and battery. Data not shown show that smaller numbers of crimes (i.e., less than 100) were committed in categories such as motor vehicle theft, and DUI.

What strategies can make a difference?

Prevention, early intervention, and appropriate services for offenders are all important to reducing the number of juvenile crimes. Identifying young people when they first begin to experiment with risky behaviors and providing them with services that focus on youth development, resiliency, and leadership can reduce the chances that they will enter or escalate in the juvenile justice system.

The following strategies have been used to decrease juvenile crime:

- Expand use of life skills training, vocational education, career development, internships, and employment opportunities.
- Increase availability of mentoring programs, particularly for youth at risk.
- Identify and provide early intervention for youth who are truant.
- Provide high quality and age appropriate after school programming for students K-12.
- Increase access to culturally appropriate, community-based mental health and substance abuse services for youth at school and in the community.
- Use approaches shown effective in reducing disproportionate arrests and detention for youth of color.
- Provide trauma-informed assessments, interventions, and treatment.
- Provide services such as problem-solving, anger management, mediation, and conflict resolution instruction (e.g., Second Step).
- Offer academic support, credit recovery, and tutoring for low performing students.
- Expand prevention programs to connect youth to school, encourage positive behavior, and reduce gang involvement (e.g., Gang Violence Reduction Program).
- Provide appropriate, community-based alternatives to detention.
- Expand community-based Juvenile Diversion programs for low level offenders, in partnership with police and sheriff departments.
- Support successful and safe transitions for young fathers and young mothers moving from detention, out-of-home placement, or incarceration back to their families and communities.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Increase lighting, maintenance, and security for public parks, recreation centers, and school fields for use during evenings and weekends.
- Increase County and municipal services for youth during summer and school holidays, including internships, expanded learning programs, and sports and recreation opportunities.

Programs & Services

- Expand career and college readiness programs to include paid internships, targeting high-risk/high-need youth based on crime data and poor school performance.
- Develop mental health and trauma screening, assessment, and services for middle school and high school youth in zip codes with high percentages of crime.

Family & Community

- Provide one-on-one or small group mentoring services with positive role models for middle school youth.
- Develop family dinner, game, and movie nights to increase quality family time and increase parent and adolescent communication.

Ages 13–18 (Adolescence): JUVENILE PROBATION

Why is this important?

Entering the juvenile justice system after committing a crime has a negative impact on a young person’s life immediately and in the future. A youth who enters the juvenile justice system and has a sustained petition (also known as “true find”) is placed on probation. Probation is structured supervision to assure that young people successfully complete their court orders and get back on track. While probation is an important tool, it is costly for the public and often represents failure to address early warning signs of risky behavior and unmet needs of youth.

What is the indicator?

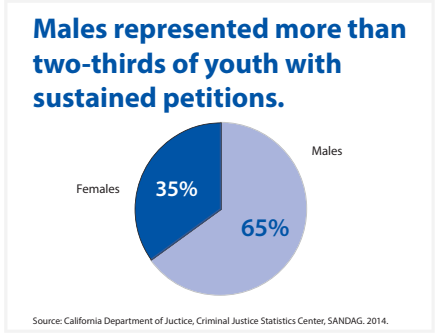
This indicator—the number of sustained petitions (true finds) in juvenile court among youth ages 10-17—reports on the juvenile equivalent of being found guilty in adult court. This indicator includes only sustained petitions for misdemeanor or felony offenses. Status offenses such as curfew or truancy violations are not included here. These data are routinely reported by the San Diego County Probation Department.

What is the trend?

The trend is improving. The number of sustained petitions in juvenile court has decreased steadily since 2007.

Number of youth that received sustained petitions (“true finds”) for misdemeanor or felony offenses in San Diego County in 2014

2,330

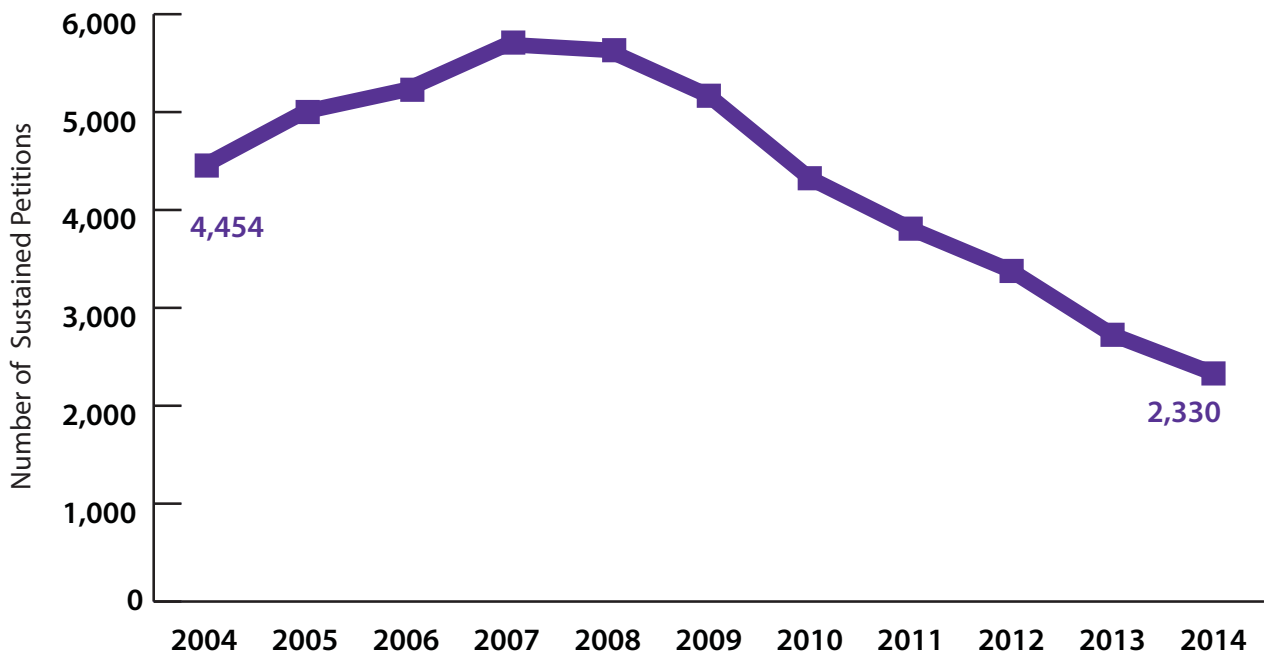


395

Fewer sustained petitions in San Diego County in 2014 than in 2013

Source: California Department of Justice, Criminal Justice Statistics Center, SANDAG, 2014.

Number of Sustained Petitions (“True Finds”) in Juvenile Court, Youth Ages 10-17, San Diego County, 2004-2014



What strategies can make a difference?

Consistent, evidence-based strategies from arrest and detention, to after care, and through probation completion are key to success. Holding young people accountable for their actions, while supporting them in making better decisions, provides them with an understanding of appropriate boundaries, an opportunity to learn from their mistakes, and the ability to get back on track. Providing appropriate treatment, along with consistent and direct community supervision and support, has been found to be effective in preventing increased delinquent behaviors, reducing recidivism, and improving public safety.

The following strategies have been used to reduce arrests and escalation in the justice system.

- Use a continuum of services and interventions.
- Offer job readiness, career and technical education, internships, and subsidized employment approaches for youth on probation.
- Provide academic support for reading proficiency, credit recovery, and high school completion for low performing students.
- Offer no cost parent education and training to improve family communication, youth development, decision-making, and conflict resolutions skills for youth on probation and their families.
- Provide mental health evaluation and clinical supervision, substance abuse services, and cognitive-behavioral treatment.
- Implement interventions to reduce gang involvement and to help youth exit a gang lifestyle.
- Provide restorative justice evidence-based practices, such as victim-offender mediation, empathy training, and restitution.
- Provide alternatives to detention, such as community-based supervision with wrap-around services, cool beds, and day reporting centers.
- Develop transition plans for youth, including comprehensive re-entry and after care services.
- Provide immediate and consistent mental health services and residential bed space for juvenile offenders.
- Implement nationally recognized and evidence-based youth development, family engagement, and recidivism reduction models (e.g., NEON, Missouri Model).

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Develop community located multi-agency centers for juvenile offenders that include probation, education, employment services, trauma informed counseling, and public assistance programs.
- Update juvenile institution policies to reflect best practices including: reducing use of solitary confinement, reduction of use of force, and increase of family and positive role model visitation.

Programs & Services

- Implement mental health services and local residential mental health beds for juvenile offenders.
- Provide comprehensive wrap-around services to youth transitioning out of juvenile institutions, including employment assistance, re-engagement to schools and community, and trauma informed counseling and services.

Family & Community

- Provide mentoring services with positive role models to middle school youth.
- Offer more job and career exploration, job shadowing, and college visits for high school students.

Ages 13–18 (Adolescence): YOUTH DUI

Why is this important?

U.S. teens have higher motor vehicle crash rates than adults, with driving under the influence (DUI) a major contributing factor. Driving under the influence of alcohol and/or drugs is a serious hazard to health and safety for youth and the community at large. Youth report that it is “no trouble” obtaining alcohol. One in 10 high school students reports drinking and driving, and one in four rides with a driver who has been drinking. At any level of impairment, youth are more likely to be involved in a vehicle crash than adults. Motor vehicle crashes are a leading cause of death for youth ages 15 to 20, accounting for one-third of all U.S. teen deaths.

What is the indicator?

This indicator—the number of DUI arrests among youth under age 21—measures one aspect of the problem of alcohol- and drug-related collisions. This is a subset of a larger number of youth who engage in DUI but are not caught. These data are routinely reported by the California Department of Motor Vehicles.

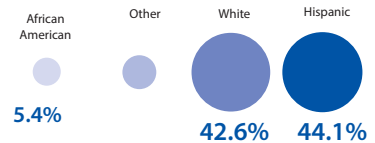
What is the trend?

The trend is improving. The number of DUI arrests among youth under 18 and 18-20 years old has declined in recent years.

Number of DUI arrests among drivers under age 21 in San Diego County in 2013

780

Hispanic and white youth most likely to have DUI arrests.



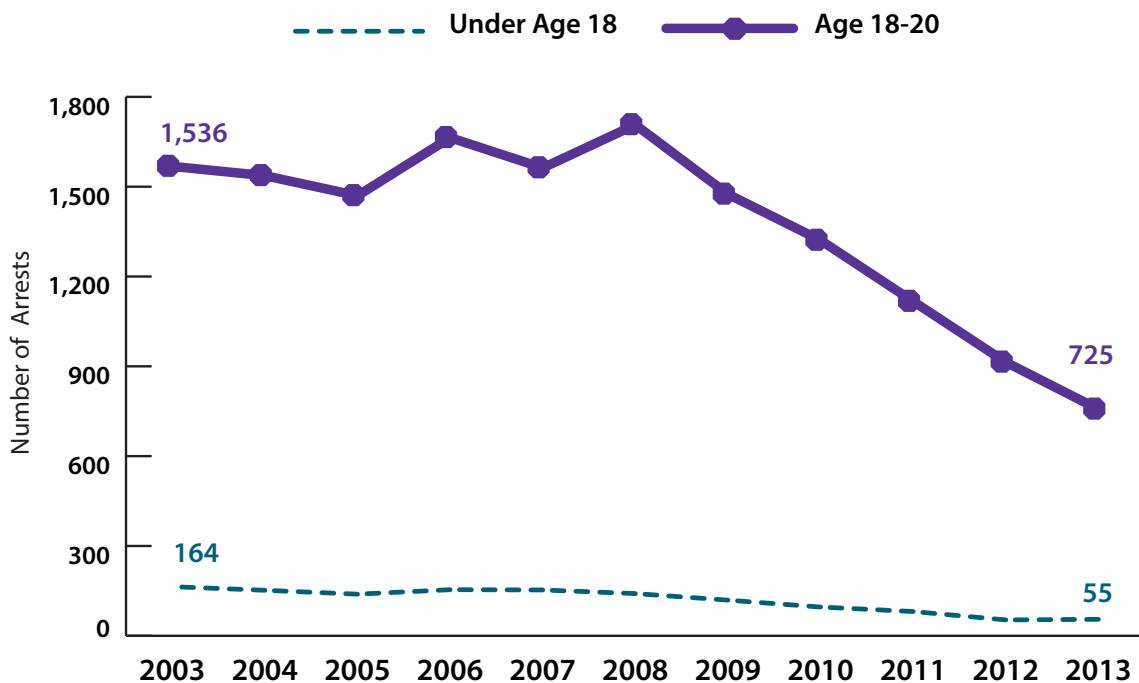
Source: Annual Report of the California Department of Motor Vehicles, DUI Management Information System, 2015.

Average number of crashes per year in San Diego County involving at least one 16-20 year-old driver who had been drinking or was under the influence of drugs in 2010-2012

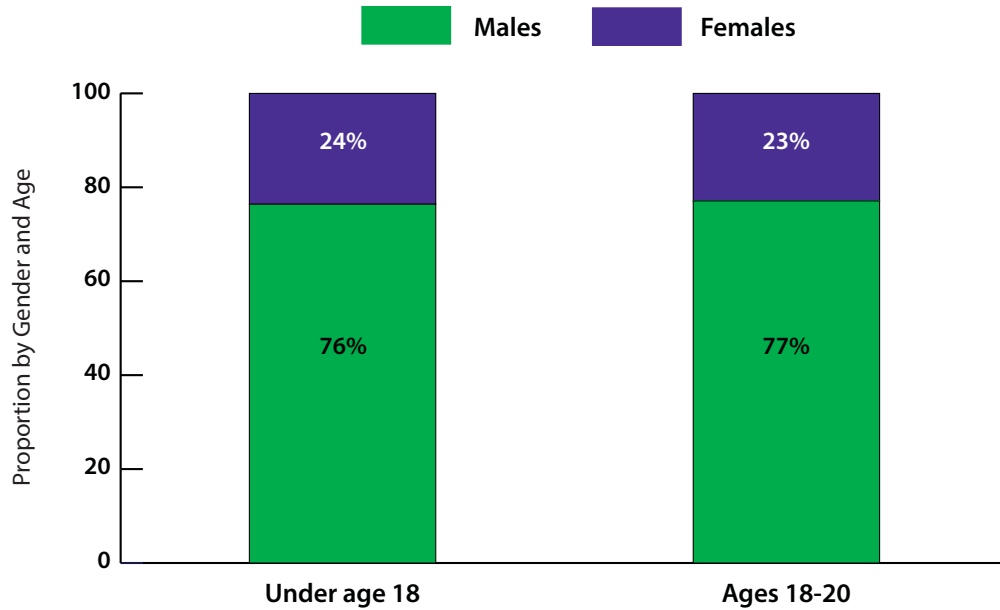
170

Source: Collision data from County of San Diego, HHS, PHS, EMS, SWITRS Database, 2010-2012.

Number of DUI Arrests, Youth Under Age 18 and 18-20, San Diego County, 2003-2013

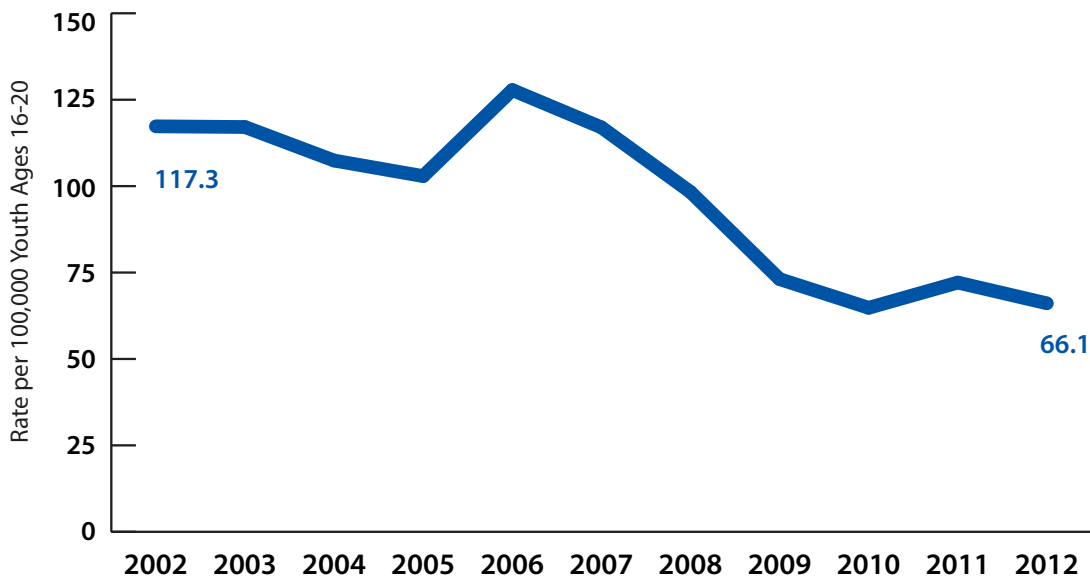


Proportion of DUI Arrests, Youth Under Age 18 and 18-20, By Gender, San Diego County, 2013



Males account for a greater proportion of DUI arrests than females. This is true for both youth under age 18 and those 18-20 years old.

Rate of Non-Fatal Crashes Involving Drivers Ages 16-20 Under the Influence of Alcohol or Drugs, Per 100,000 Population, San Diego County, 2002-2012



The trend in non-fatal crashes has declined dramatically since 2006, with the rate cut in half over that same period from 128 per 100,000 in 2006 down to 66 per 100,000 in 2012. Progress has leveled off since 2009.

What strategies can make a difference?

Drinking and DUI both are against the law for youth under age 21. Parents, youth, community leaders, and law enforcement all have a role to play in reducing youth DUI and its damages. A continuum of efforts and interventions are needed to eliminate access, enforce the law, and teach youth to make safe and positive decisions.

The following strategies have been used to reduce DUI and related crashes:

- Maintain a legal drinking age of 21.
- Aggressively enforce existing blood-alcohol level laws (i.e., zero BAC), minimum legal drinking age laws, and zero tolerance laws for drivers younger than 21 years old in all states.
- Eliminate youth access to alcohol and drugs.
- Change social norms regarding the use of alcohol and drugs by youth.
- Educate adults about the risks and liabilities of “supervised” drinking.
- Institute community- and school-based programs to increase student and parent awareness about the dangers of drinking and driving.
- Provide affordable, high-quality drivers education and training lasting at least three months.
- Implement graduated driver licensing that includes a mandatory waiting period, nighttime driving restriction, at least 30 hours of supervised driving, and passenger restrictions.
- Limit youth driving privileges during the first 12 months with a new license.
- Promptly suspend the driver’s licenses of people who drive while intoxicated.
- Conduct sobriety checkpoints, particularly targeted at communities with highest incidence of alcohol- and drug-related accidents involving youth and in locations where youth congregate.
- Promote youth development programs and activities to empower youth and build resistance and problem-solving skills.
- Implement safe and engaging weekend and evening activities (e.g., midnight basketball, beach clean ups).

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Increase enforcement operations on alcohol-related sales to minors.
- Increase enforcement of social host ordinances throughout San Diego County.

Programs & Services

- Regularly conduct parent/youth education workshops on the dangers of youth DUI and alcohol, marijuana, drugs, and prescription medication in schools, youth organizations, probation, and parks and recreation centers.
- Provide low-cost, high-quality driver’s education and training.

Family & Community

- Host evening and weekend holiday activities to promote youth engagement and empowerment.
- Use community-based organizations to provide culturally relevant education and incentives for youth related to stopping DUI.

Community and Family (Cross Age):

CHILD POVERTY

1 in 5
 San Diego County
 children under age 18
 lived in poverty in 2014

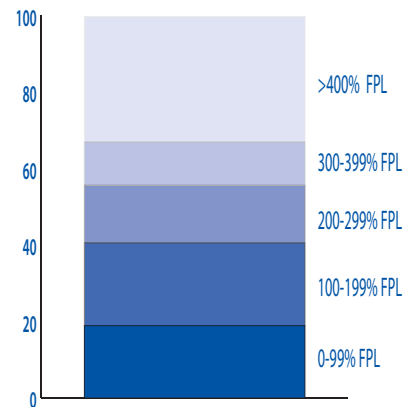
Why is this important?

Children living in poverty are disproportionately exposed to inadequate nutrition and housing, parental depression or substance abuse, maltreatment, low quality education and child care, and environmental hazards. The “dose” of poverty matters; the more severe the poverty or the more years in poverty, the worse the impact. Adolescents raised in poverty are more likely to engage in risky behaviors including: smoking, substance abuse, sexual activity, and school drop out. Increasing income for poor families—without other changes—can positively affect child development.

SAN DIEGO COUNTY HAS CHILDREN LIVING AT ALL INCOMES. WHILE APPROXIMATELY ONE THIRD OF CHILDREN LIVE IN WELL-OFF FAMILIES WITH INCOME ABOVE 400% OF THE FEDERAL POVERTY LEVEL (FPL), MORE THAN 40% OF CHILDREN LIVE IN A LOW-INCOME FAMILY, WITH INCOME BELOW 200% FPL.

What is the indicator?

The indicator—the percentage of children under age 18 living below 100% of the Federal Poverty Level—reflects the proportion of children living in households with annual income below federal guidelines for “poverty.” The Federal Poverty Level was set at \$24,250 for a family of four in 2015. These data are routinely reported by the U.S. Census Bureau and SANDAG.

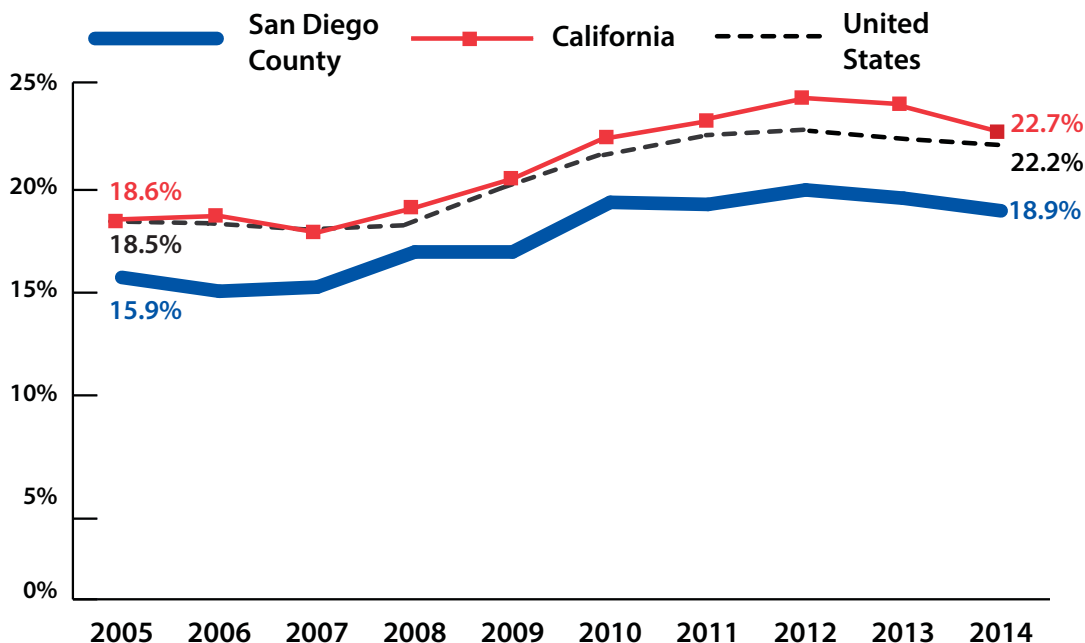


Source: U.S. Census Bureau, American Community Survey, September, 2015.

How are we doing?

The trend is moving in the wrong direction. Child poverty is increasing at the county, state, and national levels.

Percentage of Children Ages 0-17 Living in Poverty, San Diego County, California, and United States, 2005-2014



Community and Family (Cross Age):

ADULT POVERTY

Why is this important?

Adult poverty has been on the rise in recent years. Poverty is associated with inadequate food and nutrition, housing, and community safety. As the economic recession continues, many parents continue to be un- or under-employed, with income insufficient to raise them above the poverty level. From a lifecourse perspective, poverty is an important social determinant, with potentially lifelong negative effects. Childhood poverty is associated with adult health conditions such as: obesity, mental health conditions, asthma, and heart disease. Lower educational attainment and less annual income throughout life are also effects of childhood poverty.

What is the indicator?

The indicator—the percentage of adults ages 18-64 living below 100% of the Federal Poverty Level—reflects the proportion of non-elderly adults living in poverty. The Federal Poverty Level was set at an annual income of \$24,250 for a family of four in 2015. Not all of these adults have children. These data are routinely reported by the U.S. Census Bureau and SANDAG.

How are we doing?

The trend is moving in the wrong direction. San Diego County is just below both the state and the nation.

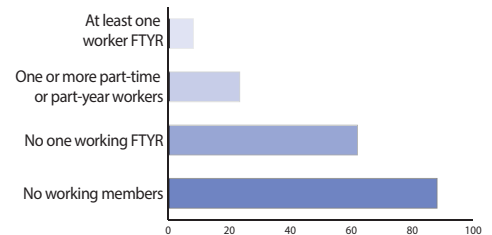
Estimated number of San Diego County adults ages 18-64 living in poverty in 2014

292,268

Percentage of San Diego County families with children under age 18 living in poverty in 2014

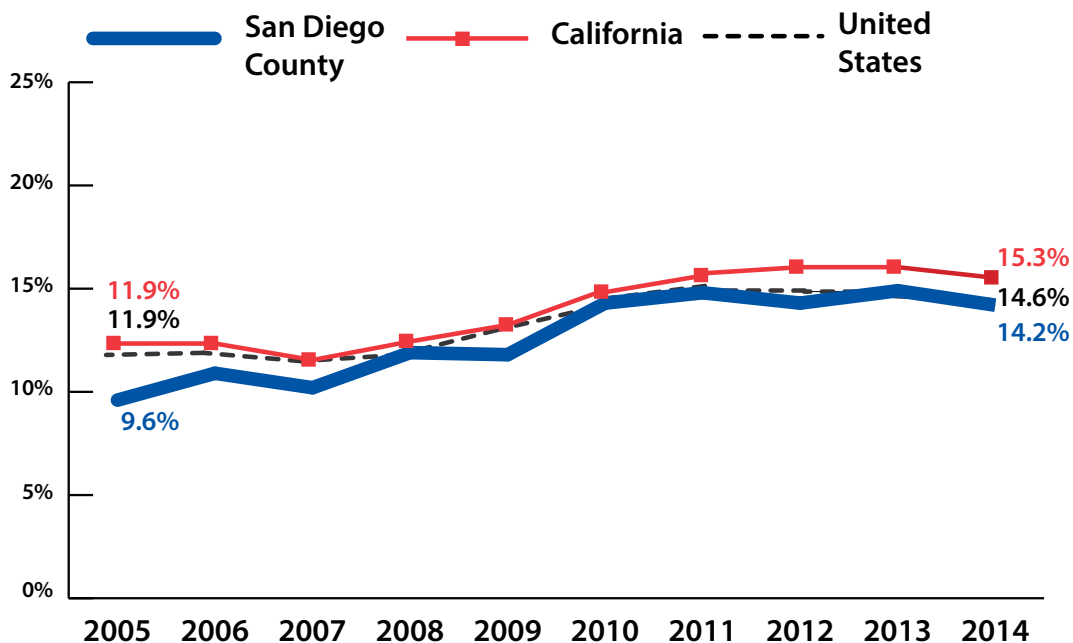
15.5%

BETTER EMPLOYMENT AND WAGES—WORKING FULL-TIME AND/OR FULL-YEAR WORK (FTYR)—DECREASES POVERTY. GRAPH SHOWS PERCENTAGE OF FAMILIES WITH CHILDREN UNDER AGE 6 IN POVERTY BY WORK STATUS IN 2013.

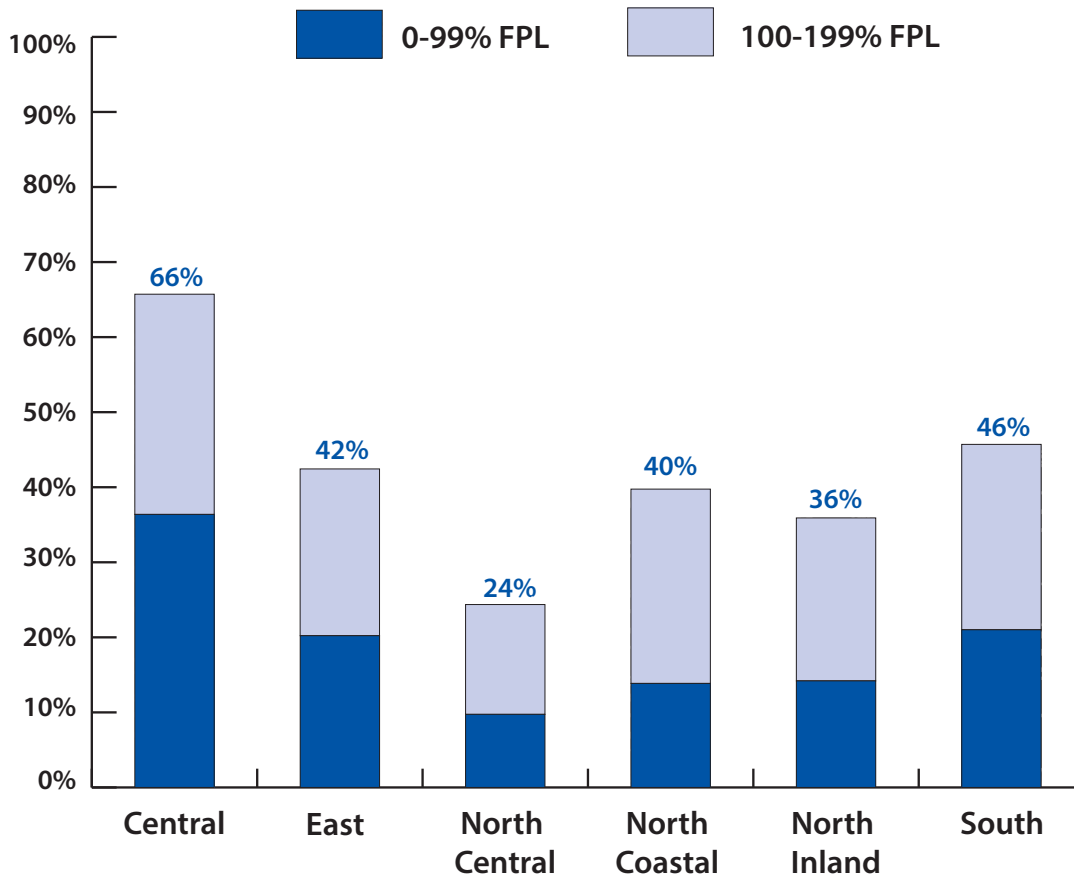


Source: U.S. Census Bureau. People in Families With Related Children Under 6 by Number of Working Family Members and Family Structure. San Diego County, 2013.

Percentage of Adults Ages 18-64 Living in Poverty, San Diego County, California, and United States, 2005-2014



Percentage of Children Under Age 18 in Low-Income Households, By Poverty Level and Region, San Diego County, 2014



Poverty is defined as having income below 100% of the Federal Poverty Level, and low-income children are those living below 200% of the Federal Poverty Level. The percentage of San Diego County children under age 18 who are low income varies considerably by region. Children and families in the Central Region are much more likely to live with the risks of poverty; however, 4 in 10 children in the East, North Coastal, and South Regions are low income.

What strategies can make a difference?

Poverty places families at risk. In San Diego County, the level sufficient to meet basic needs such as housing and food is closer to 200% of the Federal Poverty Level (\$48,500). Despite some improvement, the economic recession continues to affect many families with children. Government programs and subsidies for low-income working families can help families move out of poverty. Assistance with income, housing, job training, food, child care, utilities, and related benefits encourage, support, and reward work by helping families close the gap between low wages and basic expenses. Other effective practices address family, cultural, neighborhood, educational, and job skill factors. The Earned Income Tax Credit (EITC), child tax credits, and other tax credits for low-income families are effective in improving outcomes in terms of health and wealth.

The following strategies have been used across the country to reduce child and family poverty:

- Streamline application processes and assist qualified families in enrolling in anti-poverty programs such as child care subsidies, nutrition assistance, cash assistance, and housing assistance.
- Strengthen referrals and connections among agencies providing assistance to poor families.
- Assist families who qualify for the federal and state EITC, child tax credits, and refundable tax credits for low-income individuals and families.
- Focus “welfare to work” programs on barriers to employment such as low education, poor work history, lack of transportation, substance abuse, and domestic violence.
- Encourage employers to “ban the box” to reduce the impact of prior incarceration on employment.
- Implement jobs programs aimed at reducing unemployment and advancing job creation.
- Give priority in housing assistance to pregnant women and families with infants in order to reduce housing instability, preterm birth, and infant mortality.
- Increase parents’ access to literacy, post-secondary, and vocational education.
- Offer low-cost job training and GED courses for unemployed and working parents.
- Provide child care at education and training sites.
- Increase levels of education achievement and reduce the number of high school dropouts.
- Assist families in opening Individual Development Accounts (IDAs) to help them get bank accounts, save money, and accumulate assets.
- Offer Individual Training Accounts (ITAs), which serve as vouchers that can be exchanged for training at approved learning institutions.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Ensure all County and city departments connect clients to health coverage, eligible child care subsidies, and nutrition and housing assistance.
- Establish a countywide priorities and goals for improving the use of tax and savings programs for eligible residents.

Programs & Services

- Expand the number and increase access to low-cost job training and ITAs for unemployed and working parents.
- Expand enrollment assistance to eligible families for federal and state EITC, ITAs, and other public anti-poverty programs.

Family & Community

- Host local job fairs on weekends and evenings for parents and youth.
- Develop local ride share programs for increased access to employment opportunities for community residents.

Safe and Stable Housing — A Must for All

Safe, secure, and affordable housing is basic necessity for community and family health, safety, and wellbeing. For too many low-income families in San Diego, inadequate, unsafe, or unstable housing and reoccurring homelessness is a frightening reality. In a recent SANDAG Regional Housing Progress Report it was noted that in 2013 there were approximately 120,000 extremely low-income families and only 20,000 affordable units available for them in San Diego. The San Diego 2015 WeALLCount report spotlights the point-in-time homeless count in San Diego, which found 631 homeless families, representing a total of more than 1,800 homeless children and parents living on the streets or in temporary shelters on a given night in January 2015.

Studies show that families generally become homeless after loss of employment, increases in rent and living expenses, and unanticipated and significant medical expenses. Families with unstable housing are forced to resort to emergency shelters, transitional housing, vehicles, the outdoors, or other precarious locations. Often, they first attempt to double and triple up with relatives and friends, causing overcrowded and cramped living spaces. Life becomes noisy, chaotic, and lacking in privacy - with an increased likelihood that families will separate and not be able to live together in one place.

Experiences of unstable and unsafe housing profoundly affect a child's growth, development, and education. The intense stress of a housing crisis impacts a child's brain development, compounded by strained supports from a parent who is also struggling with physical and mental well-being. Both the timing and the duration of unstable housing and homelessness result in negative health outcomes such as developmental delays, increased rates of illness, hospitalizations, and obesity, particularly for children who are homeless for six months or more. Children who are forced to move frequently from shelter to shelter or unstable home to unstable home show increased school absenteeism, lack of academic progress and basic skill mastery, and increased behavior problems. Unstable housing and homelessness also affect a child social and emotional well-being, influencing self-esteem, levels of trust and anxiety, and feelings of connection and belonging.

Across our nation and in San Diego advocacy groups, businesses and government leaders have been researching and implementing effective housing solutions, focusing on affordable housing, rapid re-housing, and supportive housing as a priority. Affordable housing provides an option in which a family pays 30-40% of household income toward rent. With basic housing needs met, families have a stable platform that enables them to focus on other goals, such as employment and education. Rapid re-housing is a time limited rental subsidy for families who do not have significant barriers. Studies show that 85-90% of families receiving rapid re-housing assistance stabilize and are nearly five times less likely to return to homelessness than families living in shelters. Supportive housing provides highly affordable housing along with wrap-around services designed to promote housing stability. A recent Keeping Families Together pilot project demonstrated when children had been removed from their families and supportive housing was subsequently provided the families were reunited without recurrence of maltreatment. In addition, 61% of the families who had long histories of homelessness and behavioral health issues had their child welfare cases resolved favorably within 10 months with such housing support. Using these approaches, community advocates and leaders together continue to work to end homelessness for the most vulnerable families in San Diego.

Community and Family (Cross Age): NUTRITION ASSISTANCE

Why is this important?

Adequate nutrition is essential to healthy development. The federal Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, provides nutrition assistance to low-income individuals and families. The combined use of Food Stamps and EITC can lift a family of four with one minimum-wage earner to reach or surpass the poverty line. Young children enrolled in SNAP have lower rates of nutritional deficiency and improved intake of iron, zinc, niacin, thiamin, and vitamin A. Nutrition assistance also benefits the community: every \$1.00 of SNAP generates \$1.85 in local economic activity. Another advantage is the ability to quickly meet nutrition needs in emergency or changing economic situations.

What is the indicator?

This indicator—the number of children ages 0-18 receiving Food Stamps—tracks how many eligible San Diego County children are participating in CalFresh. This information is collected through the Health and Human Services Agency Benefits CalWIN program.

What is the trend?

The trend is improving. This is true for children and adults.

Percentage of San Diego County households experience food insecurity

22%

Source: Kids Data; Feeding America. Data for 2009-2013

Between August 2009 and August 2015, San Diego County enrollment in CalFresh increased by 26%.

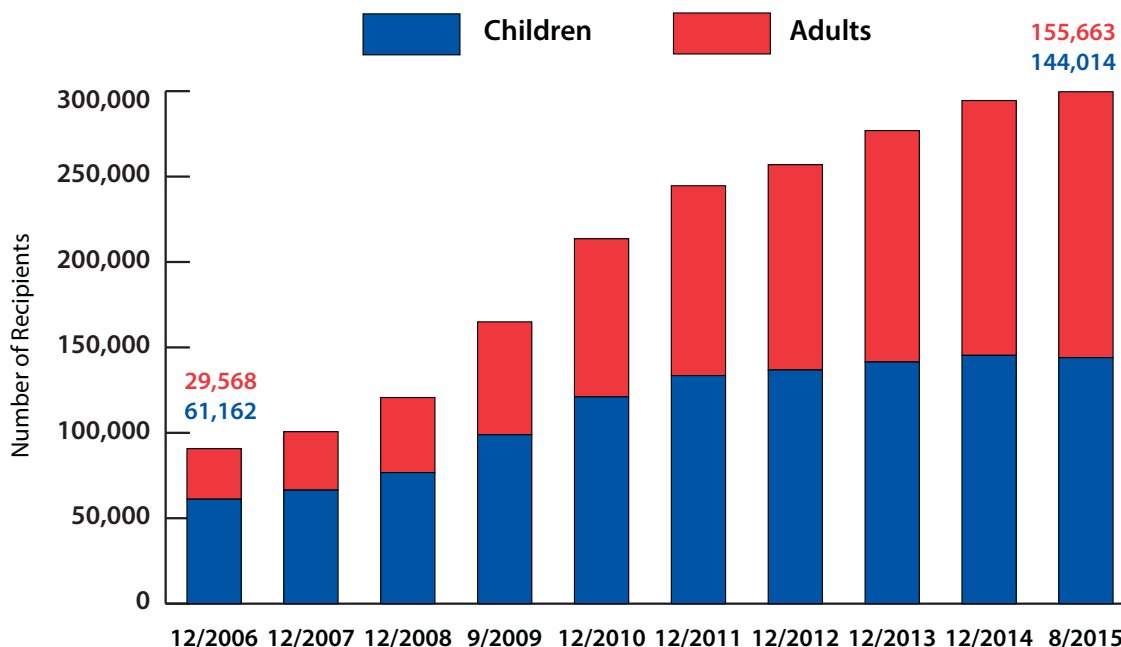
Source: San Diego County Health and Human Services Agency.

\$4.45

is the average daily CalFresh benefit per person

Source: San Diego County Health and Human Services Agency.

Number of Food Stamp Recipients, Children Ages 0-18 and Adults Age 19 and Older, San Diego County, 2006-2015



What strategies can make a difference?

Approaches to assuring food assistance to those in need have changed with the times, now more often being electronic (electronic benefit transfer—EBT—systems), supporting better food choices, and being used at varied outlets where food is sold. SNAP/CalFresh offers an effective aid to improve the nutritional status of low-income families; however, utilization rates have been low in some communities. Improving the use of nutrition assistance by eligible individuals involves outreach campaigns, inter-agency strategies, and non-traditional points of access. Increased use of SNAP/CalFresh means better nutrition for families and community economic development.

Nationally, the following strategies have been used to increase SNAP/CalFresh participation:

- Simplify the application process, both online and on paper, and advertise the availability of online applications via libraries, food stores, pharmacies, etc.
- Use outreach to underserved populations such as military families, Native Americans, immigrants, refugees, seniors, residents in rural communities, and persons with disabilities.
- Include SNAP eligibility information and prescreening in hotlines and helplines.
- Increase partnerships for outreach with schools, food banks, employers, and utility companies.
- Extend hours (e.g., evenings and weekends) of application centers.
- Employ multilingual and culturally diverse outreach and enrollment workers in application offices, as well as in community settings such as schools, community clinics, fast food outlets, and shelters.
- Provide assistance in completing applications, with appropriate certification periods and follow-up after application to assure completion.
- Use direct certification processes (e.g., automatically qualifying for school meals if they receive SNAP).
- Provide science-based nutrition education through direct education (e.g., nutrition classes for children and/or adults), indirect education (e.g., brochures, videos), and social marketing (e.g., media messages).
- Offer incentives to SNAP clients, such as providing coupons or vouchers to purchase fruits and vegetables at farmers' markets or other retailers, or giving a certain amount of money back on an EBT card for every dollar spent on fruits and vegetables.
- Promote use of SNAP at farmer's markets, in Community Supported Agriculture and other farm-to-consumer venues.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Co-locate multilingual and culturally diverse enrollment workers in community-based organizations, shelters, and other settings.
- Increase availability of enrollment workers during weekends and evenings.

Programs & Services

- Target outreach for enrollment to underserved families, prioritizing military, Native Americans, refugees, and those living in rural areas.
- Develop and distribute SNAP eligibility information to schools, community clinics, shelters, and health care providers.

Family & Community

- Develop and increase access to local food pantries through community organizations, faith groups, and neighborhood associations.
- Develop and expand community and school gardens.

Community and Family (Cross Age): CHILD HEALTH COVERAGE

Why is this important?

The single greatest barrier to receiving medical care is lack of health coverage. Uninsured children are less likely than their insured counterparts to receive preventive services and needed treatments. For children with special health needs (i.e., chronic conditions that require extra care and treatment), lack of coverage can mean more hospitalizations for untreated asthma, untreated vision or hearing problems, and worsening disabilities. Research has shown that children with publicly subsidized health coverage (e.g., Medi-Cal) use services in approximately the same amounts and patterns as those who have private insurance. Increasing parents' coverage also has benefits for children.

What is the indicator?

This indicator—the percentage of children ages 0-17 without health coverage in San Diego County—monitors public and private coverage trends. These data are routinely reported through the California Health Interview Survey.

What is the trend?

The trend is improving. The percentage of children without health coverage is less than in 2003. Note that fluctuations may be due in part to changes in data collection.

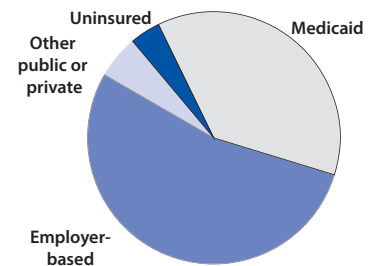
Estimated number of children ages 0-17 who were uninsured in San Diego County, 2014

30,000

MORE THAN 80% OF UNINSURED CHILDREN IN SAN DIEGO ARE POOR—eligible for Medicaid but uninsured.

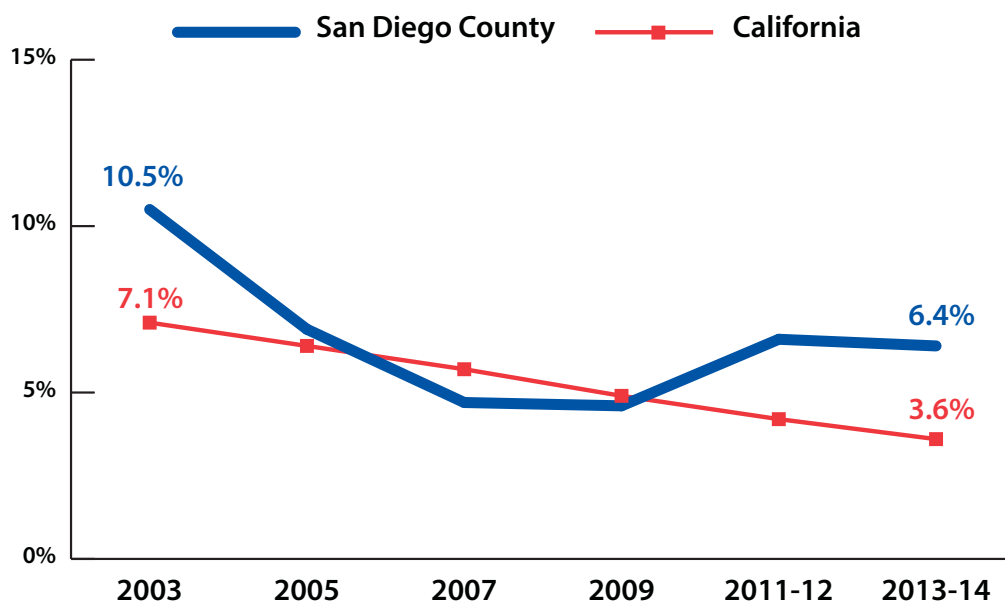
Source: KidsData analysis of data from the U.S. Census Bureau, American Community Survey, 2014.

Just over half of San Diego County children have employer-based health coverage, and more than one-third are enrolled in Medicaid.



Source: California Health Interview Survey (CHIS), 2014.

Percentage of Children Ages 0-17 without Health Coverage, San Diego County and California, Selected Years 2003–2013-14



Community and Family (Cross Age): ADULT HEALTH COVERAGE

Why is this important?

Lack of health insurance makes a difference for adults, children, and families. Adults without coverage are less likely to have access to health care. When adults forgo preventive services or needed treatments, their health conditions may worsen and lead to higher costs, chronic problems, and premature death. Children's health is adversely affected when their parents are uninsured. Children are more likely to be insured if their parents are insured. In households with continuous coverage, the odds increase that children are insured. Children with uninsured parents are significantly more likely to have no usual source of primary care (i.e., a medical home) and to have unmet health needs.

What is the indicator?

The indicator—the percentage of adults ages 18-64 without health coverage—monitors public and private health coverage. These data are routinely reported through the California Health Interview Survey.

What is the trend?

The trend is improving. With major expansions of health coverage under federal and state health reform policies, fewer working age adults are uninsured.

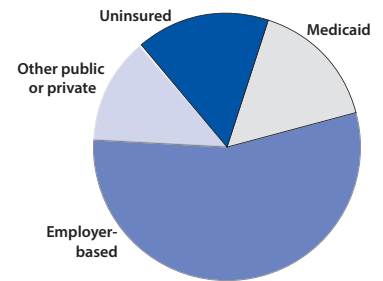
Estimated number of adults ages 18-64 who were uninsured in San Diego County, 2014

300,000

African Americans between the ages of 18 and 24 years in San Diego County were the least likely to have health insurance.

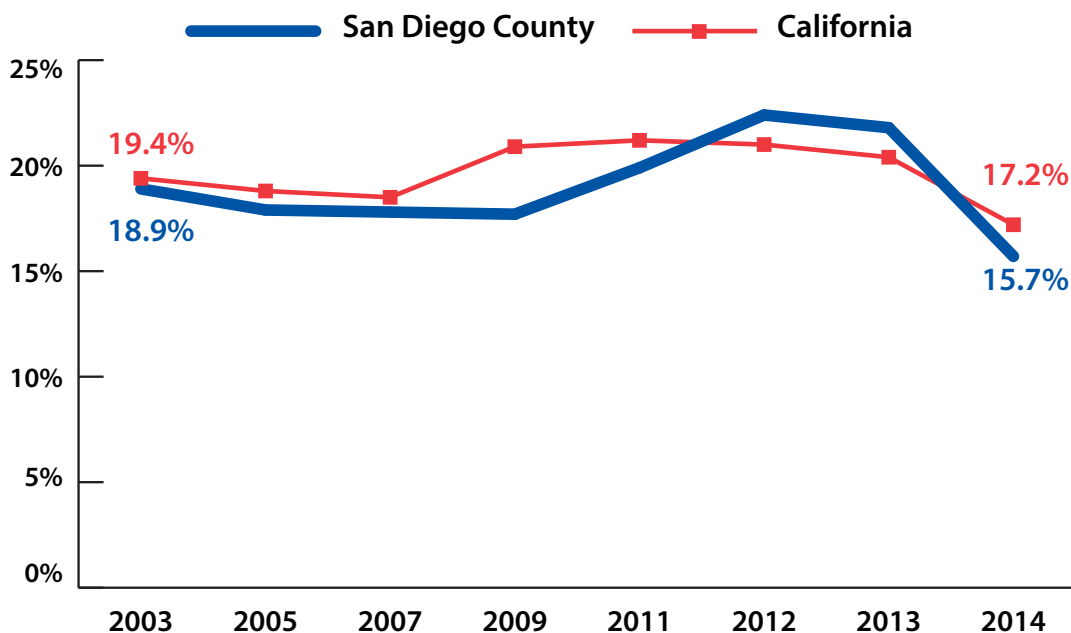
Source: Identifying Health Disparities to Achieve Health Equity in San Diego County: Race/ethnicity. San Diego County Health and Human Services Agency, 2015.

Distribution of Health Coverage for Adults Ages 18-64, By Type, 2014



Source: California Health Interview Survey (CHIS), 2014.

Percentage of Adults Ages 18-64 without Health Coverage, San Diego County and California, Selected Years 2003-2014



What strategies can make a difference?

The Affordable Care Act increased coverage for millions of uninsured parents, particularly those with low wages living just above the poverty level. Under this program, known as Covered California, more affordable and subsidized health plans offering essential, minimum benefits are now available. Medicaid (known as Medi-Cal in California) provides coverage to the poorest children and adults. Most uninsured children with family income below 300% of the Federal Poverty Level are eligible for publicly subsidized coverage.

The following strategies have been used across the country to increase health coverage for children:

- Use health navigators (Covered California’s Navigator Program) in partnership with community organizations (e.g., San Diego 211 infoline, Access California, Council of Community Clinics, Family Health Centers). Navigators are Certified Enrollment Counselors that assist through a variety of outreach, education, enrollment, and renewal support services.
- Offer additional assistance through community health workers, home visitors, and others.
- Implement policies developed under the Affordable Care Act regarding simple enrollment, consumer informing, and other approaches to expand coverage.
- Simplify and streamline the application process and enrollment policies (e.g., shorter forms, applications by mail or Internet, no asset tests, no application fees).
- Provide automatic eligibility determinations and renewals for health coverage when families complete applications or recertification for other public assistance programs.
- Develop effective outreach and enrollment strategies such as tools from the Connecting Kids to Coverage National Campaign used at the state and community level, including:
 1. Campaigns to promote awareness of available coverage (e.g., social media tools, culturally specific marketing tools, outreach through employers, billboards and posters);
 2. Assistance in distributing and completing applications in schools, homeless shelters, community-based organizations, health care providers, faith communities, and the workplace;
 3. Incentives for schools, employers, and community-based organizations to identify eligible families and help them enroll their children.
- Ensure that families are informed about the different health coverage policies and affordable health plans for children and adults.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Ensure enrollment of all eligible children and adults in Medi-Cal.
- Provide County support for efforts to ensure that families are educated about the benefits of enrolling in health care coverage and about their coverage options.

Programs & Services

- Prioritize outreach for health care enrollment in areas with high concentrations of low-income families.
- Work with health providers to ensure that all families are informed about coverage options prenatally and that all newborns are enrolled in coverage prior to leaving the hospital.

Family & Community

- Collaborate with community partners to educate families about health care coverage options and provide access to enrollment pathways.
- Promote culturally appropriate consumer information to families about access to and benefits of health care coverage.

Community and Family (Cross Age): DOMESTIC VIOLENCE

Why is this important?

Domestic violence negatively affects everyone involved. The abused partner may suffer both physical and emotional trauma, as well as post-traumatic stress. Exposed children live in fear, often perform poorly in school, and typically do not participate in normal childhood play and social activities. Children who have these adverse experiences—even when the violence is not directed at them—have increased risk of victimization, aggression, problems with social relationships, and lifelong health problems. Domestic violence typically escalates over time, moving from verbal abuse, to emotionally abusive behavior, to physical abuse, and may result in death.

What is the indicator?

This indicator—the rate of domestic violence reports per 1,000 households—measures reports of domestic and intimate partner violence made to San Diego County law enforcement agencies. Police reports are closer to the actual rate of occurrence than arrest rates. These data are routinely reported by ARJIS and the California Department of Justice.

What is the trend?

The trend is improving, with drops in the rates for both San Diego County and California. Progress has slowed since 2008.

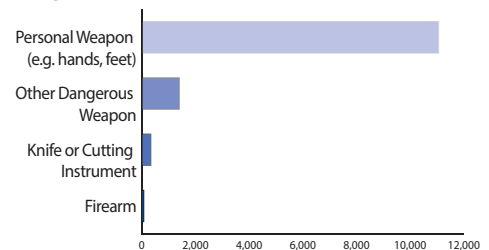
Number of domestic violence incidents reported to law enforcement in San Diego County in 2014

16,897

THERE WERE AS MANY AS 16 DOMESTIC VIOLENCE HOMICIDES IN SAN DIEGO COUNTY IN 2014, UP FROM 9 THE PRIOR YEAR. Many cases are still under investigation.

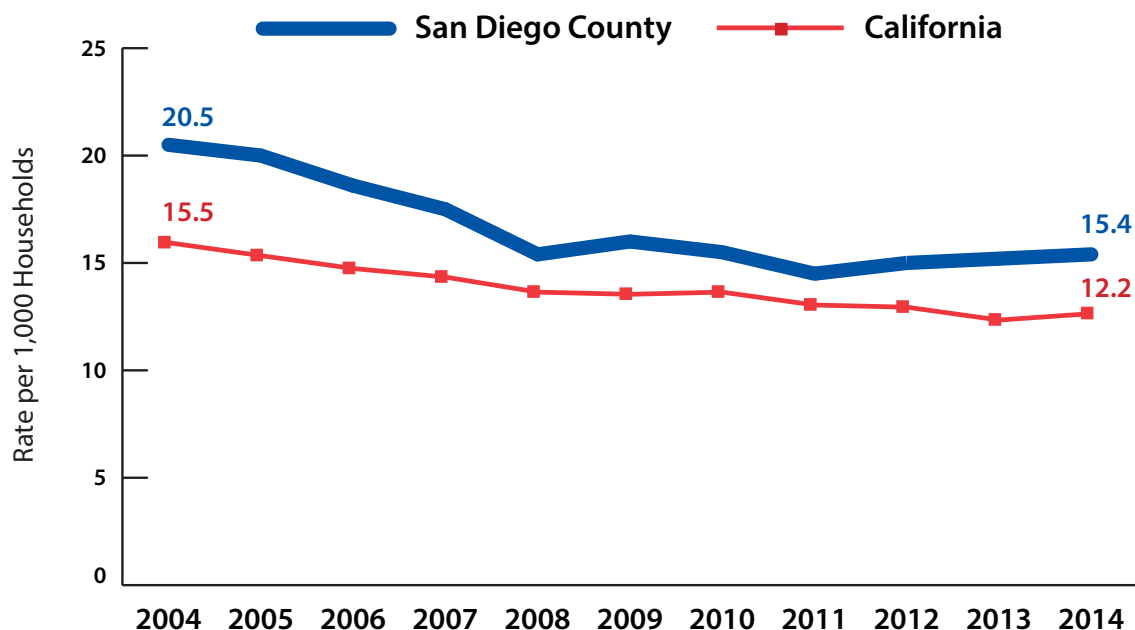
Source: San Diego County Domestic Violence Fatality Review Team.

The graph shows the three-quarters of domestic violence incidents that involved a weapon. Weapons included: hands and feet, knives, guns, and other.



Source: California Department of Justice Office of the Attorney General and Automated Regional Justice Information System (ARJIS), SANDAG, 2014.

Rate of Domestic Violence Reports Per 1,000 Households, San Diego County and California, 2004-2014



What strategies can make a difference?

Domestic violence is preventable. Primary (before the fact) and secondary (after the fact) prevention strategies must both be used. Effective strategies include early screening and identification, trauma-informed services for adult victims and children, and restraints and consequences for perpetrators. Multi-agency, cross-systems efforts are essential.

The following strategies have been used across the country to reduce the incidence of domestic violence:

- Provide cross-system targeted training on domestic violence, conflict resolution, healthy relationships, self-sufficiency, and related topics for staff that work with at-risk families.
- Link data and cases across child abuse, domestic violence, and court systems to assure more consistent handling of domestic violence, intimate partner violence, and child abuse cases.
- Update regularly data collection protocols and practices, including cross-system protocols related to domestic violence and intimate partner violence.
- Screen routinely for domestic violence and child abuse in health care settings or home visits, with follow-up referrals as necessary.
- Educate judges about domestic violence to ensure consistency in sentencing (i.e., prevalence across racial/ethnic and income groups, similar to assault).
- Assure enforcement of perpetrators' mandated treatment, including monitoring of active participation in yearlong violence prevention programs and other terms of probation.
- Enforce the removal/submission of firearms among individuals who have been convicted of domestic violence.
- Implement routine developmental screening in early childhood (i.e., with validated tools by early care and education and health professionals) for early identification of young children exposed to violence and other trauma.
- Use school and youth programs to educate young people about how to have healthy relationships and the risk of teen dating violence, as well as to provide resources to support youth.
- Provide trauma-informed services (e.g., shelters, legal assistance, counseling, case management) for victims and their children.
- Help victims develop and continually update their safety plans.
- Implement risk assessment and management for domestic violence perpetrators.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Uniformly and consistently use the Law Enforcement Domestic Violence Supplemental Form (13700 P.C.).
- At the county level, annually collect and report the data on the Law Enforcement Domestic Violence Supplemental Form in relation to children exposed to domestic violence.

Programs & Services

- Expand therapeutic early childhood programs for children exposed to violence.
- Provide trauma-informed counseling at schools, community clinics, and community-based organizations in high-need areas.

Family & Community

- Increase safe zones for domestic violence victims to receive assistance and support in implementing their emergency safety plan.
- Host community events to raise awareness about domestic violence, teen dating violence, and the availability of local services and support.

Community and Family (Cross Age): CHILD ABUSE AND NEGLECT

Why is this important?

Child abuse and neglect has profound and long-term effects on a child’s physical, mental, and emotional development. Physical effects include injury and even death, and psychological effects include depression, anger, anxiety, and aggression. Children who have been abused or neglected often have social and behavioral problems. The Adverse Childhood Experience (ACE) studies show that child abuse and neglect can have a lifelong impact on health and well-being, including increased risk of heart disease, obesity, and depression as an adult.

What is the indicator?

This indicator—the rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17—shows the trend in reports of child abuse and neglect that are found through investigation to have sufficient evidence to warrant a child welfare services case being opened or having the family referred for services. These data come from reports filed by the County Health and Human Services Agency to a state database managed by the University of California Berkeley.

What is the trend?

The trend is improving. The rate of substantiated cases of child abuse and neglect in San Diego County has declined continuously since 2007.

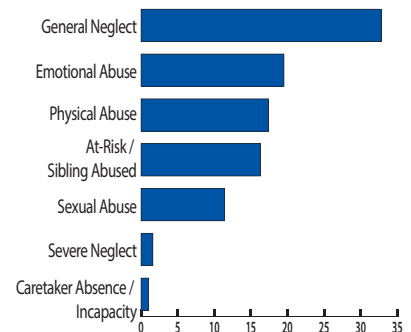
Number of substantiated cases of abuse and neglect in San Diego County, 2014

5,258

CHILD ABUSE IS NOT CONCENTRATED IN ONE GEOGRAPHIC AREA. In 2014, 26 zip codes across the county had rates for substantiated cases of child abuse and neglect at 10 per 1,000 or higher.

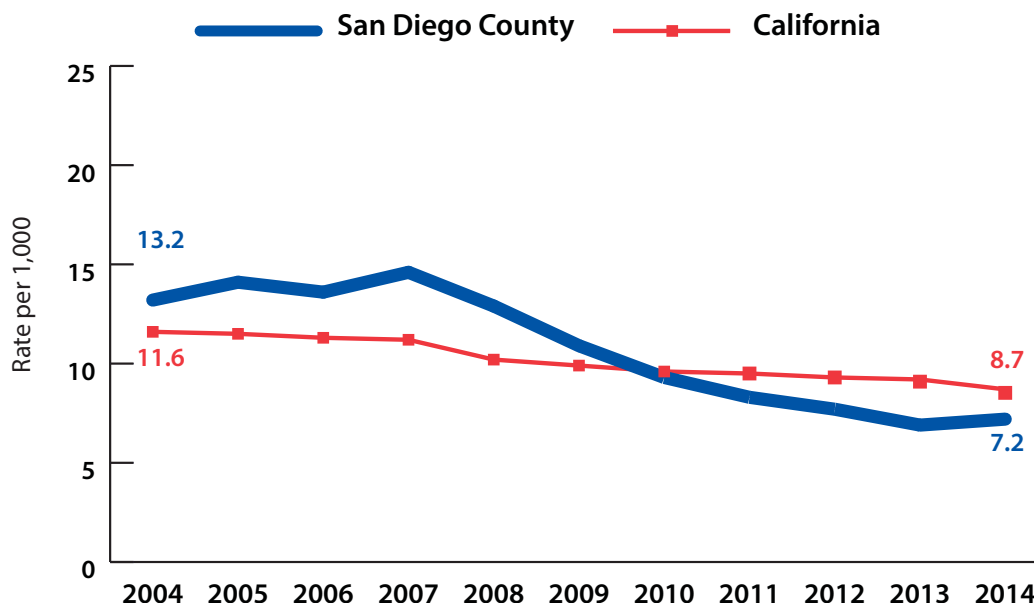
Source: California Child Welfare Indicators Project Reports, University of California at Berkeley Center for Social Services Research, 2014.

Number of Child Abuse and Neglect Reports in San Diego County, By Type, 2014



Source: California Child Welfare Indicators Project Reports, University of California at Berkeley Center for Social Services Research, 2014.

Rate of Substantiated Cases of Child Abuse and Neglect Per 1,000 Children Ages 0-17, San Diego County and California, 2004-2014



Identifying and Addressing Disproportionality in Child Welfare Services

National data show that significantly greater proportions of African-American children enter and remain in foster care than children of other races. Nearly all (46) states have disproportionate representations of African-American children in their child welfare systems. In seven states, including California, the proportion of African-American children in foster care is considered “extreme.”

The National Incidence Study of Child Abuse and Neglect found no significant racial differences in the incidence of maltreatment; however, children of color are disproportionately represented at every decision point in the system. The degree of disproportionality increases as family cases move through the system. For example, reports of child abuse and neglect among African-American children are significantly higher than for their peers. African-American families and children represent 13% of the substantiated abuse allegations, 16% of the entries into foster care, and 21% of the children who are in out-of-home care.

The negative effects on the lifecourse and developmental trajectory for many of these children are well documented. Research shows that children and youth in foster care are far more likely than their peers in the general population to endure poverty, compromised health, homelessness, unemployment, incarceration, and other adversities after they leave the foster care system.

The County of San Diego Child Welfare Services sets priority on safely stabilizing and preserving families. When that is not possible, the aim is to safely care for children and reunify them with their family of origin, and if that is not possible, to support the development of lifelong relationships. Most families come into contact with the child welfare system due to a report of suspected abuse or neglect.

In San Diego County, despite the fact that African-American children make up only 5% of our child population (33,264 of 689,266 children), they make up 13% of the children referred to the County of San Diego’s Child Abuse Hotline.

Native American children make up only 0.4% of the child population (3,100 of 689,266) of San Diego County. However, they make up 1% of the children referred to the County of San Diego’s Child Abuse Hotline, 2% of the substantiated abuse allegations, 2% of the entries into foster care, and 2% of the children who are in out-of-home care.

Research points to the need for specific and consistent efforts to address disproportionality in the child welfare system. Programs of child welfare governmental entities are only one of several critical components of a comprehensive, community-wide strategy to address disproportionality. Prevention services can strengthen families and decrease the number of children entering foster care. Once maltreatment has been substantiated, culturally competent and relevant services are integral to supporting families. Diversion programs and other early intervention approaches also can decrease out-of-home placement. Disproportionality in child welfare services can best be addressed through partnerships among stakeholders such as schools, public safety agencies, courts, mental and physical health providers, and community and faith-based organizations. Each entity provides unique value to creating a system that can offer equitable, early, and continuing supports and services.

What strategies can make a difference?

Child abuse and neglect are associated with many factors, including parental history of abuse, substance abuse, unemployment, poverty, domestic violence, anger, isolation, mental health, and stress. Effective interventions should be tailored to individual situations. At the same time, preventing the harm of child abuse and neglect will require county-wide, systemic community efforts.

The following strategies have been used nationally to reduce the incidence of child abuse and neglect:

- Train health providers, teachers, and other care providers to recognize signs of abuse and neglect, as well as providing information regarding community resources available.
- Use trauma-informed services in the health, child welfare, mental health, and justice systems to reduce multi-generational abuse.
- Use evidence-based parenting classes and support groups to teach age-appropriate communication and positive discipline from birth (e.g., Incredible Years or Strengthening Families curriculum)
- Provide interventions to improve parent-child relationship skills, fulfill basic needs, and increase social supports for at-risk families.
- Provide high quality, evidence-based home visiting programs for at-risk families that have been shown to be effective in reducing child abuse and neglect (e.g., Nurse Family Partnership, Child First, Healthy Families America).
- Implement the SafeCare model, an intensive, evidence-based home visitation program focused on children from birth to 12 years old that has been shown to reduce child abuse and neglect among families with a history for maltreatment.
- Implement the Positive Parenting Program (Triple-P), shown to be effective in prevention of childhood social-emotional and behavioral problems and child maltreatment.
- Use approaches such as the Period of PURPLE Crying (an evidence-based shaken baby syndrome prevention program) to help parents and other caregivers.
- Provide respite care for families facing high-stress and/or emergency situations.
- Use the court to support use of effective family treatments and interventions designed to reduce abuse and neglect.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Expand funding for culturally appropriate, evidence-based home visiting services in high-need zip codes.
- Implement trauma informed services in the child welfare, mental health, juvenile justice, and health care systems.

Programs & Services

- Implement Positive Parenting Program (Triple-P) and other evidence based parent education programs in zip codes with high rates of substantiated child abuse.
- Provide wraparound services to families at risk of child welfare involvement, including services such as counseling, employment, and child development.

Family & Community

- Develop community support groups that provide low-income families with a network of support for peer connections, transportation, mentoring, and community resources.
- Create community hubs that provide food pantries, clothing, diapers, and basic necessities for families.

Community and Family (Cross Age):

CHILD VICTIMS OF VIOLENT CRIME

Why is this important?

When children are the victims of violent crime it often has lifelong effects on development, school achievement, mental health, and substance use. Post-traumatic stress disorder may follow for the victim. Sadly, crimes are committed against children at every age. Those ages 12 to 14 were more likely than older adolescents to be victims of any violent crime, particularly assault. Teens are two to three times more likely than adults to be the victims of assault, robbery, or rape. Most female victims are attacked by someone they know, typically adult men. The rates and types of crimes vary by age of youth, race/ethnicity, urban or rural area, and time of day, but all are preventable.

What is the indicator?

This indicator—the rate of violent crime victimization of children—reflects trends in four types of crime (aggravated assault, robbery by force or threat, rape/sexual assault, homicide). The data are from ARJIS, so only those incidents that result in an arrest report are represented.

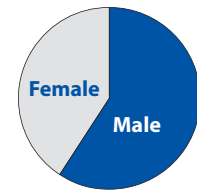
What is the trend?

The trend for all ages is improving (data not shown). However, the improvement is mainly for teens, not for younger children. This is consistent with national trend data.

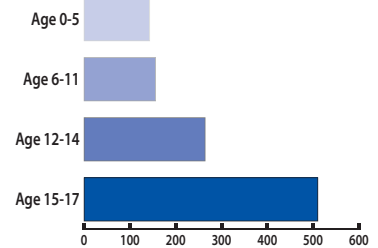
Number of children ages 0-18 who were victims of violent crime in San Diego County, 2014

1,073

Males were more likely than females to be child victims of violent crime.

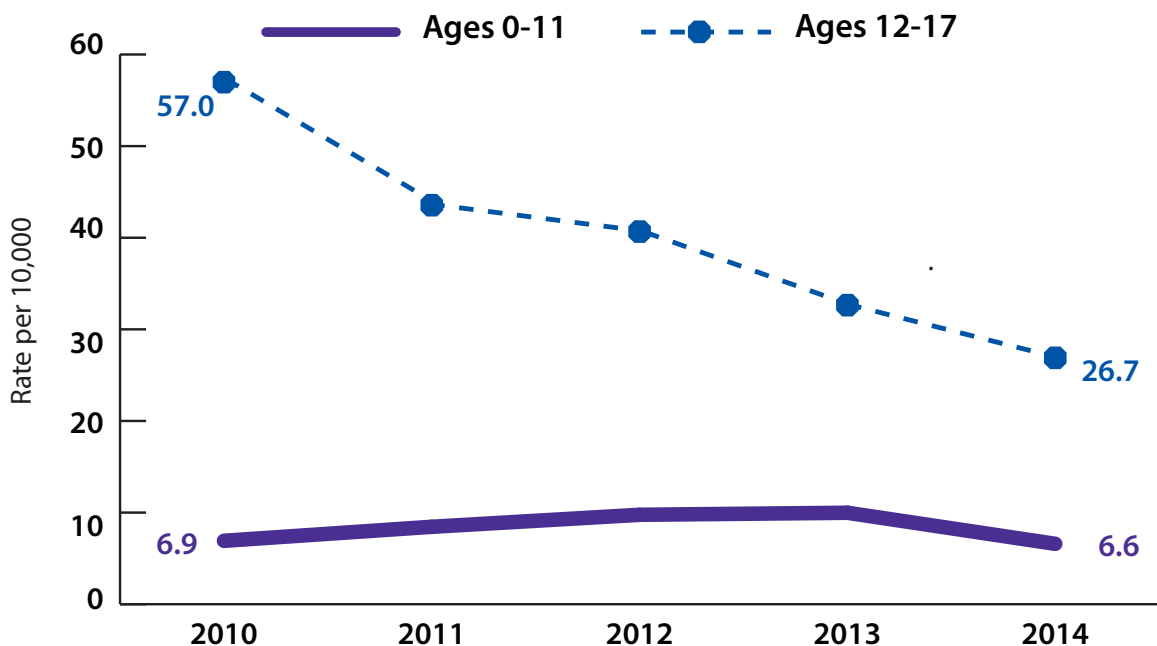


Number of Child Victims of Violent Crime, By Age, San Diego County, 2014

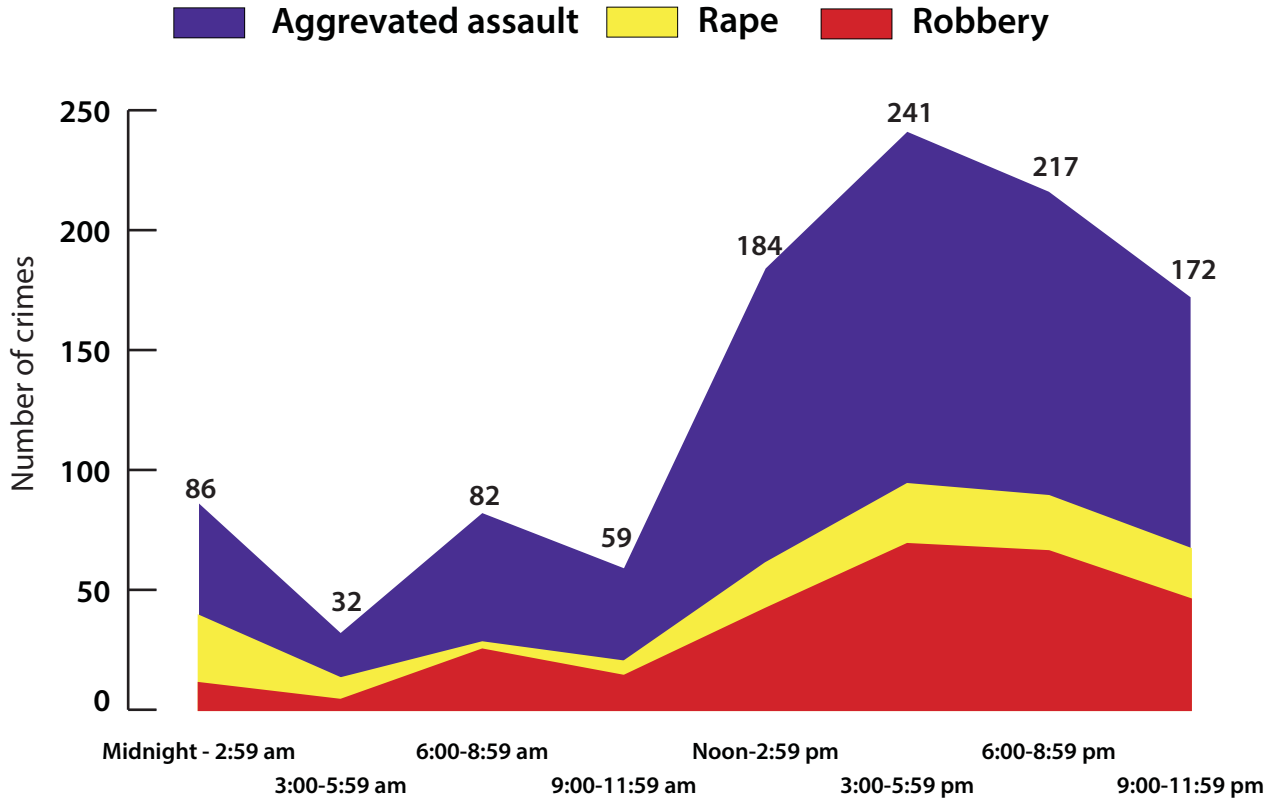


Source: Automated Regional Justice Information System (ARJIS), SANDAG, 2014.

Rate of Violent Crime Victimization Per 10,000 Children, Ages 0–11 and 12–17, San Diego County, 2010-2014



Number of Violent Crimes with Child Victims Ages 0-17, By Time of Day, San Diego County, 2014



The number of violent crimes committed against children and youth increases dramatically after school, peaking between the hours of 3:00 p.m. and 6:00 p.m. High numbers of crimes continue into the evening until midnight. (Note that one homicide occurring between 6:00 and 8:59 p.m. does not show on graph.)

What strategies can make a difference?

Reducing bullying, harassment, hate crimes, and other forms of child victimization have become national priorities. Consistent adult supervision, safe communities, and positive, pro social behaviors all support the reduction of violent crimes against children. Providing children, youth, and families opportunities for services after school, in the evening, and on weekends is proven to help keep kids safe.

Nationally, the following strategies have been used to reduce violent crime victimization of children and youth:

- Ensure adequate adult supervision of children and youth in non-school hours.
- Train parents, school personnel, after school staff, youth-serving organizations, health providers, and juvenile justice professionals in the identification and prevention of bullying, racism, intimidation, sexual harassment, and hate crimes.
- Support safe passages for children and youth to and from school.
- Develop anti-violence and anti-bullying programs such as: Olweus Bullying Prevention, PeaceBuilders, Promoting Alternative Thinking Strategies (known as PATHS), and Resolving Conflict Creatively Program.
- Implement conflict resolution programs in schools, after school programs, and in youth-serving community organizations.
- Expand programs aimed at reducing gang participation.
- Provide after school and evening activities in high crime communities, including after school programs, teen centers, job internships, etc.
- Use schools as community hubs, including ball fields, libraries, and other common spaces.
- Implement gender-specific services for girls.
- Increase youth and parent knowledge of and ability to protect against sexual assault and rape.
- Educate parents, caregivers, and youth-serving organizations about Internet safety, including monitoring and restriction of use and Internet controls.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Institute mandatory, annual training on the identification and prevention of bullying, racism, intimidation, sexual harassment, and hate crimes for all adults who work with youth, including at schools, community-based organizations, sporting groups, and government entities.
- Adopt and implement violence prevention programs (e.g., Peace Builders, Resolving Conflict Creatively Program, and Olweus Bullying Prevention) in middle and high schools.

Programs & Services

- Expand and strengthen gender-specific services for girls.
- Implement Internet safety programs for elementary and middle school students including risks of information sharing, location tracking, cyber bullying, and dangers of social network trolling.

Family & Community

- Educate parents and caregivers about Internet safety, including monitoring use and utilizing tools to restrict access.
- Educate parents about adequate adult supervision of children and youth in non-school hours and how to develop a supervision plan.

Community and Family (Cross Age): UNINTENTIONAL INJURY

Why is this important?

Injuries are not accidents. They can be prevented by changing the environment, behaviors, products, social norms, and policies. More children die or become seriously hurt from injuries than from all childhood diseases combined. Childhood injuries can result in children having long-term disabilities. Native American, rural, and older children and youth are most at risk. Motor vehicle crashes, falls, drowning, burns, poisoning, and suffocation are common causes of unintentional injury. Childhood injuries cost society more than \$400 billion annually in lost productivity and associated medical expenses.

What is the indicator?

This indicator—the rate of fatal and non-fatal unintentional injuries per 100,000 children ages 0-18—shows trends in how many children are injured severely enough to require hospitalization or who die of accidental causes. These data are routinely reported on hospital discharge reports and death certificates.

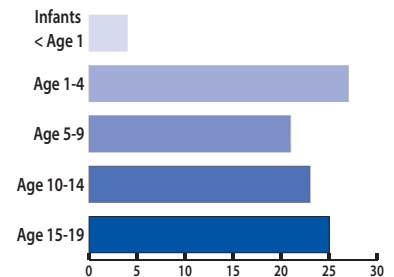
What is the trend?

The trend is improving; however, San Diego County rates for unintentional injuries continue to be above the state average.

Number of non-fatal unintentional injuries requiring hospitalization among children ages 0-18, San Diego County, 2013

1,661

Percentage of Children's Emergency Department Visits for Non-fatal Unintentional Injuries, By Age, 2013



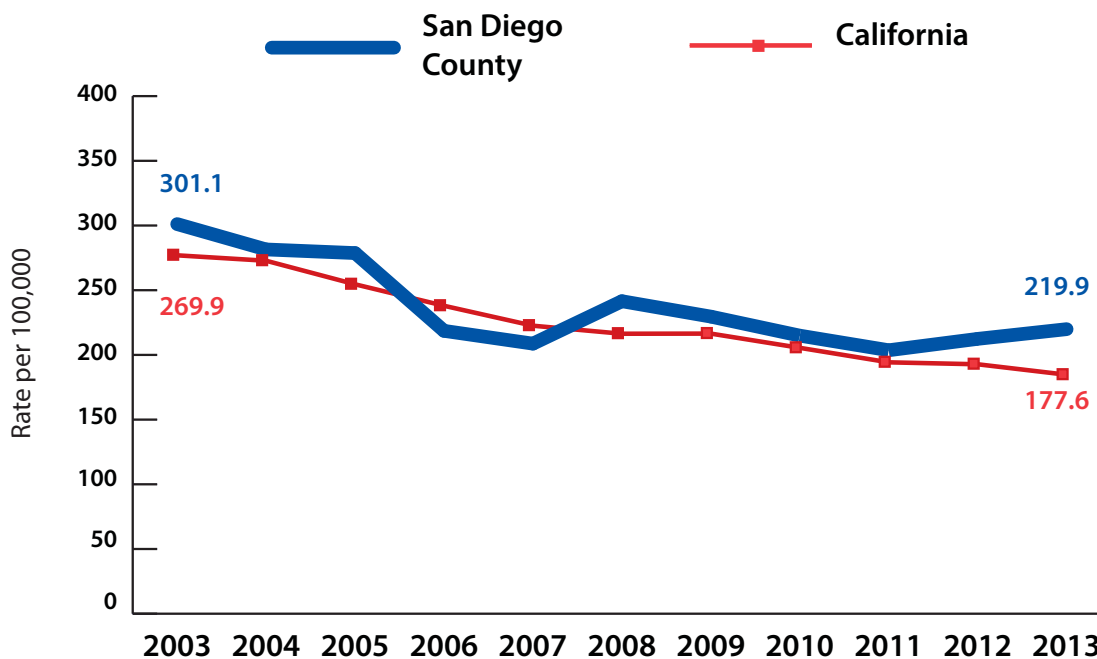
Source: California Office of Statewide Health Planning and Development, Emergency Department Data. Prepared by Department of Public Health, Safe and Active Communities Branch, 2013.

Number of emergency department visits related to falls among children ages 0-18, San Diego County, 2013

19,572

Source: California Office of Statewide Health Planning and Development, Emergency Department Data. Prepared by Department of Public Health, Safe and Active Communities Branch, 2013.

Rate of Fatal and Non-Fatal Unintentional Injuries per 100,000 Children Ages 0-18, San Diego County and California, 2003-2013



What strategies can make a difference?

Although unintentional injuries are the leading cause of death among children, it is important that each cause be addressed individually. Specific prevention and intervention approaches are needed for each cause. Legal mandates and public education about safety are the primary strategies for reducing injuries.

The following two categories of strategies have been used to reduce unintentional injuries:

Providing education about:

- Firearm safety, including safe gun storage (e.g., Asking Saves Kids—ASK).
- Protective gear such as helmets for biking, snowboarding, skiing, skateboarding, off-road vehicles, and other sports.
- Protective restraints such as child car seats, booster seats, and seat belts.
- Crib safety for infants.
- Common causes of choking and suffocation.
- Common causes of drowning including swimming pools, buckets of water, and bathtubs.
- Home safety such as outlet covers, cabinet locks, safety gates, and hot water heater controls.
- Fire prevention and reaction, including fire skills training.
- Hazardous clothing, including flammable sleepwear and suffocation from costumes.
- Safe driving practices for parents and youth.
- Parental supervision and child-proofing environments (e.g., lead paint, access to poison).
- Signs and symptoms of head injury and appropriate follow-up actions.
- Family disaster preparedness.

Enacting and enforcing legislation and regulations to require:

- Smoke detectors, hot water heater controls, and safety gates in rental and owned properties.
- Protective restraints such as car seat belts, child safety car seats, and booster seats.
- Pool fencing, self-closing gates, and pool alarms.
- Graduated licensing for teens.
- Toy manufacturer safety standards.
- Use of helmets for all sport recreation activities (motorized and non-motorized) that place children at risk for traumatic brain injury and other head injuries.
- Prohibitions on cell phone use (including hands-free) and texting among youth while driving.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

Policy

- Increase enforcement of safety regulations—cell phone and texting while driving, protective restraints, such as car seats; use of protective gear, such as helmets for biking and skateboarding; fencing around pools; and rental property regulations.
- Develop subsidized driver's education for low-income youth.

Programs & Services

- Provide parents, early care and education providers, and school staff with education and training on mandated use of helmets, protective restraints, toy safety, and burn prevention.
- Offer free home safety products to parents and caregivers, including smoke detectors, safety gates, furniture straps, and gun locks.

Family & Community

- Educate parents and caregivers about the prevalence of falls and proper car restraints and steps to prevent unintentional injuries.
- Develop a local community awareness campaign about unintentional injuries specific to each region.

Community and Family (Cross Age): CHILDHOOD MORTALITY

Why is this important?

Child mortality is a core indicator of a community or country's well-being. Many child deaths are preventable. Child mortality is related to a variety of health factors (e.g., risk of disease, safety practices) and socioeconomic conditions (e.g., housing, environmental hazards). The leading causes of death vary by age. Two-thirds of infant deaths occur in the first month, primarily due to low birthweight, preterm birth, or birth defects. Older children are more likely to die of external causes such as motor vehicle crashes, drowning, suicide, and homicide. Nationally, among children and adolescents, unintentional injuries are a leading cause of death, accounting for nearly a third of deaths among children ages 1 to 4 and 5 to 14, and more than four in ten deaths among teens ages 15 to 19.

What is the indicator?

This indicator—the rate of mortality for children ages 0-17—monitors the rates at which infants, children, and youth die. These data are recorded on death certificates and routinely reported as part of local, state, and federal vital statistics.

What is the trend?

The trend is improving for ages 5-14 and 15-17, but not for ages 1-4.

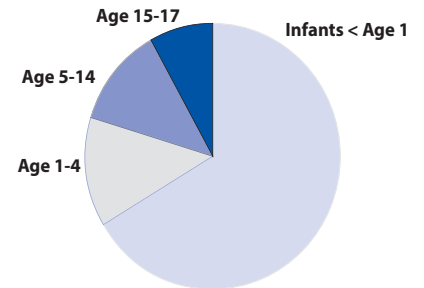
Average number of deaths per year among infants under age 1, San Diego County, 2011-13

187

Average number of deaths per year among children ages 1-17, San Diego County, 2011-13

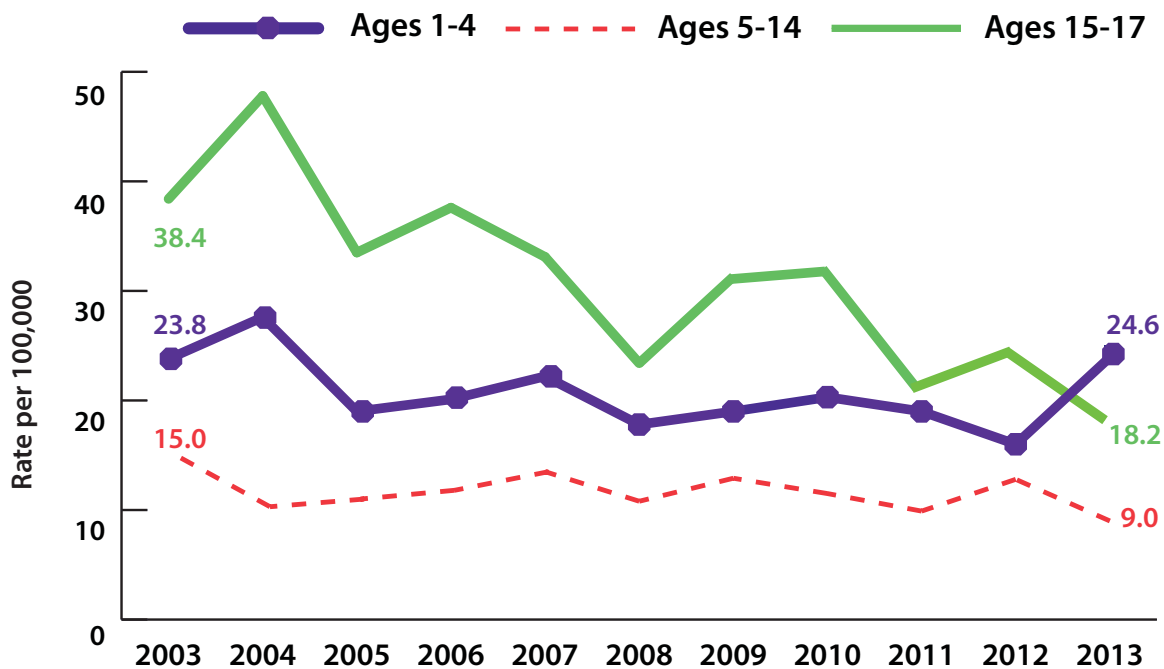
101

Percentage of Child Deaths, San Diego County, By Age, 2013

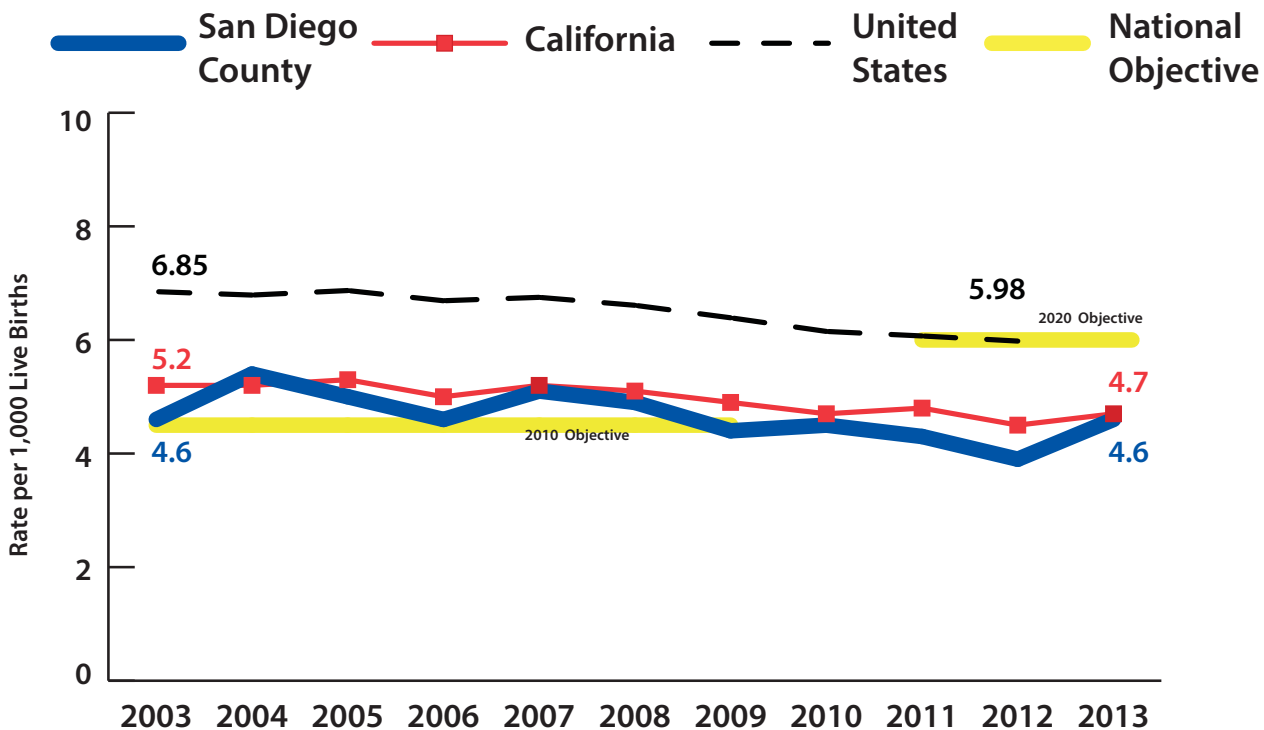


Source: California Department of Public Health. Prepared by San Diego County Health and Human Services Agency. Data for 2013.

Mortality Rate Per 100,000 Children Ages 1-4, 5-14, and 15-17, San Diego County, 2003-2013



Infant Mortality Rate Per 1,000 Live Births, San Diego County, California, and United States Compared to National Objective, 2003-2013



The infant mortality rate is maintaining, not consistently improving, for San Diego County. Slightly more improvement is shown for California, and the United States. Both the county and state rates are below the national average, and the county rate is among the lowest in the nation. At the same time, the San Diego County infant mortality rate is above that of several other large and diverse California counties. The national objective was made easier to achieve for the decade 2010-2020.

What strategies can make a difference?

Many of the recommended actions throughout this *Report Card* are key to childhood mortality prevention. Infant, child, and adolescent mortality rates reflect an array of risks and conditions such as lack of access to health services, poor maternal health, risk of disease, environmental hazards, risky behaviors, housing safety, and other factors. The most common causes of unintentional injury—motor vehicle crashes, falls, drowning, burns, poisoning, and suffocation—are also common causes of death. To respond, communities must develop and implement strategies that are age appropriate and developmentally suitable.

The following strategies have been used across the country to reduce childhood mortality:

- Support child death or fatality review teams to identify risk factors, policies, and interventions that could prevent future deaths.
- Conduct community campaigns on factors that place infants, children, and adolescents at risk for premature death.
- Ensure access to services and supports that reduce the underlying causes of infant death, including preterm and low-birthweight birth.
- Educate parents before they leave the hospital with a newborn about sleeping position (“safe sleep” and “back to sleep”) to prevent sudden infant death syndrome (SIDS), and about shaken baby syndrome.
- Provide free or reduced cost car and booster seats for infants, toddlers, and young children.
- Provide free or reduced cost helmets for children.
- Use interventions (e.g., home visiting, Strengthening Families) to reach and intervene with families at risk for child abuse and neglect.
- Promote use of immunizations to reduce vaccine-preventable disease such as measles, mumps, diphtheria (whooping cough), and rubella.
- Educate parents and children about the risks of drowning at home and in the community.
- Promote gun safety (e.g., safe gun storage, “safe surrender” programs).
- Implement suicide awareness and prevention programs.
- Require driver safety education programs for teen drivers.
- Reduce family and community violence.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the priorities for action are:

- | Policy | Programs & Services | Family & Community |
|---|--|--|
| <ul style="list-style-type: none">• Use local ordinances to require landlords to provide smoke detectors, hot water heater controls, window locks, and safety gates on stairs.• Continue and expand gun safety programs, particularly safe gun storage and free gun lock distribution. | <ul style="list-style-type: none">• Develop and distribute culturally and linguistically appropriate parent safety education materials.• Provide grief counseling and related supports to families who have experienced the death of a child or pregnancy loss. | <ul style="list-style-type: none">• Offer suicide prevention programs in faith-based, community, and school settings.• Use community-based settings to educate families about safe sleep practices for infants. |

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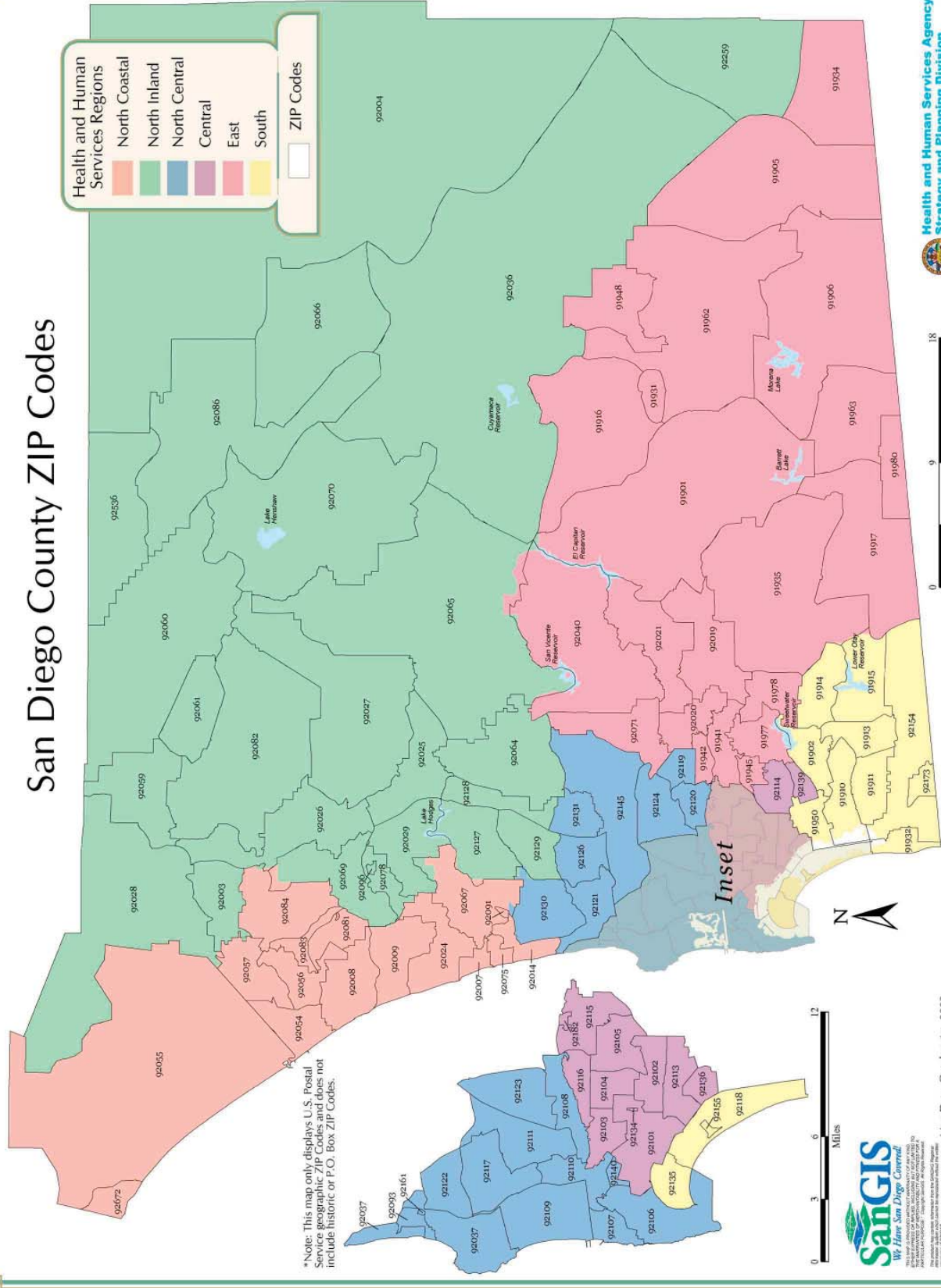
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San Diego County ZIP Codes

Health and Human Services Regions

- North Coastal
- North Inland
- North Central
- Central
- East
- South

ZIP Codes



*Note: This map only displays U.S. Postal Service geographic ZIP Codes and does not include historic or P.O. Box ZIP Codes.

Inset



This map is a product of the County of San Diego, Department of Public Health, Health and Human Services Agency, Research and Planning Division. It is not intended to be used for any other purpose. The County of San Diego is not responsible for any errors or omissions in this map. © 2003 County of San Diego.

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