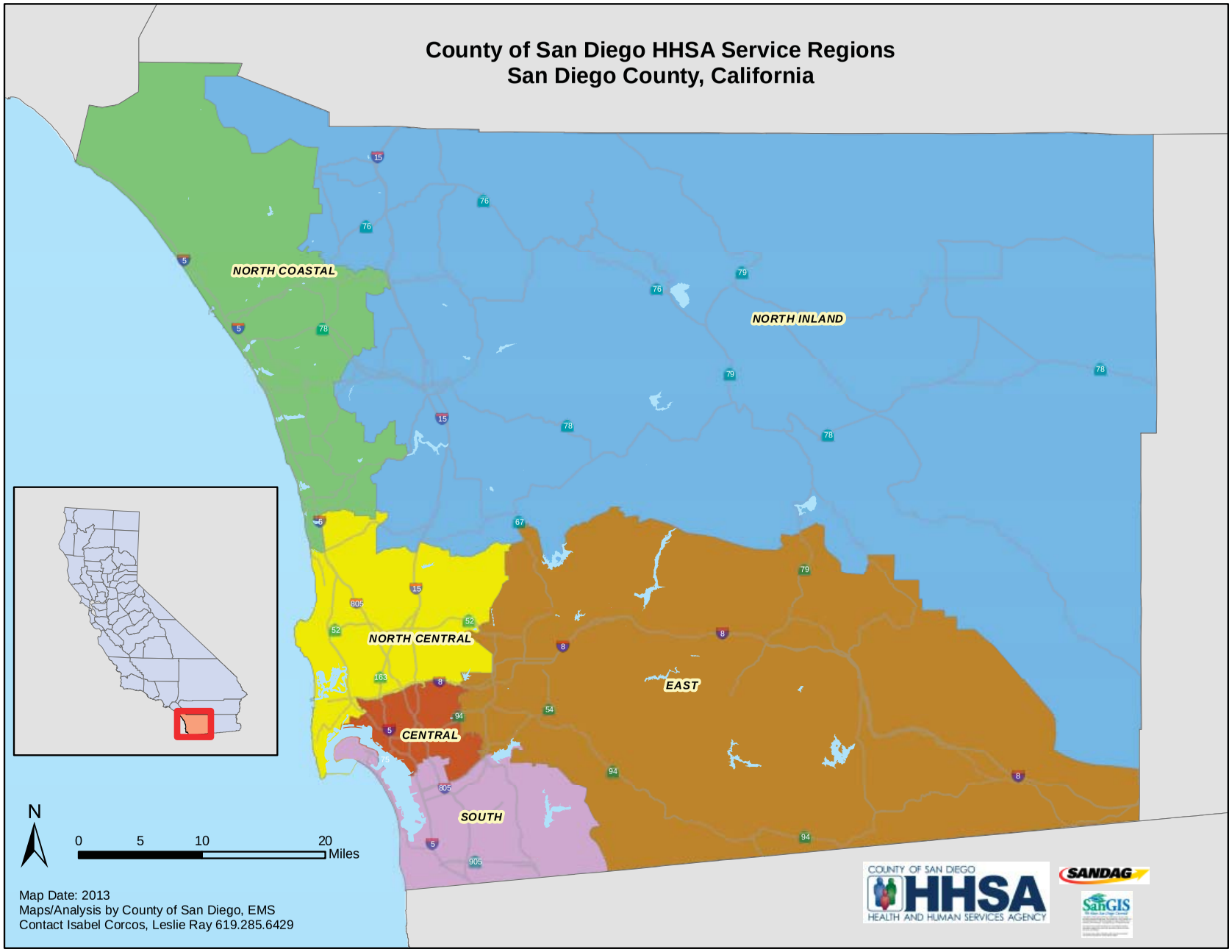
# San Diego County
# Report Card on Children and Families

**REPORT CARD 2013**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COUNTY OF SAN DIEGO
HHSA
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# San Diego County Report Card on Children and Families

## 2013 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***

The Children's Initiative

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References, data sources, and technical notes can be found online at ***www.thechildrensinitiative.org***

# EXECUTIVE SUMMARY

The *2013 San Diego County Report Card on Children and Families* documents the status of health 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, 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 through action to accelerate improvement in trends. The 2013 *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 and well-being of our San Diego County children, youth, and families. This *Report Card* continues to build on *Live Well, San Diego!* —a long-term County initiative to achieve the vision that all residents 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 *2013 Report Card*. The Children's Initiative calls on and utilizes advice and expertise from a diverse group of stakeholders including: subject matter experts in the areas of juvenile justice, education, and health, government executives, epidemiologists, community-based organizations, parents, and youth. Funders include: County of San Diego Health and Human Services Agency, The California Endowment, McCarthy Family Foundation, The Mayer & Morris Kaplan Family Foundation, and the California HealthCare 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 in 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 consistency for all indicators.

The *2013 Report Card* continues the work of previous editions, using the same 25 indicators to measure the health and well-being of children and families in San Diego County. In line with the efforts of *Live Well, San Diego!* this edition also adds 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.

As in the past, the *2013 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 *2013 Report Card* provides updates on current local efforts and progress since the last *Report Card* in 2011, to help guide policy development, target prevention and intervention efforts, and educate the public. This edition also includes feature boxes that highlight emerging concerns for children, youth, and families in San Diego County for which local data are not currently available.

## *Summary of Trends*

This summary of trends for the *2013 Report Card* highlights the direction of trends for indicators over time, using three distinct categories: improving, maintaining, or moving in the wrong direction. Note that these categories offer an assessment of the overall direction of the trend, not a test for statistical significance or a specific measure of year-to-year rates.

### Birth to 3 (Infants and Toddlers)

Indicators to monitor the health and well-being of infants and toddlers point to limited progress. San Diego County compares positively to state and national rates. For infants and toddlers, trends in early prenatal care remain a concern. Progress in reducing the rate of births to teens is impressive.

- **Prenatal care.** The trend is maintaining. The proportion of mothers who started prenatal care in the first three months of pregnancy was 83.1% in 2011.
- **Low birthweight.** The trend is maintaining in San Diego County.
- **Breastfeeding initiation.** Based on three years of data, the trend is maintaining. The San Diego rate was better than the state average and the national objective in 2010–2012.
- **Births to teens.** The trend is improving. The teen birth rate was 12 per 1,000 in 2011, half of the rate in 2000. A similar trend is shown for the state and the nation.

### Ages 3 to 6 (Preschool)

To fully understand the issues for preschool age children, we need additional indicators. The challenge is to develop and/or collect more data to better measure progress toward healthy development and school readiness. Based on the available data, childhood immunization is moving in the wrong direction.

- **Immunization.** While missing data and variations year-to-year make it difficult to plot a trend, no substantial improvement in the immunization coverage of San Diego toddlers has been shown in recent years. For 2013, the rate was 81.8%, the same as in 2002.
- **Early child care and education.** The trend is maintaining, close to 50% of three and four year olds were enrolled in early care and education between 2009–2012.

### Ages 6 to 12 (School Age)

For younger school age children, more progress is needed. Too many are still obese and overweight. While school achievement in English-language arts among third graders is better, more improvement is needed in school attendance for elementary grades. The trend in oral health is improving.

- **Oral health.** The trend is improving. The percentage of children ages 2–11 who never had a dental visit has dropped dramatically since 2001.

- **School attendance.** The trend is maintaining. In 2012-13, 30% of students did not attend at least 95% of school days.

- **School achievement.** The trend for achievement in English–language arts among third graders is improving. It rose from 44% in school year 2007-08 to 53% in 2012-13.

- **Obesity.** The trend is maintaining. Approximately one in three 5th graders, one in four 7th graders, and one in five 9th graders has Body Mass Index (BMI) that places them at high risk for other health problems. An additional 13% of students need improvement in their weight.

## 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 risk such as DUI, delinquency, substance abuse, suicide, and other threats to their lives and well-being. Our adolescents are doing better in school achievement in grades 8 and 11, but English-language arts proficiency is lower for older students.

- **School attendance.** The trend is maintaining. Despite small variations, there is no measurable improvement in the attendance patterns in San Diego County school districts grades 6–12. For school year 2012–13, nearly 10% of middle and high school students did not attend at least 90% of school days.

- **School achievement.** The trend is improving gradually, and San Diego County students continue to perform somewhat better than the state average. However, proficiency is higher for younger than for older students.

- **Substance use.** Most of the trends are improving; however, the use of tobacco, alcohol, and marijuana continues to be prevalent among middle and high school students in San Diego County. The trend in tobacco use by 11th graders shows some improvement; however, by 11th grade, 10% of students smoke cigarettes. The trend in marijuana use among 7th graders is worsening.

- **Youth suicide.** It is not possible to judge the trend for this small number of youth. Year-to-year variations may not be reliable.

- **Juvenile crime.** The trend in juvenile crime shows improvement. The number of arrests in both categories declined between 2008–2012. Overall, the combined rate of juvenile arrests dropped from 43 per 1,000 juveniles in 2008 to 24 per 1,000 in 2012.

- **Juvenile probation.** The trend is improving. After peaking in 2007, the number of sustained petitions has declined in recent years. In 2012, 3,377 youth had true finds in the juvenile court.

- **Youth DUI.** The trend is improving. The number of youth DUI arrests peaked in 2001 and has been declining steadily since 2006.

### Community and Family (Cross Age)

Our community and family indicators are generally improving. Of concern is the current economic situation many of our families are faced with, which in turn negatively affects outcomes in other areas of health and well-being. The trend in poverty is moving in the wrong direction, as the impact of the deepening recession shows in these data. The good news is that progress in services and supports for low income families (e.g., health coverage, nutrition assistance) shows in positive trends.

- **Poverty.** The trend is moving in the wrong direction. In San Diego County, as in the state and the nation, both child and adult poverty is increasing. More than 142,000 children in San Diego County live in poverty.

- **Nutrition assistance.** The trend is improving. This is largely the result of deliberate outreach to eligible individuals in San Diego County and increasing poverty. In June, 2013, more than 127,000 adults and 135,000 children had the benefit of CalFresh nutrition assistance.

- **Health coverage.** The trend is maintaining, with variations overtime. The proportion of children without health coverage increased between 2009 and 2011-12.

- **Domestic violence.** The trend is maintaining. While the rate dropped from 20 per 1,000 in 2002 to 15 per 1,000 in 2008, it has remained at 15-16 per 1,000 between 2008 and 2012.

- **Child abuse and neglect.** The trend is improving. San Diego County's rate of substantiated child abuse dropped from 16.6 per 1,000 children in 2000 down to 7.6 per 1,000 in 2012. This is lower than the rate of 8.9 per 1,000 for California in 2012.

- **Child victims of violent crime.** The overall trend is improving. The rates for all ages birth to 17 were 22.7 in 2011 and 22.0 in 2012. However, this change is being driven by improvement in the rate among youth ages 12-17; the trend is moving in the wrong direction among children ages 0-11.

- **Unintentional injury and death.** The trend is improving. The combined rate of fatal and non-fatal unintentional injuries dropped from 358 per 100,000 in the year 2000 to 203 per 100,000 in 2011.

- **Child mortality.** Despite some variations, the overall trend in child mortality rates for San Diego County is improving. However, nearly 300 children and youth died in 2011, many from preventable deaths. For example, while the infant mortality rate for San Diego, California has declined, 186 San Diego County babies died in their first year of life in 2011.

## *Looking at the Life Course through Adult Indicators*

Across the country researchers, agencies, and policy makers are gaining a new understanding 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 lifespan gives new understanding to the drivers behind many health disparities.

For the *2013 Report Card* we are beginning to use select indicators to reflect factors affecting life course trajectories and inter generational impact. 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 trajectory.

Five new 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.

These adult indicators also align with the County's *Live Well, San Diego!* initiative. They represent some key measurable areas where change is needed to achieve the vision for healthy, safe, and thriving communities.

## Adult Indicator Trends

- **Adult oral health.** The trend is maintaining. While some variation is shown, between 26-29% of adults did not visit a dentist in the prior year.

- **Adult obesity.** The trend is maintaining, not improving. The proportion of adults that are obese increased from 16.5% in 2001 to 22.1% in 2011–12. San Diego and California are both below the national objective.

- **Adult substance use.** The trend is improving in adult smoking. The proportion of San Diego County adults who reported smoking dropped from 17.3% in 2001 to 12.8% in 2011–12. This means San Diego is close to the national objective of 12%.

- **Adult poverty.** The trend is moving in the wrong direction. Adult poverty increased steadily over this time period, from 9.6% in 2005 to 14.3% in 2012 in San Diego County. The proportion of adults under age 65 who are living in poverty in San Diego County is just below as the U.S. average (14.8%).

- **Adult health coverage**. The trend is moving in the wrong direction. No real progress was made between 2001 and 2009, and between 2009 and 2011–12 the proportion of adults under age 65 without health coverage increased.

The life course theory is built on a foundation of several principles. First, life course trajectories are influenced and determined by genetic, economic, social, cultural, environmental, and other factors. The interaction of these factors determines health and well-being over the lifespan. Second, experiences that happen at an early age can set a course for an individual's health and development. For example, healthy early experiences such as the good physical and mental health of a mother prior to conception, breastfeeding, and reading to infants have positive and long-lasting effects on the health of the developing child. Conversely, adverse or negative experiences such as parental smoking, maternal depression, or living with domestic violence can result directly in a disease or condition and make an individual more vulnerable or susceptible to developing a disease or condition in the future. In addition, while adverse experiences and exposures can have a negative impact at any point in life, scientists have identified "critical" periods of development (e.g., during fetal development, early childhood, early adolescence, etc.). Lastly, a growing body of research shows that while individual and isolated experiences may have short term consequences, the cumulative impact of on-going or repeated negative experiences can have significant, exponential, and profound impact for life.

One example of a positive adult behavior that has direct impact on lifelong health is breastfeeding. If a mother breastfeeds her child at birth and through the first year, it reduces her child's risk of obesity, asthma, and Type 1 and Type 2 diabetes for a lifetime. In addition, breastfeeding provides antibodies that confer immunity and reduced risks for infections for the infant in the short term. Breastfeeding also has short and long term positive impact on the health of the mother, reducing the risk of breast cancer and postpartum depression.

Other parental behaviors and attitudes influence life trajectories and make a difference for two or more generations. Parental cigarette smoking is a behavior that negatively impacts a child health over the life span. Children's exposure to secondhand smoke directly and immediately impacts child health. But, the effects are more long lasting. Parental smoking increases the chances that a youth will become a smoker even if the parent only smokes around the child when they are young. If parents fear the dentist, do not get dental care, and don't have good oral hygiene habits, their children's oral health will likely be affected. When parents are without health insurance, their children are less likely to have the care they need—even if the child is insured.

Studies using the life course theory document how childhood risks have lasting negative influences on adult health and well-being. For example, childhood obesity has effects that can last a lifetime. More than 80 percent of children who were overweight at ages 10-15 were obese at age 25, and childhood obesity significantly increased their long term risk of high blood pressure, high cholesterol, and Type 2 diabetes.

We also show trends in adult and child poverty. Poverty—with its constellation of associated risks—affects both parents and children. Poverty, in particular, is associated with significant harms to children's health, development, and opportunities for achievement. Policies and programs recommended in the *Report Card* can reduce these harmful exposures, including: income support, affordable housing, improved neighborhood environments, quality early care and education, after school programs, home visiting, and health care.

More serious Adverse Childhood Experiences (ACE), toxic stress, and trauma can have major, lifelong negative effects, hindering brain development and lifelong physical and mental health. The ACE Study (originating in San Diego) tells us that certain childhood experiences are major risk factors for the leading causes of illnesses such as depression, heart disease, obesity, and substance abuse. Parents who experience depression, mental health problems, stress, or violence unintentionally place children in surroundings proven too often to be hazardous to a child's heath, well-being, educational achievement, and success in later life.

The life course theory and the research that supports it help us understand health across generations but also call attention to the multiple points at which society can intervene through policies to interrupt the vicious cycles leading to health disparities that begin in childhood. In particular, it points to the value of: a) starting early to ensure protective factors in the earliest periods of life; b) intervening early to reduce abuse and neglect, family violence, parental depression and substance abuse; and c) providing continuous health coverage and care that prioritizes prevention and uses a strengths-based perspective.

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.
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.

## *Feature Box: Trauma Informed Services*

At least 25% of U.S. children and youth have experienced at least one traumatic event in their life such as maltreatment, physical assault, domestic or community violence, or a natural disaster. Nationally, about one million children enter into child welfare services each year, and nearly all are victims of abuse and/or neglect who have experienced trauma. An estimated 75% of youth involved in the juvenile justice system have experienced significant trauma. Many more children are traumatized as witnesses to domestic violence or violence in their community; others are child victims of violent crime.

For children, learning how to cope with adversity is an important part of healthy development and can be considered "positive stress"; however, high levels of unmitigated adversity and stress can result in unrelieved activation of the body's stress management system. "Toxic stress", caused by extreme poverty, neglect, abuse, exposure to violence, or severe maternal depression, can weaken the architecture of the developing brain, with long-term consequences for learning and both physical and mental health. Subsequent health complications in adulthood include increased risk of alcoholism, depression, eating disorders, heart disease, cancer, and other chronic diseases. The effects also manifest as poor school and work performance.

Exposure to abuse, neglect, violence, and other stressors are sometimes called "adverse childhood experiences" or ACE. For children, ACE can result in toxic stress and disrupted development and health. In addition, adults live with the consequences of ACE, including increased risk for long term health problems (e.g., heart disease, depression, smoking, intimate partner violence, risky sexual behavior, and alcohol or drug abuse). Assessing ACE scores helps identify and address the effects of trauma on children and adults.

Agencies and systems serving children and youth (e.g., physical health, mental health, education, child welfare, and juvenile justice) must have the capacity and skills to provide "trauma informed care" for those affected. Trauma informed care is an evidence-based approach to service delivery that is responsive to the needs of trauma survivors (e.g., those with ACE or toxic stress), including avoiding re-traumatization or re-victimization. A trauma informed approach to child and family services is one in which all parties involved recognize and respond to the impact of ACE, trauma, and toxic stress on children, caregivers, and providers.

Trauma-informed service systems are necessary so that children are supported and have access to appropriate and effective interventions. Trauma-informed service providers and agencies: 1) screen for trauma exposure and related symptoms; 2) use culturally appropriate, evidence-based assessment and treatment for traumatic stress and associated symptoms; 3) maximize the individual's sense of safety; 4) make resources about trauma available; 5) engage in efforts to strengthen the resilience and protective factors of children and families affected by and vulnerable to trauma; 6) address parent and caregiver trauma and its impact on the family system; 7) emphasize continuity of care and collaboration across systems; 8) support and promote positive and stable relationships in the life of the child; 9) protect children and youth in custody from further trauma and victimization; and 10) create an environment for staff that recognizes, addresses, minimizes, and treats secondary traumatic stress, as well as increases staff resilience.

To provide children and adults with trauma-informed care in San Diego County will require greater awareness, collaboration across systems, partnerships, training, and commitment. Health, mental health, education, child welfare, juvenile justice, and other systems together can assure that trauma-informed services become the norm.

# 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 | | 83.1 | 83.5 | NA |
| Percentage of infants born at low birthweight | | 6.5 | 6.8 | 8.1 |
| Percentage of mothers who initiate breastfeeding in hospital | | 95.2[2] | 92.3[2] | NA |
| Birth rate per 1,000 teens ages 15-17 years | | 12.4 | 13.7 | 15.4 |
| **Ages 3-6 (Preschool)** | | | | |
| Percentage of young children (ages 19-36 months) who completed the basic immunization series | | 81.8[3] | 71.8[2] | 71.9[2] |
| Percentage of children ages 3-4 enrolled in early care and education | | 49.4[2] | 48.8[2] | 47.7[2] |
| **Ages 6-12 (School Age)** | | | | |
| Percentage of children ages 2-11 who have never visited a dentist | | 6.5 | 10.3 | NA |
| Percentage of elementary school (K-5) students who did not attend school at least 95% of school days | | 29.5 | NA | NA |
| Percentage of students in grade 3 scoring proficient or advanced on the English–Language Arts achievement test | | 53.0 | 46.0 | NA |
| Percentage of students not in the Healthy Fitness Zone (at high risk/obese) | | | | |
| Grade 5 | | 30.7 | 33.7 | NA |
| Grade 7 | | 27.2 | 30.1 | NA |
| Grade 9 | | 23.1 | 26.2 | NA |

| Indicator | | San Diego County | California | United States |
|---|---|---|---|---|
| **Ages 13-18 (Adolescents)** | | | | |
| Percentage of middle and high school students (grades 6-12) who did not attend school at least 90% of school days | | 9.8 | NA | NA |
| Percentage of students scoring proficient or advanced on the English–Language Arts achievement test | | | | |
| Grade 8 | | 63.0 | 57.0 | NA |
| Grade 11 | | 51.0 | 48.0 | NA |
| Percentage of students who report using cigarettes in past 30 days | | | | |
| Grade 7 | | 4.5 | NA | NA |
| Grade 9 | | 7.6 | NA | NA |
| Grade 11 | | 9.8 | NA | NA |
| Percentage of students who report using alcohol in past 30 days | | | | |
| Grade 7 | | 10.8 | NA | NA |
| Grade 9 | | 18.8 | NA | NA |
| Grade 11 | | 27.5 | NA | NA |
| Percentage of students who report using marijuana in past 30 days | | | | |
| Grade 7 | | 7.1 | NA | NA |
| Grade 9 | | 14.3 | NA | NA |
| Grade 11 | | 19.3 | NA | NA |
| Percentage of male students (grades 9-12) who report they attempted suicide in previous 12 months | NA | 6.5[3] | NA | NA |
| Percentage of female students (grades 9-12) who report they attempted suicide in previous 12 months | NA | 10.1[3] | NA | NA |
| Number of arrests for misdemeanor and felony crimes among youth ages 10-17 | | 8,134[2] | NA | NA |
| Number of sustained petitions (true finds) in Juvenile Court among youth ages 10-17 | | 3,377[2] | NA | NA |
| Number of DUI arrests among youth under age 18 | | 81 | 891 | NA |
| Rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population | | 54.3[1] | NA | NA |

| Indicator | | San Diego County | California | United States |
|---|---|---|---|---|
| **Community and Family (Cross Age)** | | | | |
| Percentage of children ages 0-17 living in poverty | | 19.8[2] | 23.8[2] | 22.6[2] |
| Number of eligible children receiving Food Stamps | | 135,478[3] | NA | NA |
| Percentage of children ages 0-17 without health coverage | | 6.3 | 4.2 | NA |
| Rate of domestic violence reports per 1,000 households | | 15.0[2] | 12.5[2] | NA |
| Rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17 | | 7.6[2] | 8.9[2] | NA |
| Rate of violent crime victimization per 10,000 children or youth | | | | |
| Ages 0-11 | | 9.0[2] | NA | NA |
| Ages 12-17 | | 46.7[2] | NA | NA |
| Rate of unintentional injuries per 100,000 children ages 0-18 | | 203.6 | 187.2 | NA |
| Infant mortality rate per 1,000 live births | | 4.26 | 4.80 | 6.15 |
| Rate of mortality per 100,000 children | | | | |
| Ages 1-4 | | 17.8 | 19.9 | NA |
| Ages 5-14 | | 8.6 | 9.6 | NA |
| Ages 15-17 | | 20.7 | NA | NA |
| **Adult Indicators** | | | | |
| Percentage of adults ages 18 and older who had not visited a dentist within prior 12 months | | 25.9[1] | 30.4[1] | NA |
| Percentage of adults ages 18 and older that are obese | | 22.1 | 24.8 | NA |
| Percentage of adults ages 18 and older that reported smoking | | 12.8 | 13.6 | NA |
| Percentage of adults ages18-64 living in poverty | | 14.3[2] | 15.6[2] | 14.8[2] |
| Percentage of adults ages 18-64 without health coverage | | 22.0 | 21.4 | NA |

Notes: Unless otherwise noted, table data are for year 2011, California Health Interview Survey combined years 2011-12, or school year 2012-13.

[1] Data from 2010 and/or school year 2011-12.

[2] Data from 2012.

[3] Data from 2013.

# SAN DIEGO COUNTY REPORT CARD ON CHILDREN AND FAMILIES, 2013

## *Introduction*

This *2013 San Diego County Report Card on Children and Families* documents how well San Diego County's children and their families are doing in terms of health, education, safety, and economic security. Report cards monitor trends and can point to troublesome trends or positive results, 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, or 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. Report Cards use indicators as benchmark measures for monitoring progress toward desired results.

The *2013 Report Card* continues to use 25 child indicators selected to measure the health and well-being of infants and toddlers, preschoolers, school age children, adolescents, families, and communities, as well as status across age groups. This edition also includes five indicators of adult well-being that are related to child measures 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 *2013 Report Card* continues to support and begins to document the success of the County *Live Well, San Diego!* initiative, showing indicators and trend data that reflect the health, safety, and well-being of children, youth, and adults. While they are not the *Live Well, San Diego!* top ten indicators, these five adult indicators relate to the areas of influence—health, knowledge, standard of living, community, and social—in *Live Well, San Diego!,* as well as to the life course trajectory.

This edition also includes feature boxes highlighting specific topics where local data are not currently available, but there are emerging concerns for children, youth, and families in San Diego County. Feature boxes examine topics in the news but not yet measured routinely.

This *2013 Report Card* provides updates on current local efforts and progress since the last edition in 2011, offering valuable information that can help to guide policy development, target prevention and intervention efforts, and educate the public. We describe progress toward past recommendations and current efforts that align with "what works" strategies.

As in the past, the *2013 Report Card* offers San Diego–specific recommendations, based on what works and what is already underway, in order to improve results for our children and their families.

## *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 fourth edition.

This *2013 Report Card* was developed and published as a public-private partnership and in alignment with the County of San Diego *Live Well, San Diego!* initiative. 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 experts in the areas of juvenile justice, education, and health, government executives, epidemiologists, 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 in the selection of indicators, content of feature boxes, identification of San Diego efforts, and development of specific recommendations.

The research and analysis has been overseen by a Scientific Advisory Review Committee, including statisticians, epidemiologists, and program data managers from these same fields of study. 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 feature box information.

The document also reflects the advice and expertise of a broad array of stakeholders, 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 *2013 Report Card* include: County of San Diego Health and Human Services Agency, The California Endowment, McCarthy Family Foundation, The Mayer & Morris Kaplan Family Foundation, and California HealthCare 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 2010, 2011, or 2012. School related data is generally provided for school year 2012-13.

Trend charts 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 SNAP/ CalFresh.

Most graphs use calendar years as a measure for trends. Three-year averages are used when the population referred to is small, or when the data are likely to have year-to-year fluctuations that do not indicate actual underlying change in the indicator. For education data, the trends are shown in school years (e.g., 2012-13).

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. New 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, universities, government agencies, and other research organizations. These sections offer examples and are not 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. Where available, updates on current local efforts and progress since the last *Report Card* are provided.

## *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 *2013 Report Card* that illustrate the occurrence of selected indicators according to more precise and easily understood community boundaries (e.g., zip code areas).

The county's total population for 2010 was estimated at 3,095,313, and it is the second most populous county in the state, after Los Angeles County. Children under age 18 represent 23% of our population. (Note that this is a revised population estimate.)

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

San Diego County is an ethnically diverse community. According to the 2010 Census, the overall population consists of: 48% non-Hispanic white; 32% Hispanic; 5% African-American; 11% Asian, Hawaiian, or other Pacific Islander; 3% other; and less than 1% Native American or Alaskan Native. The population of children is predominately Hispanic (47%) and non-Hispanic white (34%) 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.

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

## *What is the indicator?*

**The percentage of mothers receiving early prenatal care.**

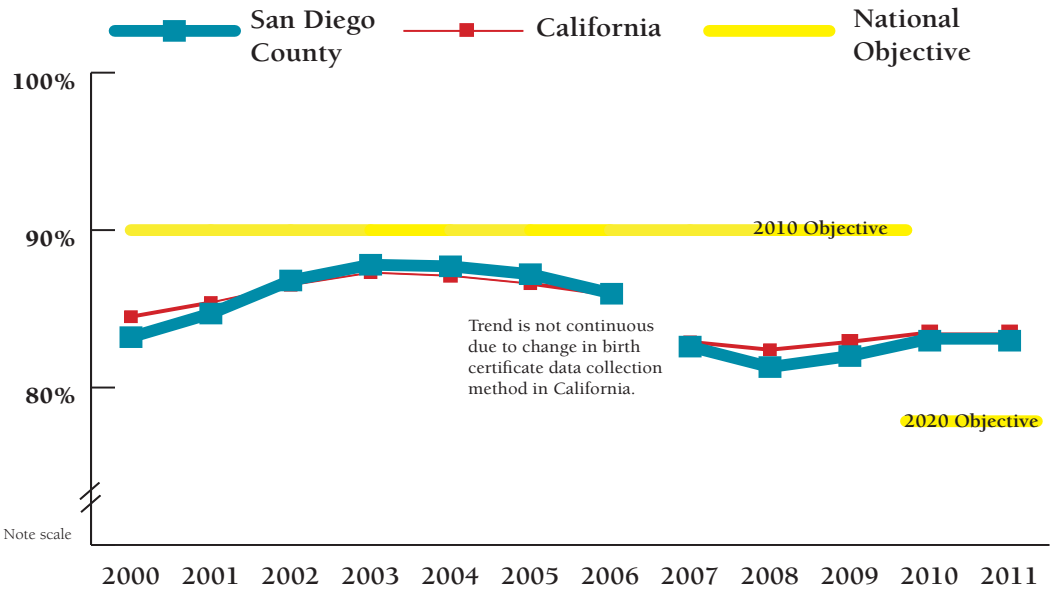
This indicator—the percentage of mothers receiving early prenatal care—reflects the proportion of women who receive prenatal care beginning in the first three months (referred to as the first trimester) of pregnancy. Prenatal care information is recorded on the birth certificate and reported as part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

## *Why is this important?*

Early and comprehensive prenatal care is associated with healthier babies, better birth weights, and a lower risk of premature births. Inadequate prenatal care (starting late or too few visits) has been associated with premature birth, low-birthweight birth, and increased risk of mortality for the fetus, infant, and mother. Prenatal care from a qualified health professional helps to ensure the health of a woman and her baby. Optimal, quality care includes medical services and health promotion and education, with psychosocial supports as needed. Starting care even before conception (preconception care) is recommended to reduce health risks to both mother and baby.

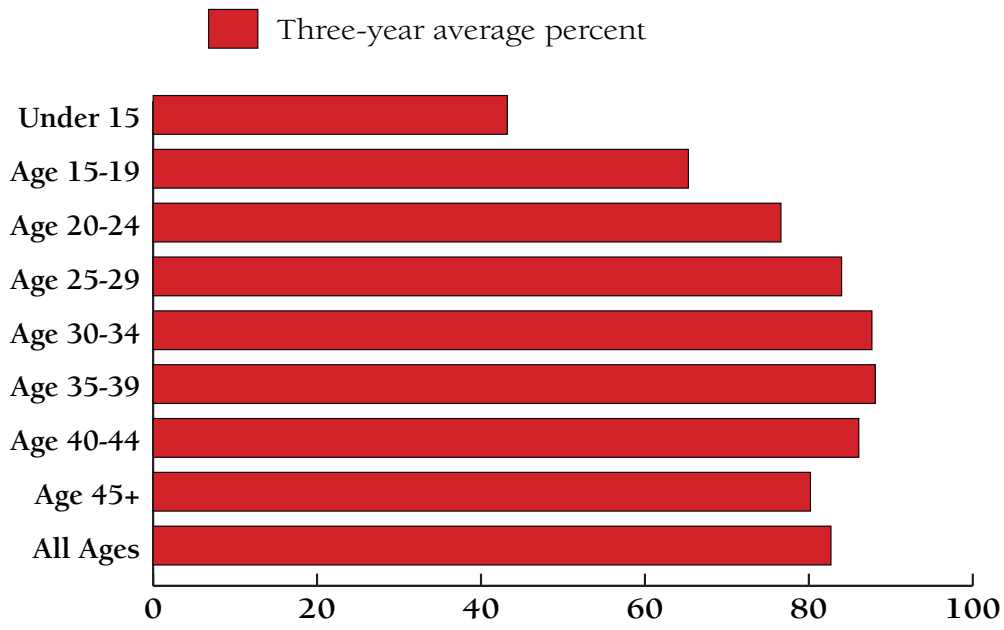
## *How are we doing?*

**Percentage of Mothers Receiving Early Prenatal Care, San Diego County and California Compared to National Objective, 2000-2011**

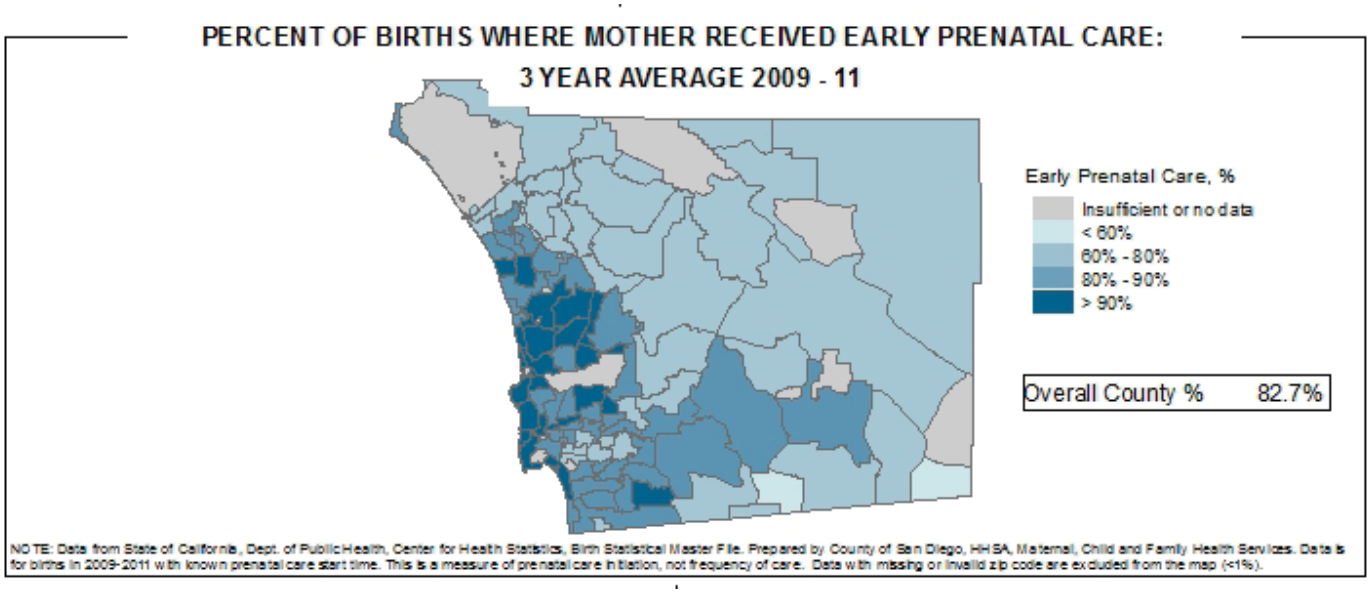



*The trend is maintaining. The proportion of mothers who started prenatal care in the first three months of pregnancy remained constant at 83.1% in 2010 and 2011. The national objective was made easier to achieve for the decade 2010–2020.*

## Percentage of Mothers Receiving Early Prenatal Care, By Age, San Diego County, Three-Year Average 2009-11




*San Diego's youngest mothers are less likely than older women to begin prenatal care early. This is particularly true among pregnant teens, but even those ages 20-24 fare less well.*



## What strategies can make a difference?

The timing and use of prenatal care is influenced by many factors. First, financial barriers due to lack of health coverage for maternity care still affect many families. Second, the context of care has a significant impact (e.g., long waits after arriving for appointments, lack of cultural competence, negative attitudes, and biased treatment by health care providers). Third, the accessibility of care (e.g., transportation, difficulties obtaining an appointment, inconvenient hours) makes a difference. Lastly, personal attitudes, and behaviors (e.g., lack of understanding about the importance of prenatal care, ambivalence about the pregnancy) are barriers to timely 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:

- Expanding access to affordable health coverage (e.g., Affordable Care Act Exchange plans, Medi-Cal, and private plans with maternity coverage).
- Using outreach to get women enrolled in health coverage, connected with a prenatal provider, and into early and continuous care.
- Use of safety net providers such as community clinics and Federally Qualified Health Centers (FQHC) to provide prenatal care.
- Assuring prenatal care services are available and accessible (e.g., accessible by public transportation, flexible service hours).
- Providing prenatal services that are culturally and linguistically appropriate.
- Using evidence-based home visiting programs, particularly for high risk mothers.
- Using approaches such as "Centering Pregnancy," which uses group care sessions to reduce costs and enhance the content of care.
- Providing comprehensive care (e.g., the California Comprehensive Perinatal Care Services package), which incorporates education and counseling along with medical care to reduce risk.
- Offering transportation assistance such as vouchers for public transportation or taxis.

## How can we improve the trend in San Diego County?

San Diego's public and private partners are continuing to focus on and prioritize increasing the number of at-risk moms receiving early and consistent prenatal care. The County of San Diego, Health and Human Services Agency is continuing to implement previous *Report Card* recommendations by expanding their Nurse Family Partnership project (an intensive home visiting approach for high risk, first time pregnant women). Additionally, First 5 San Diego funded the First Steps Program, partnering with Palomar Health, SAY San Diego, South Bay Community Services, and Home Start. First Steps offers intensive home visiting to four target populations: low-income mothers living below 200% of the federal poverty level, military moms, new refugee and immigrant moms, and teen moms. In the first year it is anticipated that more than 480 moms will receive services.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with community clinics, hospitals, health care providers, First 5 San Diego, Public Health, March of Dimes, United Way of San Diego County, faith communities, Metropolitan Transit System, municipalities, 211, and community based organizations to:

1. Expand access to affordable health coverage before, during, and after pregnancy.
2. Expand use of intensive home visiting for high risk pregnant women, including teens.
3. Assist physicians, group practices, and clinics in delivering comprehensive prenatal care and adopting group prenatal care and education, including culturally competent practices.

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

## *What is the indicator?*

**The percentage of infants born at low birthweight.**

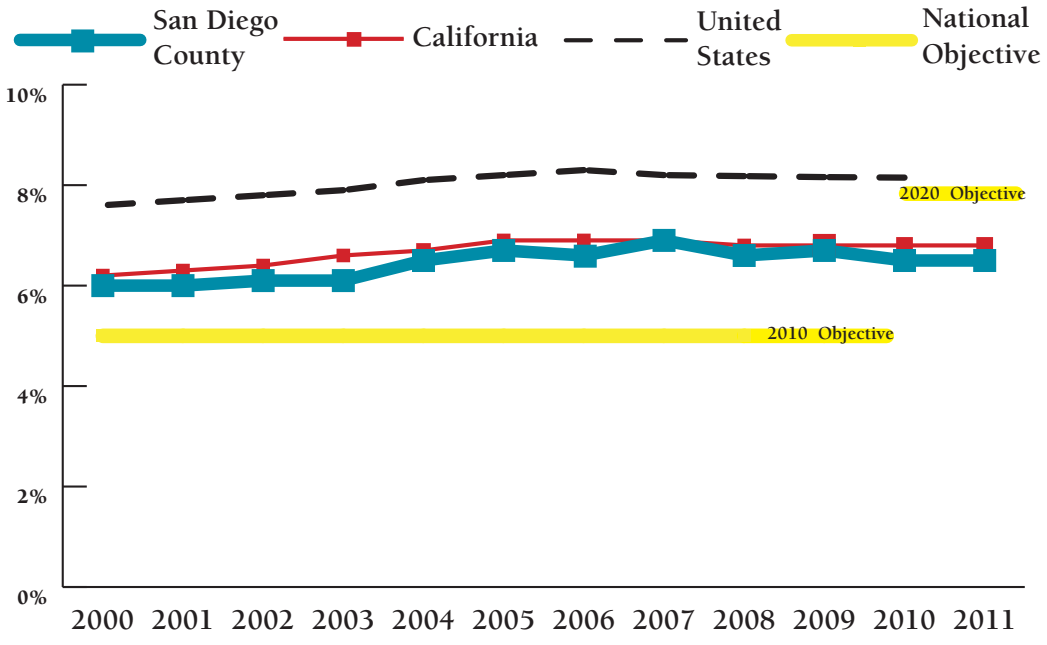
This indicator—the percentage of infants born at low birthweight—is defined as weighing less than 2500 grams (5.5 lbs), and very low birthweight is defined as weighing less than 1500 grams (3.3 lbs) at birth. Both are included in this measure. These data are recorded on birth certificates and reported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

## *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 in the rate of low birthweight, and together these two conditions are the leading cause of infant mortality. With advances in neonatal intensive care, many born at low birthweight or prematurely survive but will experience short and long-term problems such as cerebral palsy, vision and hearing disorders, learning disabilities, and behavior disorders. Individuals who were born at low birthweight have higher risks for adult chronic health conditions such as high blood pressure, heart disease, and adult onset diabetes.

## *How are we doing?*

**Percentage of Infants Born at Low Birthweight, San Diego County, California, and United States Compared to National Objective, 2000-2011**




*The trend is maintaining in San Diego County. The proportion of babies born at low birthweight remains of concern. The national objective was made easier to achieve for the decade 2010–2020.*

## What strategies can make a difference?

While all of the causes of low birthweight and preterm birth are not known, we know how to reduce some risks. Smoking and heavy drinking while pregnant are two of the most widely known behavioral factors associated with low birthweight and premature birth, as well as certain infections and low maternal pre-pregnancy weight. 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 are also more at risk. Quality 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 babies. For women who have a low birthweight or preterm birth, experts also recommend "interconception care" to reduce risks prior to any subsequent pregnancy.

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

- Educating women about risks for pregnancy complications such as use of alcohol and drugs, tobacco, prescription drugs, sexually transmitted diseases, hypertension, and diabetes.
- Increasing use of prenatal care early and often to screen for and address risk factors.
- Eliminating elective deliveries prior to 39 weeks gestation (i.e., early elective deliveries).
- Eliminating smoking and exposure to secondhand smoke before and during pregnancy.
- Eliminating pregnancies among younger teens.
- Reducing stress and exposure to violence.
- Promoting proper nutrition and healthy weight before and during pregnancy.
- Using intensive, evidence-based home visiting for high-risk pregnant women.
- Promoting family planning and pregnancy spacing.
- Avoiding multiple births that result from assistive reproductive technology.
- Promoting health and reducing risks before pregnancy with preconception care.
- Using interconception care to provide augmented services for 24 months to the highest-risk, lowest-income women who have had a low birthweight or preterm birth or fetal/infant death.

## How can we improve the trend in San Diego County?

Building on previous *Report Card* recommendations, hospitals in San Diego and Imperial Counties are working to reduce early elective delivery rates (between 37 and 39 weeks) to less than or equal to 3% of all deliveries. The Ending Early Elective Deliveries project, led by Hospital Association of San Diego and Imperial Counties, is a partnership with UCSD Regional Perinatal System, March of Dimes, and other hospital networks which have made great progress in meeting these goals. San Diego County providers also are making progress through the County Tobacco Control Resource Program which promotes the use of the 5A's evidence-based model. Additionally, Medi-Cal is now financing more prenatal smoking cessation interventions.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with health providers, March of Dimes, Health and Human Services Agency, WIC, Red Cross, First 5 San Diego, United Way of San Diego County, community clinics, office-based physicians, text4baby, 211, community-based organizations, and faith communities to:

1. Increase enrollment in text4baby among pregnant women and new mothers in San Diego.
2. Ensure all women in Medi-Cal have access to evidence-based smoking cessation programs and hot lines, now financed through the Affordable Care Act.
3. Finance interconception care services for 24 months to the highest-risk women who have had a low birthweight or preterm birth or fetal/infant death.

# *Birth to Age 3 (Infants and Toddlers):* BREASTFEEDING

## *What is the indicator?*

**The percentage of mothers who initiate breastfeeding before leaving hospital.**

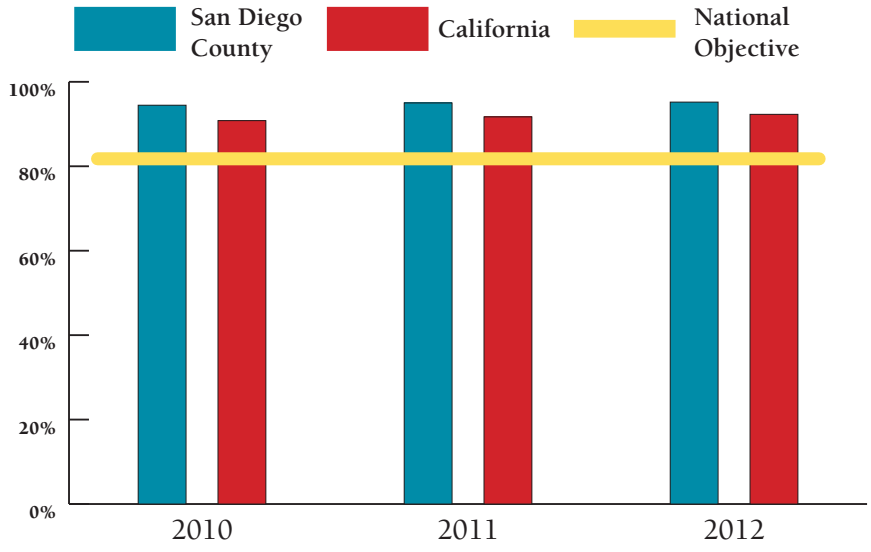
This indicator—the percentage of mothers who initiate breastfeeding before leaving hospital—estimates what proportion of infants receive any breast milk. Recommendations call for 6 to 12 months of breastfeeding, but data on continuation rates are available for only a fraction of the population. The data 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).

## *Why is this important?*

Breastfeeding is one of the most effective and cost-effective preventive health practices. For children, it enhances immunity to disease and decreases the rate and severity of diarrhea, respiratory infections, and ear infections. Breastfeeding is associated with improved brain development and reduced risk of childhood obesity. Breastfeeding reduces lifelong risks for chronic health problems such as cardiovascular disease and diabetes. Benefits to the mother include: reduced incidence of breast, ovarian, and uterine cancer; quicker recovery after pregnancy; and missing less work due to child illness.

## *How are we doing?*

**Percentage of Mothers Who Initiate Breastfeeding of Newborn in Hospital, San Diego County and California Compared to National Objective, 2010-2012**




*Based on three years of data, the trend is maintaining. The San Diego rate was consistently better than the state average and the national objective over this time period.*
*African American and Native American mothers were least likely to initiate breastfeeding (not shown).*
*The national objective remained the same for 2010 and 2020.*

## 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. Lack of workplace support remains a significant barrier to breastfeeding.

The following strategies have been used to increase breastfeeding:

- Supporting health promotion and education during the prenatal period.
- Providing ongoing breastfeeding support and lactation education, particularly from trained and experienced lactation consultants, home visitors, and/or nurses, as well as equipment such as breast milk pumps.
- Assuring that all birthing hospitals and centers encourage breastfeeding through programs such as the "Baby-Friendly Hospitals Initiative," which supports mothers in learning how to breastfeed and promotes exclusive use of breast milk.
- Implementing laws that protect breastfeeding in public and require workplace supports, including provisions of the Affordable Care Act requiring employers to provide reasonable, though unpaid, break time for a mother to express milk and a place, other than a restroom, that is private and clean where she can express her milk.
- Offering other workplace breastfeeding support (e.g., health education, paid breaks, and options to safely store breast milk).
- Encouraging eligible families to use the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which offers incentives and support for breastfeeding.
- Providing culturally and linguistically appropriate education for mothers.
- Using the Business Case for Breastfeeding national "toolkit," prepared by the U.S. Department of Health and Human Services.
- Limiting the marketing of breast milk substitutes (i.e., formula).

## How can we improve the trend in San Diego County?

Continuing to implement *Report Card* recommendations, the County Health and Human Services Agency used First 5 San Diego and Community Transformation Grant funds for the Workplace Lactation Program through Healthy Works. The goals are to increase the number of hospitals, schools, and businesses that adopt supportive breastfeeding and lactation accommodation policies. To date, 25 work sites and 7 school districts have been trained and provided with technical assistance to improve lactation accommodations in the workplace. The *2011 Report Card* noted that California passed Senate Bill 502—the Hospital Infant Feeding Act—providing mothers with access to a breastfeeding consultant and information. Since then, California has passed Senate Bill 402 which requires hospitals to adopt the 10 Steps for Successful Breastfeeding program with evidence-based practices.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with health providers, local Chambers of Commerce, businesses and business associations, San Diego Workforce Partnership, WIC, First 5 San Diego, Health and Human Services Agency, Childhood Obesity Initiative, and health plans to:

1. Implement Senate Bill 402, the Ten Steps of Successful Breastfeeding program in hospitals.
2. Provide lactation consultants and other supports to mothers, at the hospital, home, and work.
3. Assist more employers in implementing the federal law that requires appropriate and adequate space and break time for breastfeeding.

*Birth to Age 3 (Infants and Toddlers):*

# BIRTHS TO TEENS

## *What is the indicator?*

**The birth rate per 1,000 teens ages 15-17 years.**

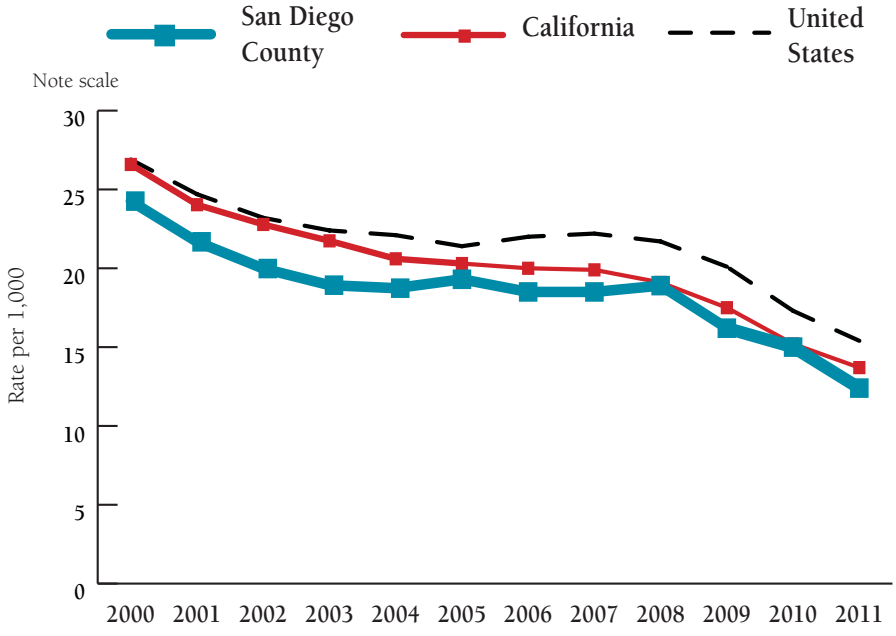
This indicator—the birth rate per 1,000 teens ages 15-17 years—monitors trends in births for teens ages 15-17. Reliable data are available annually from birth certificates and reported as part of local, state, and federal vital statistics. It is not possible to get reliable data on the number of teens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

## *Why is this important?*

The teen pregnancy rate in the United States is the highest 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. Half of teen parents do not graduate from high school. Their babies are at greater risk for abuse, neglect, and developmental delays. Teen parenthood places two generations at risk. A major concern is the number of adult-age males fathering children born to teens.

## *How are we doing?*

**Birth Rate per 1,000 Teens Ages 15-17, San Diego County, California, and United States, 2000-2011**




*The trend is improving. The teen birth rate was 12 per 1,000 in 2011, half of the rate in 2000. A similar downward trend is shown for the state and the nation.*

## 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:

- Promoting strong positive family engagement. Teens who report a positive relationship with their parents are less likely to engage in sexual activity and other risky behaviors.
- Teaching comprehensive life skills and reproductive health education in schools through use of effective curriculum-based sex and STD/HIV education programs.
- Involving 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.
- Providing access to comprehensive and confidential reproductive health services, including education about contraceptive methods and family planning services.
- Providing after school programs and activities to engage teens after school and weekends.
- Providing programs to engage youth during the summer and school holidays.
- Increasing cultural relevance of activities for teens.
- Encouraging teen parents to continue in school to help reduce subsequent pregnancies.

## How can we improve the trend in San Diego County?

To support *Report Card* recommendations, multiple high school districts and the San Diego Adolescent Pregnancy and Parenting (SANDAPP) program and the California School Age Families Education (Cal-Safe) programs implemented Cal-Learn. The goals of the program are to reduce teen pregnancy rates and long-term welfare dependency. The Cal-Learn program targets teen parents receiving California Work Opportunity and Responsibility to Kids (CalWORKs). This effort consists of three coordinated services designed to help teens become self-sufficient adults and responsible parents: intensive case management to assist teen parents in obtaining education, health, and social services; support for needed child care, transportation, and educational expenses; and incentives to support improved school attendance and good grades. Four $100 incentives per year may be earned based on grades plus a one-time $500 incentive for graduating or attaining an equivalent high school diploma.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with parents and parent organizations, schools and school districts, teen pregnancy prevention programs, Health and Human Services Agency, Behavioral Health, First 5 San Diego, SANDAPP, health providers, community-based organizations, and Cal-Safe to:

1. Expand access to health and mental health services that counsel teens regarding healthy and safe lifestyle choices, abstinence, and contraception.
2. Use effective programs in schools and community settings that foster parent-to-teen communication (e.g., National Campaign to Prevent Teen and Unplanned Pregnancy).
3. Expand support for successful pregnancy prevention and teen parenting programs.

# *Ages 3–6 (Preschool):* IMMUNIZATION

## *What is the indicator?*

**The percentage of young children (ages 19-36 months) who completed the basic immunization series (4:3:1:3:3:1).**

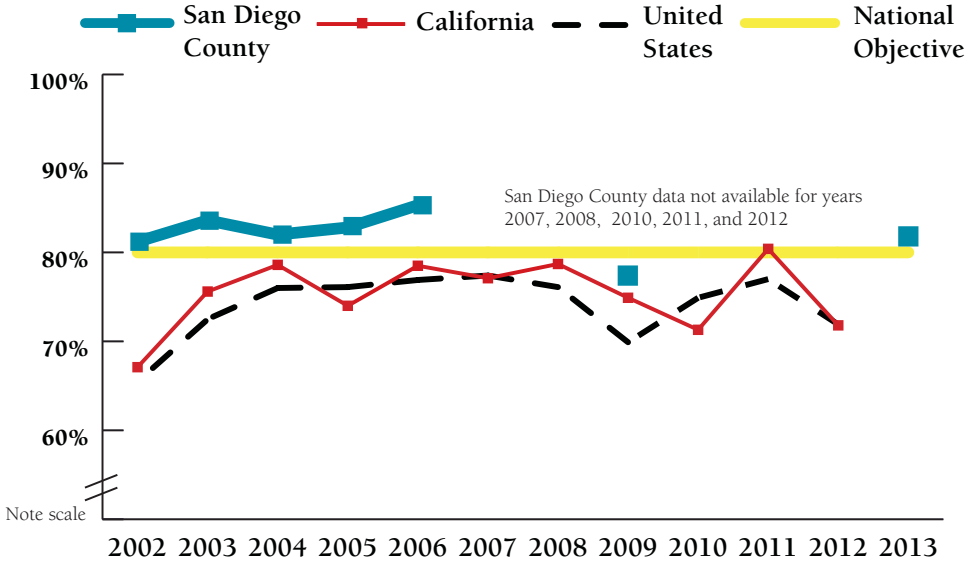
This indicator—the percentage of young children (ages 19-36 months) who have received the basic recommended childhood immunization series—monitors use of recommended vaccines in the first three years of life. While the basic series of vaccines are due by age 24 months, no data exist to track children 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.

## *Why is this important?*

Childhood immunizations save millions of lives each year. Children who are not adequately immunized put others at risk for illness and death. Childhood vaccines are highly effective and cost-effective. Every dollar spent on immunization saves $6.30 in direct medical costs. Success will depend upon public/private partnerships involving researchers, policy makers, vaccine manufacturers, public and private health professionals who administer vaccines, and, of course, families who voluntarily participate in immunization programs. It is critical to ensure that vaccines are available and that families have access to these safe, effective, and recommended childhood vaccines.

## *How are we doing?*

**Percentage of Young Children (Ages 19-36 months) Who Completed the Basic Immunization Series, San Diego County, California, United States, and National Objective, 2002-2013**




*While missing data and variations year-to-year make it difficult to plot a trend, no substantial improvement in the immunization coverage of San Diego toddlers has been shown over time. For 2013, it was 81.8%, the same as in 2002. Lack of data creates a challenge for monitoring progress.*

## What strategies can make a difference?

High immunization rates are critical for the health of children, families, and communities. Maintaining population-wide "herd" immunity is the key to preventing disease and protecting the more vulnerable (e.g., infants not yet immunized, individuals with compromised immune systems). Achieving high immunization rates for each new cohort of children requires ongoing awareness, acceptance, financing, and access. San Diego's progress in preventing disease has been affected by unimmunized and underimmunized children.

The following strategies have been used to increase immunization rates:

- Assuring an adequate supply of affordable vaccines, including sufficient funding for the federal Vaccines for Children (VFC) program.
- Educating parents about the importance and safety of childhood vaccines.
- Educating 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.
- Providing access to vaccines through pediatricians, family physicians, local health departments, community clinics, pharmacies, and other locations.
- Using immunization registries and surveys to monitor who is up-to-date.
- Contacting and providing support and information for families whose children are not up to date for recommended vaccines.
- Providing more intensive education and support for families who refuse immunizations and those with less access.
- Using community-wide and targeted campaigns and education to inform parents about the importance of immunizing "every child by two" and the risk of vaccine-preventable disease.
- Supporting providers with quality improvement projects.
- Protecting providers who deliver vaccines from excessive liability costs and concerns by continuing the National Vaccine Injury Compensation Program.

## How can we improve the trend in San Diego County?

In response to the decrease in the number of children receiving the basic recommended series of immunization and the recommendations featured in the *2011 Report Card*, Rady Children's Hospital entered into an innovative partnership with First 5 San Diego, Children's Physicians and primary Care Medical Groups, and the American Academy of Pediatrics to launch a multi-pronged initiative called Immunization for San Diego Kids. This effort aims to increase parent knowledge about the importance and safety of immunization and increase the rate of fully immunized children in the county. Rady's works with parents, physicians, and the hospital to support all parents in having their children fully immunized. They also began a proactive immunization program to advocate for the increased participation by providers in the San Diego Immunization Registry.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego Immunization Coalition, American Academy of Pediatrics, Health and Human Services Agency, First 5 San Diego, parents and parent organizations, health providers, community-based organizations, faith communities, local media partners, and 211 to:

1. Implement a targeted campaign to inform and engage parents about the importance of immunization, particularly those who refuse immunizations and/or are not up-to-date.
2. At the county level, collect and report immunization survey data every other year.
3. Incentivize all health providers to participate in the San Diego Immunization Registry.

# *Ages 3–6 (Preschool):*
# EARLY CARE AND EDUCATION

## *What is the indicator?*

**The percentage of children ages 3-4 enrolled in early care and education.**

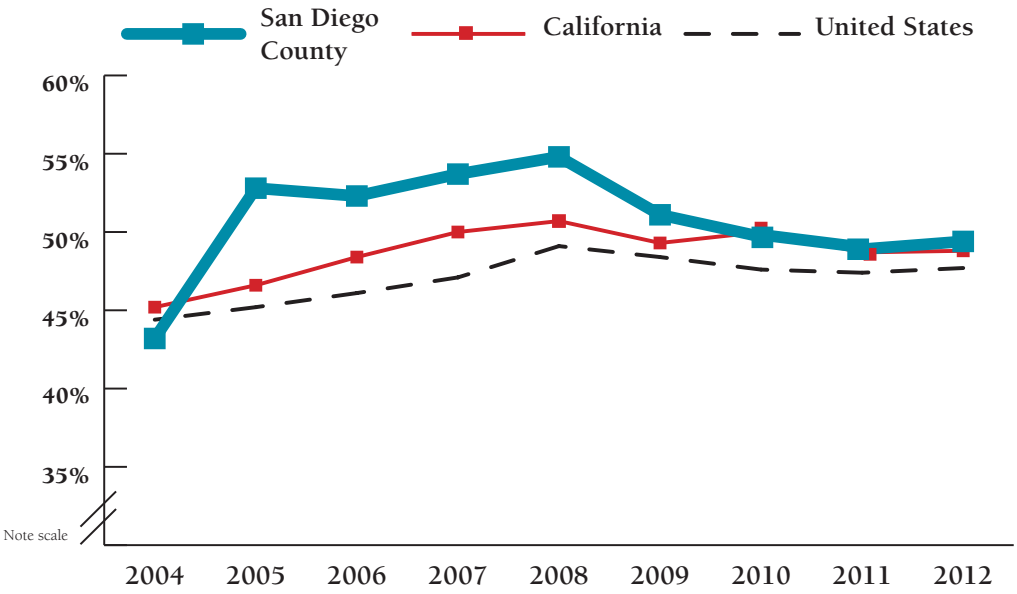
This indicator—the percentage of children ages 3-4 enrolled in early care and education—shows trends in early childhood care and education for our county's preschool age children who are regularly attending an out-of-home and non-relative early care and education setting. This setting may be a child care center, family child care setting (licensed or unlicensed), preschool, or Head Start program. The data are routinely gathered and reported by the U.S. Census Bureau American Communities Survey.

## *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 (including child care, preschool, Head Start, etc.) improves school readiness and overall development of young children, as well as long-term education and employment outcomes throughout life. Quality early care and education from birth to five years cannot only help a child, but also produce economic benefits to society that far exceed the initial investment. The greatest return on investment comes from providing quality early care and education for low-income and other at-risk children.

## *How are we doing?*

**Percentage of Children Ages 3-4 Enrolled in Early Care and Education, San Diego County, California, and United States, 2004-2012**




*The trend is maintaining. In San Diego County, close to 50% of three and four year olds were enrolled in early care and education between 2009 and 2012. Similar rates were shown for California.*

## What strategies can make a difference?

Early care and education includes child care, preschool/pre-kindergarten, and Head Start. Children in high quality early care and learning environments gain more advanced language, school readiness, and better social skills.

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

- Implementing a state quality rating system to give families information to identify quality programs and provide incentives to providers that reach high standards.
- Targeting child care subsidies for low-income families to quality early care and eduction (i.e., with high quality rating or other demonstrated quality performance).
- Increasing access to quality preschool, Head Start, and pre-kindergarten (pre-K) programs, which have been shown to provide a boost in skills for children ages 3 to 5. Combining programs into a "preschool for all approach" helps to maximize resources.
- Offering child care resource and referral lines or community-based centers that assist families in finding quality early care and education that meet their needs.
- Adopting teacher training and credentialing standards associated with quality.
- Increasing access to and quality of infant and toddler care.
- Providing no-cost technical assistance and training to family day care homes/centers to ensure good quality care and financial sustainability.
- Training and deploying child care health and mental health consultants to provide supportive services to children in early care and education settings.
- Having a comprehensive early childhood education system at the local level that offers parents varied, high quality options to meet families' needs.

## How can we improve the trend in San Diego County?

In line with the *2011 Report Card* recommendation to improve the quality of child care, San Diego was awarded a US Department of Education's Race to the Top-Early Learning Challenge (RTT-ELC) working to improve quality and to narrow the achievement gap for vulnerable young children. First 5 San Diego and the San Diego County Office of Education received RTT-ELC to develop a Quality Rating and Improvement System (QRIS) for early learning centers. QRIS is a systematic approach to assess and improve the level of quality in early care and education programs. San Diego's Quality Preschool Initiative has QRIS standards that include the use of evidence-based assessment with a valid developmental screening tool, minimum qualifications of a degree in Early Childhood Education for teaching staff, and setting an optimal ratio between students and qualified staff.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with First 5 San Diego, Child Care and Development Planning Council, child care resource and referral agencies, early care and education providers, San Diego County Office of Education, community colleges and universities, faith communities, Health and Human Services Agency, mental health service providers, businesses, and municipalities to:

1. Increase the amount of available child care subsidies so that more low-income and working poor families have access to quality child care, particularly for infants and toddlers.
2. Develop and implement a local quality rating system for early care and education to help families identify quality programs.
3. Provide no-cost technical assistance and training to family day care homes/centers to promote quality care.

# *Ages 6–12 (School Age):*
# ORAL HEALTH

## *What is the indicator?*

**The percentage of children ages 2-11 who had never visited a dentist.**

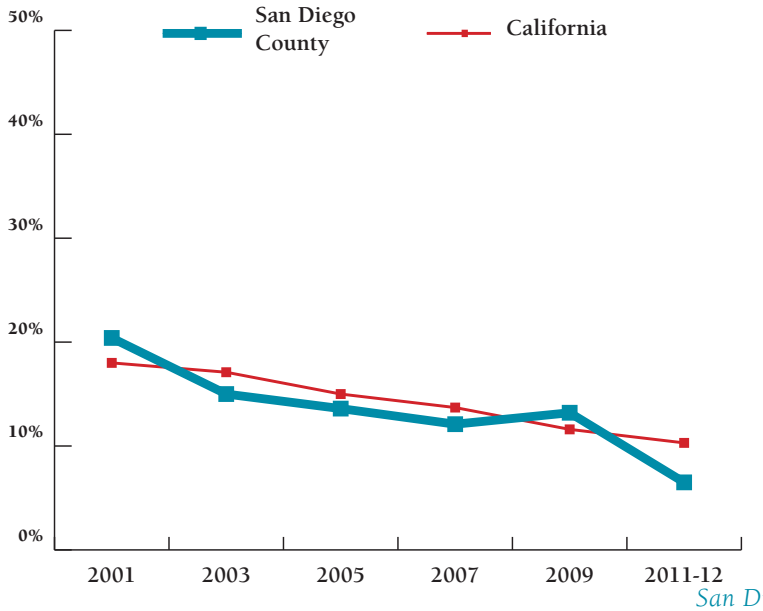
This indicator—the percentage of children ages 2-11 who had never visited a dentist—represents the most important years to prevent and treat dental disease and decay. National recommendations from dentists and pediatricians and the California Child Health and Disability Prevention (CHDP) program call for dental care to start by 12 months. These data are routinely reported in the California Health Interview Survey. A new, year-round data collection method was instituted in 2011–12.

## *Why is this important?*

One-quarter of U.S. children—mostly poor, minority, and/or with special health care needs—experience 80% of all decayed teeth. Even decayed "baby" teeth affect child health and adult teeth. Dental caries (the disease that causes cavities and tooth decay) is the single most common chronic disease of childhood. Children with untreated cavities often live with chronic pain, which affects concentration, school achievement, mood, sleep, nutrition, and even play. By age 17, more than 7% of U.S. children have lost a permanent tooth to tooth decay. Routine and preventive dental care is essential to: 1) educate families about dental hygiene at home, 2) apply protection such as fluoride treatments and sealants, and 3) provide intervention for dental caries.

## *How are we doing?*

**Percentage of Children Ages 2-11 Who Had Never Visited a Dentist, San Diego County and California, 2001, 2003, 2005, 2007, 2009, and 2011-12**




*The trend is improving. The percentage of children ages 2–11 who never had a dental visit has dropped dramatically since 2001. The change in data collection methods may have contributed to the sharpness of decline between 2009 and 2011-12; however, real improvement has been shown.*

# *Adults:*
# ORAL HEALTH

## *What is the indicator?*

**The percentage of adults age 18 and older who had not visited a dentist within prior 12 months.**

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 had no recommended annual visit to prevent and treat dental disease and decay. These data are routinely reported in the Behavioral Risk Factor Surveillance System of the U.S. Centers for Disease Control and Prevention (CDC).

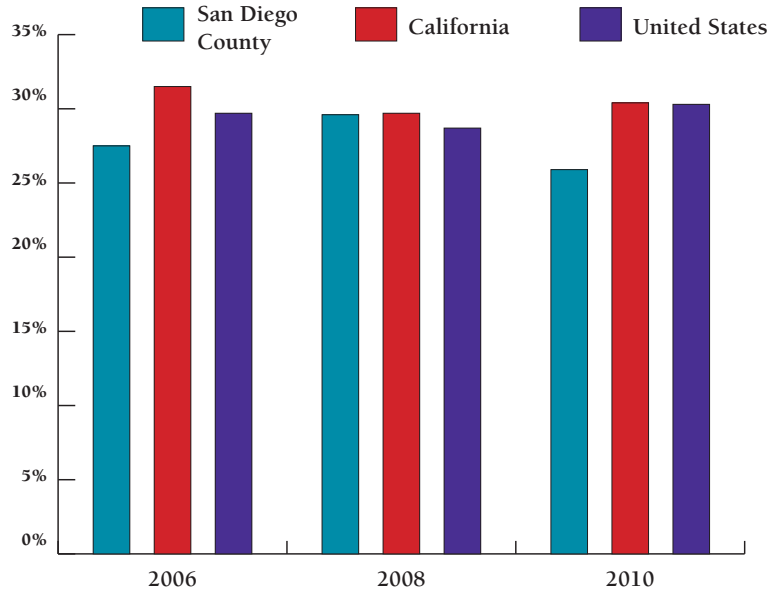
## *Why is this important?*

Millions of U.S. adults are not getting needed dental care and are suffering with untreated disease. Adult dental risks include dental caries, oral cancers or pre-cancers, and periodontal disease. Each year, oral (mouth) and pharyngeal (throat) cancers are diagnosed in approximately 30,000 people, and about 8,000 adults die of these diseases. Lack of preventive dental visits is linked to tooth loss. Individual risks dictate the frequency of visits needed. While individuals with little risk of cavities or gum disease may achieve good oral health by visiting a dentist once a year, some risks (e.g., tobacco, diabetes, gum disease, stress) call for more frequent dental visits.

The life course perspective helps in understanding the importance of child and adult patterns of dental care. For low-income families, adults' low use of dental care often predicts and is interrelated with inadequate dental care for children. Immigrant and refugee families also face barriers to care. Lack of dental insurance, long term poverty, and family misinformation are negative influences. Positive dental experiences for children, affordable dental coverage, and health promotion for children's visits through programs such as Head Start and home visits can improve both children's and parents' use of dental services.

## *How are we doing?*

**Percentage of Adult Ages 18 and Older Who Had Not Visited a Dentist within Prior 12 Months, San Diego County, California, and United States, 2006, 2008, and 2010**




*The trend is maintaining. While some variation is shown, between 26% and 29% of adults did not visit a dentist in the prior year.*

## What strategies can make a difference?

Good oral health depends on access to dental care and personal hygiene. Experts tell us that the key elements for assuring optimal oral health are: 1) sound nutrition, 2) consistent use of "self-care" practices (e.g., brushing and flossing), and 3) access to dental prevention and treatment services through a "dental home" beginning at age 1. Many prevention strategies work best when started with infants and toddlers and continued through the life span.

The following strategies have been used to improve oral health among children and adults:

- Expanding access to dental services in low-income and underserved communities (e.g., dental services in community clinics, mobile dental clinics).
- Increasing effective use of primary health care providers, early childhood education, and community-based organizations to educate parents about the importance of oral health and how to screen children for oral health problems.
- Assuring access to preventive services, including sealants and fluoride varnish through dental providers, primary care providers, and school-based services.
- Increasing both adult and child coverage for dental services, particularly through Medicaid/ Medi-Cal and Covered California Affordable Care Act Exchange plans.
- Increasing the number of trained dental professionals, including dentists and dental hygienists (e.g., increasing the number of training slots and offering loan repayment options in exchange for serving in low-income communities).
- Assuring community water fluoridation.
- Implementing health promotion campaigns to increase awareness of the importance of flossing and brushing (from infancy), as well as preventive dental visits for children and adults.

## How can we improve the trend in San Diego County?

San Diego has implemented two of the *2011 Report Card* recommendations for oral health. Share the Care is a public-private partnership between the County Health and Human Service Agency, San Diego County Dental Society, and the Dental Health Coalition. This initiative provides access to emergency dental care for eligible children, as well as education to professionals, parents, and children to promote preventive care. In Fiscal Year (FY) 2012–13, 2,679 children received pro bono emergency and preventive dental care, and 924 families were assisted in finding emergency or preventive oral care for their children. In addition, the Oral Health Initiative, funded by First 5 San Diego, provides dental screenings, examinations and treatment services for pregnant women and children ages 1 through 5. During FY 2012–13, providers screened 26,293 children and 4,389 pregnant women. For clients identified at high risk for dental disease, 81% of children and 78% of pregnant women received treatment services.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the First 5 San Diego Oral Health Initiative, Share the Care, Dental Health Initiative, Health and Human Services Agency, dental and pediatric professionals, parents and parent organizations, community clinics, faith communities, schools, local media partners, and 211 to:

1. Incentivize each dental provider to accept five new patients and/or families with Medi-Cal or publicly subsidized coverage and become their dental home.
2. Offer oral health prevention and screening services in schools, mobile dental clinics, at work, and other community settings.
3. Enroll more children and adults into affordable dental coverage through Medi-Cal, Covered California Exchange plans, and other programs.

# *Ages 6–12 (School Age):*
# SCHOOL ATTENDANCE

## *What is the indicator?*

**The percentage of elementary school (K-5) students who did not attend school at least 95% of school days.**

This indicator—the percentage 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. It includes students who are absent approximately nine days of the school year, for any reason. These data include school districts representing 98% of the student population. Note, this is not Average Daily Attendance.

## *Why is this important?*

Consistent school attendance—at least 95% for this age group—is one of the strongest predictors of school success or failure. Students in elementary school are learning the basic reading, writing, math, reasoning, social, and study skills that are critical to success and fulfillment in the higher grades. Chronic absence as early as pre-K and Kindergarten is prevalent and can lead to deficits in later school achievement and reduced chances of graduation. A high chronic absence rate can affect the whole classroom or school. Whether children miss school as a result of illness, family vacations, or truancy, missing too many days of school affects: the student who must catch up on missed learning, the teacher who must re-teach the material, and the other students whose educational progress is slowed as a result.

## *How are we doing?*

**Percentage of Elementary School Students (Grades K-5) Who Did Not Attend at Least 95% of School Days, School Years 2006-13**


*The trend is maintaining in San Diego County schools. Despite small variations, there is no substantial improvement in the attendance patterns of elementary school in San Diego County school districts. In 2012-13, 30% of students did not attend at least 95% of school days.*

## What strategies can make a difference?

Consistent school attendance can be affected by many factors, such as illness, transportation problems, inadequate child care, and lack of parent supervision and support. To address chronic absences and truancies, schools, parents, community providers, and law enforcement must work together to develop policies, services, and programs that support children and families.

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

- Increasing parent and community awareness of the importance of regular attendance through education, outreach, and consistent engagement.
- Maintaining a school climate and practices that promote parent and family involvement.
- Developing accurate and daily monitoring of attendance, with feedback to parents (e.g., using multiple languages, school websites, e-mail, and other forms of communication).
- Implementing sound, reasonable, and well-communicated attendance policies and practices.
- Using positive reinforcement and acknowledgement (e.g., student commendation letters, attendance recognition events, front-of-line privileges at lunch, and extra computer time).
- Providing early interventions that address the specific cause of absenteeism and involve families as partners.
- Keeping the 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.
- Linking schools, parents, health care providers, social workers, and mental health professionals, and community supports to efforts to reduce absenteeism.
- Offering high-quality, school-based, after school programs to strengthen connection to school.
- Providing students with chronic absenteeism one-on-one and group mentoring to re-engage them in school.

## How can we improve the trend in San Diego County?

The *2011 Report Card* recommended the development and implementation of effective school policies and practices related to attendance. The Lemon Grove School District developed a data system that consistently monitors student attendance. In the last school year, the district reduced their chronic absenteeism rate by 25%. Achieving and maintaining good attendance is a priority for the superintendent, principals, teachers, students, and their parents. The efforts start at Kindergarten orientation where the importance of attendance is emphasized. In addition, each school has a part-time social worker who is the lead for attendance support and intervention efforts. Breakfast in the classroom is offered to all students at no charge which greatly assists with getting children to school each day and on time.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, school boards, families, parents and parent associations, businesses, Health and Human Services Agency, United Way of San Diego County, community-based organizations, local media partners, and colleges and universities to:

1. Increase communication, connection to school, and parent and family involvement, starting in Kindergarten.
2. Implement proven and effective school attendance improvement strategies such as positive reinforcement, early interventions, and family engagement.
3. Increase the number of schools with social workers available to target chronic absenteeism.

# *Ages 6–12 (School Age):*
# SCHOOL ACHIEVEMENT GRADE 3

## *What is the indicator?*

**The percentage of students in grade 3 scoring proficient or advanced on the English-Language Arts achievement test.**

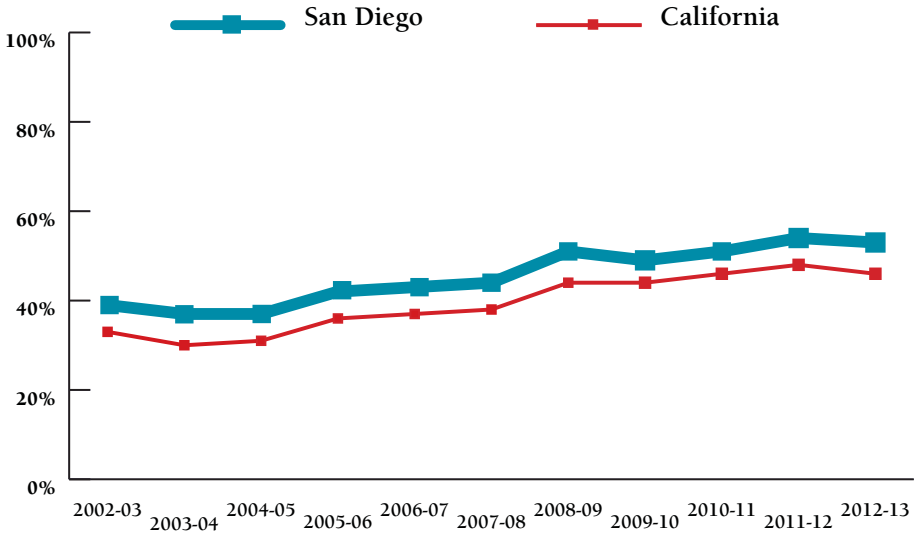
This indicator—the percentage of students in grade 3 scoring proficient or advanced on the English-Language Arts achievement test—measures students' scores on the English-Language Arts test of the annual California Standardized Testing and Reporting (STAR) program. These data have been routinely reported by the California Department of Education; however, this will be the last year for collection of these data. California is developing new tests to fit with the national common core standards.

## *Why is this important?*

The best predictor of overall school achievement is performance on the English-Language Arts test at grade 3. Early attainment of basic literacy skills is critical. Mastery of language skills is the foundation to understanding information taught in other subjects. In the primary grades, children are learning to read; but from that point on, they must read to learn. A child who does not master the basic skills for reading and literacy does not have the foundation for future success in school and life.

## *How are we doing?*

**Percentage of Students in Grade 3 Scoring Proficient or Advanced in English-Language Arts Test, San Diego County and California, School Years 2002-03 to 2012-13**




*The trend for achievement in English-language arts for third graders is improving. It rose from 44% in school year 2007-08 to 53% in 2012-13.*
*Disparities continue to exist by race/ethnicity (not shown).*

## What strategies can make a difference?

The best approach for developing language arts and other reading skills is to begin learning experiences early and to incorporate literacy and reading skills into all areas of a child's life.

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

- Assessing children in pre-Kindergarten (including Head Start and preschool) and at school entry to identify those in need of additional supports for reading education and skill building.
- Providing supports and services for children ages 3 to 5, based on assessed needs.
- Targeting services for parents of young children who do not speak English or who speak English as a second language.
- Expanding the use of special programs that support early childhood and family literacy, such as Raising A Reader or Reach Out and Read.
- Offering intensive English-language arts instruction including: phonics based instruction, word/language study, small group instruction, and use of interesting and relevant reading materials. This is particularly important in grades Kindergarten, 1, and 2.
- Providing Supplemental Educational Services (SES) to children who require special assistance to succeed in school.
- Developing appropriate intervention programs, including before and after school, summer, and in-school reading support.
- Promoting independent reading and writing—at home and at school.
- Encouraging reading across the curriculum in schools (e.g., story problems in math).
- Ensuring professional development for all teachers (e.g., Peer Assisted Learning Strategies).
- Using teaching strategies that are culturally and linguistically appropriate, including opportunities for students to share their cultural heritage and life experiences.
- Limiting "screen time" such as computers, television, and video games.

## How can we improve the trend in San Diego County?

Aligned with the recommendations of the *2011 Report Card* to ensure early identification of kindergartners lacking in learning fundamentals, the City Heights Partnership for Children coordinated an effort to provide developmental screenings for incoming kindergartners at ten City Heights elementary schools. Early screening measures have proven to be highly predictive of third grade achievement. The City Heights Partnership for Children offered parents of incoming kindergartners the opportunity to work with San Diego State University student interns and public health nurses to assess their child's development and screen for potential developmental delays by administering the Ages and Stages Questionnaire (ASQ-Third edition). To date, 600 in-coming kindergartners were assessed with the ASQ-3.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, school boards, First 5 San Diego, parents and parent associations, United Way of San Diego County, literacy and reading support organizations, libraries, and San Diego Council on Literacy to:

1. Implement a single, standardized, county-wide Kindergarten entrance assessment of school readiness.
2. Provide immediate intervention when a child demonstrates difficulty with basic pre-reading and reading related skills.
3. Provide access to proven, effective early childhood and family literacy programs.

# *Ages 6–12 (School Age):*
# CHILD OBESITY

## *What is the indicator?*

**The percentage of students not in the Healthy Fitness Zone and at health risk in grades 5, 7, and 9.**

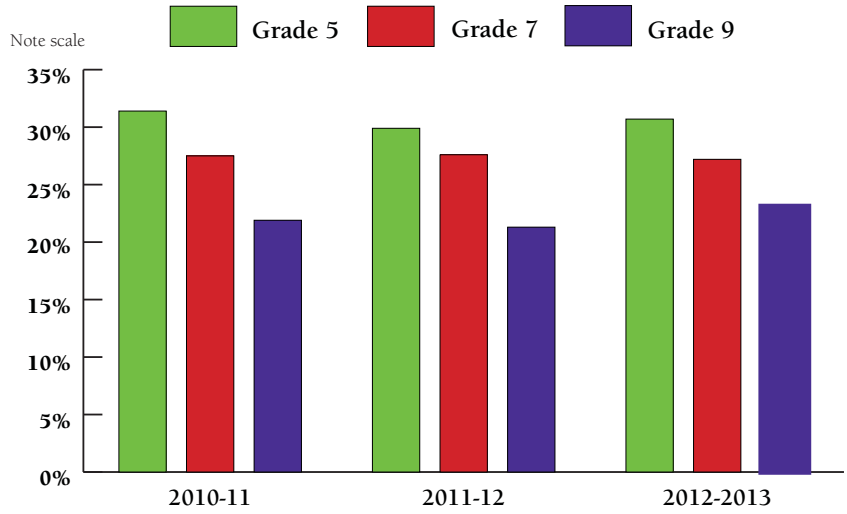
This indicator—the percentage of students not in the Healthy Fitness Zone and at health risk in grades 5, 7, and 9—is a measure for obesity. The California Fitness test is given to students in grades 5, 7, and 9 each year. This indicator uses components of the test that measure body composition and body mass index (BMI). It reports on those who are at a weight that places them at high risk for health problems. The criteria were changed for 2010-11 to better fit with federal criteria, and the proportion of students not in the "Healthy Fitness Zone" was expected to increase. These data are reported by the California Department of Education.

## *Why is this important?*

Being overweight or obese can have short and long term consequences for a child's health and well-being. Approximately 17% of children ages 2 to 19 years—12.5 million—are obese. Reports show that 80% of children who were overweight at ages 10–15 were 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 of today's children will develop diabetes in his or her lifetime as a result of obesity and being overweight. In addition to the physical health risks, many overweight and obese children experience social discrimination, isolation, and bullying.

## *How are we doing?*

**Percentage of Students Not in Healthy Fitness Zone and At Health Risk, Grades 5, 7, and 9, San Diego County, School Years 2010-11 to 2012-13**




*The trend is maintaining. Approximately one in three 5th graders, one in four 7th graders, and one in five 9th graders have a weight that places them at high risk. An additional 13% to 15% of students in these grades need improvement (reduction) in their weight. In summary, just over half of students in these grades are in the Healthy Fitness Zone, with a healthy Body Mass Index (BMI).*

# ADULT OBESITY

## *What is the indicator?*

**The percentage of adults age 18 and older that are obese.**

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.

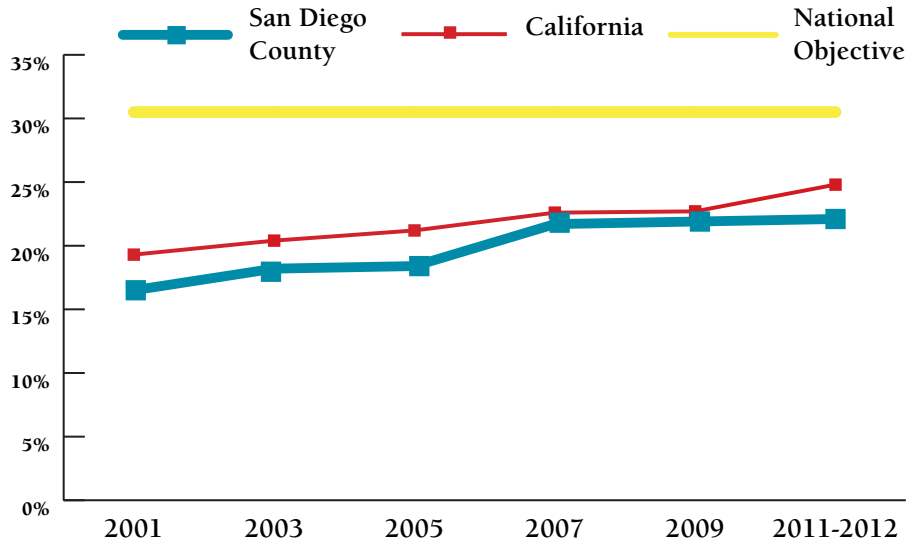
## *Why is this important?*

Obesity is common and costly, with more than one-third of U.S. adults being obese. The estimated annual medical cost of obesity in the U.S. was $147 billion in 2008; the medical costs for people who are obese were $1,429 higher than those of normal weight. Obesity has both short and long term health consequences for children and adults.

Obesity has major impact from a life course and intergenerational perspective. Having obese parents places a child at increased risk for being overweight or obese. Reflecting both genetic and behavioral factors, overweight and obese children are more likely to be obese throughout their adult lives, as well as at increased risk for adult chronic conditions including high blood pressure, heart disease, and Type 2 diabetes. Factors affecting this life course trajectory include: poverty, trauma and adverse childhood experiences, poor nutrition, lack of exercise, and other lifestyle choices. Social determinants are also linked to overweight and obesity, including: parental education, race-ethnicity, residential location, inadequate school supports, access to nutritious food, and availability of safe recreational areas.

## *How are we doing?*

**Percentage of Adults Ages 18 and Older that are Obese, San Diego County and California compared to National Objective, 2001, 2003, 2005, 2007, 2009, and 2011-12**




*The trend is maintaining. The proportion of adults that are obese increased from 16.5% in 2001 to 22.1% in 2011–12. San Diego and California are both below the national objective. The national objective remained the same for 2010 and 2020.*

## What strategies can make a difference?

From the White House to the community level, parents, schools, and children are taking action to achieve healthy weight. Adults and children are aiming to increase access to nutritious food, physical activity, healthy lifestyle choices, and access to recreation areas.

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

- Increasing rates of breastfeeding which benefits mother and baby.
- Using fitness and weight assessments starting at kindergarten, with interventions as needed.
- Increasing nutrition education and services to children and adults.
- Expanding the availability and affordability of fresh fruits and vegetables.
- Promoting the availability of farmer's markets, farm-to-school programs, community gardens, and similar projects in low-income communities.
- Increasing levels of physical activity for all, in schools, workplaces, and community settings.
- Increasing the frequency of walking to and from school, using models such as "Walking School Bus" or "Safe Passages".
- Providing extended hours and night time lights and security at public parks, sporting complexes, school fields, and community recreation centers.
- Encouraging smaller portion size options in schools and other public settings.
- Reducing 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.
- Encouraging eligible families to participate in the Supplemental Nutrition Program for Women, Infants, and Children (WIC), which now provides healthier foods.
- Encouraging eligible individuals to participate in the Supplemental Nutrition Assistance Program (SNAP, known as CalFresh in California) in order to secure and use Food Stamps.

## How can we improve the trend in San Diego County?

Prior *Report Card* recommendations are being implemented with public and private partnerships to help families reduce obesity, eat healthy, and get fit. Kaiser Permanente implemented a Thriving Schools Initiative-Fire up Your Feet educating and encouraging families, students, and schools to work together to create active lifestyles. The city of Carlsbad is focusing on getting people to bike more by adding additional bike lanes and the City of San Diego is developing a bike sharing program that will make more than 1,800 bikes available for self-service. The Chula Vista Elementary District and County officials released the Body Mass Index Surveillance Kit, a how to guide for schools to measure and reduce obesity among students. Additionally, more than half of the school districts in our County report that they purchase regionally grown produce and many buy directly from a local San Diego grower to provide students with the freshest fruits and vegetables available.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego County Childhood Obesity Initiative, Health and Human Services Agency, First 5 San Diego, parents and parent organizations, schools and school districts, 211, municipalities, community-based organizations, neighborhood associations, local farmers, food banks, San Diego Hunger Coalition, local businesses, and faith communities to:

1. Offer regular, county-wide opportunities for increased physical activity for adults and children through public parks, community classes, bicycle access, and workplace fitness programs.
2. Encourage eligible families to participate in WIC and CalFresh, setting targets for enrollment.
3. Increase the availability of healthy food choices, including fresh fruits and vegetables, in low-income communities using gardens, farmer's markets, and small and large stores.

# *Ages 13–18 (Adolescence):*
# SCHOOL ATTENDANCE

## *What is the indicator?*

**The percentage of middle and high school students (grades 6–12) who did not attend school at least 90% of school days.**

This indicator—the percentage of middle and high school students who did not attend school at least 90% of school days—monitors school attendance based on 90% attendance on the Second Principal Apportionment (P2) reporting date of each district's school year. It includes students who are absent approximately 18 days of the school year, for any reason. These data include school districts representing 98% of the student population. Note, this is not Average Daily Attendance.

## *Why is this important?*

Regular school attendance is critical for school success and graduation. Regular school attendance teaches students responsibility, discipline and punctuality—skills needed to be successful in college and the workplace. Students who attend at least 90% of the time have a better chance of academic success, including higher achievement scores and the grades needed to gain acceptance to college. Chronically poor attendance is associated with lower achievement, lower test scores, literacy problems, dropout, and delinquent behavior. Poor attendance is not just truancy-related—whether children miss school as a result of illness, family vacations, or substance abuse problems, missing too many days of school directly affects learning and future opportunities in education, career, and life.

## *How are we doing?*

**Percentage of Middle and High School Students (Grades 6-12) Who Did Not Attend at Least 90% of School Days, School Years 2006-13**


*The trend is maintaining. In San Diego County, 10% of students in grades 6–12 attended less than 90% of school days for school year 2012-13.*

## What strategies can make a difference?

To ensure attendance by middle and high school students, schools must actively engage students and parents in the educational process.

The following strategies have been used to increase school attendance:

- Offering relevant education, career academies, service learning, workplace learning programs, and college, career, and technical education programs to keep students successfully engaged in learning.
- Developing accurate and daily monitoring of attendance, with feedback to parents (e.g., using multiple languages, school websites, e-mail, and other forms of communication).
- Implementing sound, reasonable, and well-communicated attendance policies.
- Providing positive reinforcement such as commendation letters, incentives, and leadership roles for students.
- Providing early interventions that address the specific cause of absenteeism, such as tutoring, credit recovery, mentoring, and connection to support resources.
- Keeping the students safe and supported at school—in particular, implementing evidence-based anti-bullying and anti-cyber-bullying strategies.
- Providing high quality and relevant after school programs and activities to engage teens after school and on weekends (e.g., ASSETS After School Safety and Enrichment for Teens).
- Building linkages between schools, medical providers, mental and behavioral health providers, and law enforcement.
- Connecting students and parents to community resources and supports.

## How can we improve the trend in San Diego County?

In line with the recommendations from the *2011 Report Card* to improve school attendance, the Chula Vista Promise Neighborhood in Castle Park is implementing the Granger Turnaround Model (GTM) at Castle Park Middle School. This innovative model has produced immediate and significant results in student attendance as well as academics. Through a well-defined, data driven system and coordinated services, interventions are provided to keep students from falling behind. GTM focuses on attendance, behavior, and academic interventions. For example, when students are absent, they can make-up the lost learning time at their school, over the weekend. At Castle Park Middle School, during the first year of the implementation of GTM, truancy rates decreased from 32% to 17% and the academic performance index (API) increased 44 points.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, school boards, colleges and universities, San Diego Workforce Partnership, parents and parent associations, Health and Human Services Agency Behavioral Health, health providers, local businesses, law enforcement agencies, Probation Department, and community-based organizations to:

1. Increase the availability of: after school programs; service learning and workplace learning opportunities; and college, career, and technical education programs.
2. Expand early interventions such as tutoring, credit recovery, mentoring, and connection to support resources.
3. Build strong linkages between schools, medical providers, mental and behavioral health providers, and law enforcement.

# *Ages 13–18 (Adolescence):*
# SCHOOL ACHIEVEMENT GRADES 8 AND 11

## *What is the indicator?*

**The percentage of students in grades 8 and 11 scoring proficient or advanced on the English-Language Arts achievement test.**

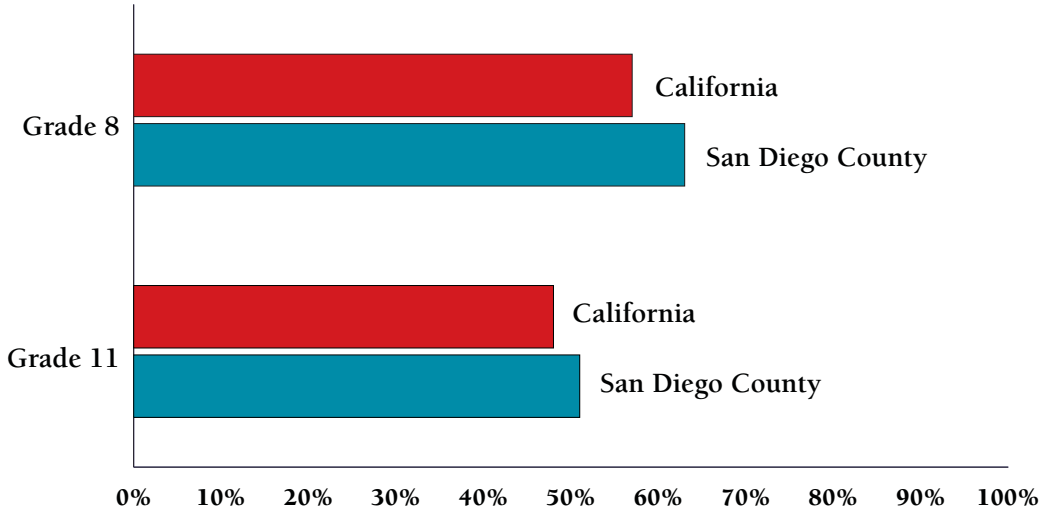
This indicator—the percentage of students in grades 8 and 11 scoring proficient or advanced on the English-Language Arts achievement test—measures students' scores on the English-Language Arts test of the annual California Standardized Testing and Reporting (STAR) program. These data were routinely reported by the California Department of Education; however, this will be the last year for collection of these data. California is developing new tests to fit with the national common core standards.

## *Why is this important?*

English-language arts skills (e.g., reading and writing) and literacy are among the strongest predictors of graduating from high school. Strong English-language arts and literacy skills are associated with positive self-image, resistance to delinquency, graduation, college attendance, and higher earnings. Poor English-language arts and literacy skills are correlated with higher drop out rates, adult unemployment, and adult poverty.

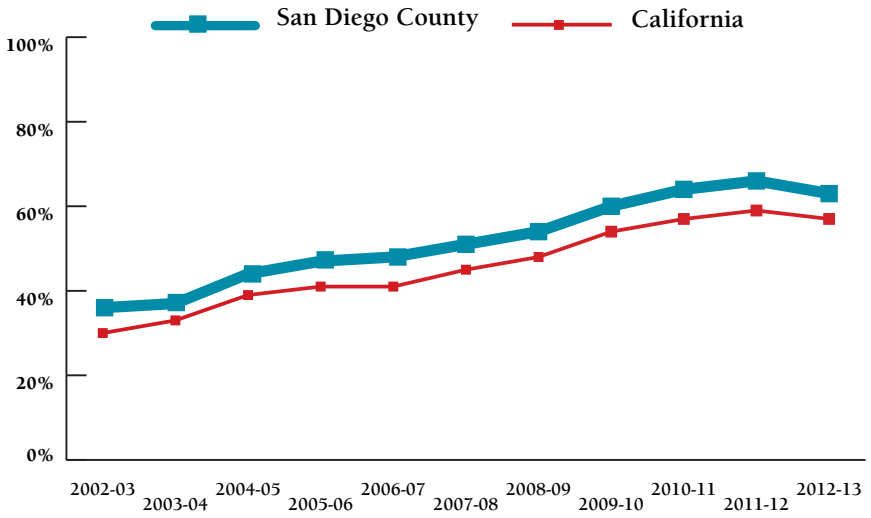
## *How are we doing?*

**Percentage of Students Scoring Proficient or Advanced in English-Language Arts Test, Grades 8 and 11, San Diego County and California, School Year 2012-13**



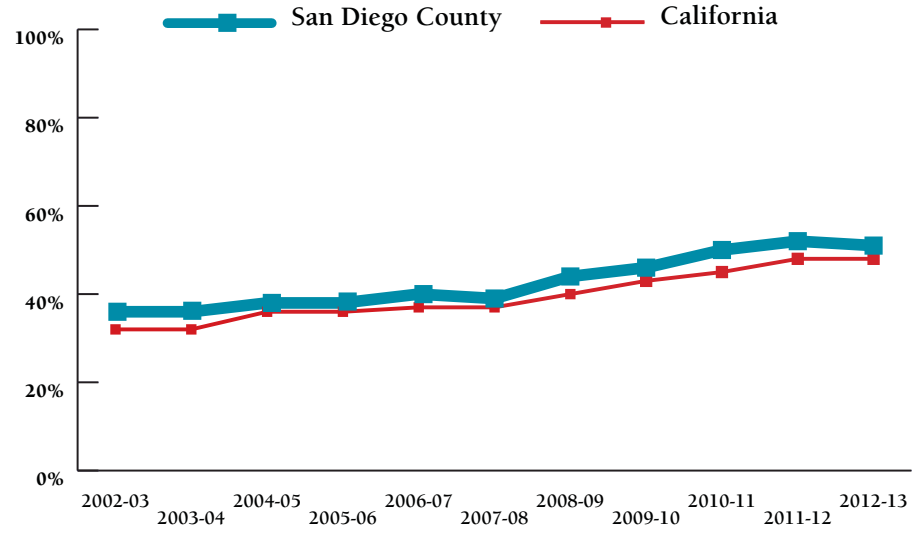

*The trend is improving gradually, and San Diego County students continue to perform somewhat better than the state average. However, younger students show stronger scores than older students. While 63% of 8th graders are high performers, only half of 11th graders scored proficient or above. Moreover, compared to 8th graders, twice the proportion of 11th graders were far below basic (data not shown).*

## Percentage of Students Scoring Proficient or Advanced in English-Language Arts Test, Grade 8, San Diego County and California, School Years 2002-03 to 2012-13




*The trend improved from 36% in 2002-03 to 63% in 2012-13. However, no real improvement was shown for San Diego 8th graders between 2010 and 2013. County students consistently perform better than the state average.*

## Percentage of Students Scoring Proficient or Advanced in English-Language Arts Test, Grade 11, San Diego County and California, School Years 2002-03 to 2012-13




*The trend for San Diego County students is improving steadily, going from 36% in 2002-03 to 51% in 2012-13. As is true for 8th graders, however, the 11th grade scores showed no real improvement between 2010 and 2013.*

## What strategies can make a difference?

For middle and high school students, being successful at and connected to school is increasingly important for school, attendance, achievement, and graduation. Identifying and providing support for learning and achievement problems is critical.

The following strategies have been used to increase proficiency in English-language arts:

- Implementing consistent academic monitoring to identify low performing students.
- Expanding and targeting supportive services to underperforming students (e.g., reading specialists, tutors, one-to-one instruction).
- Developing appropriate intervention programs, including after school, summer programming, and in-school reading support (e.g., Quantum Opportunity Program).
- Evaluating and addressing underlying issues of poor academic performance (e.g., substance abuse, mental health, safety concerns).
- Providing supports for the middle school to high school transition, particularly for underperforming students and students of color.
- Providing specialized reading trainings and instructional strategies for teachers and classroom support staff (e.g., Project CRISS).
- Improving access to free books, cultural events, and other social activities that promote literacy.
- Encouraging reading and writing at school and at home.
- Using smaller schools, schools within school models, smaller class sizes, and industry-specific, career academies.

## How can we improve the trend in San Diego County?

Implementing recommendations from the *2011 Report Card*, the Chula Vista Promise Neighborhood Initiative utilizes a number of strategies and provides a seamless continuum of 'cradle to career' solutions that provide a clear and viable pathway to college and career. One program is the Literacy Café which challenges students to think about literature beyond the pages of the book and promotes exploration, creativity, language, writing, and learning on multiple levels. Another is Achieve 3000 for middle and high school youth to help to build literacy skills required for college and career readiness. This model assists students with strengthening literacy skills while concurrently acquiring content area knowledge. Lessons require students to synthesize information from a variety of sources and acquire content area knowledge which are the key skills required under the new Common Core State Standards.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, school boards, colleges and universities, San Diego Workforce Partnership, local businesses and business associations, substance abuse prevention programs, mental health providers, and literacy support organizations to:

1. Target youth development programs, including after school, summer programming, and leadership to support underperforming students in the middle school to high school transition.
2. Provide academic intervention for 8th and 9th grade underperforming students, such as reading specialists and academic tutors.
3. Develop industry-specific, career academies at the high school level.

# *Ages 13–18 (Adolescence):*
# SUBSTANCE USE

## *What is the indicator?*

**The percentage of students (grades 7, 9, and 11) who reported use of cigarettes, alcohol, or marijuana in the past 30 days.**

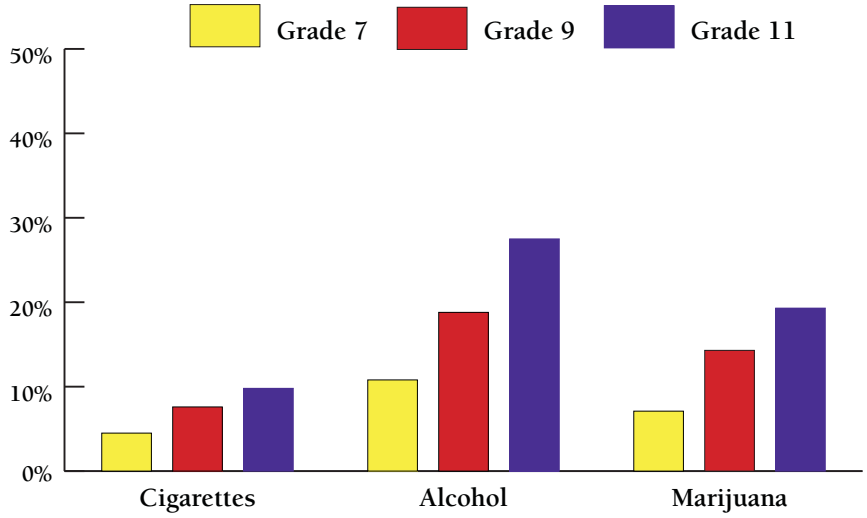
This indicator—the percentage of students in grades 7, 9, and 11 who reported use of cigarettes, alcohol, or marijuana in the last 30 days—reflects substance abuse trends among teens. These data are collected in the California Healthy Kids Survey, administered biennially to students in grades 7, 9, and 11. The questions mirror the questions in the Youth Risk Behavior Survey, a CDC-designed survey used by schools in other states across the country.

## *Why is this important?*

Tobacco, drugs, and alcohol have negative impact on an adolescent's physical, mental, and developmental status. Prolonged or intensive use of alcohol and drugs can negatively affect academic success, employment potential, family dynamics, and mental health. Students are starting use of dangerous substances at younger ages, and misuse of prescription medications is increasing. Inappropriate use of prescription drugs is right behind marijuana use and often continues into adulthood. The increased use of smokeless tobacco and the rise of e-cigarette use are additional trends of concern.

## *How are we doing?*

**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 2012-13**




*Most of the trends are improving; however, the use of tobacco, alcohol, and marijuana continues to be prevalent among middle and high school students in San Diego County. While the trend in tobacco use by 11th graders shows some improvement, 10% of students smoke cigarettes. The trend in marijuana use among 7th graders is worsening.*

# ADULT SUBSTANCE ABUSE

## *What is the indicator?*

**The percentage of adults ages 18 and older that reported smoking.**

This indicator—the percentage of adults that reported smoking—reflects one type of substance abuse among adults. These data show current, but not former smokers. These data are routinely collected in the California Health Interview Survey.

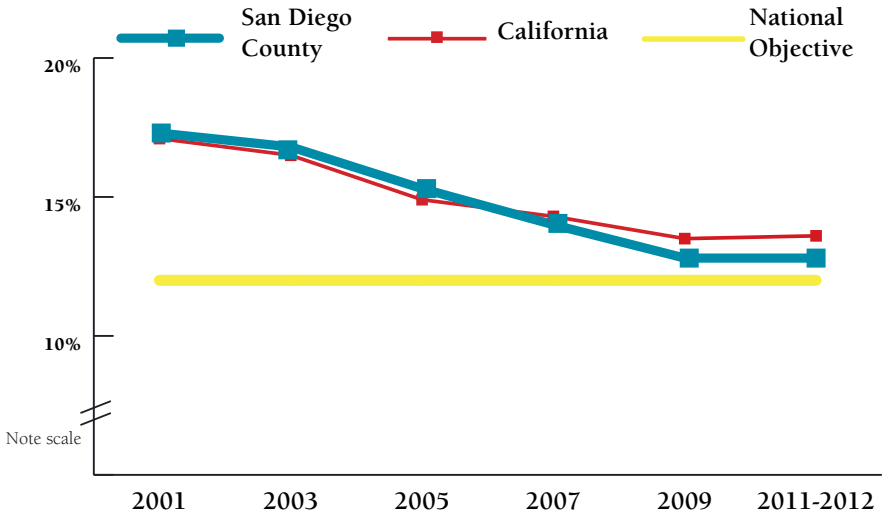
## *Why is this important?*

While smoking among adults declined from 20.9% in 2005 to 19.3% in 2010, about 1 in 5 adults (45.3 million) smokes tobacco. Individuals who are poor, and have less education are more likely to smoke—30% of poor adults are smokers. Half of adults who continue to smoke will die from smoking-related causes. For every smoking-related death, another 20 people suffer with a smoking-related diseases such as cancer or heart disease. Smoking costs about $96 billion each year in U.S. direct medical costs.

From a life course perspective, adult smoking affects the health of the next generation. Smoking makes it more difficult to become pregnant, increases risk of miscarriage, and during pregnancy smoking leads to greater risks for premature birth, certain birth defects, and infant death. Infants exposed to cigarette smoke during and after pregnancy are more likely to die from Sudden Infant Death Syndrome (SIDS). Children who breathe in other people's cigarette smoke (are exposed to second hand smoke) are more likely to have ear infections and have more frequent asthma attacks. Parental smoking can promote smoking among adolescents, both by exposure and by role model.

## *How are we doing?*

**Percentage of Adults Ages 18 and Older that Reported Smoking, San Diego County and California compared to National Objective, 2001, 2003, 2005, 2007, 2009, and 2011-12**




*The trend in adult smoking is improving in San Diego County. Among adults ages 18 and older, 12.8% smoke cigarettes. This is just above the national objective of 12%.*

## What strategies can make a difference?

Reducing substance use requires focus on both prevention and intervention policies, services, and programs at the local community level. Services are most effective when they are available immediately, community based, and holistic. For tobacco, a combination of laws, price increases, access to proven quitting treatments and services, and media campaigns have reduced smoking and saved lives.

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

- Building youth resiliency, social competency, and problem-solving skills.
- Promoting youth development strategies to empower youth and increase connectedness to school and community.
- Increasing students' ability to resist social pressure to use tobacco, alcohol, illicit drugs, and non prescribed medications through family, school, and community programs (e.g., Project Alert, Project Towards No Drug Abuse).
- Eliminating youth access to tobacco, alcohol, illicit drugs, and non prescribed medications.
- Teaching parents the skills they need to improve family communication and bonding through programs such as Guiding Good Choices.
- Working with parents and community to educate about the dangers of substance use.
- Enforcing local ordinances such as those prohibiting the sale of tobacco and alcohol to minors and social hosting. Incorporating culturally competent and relevant substance abuse education, especially in areas with a high density of minority youth.
- Offering affordable smoking cessation treatment for youth and adults.
- Increasing availability of community-based drug and alcohol treatment programs, both day treatment and residential.
- Increasing the cost of cigarettes through use of tobacco taxes.

## How can we improve the trend in San Diego County?

The County of San Diego, law enforcement, and school districts have continued to implement *Report Card* recommendations to reduce substance abuse. The County has expanded their prescription drug turn-in project to more sites across the county and with more frequency, resulting in more than 55,000 pounds of unused prescription drugs turned in over the past three years. County Behavioral Health Services added mental health and drug and alcohol counselors to each of the nine Teen Recovery Centers to ensure timely treatment for at-risk youth. Moreover, many school districts across the county also implemented school and community education campaigns to raise awareness of the danger of abusing prescription drugs and to prevent first time use by teens. Starting in 2013, parents can have their teens drug tested at no cost at one of 11 teen treatment centers funded by the County.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, parents and parent associations, San Diego County Office of Education, Health and Human Services Agency, substance abuse prevention agencies, Probation Department, law enforcement, County Board of Supervisors, municipalities, community-based organizations, faith communities, and media partners to:

1. Expand access to treatment, including day treatment and residential bed space in a community setting based on regional needs.
2. Develop a campaign aimed at adults to eliminate social hosting and reduce access to alcohol and other drugs.
3. Develop local policies to reduce youth access to e-cigarettes and other smokeless tobacco.

# *Ages 13–18 (Adolescence):*
# YOUTH SUICIDE

## *What is the indicator?*

**The percentage of students who reported they attempted suicide in the previous 12 months.**

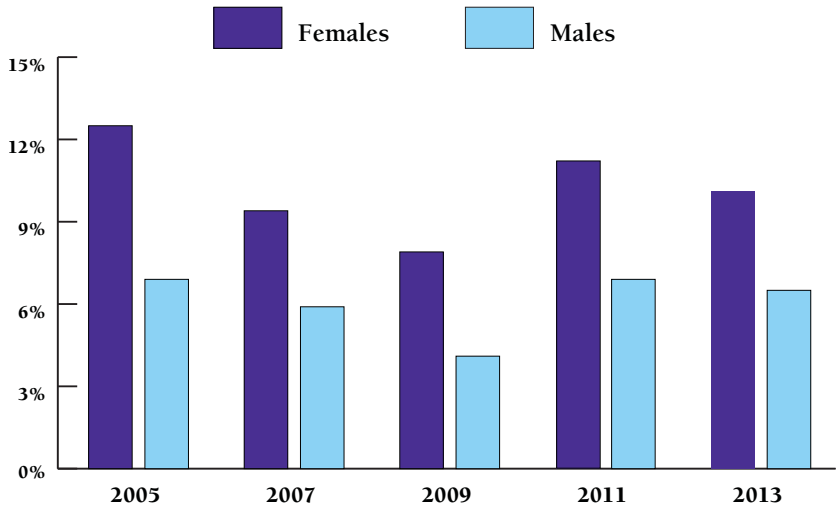
This indicator—the percentage of high school students who self-report having made a suicide attempt in the previous 12 months—reflects trends among a subset of youth. These data are collected and reported from the San Diego Unified School District's Youth Risk Behavior Surveillance System (YRBSS). YRBSS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

## *Why is this important?*

Suicide is preventable. Support, guidance, and interventions can be provided to youth. While only approximately 10-13 San Diego youth commit suicide each year, others are injuried or hospitalized as a result of attempts. Many other youth report suicide attempts and suicide ideation (contemplation). The three most common methods among young people are firearms, suffocation, and poison/overdose. In addition to the tragedy of death, suicide has a lasting emotional and traumatic effect on the community, family, and friends.

## *How are we doing?*

**Percentage of Students Grades 9-12 Who Reported They Had Attempted Suicide in the Past 12 Months, By Gender, San Diego Unified School District, 2005-2013**




*Due to decreases in funding for the administration of the California Healthy Kids Survey suicide module, trend data for a large number of school districts cannot be reported. San Diego Unified School District administers the YRBSS. Note that year-to-year variations for this small number may not be statistically significant or reliable.*

## What strategies can make a difference?

Youth suicide prevention requires education of adults and youth. Youth typically do not reach out to trained professionals when they are depressed. Peers, teachers, health professionals, and parents are the people most likely to have contact with a depressed youth, and thus in the best position to intervene.

The following strategies have been used to prevent youth suicide:

- Informing families, schools, and community leaders about the signs of depression and suicidal ideation (i.e., thinking or talking about dying or committing suicide).
- Reducing the stigma associated with seeking support and help for mental health problems.
- Educating parents and others about eliminating access to lethal means, particularly firearms, which remain a major instrument used by youth who attempt suicide.
- Educating 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.
- Using the federal Substance Abuse and Mental Health Services Administration (SAMHSA) *Preventing Suicide* toolkit for high schools.
- Expanding school-based programs that promote help-seeking behaviors; teach problem-solving skills; and provide assessment, motivational counseling, and peer support (e.g., Cognitive Behavioral Intervention for Trauma in Schools [CBITS]).
- Providing interventions tailored to at-risk youth of various cultural and ethnic backgrounds.
- Training primary health care providers to screen for signs of depression and suicide ideation.
- Improving data collection and reporting, particularly school-based child health surveys.

## How can we improve the trend in San Diego County?

Addressing the recommendations from the *2011 Report Card*, Question, Persuade and Refer (QPR) trainings coordinated by the Community Health Improvement Partners were offered to more than 5,000 teachers, police officers, social workers, and school administrators over the past two years. QPR trainings assist suicide gatekeepers in knowing how to approach and assist someone who might be contemplating suicide. In addition, San Diego Youth Services is offering the HERE Now (Helping, Engaging, Reconnecting and Educating) Program in East Region's middle and high schools to educate students, parents, and teachers about preventing youth suicide. HERE Now utilizes the Signs of Suicide curriculum and employs strategies that are trauma informed, increase protective factors in high risk youth, and serve to identify students who may be struggling emotionally and/or engaging in self-destructive or risky behaviors.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, American Academy of Pediatrics, Health and Human Services Agency, mental health providers, parents and parent organizations, faith communities, community-based organizations, and suicide prevention programs to:

1. Provide education at the school and community levels for adults and peers about the warning signs and risk factors of depression and suicide and steps to take when signs are present.
2. Increase access to mental health services at school and in the community.
3. Provide programs at school and in community settings that focus on suicide prevention such as Yellow Ribbon Suicide Prevention Program and Safe TALK.

## *Feature Box: Unidentified and Unmet Mental Health Needs*

Unidentified and unmet mental health issues among U.S. children and adolescent has become one of the major topics of social commentary. Sparked by acts of violence and death, there is a growing recognition that early identification, prevention, immediate intervention, and effective treatment of mental health conditions in children must become a national priority. Aside from public safety concerns, unidentified and untreated mental health disorders incur high public costs for the health, education, and justice systems. They have significant impact not only on those afflicted, but on their families and communities as well.

More than 4 million children and adolescents in this country have a serious mental health disorder, leading to significant functional impairment in daily living, educational attainment, and social interactions. When taking into account less-severe mental health issues, this estimate increases to 7.5 million children and adolescents—or one in five children. It is particularly important to focus on unmet mental health issues in children and youth given that half of all lifetime cases of mental disorders begin by age 14 and three-quarters by age 24. In addition, an increasing number of infants and young children have mental health conditions, resulting in preschool expulsions and other adverse consequences.

Only 20% of U.S. children with mental health needs receive treatment. Particularly vulnerable populations with unmet mental health needs include: uninsured children, children of color, and children involved in the juvenile justice system. Studies have estimated that 27% of children with health coverage receive mental health services, compared to only 13% of uninsured children. Studies by race and ethnicity reveal that 28% of white children, 22% of Latino children, and 20% of African American children receive mental health services – indicating unequal access to treatment.

Within the juvenile justice system, studies show that 65% of boys and 75% of girls in juvenile detention have at least one mental health disorder. Historically in the United States, rather than identifying conditions early and providing intervention, many children with mental health and behavioral disorders are being separated from their families and/or incarcerated. Another troubling consequence of unidentified and unmet mental health needs is suicide attempts and completions among youth.

The life course of unmet mental health needs from childhood to adulthood is tragic for the individual and family and generates crippling costs to society. Approximately half of students 14 years old living with a mental illness drop out of high school. Children with untreated mental illness face a higher probability of failing in school, living in poverty, and having limited adult employment opportunities. Untreated early-onset mental disorders are also associated with increased births to teens, domestic violence, victimization, and marital instability, as well as community violence.

Early identification and treatment of mental illness in children and youth provides the best short and long-term outcomes. Public awareness campaigns and the education of parents, families, and communities about the value and benefits of mental health care are important for reducing the stigma of receiving mental health services. With the expansion of coverage through the federal Affordable Care Act, many families and children will now be eligible for needed mental health services. Expanded Medicaid coverage for more low income children and families will offer mental health and health benefits. The Affordable Care Act Exchange Plans will offer mental health coverage to millions of families for the first time. The next great challenge will be to ensure that communities have a sufficient number of quality mental health service providers to diagnose and treat children and youth.

# *Ages 13–18 (Adolescence):*
# JUVENILE CRIME

## *What is the indicator?*

**The number of arrests for misdemeanor and felony crimes among youth ages 10-17.**

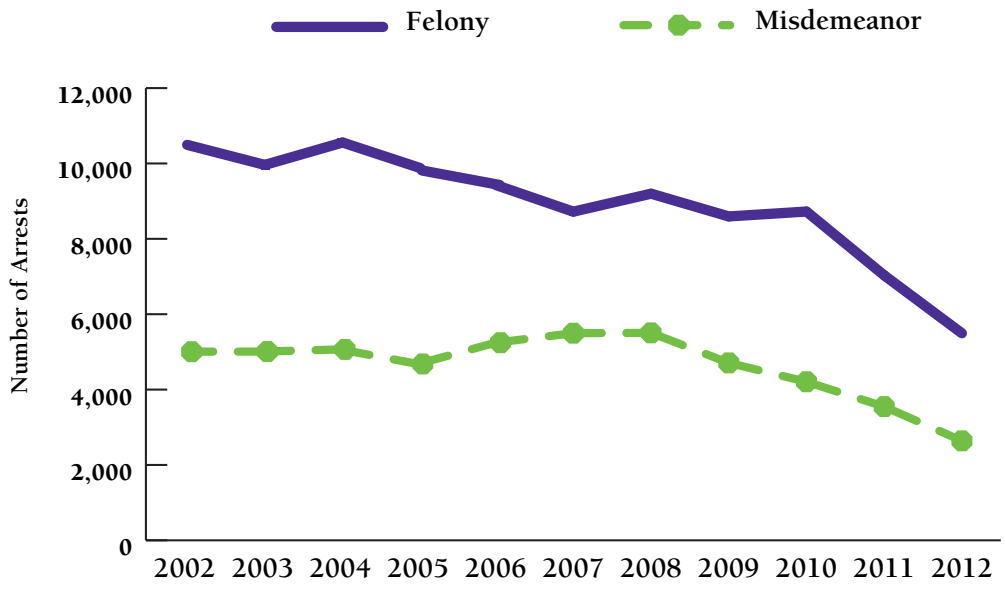
This indicator—the number of arrests for misdemeanor and felony crimes among youth ages 10-17—reports on trends in crimes. Arrests for status offenses such as curfew violations or truancy are not included. Some arrests may have more than one charge associated with them, only the most serious charge is 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).

## *Why is this important?*

Juvenile crime is costly for youth, families, and communities. First and foremost, there are lifelong consequences, with impact on education attainment, future employment, and college aspirations for the young person. In addition, crime diminishes the sense of safety in the community, and it may cost victims their property, money, health, and sense of well-being. Other costs are incurred by society for maintaining the juvenile justice system, strengthening families, and repairing damages.

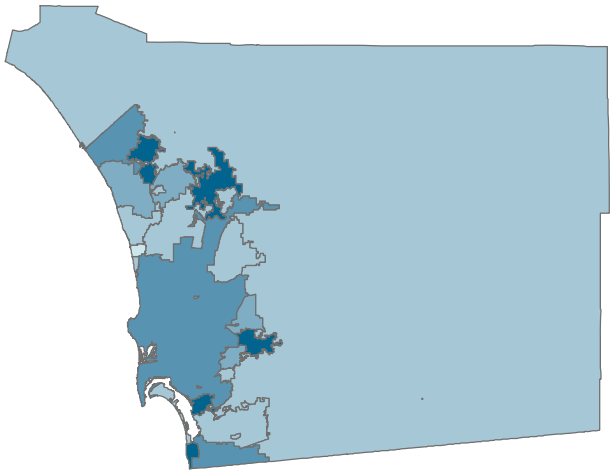
## *How are we doing?*

**Number of Arrests for Felony and Misdemeanor Offenses, Youth Ages 10-17, San Diego County, 2002-2012**




*The trend in juvenile crime shows improvement. The number of arrests in both categories declined between 2008–2012. Overall, the combined rate of juvenile arrests dropped from 43 per 1,000 juveniles in 2008 to 24 per 1,000 in 2012.*

**RATE OF ARRESTS PER 1,000 YOUTH AGES 10-17, 2011**




Overall County Rate 31.9

NOTE: Juvenile arrest data provided by CA Deapartment of Justice, Criminal Justice Statistics Center. Juvenile arrest total includes felony and misdemeanor offenses. Status offenses are not included. Data represents location of arrest not residence of youth. Rates are based upon SANDAG, Demographic/Economic Estimates, August 2012. Rates per 1,000 youth are not presented if number of arrests is less than 30.

## Ten Most Common Crimes Committed By Juveniles, Ages 10-17, San Diego County, 2012

| *Crime* | *Level* | *Number* |
|---|---|---|
| **Petty theft** | Misdemeanor | 1,136 |
| **Manslaughter/assault and battery** | Misdemeanor | 924 |
| **Drunk/liquor laws** | Misdemeanor | 722 |
| **Burglary** | Felony | 659 |
| **Drug law violations** | Misdemeanor | 622 |
| **Aggravated assault** | Felony | 526 |
| **Weapons offenses** | Felony | 292 |
| **Robbery** | Felony | 241 |
| **Vandalism** | Misdemeanor | 222 |
| **Drug law violations** | Felony | 209 |

*The largest number of crimes committed by youth was in the category of petty theft. Both misdemeanor and felony drug law violations were among the top ten most common categories of juvenile crime in 2012.*

## What strategies can make a difference?

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:

- Providing high quality and age appropriate after school programing for students K-12.
- Expanding use of life skills training, vocational education, career development, internships, and employment opportunities.
- Providing trauma-informed assessments to inform interventions and treatment.
- Increasing access to culturally appropriate, community-based mental health and substance abuse services for youth at school and in the community.
- Providing problem-solving, anger management, mediation, and conflict resolution instruction (e.g., Second Step).
- Offering academic support, credit recovery, and tutoring for low performing students.
- Identify and provide early intervention for youth who are truant.
- Expanding prevention programs to connect youth to school, encourage positive behavior, and reduce gang involvement (e.g., Gang Violence Reduction Program).
- Expanding community-based Juvenile Diversion programs for low level offenders, in partnership with police and sheriff departments.
- Providing appropriate, community-based alternatives to detention.

## How can we improve the trend in San Diego County?

Efforts have continued in implementing *Report Card* recommendations for preventing juvenile crime, re-engaging youth in school, and providing work readiness and job training opportunities. Health and Human Services Agency and Juvenile Probation have worked collectively to examine, improve, and merge early juvenile justice prevention and intervention programs such as Diversion to enhance services at the family and community levels. The Children's Initiative and community partners have continued to expand efforts in working with chronically absent and truant youth to increase school attendance and academic success. Additionally, the San Diego Workforce Partnership secured both public and private funding to redesign and expand their Summer Hire a Youth program to CONNECT2Careers. This program establishes a new approach to preparing young people for the workforce by creating meaningful paid work experiences beyond the typical summer job.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the schools, school districts, Probation Department, local law enforcement agencies, community-based organizations, Juvenile Court, District Attorney's Office, Public Defender, San Diego Workforce Partnership, parents and parent organizations, faith communities, Health and Human Services Agency, local businesses, and business associations to:

1. Provide prompt intervention for youth who are truant, chronically absent, and/or experiencing high rates of behavioral problems at school.
2. Expand alternatives to detention at the community level, including cool beds, wrap around services, and case management.
3. Use a uniform, trauma-informed assessment for all youth entering or in the juvenile justice system.

# *Ages 13–18 (Adolescence):* JUVENILE PROBATION

## *What is the indicator?*

**The number of sustained petitions ("true finds") in Juvenile Court among youth ages 10-17.**

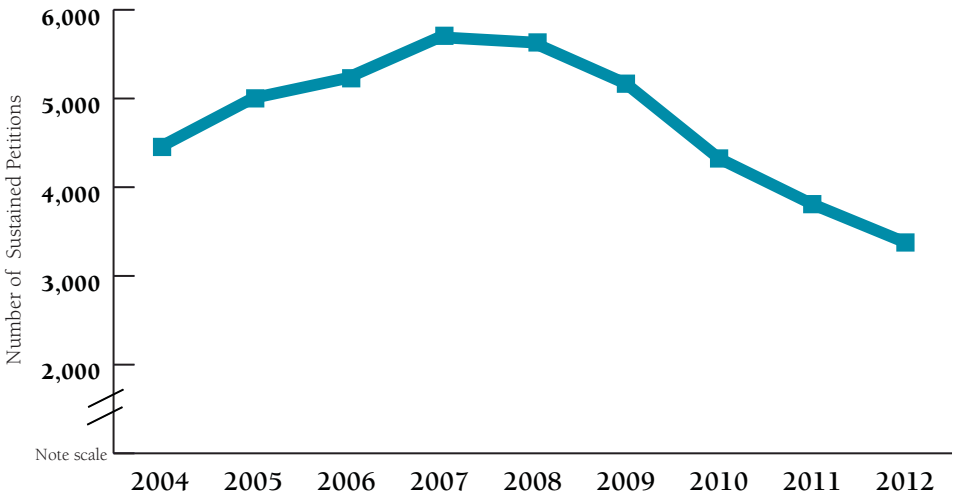
This indicator—the number of sustained petitions (true finds) in Juvenile Court among youth ages 10-17—reports on the juvenile equivalent of being found guilty in adult court. This indicator includes only sustained petitions for misdemeanor or felony offenses. Status offenses such as curfew or truancy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

## *Why is this important?*

Committing a misdemeanor or felony offense as a juvenile negatively impact a young person's life immediately and in the future. A youth who enters the juvenile justice system and has a sustained petition is placed on probation. Probation is a type of 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 failures to address early warning signs of risky behavior and problems among youth.

## *How are we doing?*

**Number of Sustained Petitions ("True Finds") in Juvenile Court, Youth Ages 10-17, San Diego County, 2004-2012**




*The trend is improving. After peaking in 2007, the number of sustained petitions has declined in recent years by 40%. In 2012, a new low of 3,377 youth had true finds in the juvenile court.*

## What strategies can make a difference?

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. Strategies must be provided consistently from arrest and detention, to after care, and through probation completion.

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

- Providing academic support for reading proficiency, credit recovery, and high school completion for low performing students.
- Offering no cost parent training to improve family communication, negotiation, and decision-making skills and to establish positive discipline.
- Providing mental health evaluation and clinical supervision, substance abuse services, and cognitive-behavioral treatment.
- Offering job readiness, vocational education, and career development support.
- Implementing interventions to reduce gang involvement and to help youth exit a gang lifestyle.
- Providing restorative justice evidence-based practices, such as victim-offender mediation, empathy training, and restitution.
- Providing alternatives to detention, such as community-based supervision with wrap-around services, cool beds, and day reporting centers.
- Providing comprehensive re-entry and after care services for youth offenders.

## How can we improve the trend in San Diego County?

Community partners and the Probation Department implemented several *Report Card* recommendations aimed at alternatives to detention and expanded services. County Probation, in partnership with the Public Defender, District Attorney, Health and Human Services Agency, and the Children's Initiative received a Positive Youth Justice Initiative (PYJI) grant. Funded by the Sierra Health Foundation, PYJI will support the justice system to improve education, employment, and well-being outcomes of cross-over youth (youth with a history in child welfare and now involved in the juvenile justice system). San Diego is one of five counties receiving $400,000. Recognizing that these youth have experienced trauma in their lives, trauma informed care is an integral part of the PYJI. South Bay Community Services received a grant from the California Board of State and Community Corrections to administer "cool beds" for low level offenders. Cool beds are a short term placement in lieu of detention and provide community based counseling, crisis invention, and supportive services.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Probation Department, Juvenile Court, District Attorney, public defender, local law enforcement agencies, community-based organizations, parent and parent organizations, school districts, faith communities, San Diego Workforce Partnership, Health and Human Services Agency, substance abuse prevention programs, mental health service providers, businesses, and business associations to:

1. Increase alternatives to detention, such as community-based supervision with wraparound services, cool beds, and day reporting centers.
2. Increase job training and employment assistance for higher risk youth and court-involved youth, as well as job shadowing and summer and after school employment opportunities.
3. Expand community-based mental health and drug treatment services for at-risk youth.

# *Ages 13–18 (Adolescence):*
# YOUTH DUI

## *What is the indicator?*

**The number of DUI arrests among youth under age 18.**

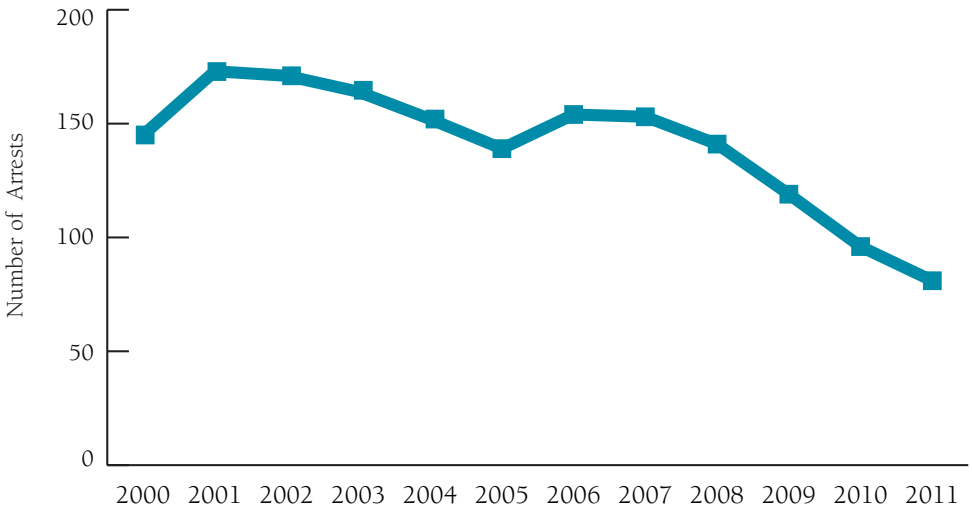
This indicator—the number of Driving Under the Influence (DUI) arrests among youth under age 18—measures one aspect of the problem of youth involved in alcohol- and drug-related collisions. It reflects youth breaking the law by both drinking and DUI. This is a subset of a larger number of youth who engage in these risky behaviors but are not caught and arrested. These data are routinely reported by the California Department of Motor Vehicles.

## *Why is this important?*

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 (ages 16-20) are not of legal age to drink, yet they report that it is "no trouble" obtaining alcohol. U.S. teens have higher motor vehicle crash rates than adults, with DUI an important contributing factor. One out of ten high school students drives after drinking, 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 the leading cause of death for those ages 15 to 20, accounting for one-third of all U.S. teen deaths.

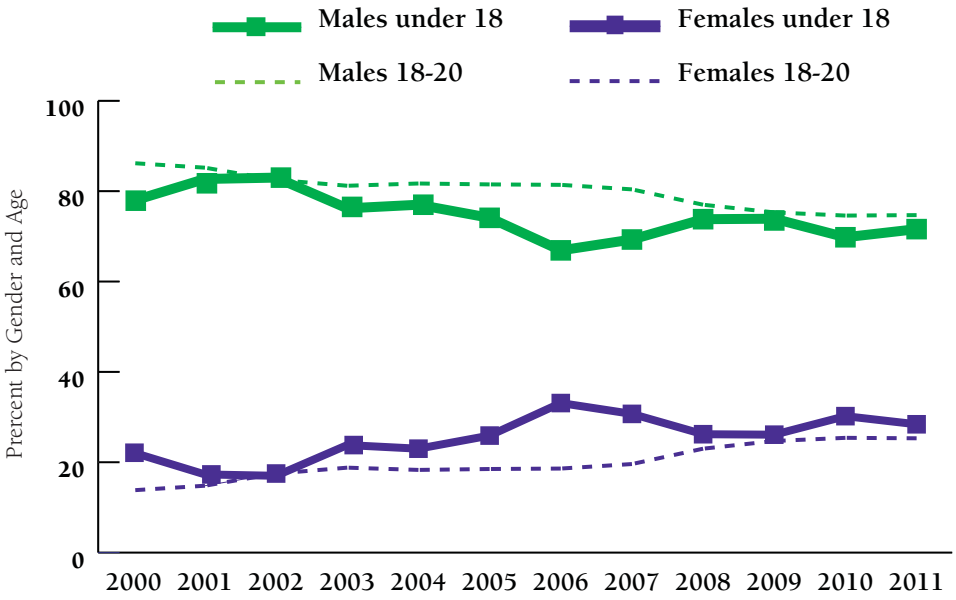
## *How are we doing?*

**Number of DUI Arrests, Youth under Age 18, San Diego County, 2000-2011**



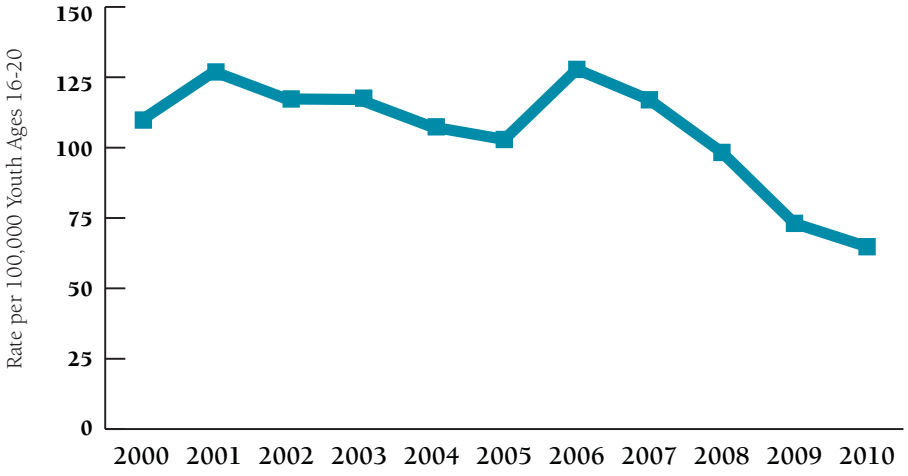

*The trend is improving. The number of youth DUI arrests peaked in 2001 and has been declining steadily since 2006. In 2011, 81 youth were arrested for DUI in San Diego County.*

## Proportion of DUI Arrests, Under Age 18 and 18-20, By Gender, San Diego County, 2000-2011




*The proportion of males who were arrested for DUI is more than twice that shown for females. The trend for males under 18 and those 18 to 20 years old show fluctuations but no substantial improvement. The trend for females shows a general worsening, reaching 30% for those under 18 in 2011.*

## Rate of Non-Fatal Crashes Involving Drivers Ages 16-20 Under the Influence of Alcohol or Drugs, Per 100,000 Population, San Diego County, 2000-2010




*The trend in non-fatal crashes has declined steadily since 2006, with the rate cut in half over that same period from 128 per 100,000 in 2006 down to 65 per 100,000 in 2010.*

## What strategies can make a difference?

Reducing youth DUI requires action by parents, youth, community and law enforcement. Collective efforts should 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:

- Eliminating youth access to alcohol and drugs.
- Changing social norms regarding the use of alcohol and drugs by youth.
- Educating adults about the risks and liabilities of "supervised" drinking.
- Promoting youth development programs and activities to empower youth and build resistance and problem-solving skills.
- Instituting community- and school-based programs to increase student and parent awareness about the dangers of drinking and driving.
- Maintaining a legal drinking age of 21.
- Providing quality drivers education and training lasting at least three months.
- Implementing graduated driver licensing that includes a mandatory waiting period, nighttime driving restriction, at least 30 hours of supervised driving, and passenger restrictions.
- Aggressively enforcing 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.
- Limiting youth driving privileges during the first 12 months with a new license.
- Promptly suspending the driver's licenses of people who drive while intoxicated.
- Conducting sobriety checkpoints, particularly targeted at communities with highest incidence of alcohol- and drug-related accidents involving youth and in locations where youth congregate.
- Implementing safe and engaging weekend and evening activities (e.g., midnight basketball, beach clean ups).

## How can we improve the trend in San Diego County?

Addressing the recommendations in the *2011 Report Card*, the San Diego Sheriff's Department and other law enforcement jurisdictions are actively enforcing local Social Host Ordinances (SHO). Social Host Ordinances hold individuals responsible for allowing underage youth to drink alcohol. Law enforcement efforts are combined with media advocacy to inform the community of the dangers of underage drinking and penalties for providing alcohol to youth. Additionally, providers in multiple areas of the county include parent and youth education about underage drinking and SHO in their prevention programs, including Vista Community Clinic, SAY San Diego, Mental Health Systems, and the Institute for Public Strategies.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with local law enforcement agencies, Health and Human Services Agency, Probation Department, school districts, parents and parent associations, driver education providers, community-based organizations, substance abuse prevention agencies, and media partners to:

1. Provide education and information to youth and parents regarding the dangers of drinking and driving.
2. Enforce zero tolerance laws and penalties for adults and/or establishments who provide alcohol to individuals under age 21.
3. Offer additional youth development programs and activities to empower and engage youth.

# *Community and Family (Cross Age):* CHILD POVERTY

## *What is the indicator?*

**The percentage of children ages 0-17 living in poverty.**

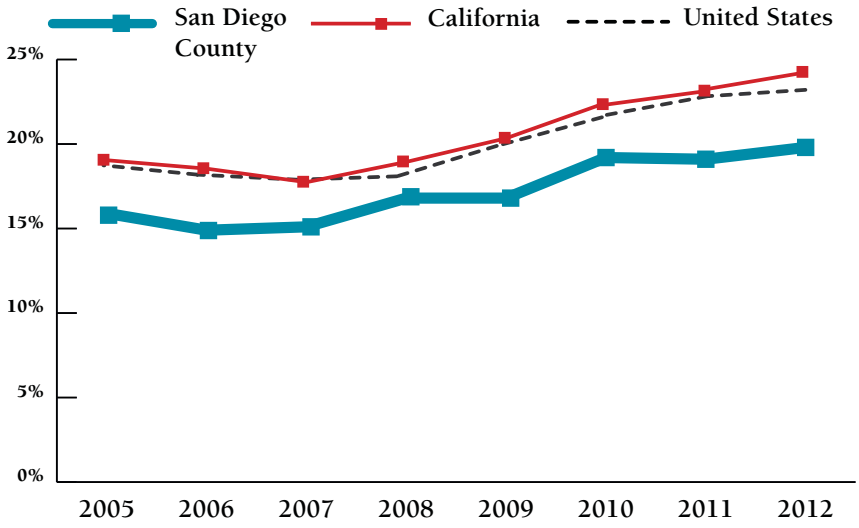
The indicator—the percentage of children ages 0-17 living in poverty—reflects the proportion of children living in households with income below 100% of the Federal Poverty Level (with an annual income of $23,550 for a family of four in 2013). In San Diego County, with a higher cost of living, income sufficient to meet basic expenses such as housing and food is closer to 200% of poverty ($47,100). The data are reported by the U.S. Census Bureau and SANDAG. Data by region are from the California Health Interview Survey.

## *Why is this important?*

Living in poverty affects a child's health, safety, education, and well-being, immediately and in the long term. The "dose" of poverty makes a difference—the more severe the poverty or the more years a child lives in poverty, the worse the impact. Poor children are disproportionately exposed to inadequate nutrition, child abuse and neglect, trauma, parental depression or substance abuse, violence, and low quality early care and education, and environmental toxins. Teens in poor families are more likely to engage in risky behaviors, including smoking, sexual activity, drug and alcohol abuse, and delinquency. Increasing the incomes of low-income families—without any other changes—positively affects children's well-being.

## *How are we doing?*

**Percentage of Children Ages 0-17 Living in Poverty, San Diego County, California, and United States, 2005-2012**




*The trend is moving in the wrong direction. In San Diego County, as in the state and the nation, child poverty is increasing. The proportion of San Diego children who lived in poverty rose from 15% in 2006 and 2007 up to 19% in 2010 and 2012. This represents more than 142,000 children in San Diego County.*

# ADULT POVERTY

## *What is the indicator?*

**The percentage of adults ages 18-64 living in poverty.**

The indicator—the percentage of adults ages 18-64 living below 100% of the Federal Poverty Level—reflects the proportion of non-elderly adults with income below 100% of the Federal Poverty Level (with an annual income of $23,550 for a family of four in 2013). Not all of these adults have children. The data are reported by the U.S. Census Bureau and SANDAG.

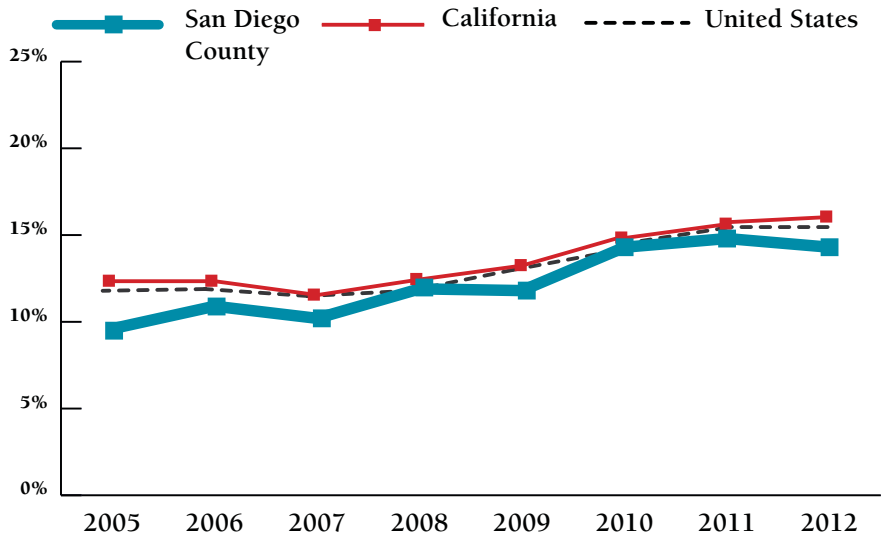
## *Why is this important?*

Recent reports indicate that the number of families with children living in poverty and going without adequate food and nutrition is on the rise, accompanied and influenced by rising unemployment, housing cost burdens, and energy costs. In San Diego County, given our higher cost of living (i.e., high housing costs, lack of public transportation, and higher food costs), 200% of the federal poverty level ($47,100) is considered a more realistic estimate of the level of income needed to meet basic expenses. In the current economic recession, many families with children are among the newly poor; other families who were already poor have been hit even harder.

From a life course perspective, poverty is an important social determinant. As discussed above, children growing up in poverty experience lifelong effects. Childhood poverty is associated with adverse conditions in adulthood, including: chronic stress and mental health conditions, obesity, less annual income and working hours, more frequent hospitalizations, and increases in heart disease and asthma. When poverty results in poorer language skills and low educational attainment, an adult's overall health and premature mortality risks increase.

## *How are we doing?*

**Percentage of Adults Ages 18-64 Living in Poverty, San Diego County, California, and United States, 2005-2012**




*The trend is moving in the wrong direction. Adult poverty increased steadily over this time period. The proportion of adults under age 65 living in poverty in San Diego County was 14.3% in 2012. This is up from 9.6% in 2005.*

## What strategies can make a difference?

Government programs and subsidies for low-income families can provide the basic necessities of life. Strategies that focus on reducing poverty among parents move children out of poverty at the same time. Such benefits encourage, support, and reward work by helping families close the gap between low wages and basic expenses.

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

- Implementing jobs programs aimed at reducing unemployment and advancing job creation.
- Assuring assistance through anti-poverty programs such as subsidized health coverage, child care subsidies, nutrition assistance, cash assistance, and housing assistance.
- Increasing parents' access to literacy, post-secondary, and vocational education, including low-cost job training and GED courses for unemployed and working parents.
- Increasing levels of educational achievement and reducing the number of dropouts.
- Providing long term unemployment benefits.
- Focusing "welfare to work" programs on barriers to employment such as low education, poor work history, disabilities, mental health, and transportation.
- Encouraging families to use the federal and state Earned Income Tax Credit (EITC), refundable tax credits for low-income individuals and families.
- Offering Individual Training Accounts (ITAs), which serve as vouchers that can be exchanged for training at approved learning institutions.
- Assisting families in opening Individual Development Accounts (IDAs) to help them get bank accounts, save money, and accumulate assets.

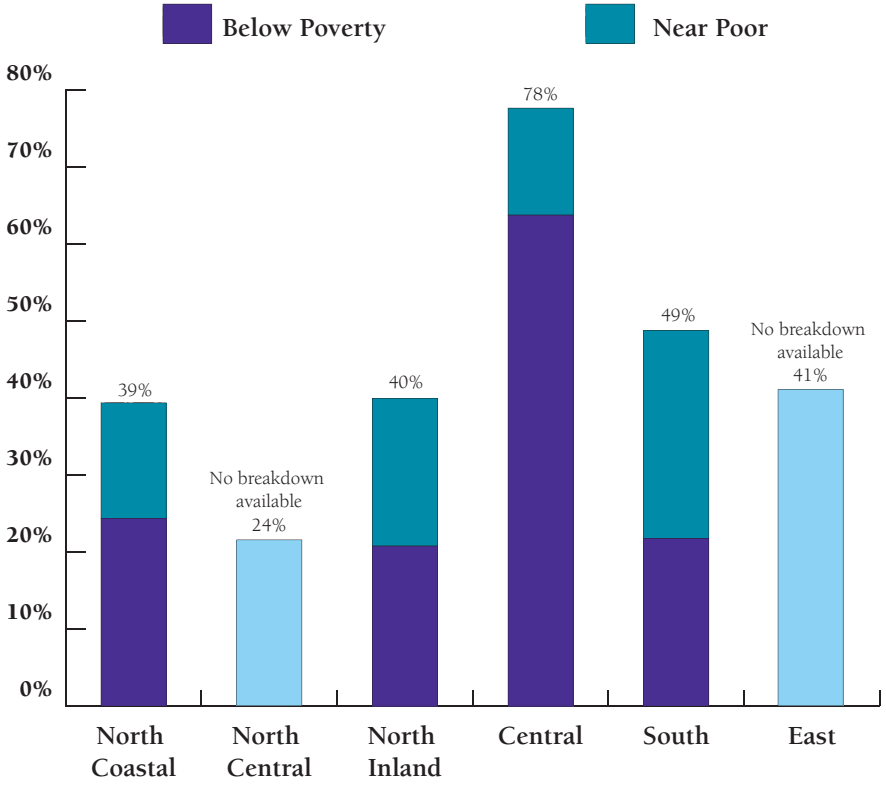
## How can we improve the trend in San Diego County?

In line with the recommendations from previous *Report Cards*, Thrive San Diego, led by United Way of San Diego and the County of San Diego, assists individuals and families in achieving financial stability. Thrive San Diego helped close to 3,000 EITC clients connect to public benefits (e.g. CalFresh, WIC, CalWorks, reduced phone and utility bills, and subsidized childcare). The Ways to Work program, co-funded by the United Way of San Diego and the Leichtag Foundation, provides low-income borrowers with low-cost financing to purchase a car, providing essential transportation needed to get to work. The San Diego Family Asset Building Coalition provides referrals to a group of local agencies including MAAC, International Rescue Committee, Home Start, and North County Lifeline. These agencies offer low-income San Diegans access to dozens of asset building programs such as financial literacy classes, matched savings programs, EITC assistance, and first time home-buyer programs.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego Workforce Partnership, community development corporations, schools, community colleges and universities, community-based organizations, faith communities, United Way of San Diego County, 211, Chambers of Commerce, businesses, mental health providers, and Health and Human Services Agency to:

1. Increase enrollment by informing low-income individuals and families about changes in application processes for health coverage, nutrition assistance, and other anti-poverty programs.
2. Create a San Diego business-public partnership to increase hiring of long term unemployed individuals and persons with disabilities.
3. Offer information and assistance through the San Diego Workforce Partnership network of providers to help families effectively use EITC, IDAs, and ITAs.

## Percentage of Children Under Age 18 Living in Low-Income Households, By Poverty Level and Region, San Diego County, 2011-12




*Poverty and economic hardship have grown dramatically in parts of San Diego County. For the Central Region, population estimates indicate that three-quarters of children are living in low-income households, earning below 200% of the Federal Poverty Level (FPL). The high proportion of families with income less than 200% of FPL indicates that too many of our children live in families with income insufficient to meet basic needs such as housing, food, and transportation in San Diego County.*

## *Feature Box: Refugee Children in San Diego County*

Over the past five years, approximately 9,316 refugee adults (ages 18 and over) and 4,466 refugee children (ages 0-17 years old) were resettled in San Diego County. The refugee population in San Diego is comprised of numerous ethnicities, cultures, languages, dialects, and ages with more than half of refugees under the age of 18. The largest numbers of recent refugees in San Diego County have come from Iraq, Burma, Iran, Somalia, and Burundi. For more than seven years, California has had the second highest number of international refugees for resettlement in the United States. San Diego County ranked first among counties in California for international refugee resettlement.

Refugee children face significant challenges, including the need to: quickly learn English to succeed in school, adapt to social norms, overcome isolation and poverty, and acculturate. A majority of refugee children come to our country having experienced psychological and physical stress due to exposure to war, poverty, malnutrition, persecution, and violence in their countries. Such toxic and debilitating stress can hinder a child's ability to develop and succeed.

Studies have shown that refugee children who come to the United States are pushed to make quick adjustments to a dissimilar school system, a new culture, and a new way of life. Many refugee children struggle with conflicting cultural traditions and family expectations. Parents may feel that their children should adhere to the strict norms of their culture, but many refugee children are influenced to "fit in" which often means hiding or abandoning their cultural traditions and language. School experiences of refugee children often include cultural and language discrimination and daily frustrations related to language inadequacies of not being able to communicate effectively and not being properly understood or accepted. In addition, refugee youth face issues learning the constructs of new social and peer networks and are faced with peer-related conflicts related to misinterpretation of social interaction and inclusion. Positive and supportive family and school environments are critical for a child's acculturation and to develop needed skills to succeed and adapt.

Early identification, positive education, and mental health services can support healing and healthy development in refugee children, helping them to overcome Post Traumatic Stress Disorder (PTSD) and other conditions. Strategies should be implemented in the educational, health, and social service systems to promote the physical and psychosocial well-being of refugee children. The aim of services and supports is to provide a sense of safety, normalcy, and adjustment to new cultural expectations, while maintaining a connection to their heritage and language.

While refugee children face obstacles in their acculturation and school success, they also bring richness and strengths to schools and communities with their broadened world perspectives and experiences. The United States was built on, and has become stronger and more diverse, by the arrival of families and individuals fleeing persecution, war, famine, and other causes of refugees' flight. These families and children bring their determination, survival skills, and strengths to the San Diego region.

# *Community and Family (Cross Age):* NUTRITION ASSISTANCE

## *What is the indicator?*

**The number of children ages 0-18 receiving Food Stamps.**

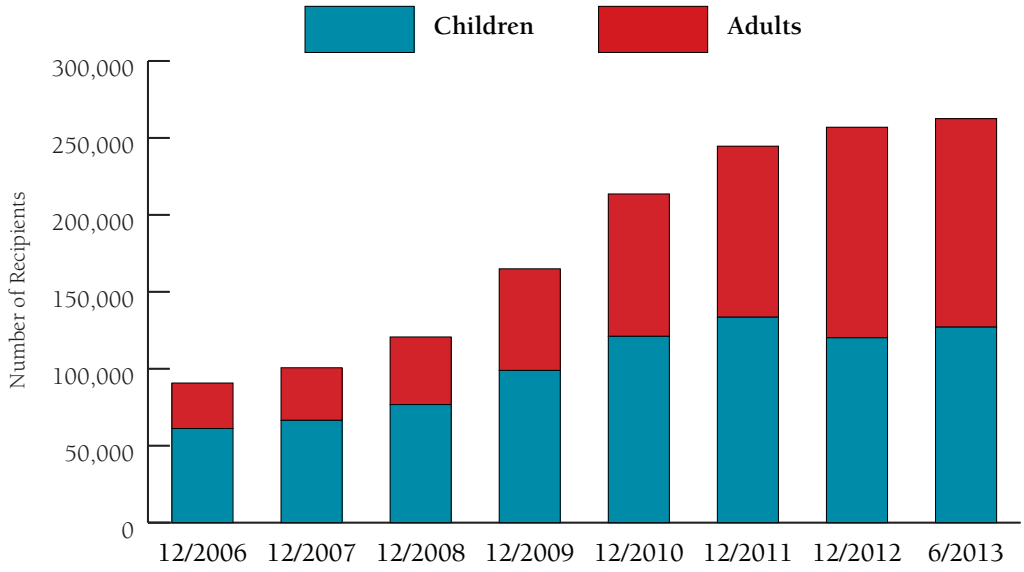
This indicator—the number of children ages 0-18 receiving Food Stamps—tracks how many eligible San Diego County children are participating in the federal Supplemental Nutrition Assistance Program (SNAP), known in California as the CalFresh program. This information is collected through the Health and Human Services Agency Benefits CalWIN program.

## *Why is this important?*

Adequate food and proper nutrition is the foundation for a child's growth and development. SNAP/CalFresh provides nutrition assistance to low-income individuals and families, a simple and effective way to assist those in need of food. An average family of four in California receives $158 per week in Food Stamps. As the economy worsens, more families struggle to provide nutrition for their children. Nutrition assistance also has benefits for the community; every $1.00 of Food Stamps generates $1.85 in local economic activity. Increased use of SNAP/CalFresh results in food for poor children and adults, as well as community economic development.

## *How are we doing?*

**Number of Food Stamp Recipients, Children Ages 0-18 and Adults, San Diego County, 2006-2013**




*The trend is improving. This is largely the result of deliberate outreach to eligible individuals in San Diego County, combined with increasing poverty. In June, 2013, more than 127,000 adults and 135,000 children had the benefit of CalFresh nutrition assistance.*

## What strategies can make a difference?

SNAP offers low-income families supportive nutritional information and aid to buy food. During the recession, enrollment increased, but some states and communities continue to have low utilization rates. Successful strategies to improve access and utilization rates involve community and school-based outreach and streamlined application processes.

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

- Streamlining and simplifying the application process, both online and on paper, including the use of combined applications for multiple public assistance programs.
- Offering options for completing online applications with an electronic signature.
- Providing extended hours (e.g., evenings and weekends) at application centers, and multilingual staff.
- Stationing outreach and enrollment workers to provide assistance in completing applications in community based organizations, schools, shelters, and other settings.
- Training and certifying community based providers to process applications for enrollment.
- Increasing outreach to underserved populations such as military families, Native Americans, immigrants, persons speaking English as a second language, seniors, residents in rural communities, and persons with disabilities.
- Increasing outreach through partners such as schools, health providers, food banks, tax preparers, and utility companies.
- Including eligibility information and prescreening on websites and helplines.

## How can we improve the trend in San Diego County?

Federal benefits were lowered across the country for SNAP/CalFresh, and in California, this equates to $36 less per month for a family of four. The reduction was triggered by the expiration of economic stimulus spending. About 4.2 million Californians are affected by this drop in benefits. California's CalFresh recipients will be spending approximately $46 million less per month in local stores. In 2012, community providers in San Diego empowered people to select healthy foods and increase physical activity through education, social marketing, and environmental supports as part of the federally funded SNAP-Ed online resource program. Public Health Services utilizing SNAP-Ed tools provided approximately 12,353 SNAP-Ed eligible participants educational materials about healthy food and lifestyle choices. Additionally, participants in SNAP, WIC, and SSI/Disability were able to sign-up for the Fresh Fund at participating farmers' markets. Once enrolled, they can receive $20 in matching funds each month to purchase fresh fruit and vegetables.

Based on what works and what we have been doing, the top three recommendations for San Diego are to work with self-sufficiency programs, family resource centers, faith communities, United Way of San Diego County, 211, food banks, schools, colleges and universities, Health and Human Services Agency, San Diego Hunger Coalition, San Diego Workforce Partnership, and community-based organizations to:

1. Offer increased options for completing online applications with an electronic signature.
2. Train and certify additional community-based providers to process applications for enrollment.
3. Target outreach efforts to underserved families, particularly families who are in the military, Native American, immigrant, and living in rural areas.

# *Community and Family (Cross Age):*
# CHILD HEALTH COVERAGE

## *What is the indicator?*

**The percentage of children ages 0-17 who are without health coverage.**

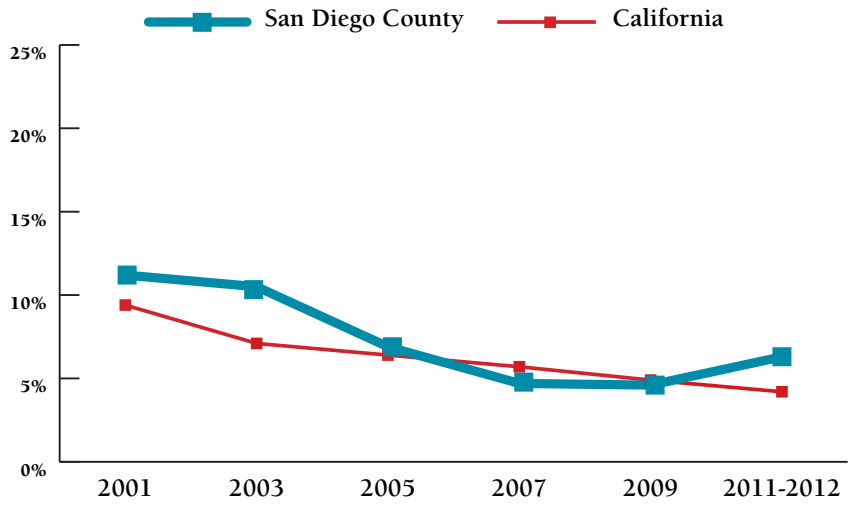
This indicator—the percentage of children ages 0-17 who are without health coverage in San Diego County—monitors public and private coverage. This information is collected every other year and reported through the California Health Interview Survey.

## *Why is this important?*

Being uninsured is the single greatest barrier to receiving consistent and quality medical care. Uninsured children are less likely than their insured peers to receive preventive services and needed treatments. At any age, health coverage for children increases the identification and treatment of health conditions. For children with special health needs (i.e., chronic conditions that require extra care and treatment), lack of coverage can result in inadequately treated vision or hearing problems, more hospitalizations for untreated asthma, and worsening disabilities. 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.

## *How are we doing?*

**Percentage of Children Ages 0-17 without Health Coverage, San Diego County and California, 2001, 2003, 2005, 2007, 2009, and 2011-12**




*The trend is not improving. It is maintaining, showing variation in the last year of data. The proportion of children without health coverage increased between 2009 and 2011-12.*

# ADULT HEALTH COVERAGE

## *What is the indicator?*

**The percentage of adults ages 18-64 without health coverage.**

This indicator—the percentage of adults ages 18-64 without health coverage in San Diego County—monitors public and private coverage. This information is collected every other year and reported through the California Health Interview Survey.

## *Why is this important?*

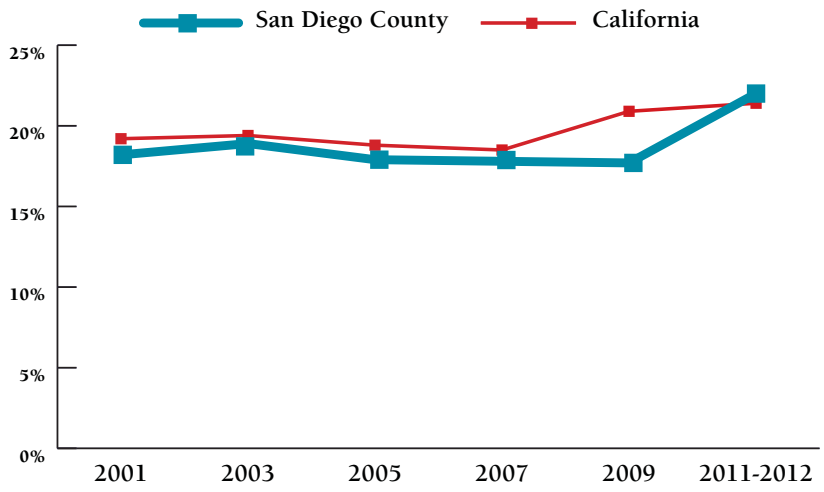
The negative effects of being uninsured are well documented. Lack of health coverage affects adults' use of health services, with many uninsured adults forgoing needed services due to the cost of care. When adults forgo preventive services or treatments needed for chronic conditions their health worsens.

Young adults often lack coverage due to their financial, work, school, or residential status. Under the Affordable Care Act, young adults ages 18-26 may continue coverage under their parents' private health plan, if available. As a result, more than 3 million young adults have gained private coverage since 2010. Young adults transitioning from foster care may be covered under Medicaid to age 26. These policies resulted in significant reductions in the percentage of young adults who delayed getting care and/or did not receive needed care.

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 all children in the household are insured. Parents' coverage status affects children's use of health services. Compared to those with insured parents, children with uninsured parents are significantly more likely to have no usual source of primary care, unmet health care needs, and have never received at least one preventive counseling service.

## *How are we doing?*

**Percentage of Adults Ages 18-64 without Health Coverage, San Diego County and California, 2001, 2003, 2005, 2007, 2009, and 2011-12**




*The trend is moving in the wrong direction. No real progress was made between 2001 and 2009, and between 2009 and 2011-12 the proportion of adults under age 65 without health coverage increased.*

## What strategies can make a difference?

Major change is happening in health coverage nationally and for California children and families, due to the expansion of Medicaid (known as Medi-Cal in California) and availability of Affordable Care Act Exchange plans through Covered California, most uninsured children and adults are now eligible for publicly subsidized coverage. The Affordable Care Act will increase coverage for uninsured adults.

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

- Providing ongoing assistance in applying for Affordable Care Act Exchange plans through Covered California.
- Implementing effective policies regarding simple enrollment, consumer information, and continuous coverage.
- Simplifying and streamlining the application process and enrollment policies (e.g., shorter forms, combined forms, and applications by mail or Internet).
- Using community-based navigators and certified enrollment specialists to assist individuals in understanding coverage options.
- Providing automatic eligibility determinations and renewals for health coverage when families complete applications or recertification for other public assistance programs.
- Developing effective outreach and enrollment strategies in community settings including:
    - Campaigns to promote awareness of available coverage (e.g., culturally specific marketing tools, outreach through employers, billboards, and posters).
    - Assistance in distributing and completing applications in schools, homeless shelters, community-based organizations, health provider sites, and the workplace.
    - Incentives for schools, employers, and community-based organizations to identify families and help them enroll their children.
- Using federally required outreach and enrollment workers at community clinics and WIC.

## How can we improve the trend in San Diego County?

Progress has been made with *Report Card* recommendations on informing families and providing outreach, linked to implementation of the Affordable Care Act. The Healthcare Access Program, supported by First 5 San Diego, assists families with children ages 0 through 5 in enrolling and maintaining their enrollment in health insurance programs available through Medi-Cal and Covered California, as well as promoting preventive care and assisting them in using health services.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Health and Human Services Agency, First 5 San Diego, health providers, health plans, Family Resource Centers, parents and parent associations, 211, San Diego Workforce Partnership, Chambers of Commerce, schools, workplaces, faith communities, and community-based organizations to:

1. Target strategies to enroll young adults ages 18-26 in affordable health coverage.
2. Target strategies to enroll low-income families with children in affordable health coverage.
3. Promote the expansion of certified enrollment specialists, community-based navigators, and other culturally and linguistically appropriate helpers to assist families in gaining access to coverage and using needed health services in Medi-Cal and Exchange/Covered California health plans.

# *Community and Family (Cross Age):* DOMESTIC VIOLENCE

## *What is the indicator?*

**The rate of domestic violence reports per 1,000 households.**

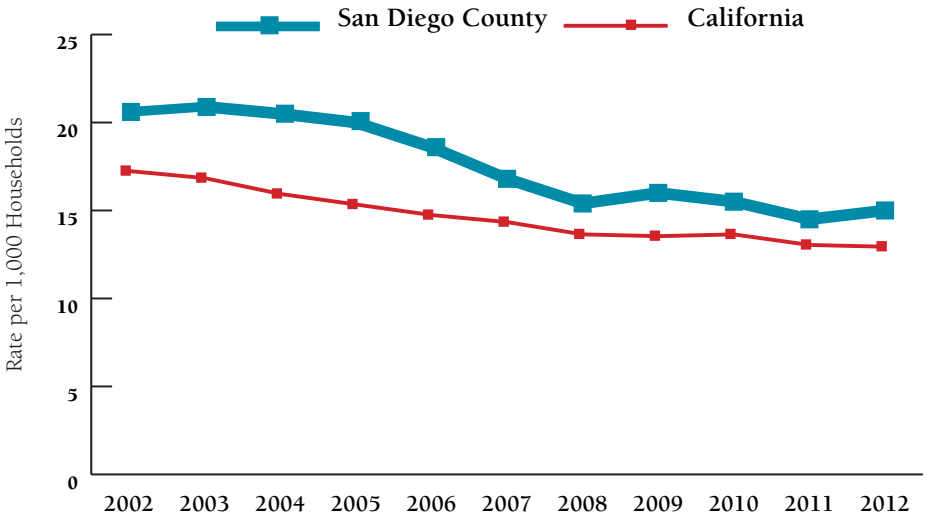
This indicator—the rate of domestic violence reports per 1,000 households—documents the rate of domestic violence and intimate partner violence reported by San Diego County law enforcement agencies. The rate of police reports is considered to be closer to the rate at which violence is occurring than is the number of arrests or convictions made; however, this is an underestimate, as many people do not contact law enforcement to report domestic violence. These data are reported by ARJIS and the California Department of Justice.

## *Why is this important?*

Domestic violence negatively affects everyone involved, either directly or through exposure to violence. Domestic violence typically escalates over time, moving from verbal abuse to emotionally abusive behavior, to physical abuse, and can result in death. Children who live with the victim and/or the perpetrator live in fear and hopelessness. They often perform poorly in school, and typically do not participate in normal childhood play and social activities. Children who have these adverse and traumatic experiences—even when the violence is not directed at them—have increased risk of victimization, aggression, problems with social relationships, and lifelong health problems. These are considered Adverse Childhood Events–ACE.

## *How are we doing?*

**Rate of Domestic Violence Reports Per 1,000 Households, San Diego County and California, 2002-2012**




*The trend is maintaining. While the rate dropped from 20 per 1,000 in 2002 to 15 per 1,000 in 2008, it has remained at 15 or 16 per 1,000 between 2008 and 2012. This rate represents more than 16,000 calls for assistance.*

## What strategies can make a difference?

Domestic violence is a threat to multiple generations, but is preventable. Effective strategies include early screening and identification, trauma-informed services for adult victims and children, as well as immediate consequences for perpetrators, and multi agency partnerships.

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

- Screening for domestic violence routinely in health care, home visits, schools, early care and education, and other appropriate community settings, with follow-up referrals as necessary.
- Ensuring developmental screening in early childhood for early identification of young children exposed to violence and other trauma.
- Providing community-based, trauma informed services for victims and their children.
- Using school and youth programs to educate young people about how to have healthy relationships and the signs and risks of teen dating violence, as well as to provide resources to support youth.
- Helping victims develop and continually update their safety plans.
- Assuring enforcement of perpetrators' mandated treatment, including monitoring of active participation in violence prevention programs and other terms of probation, as well as enforcing the removal/submission of firearms.
- Providing cross-system targeted training on domestic violence, conflict resolution, healthy relationships, self-sufficiency, and related topics for staff that work with at-risk families.
- Linking data and cases across child abuse, domestic violence, and court systems to assure more consistent handling of domestic violence and intimate partner violence cases.
- Regularly updating protocols and policies of law enforcement, courts, and providers.
- Implementing risk assessment and management for domestic violence perpetrators.

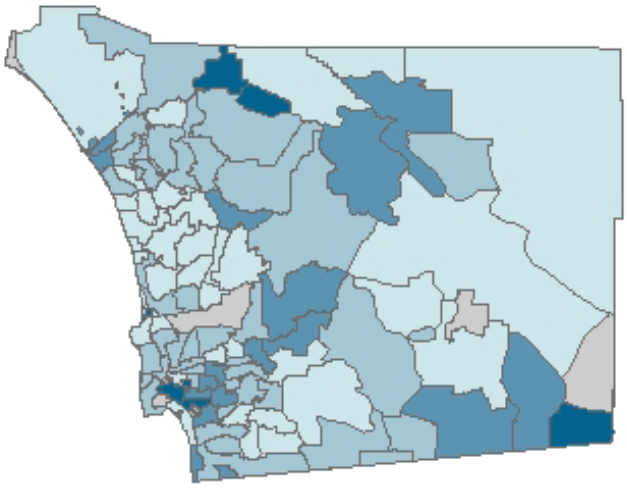
## How can we improve the trend in San Diego County?

As the *2011 Report Card* recommended, the provision of cross systems training on domestic violence is crucial since many families with children experiencing domestic violence often go unidentified and do not receive essential support services. The San Diego Domestic Violence Council offers training on "DV Essentials". This training includes the identification, screening, and assessment of domestic violence for frontline workers (social services, children's services, healthcare staff, behavioral health staff, school staff, etc.). The Council trained over 1,000 frontline workers during 2012 and 2013. In addition, the Child Health and Disability Program, as a part of well-baby exams, includes education for parents on health, safety, and information needed to create safe environments.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Health and Human Services Agency, law enforcement agencies, courts, District Attorney, Probation Department, schools, faith communities, mental health providers, health providers, early care and education, and other service providers to:

1. Routinely collect data with the Domestic Violence Supplemental Form in relation to children exposed to domestic violence to prioritize services and interventions.
2. Increase cross-system training for identification, screening, and assessment of domestic violence and intimate partner violence (e.g., public health nurses, teachers, mental health providers, alcohol and drug counselors, law enforcement officers).
3. Increase the use of developmental screening in early childhood for early identification of young children exposed to violence and other trauma.

## RATE OF DOMESTIC VIOLENCE INCIDENTS PER 1,000 HOUSEHOLDS: 2012




NOTE: Data from Automated Regional Justice Information System, ARJIS. Data prepared by County of San Diego Health and Human Services Agency with assistance from the District Attorney's Office. Rates calculated using SANDAG 2012 Household Estimates.

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

## *What is the indicator?*

**The rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17.**

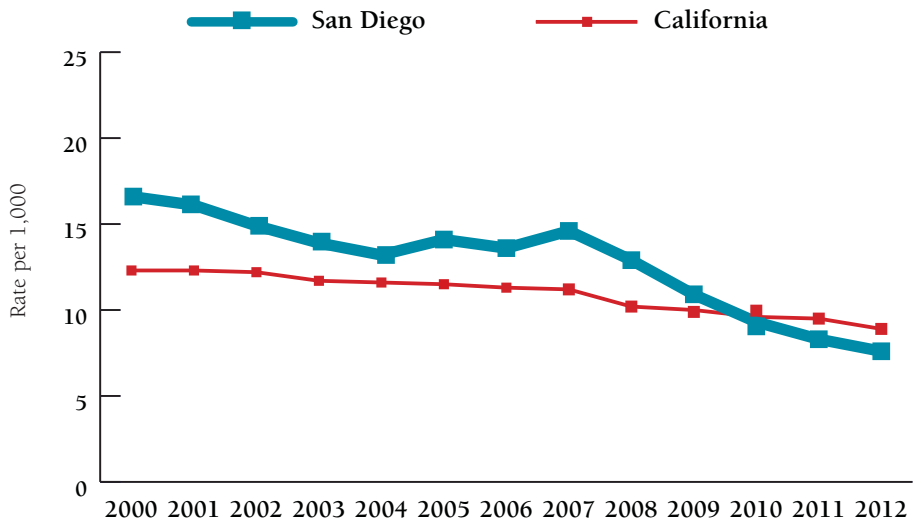
This indicator—the rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17—measures the trend in reports of child abuse and neglect that have sufficient evidence to warrant a child welfare services case being opened or having the family referred for services. These data come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

## *Why is this important?*

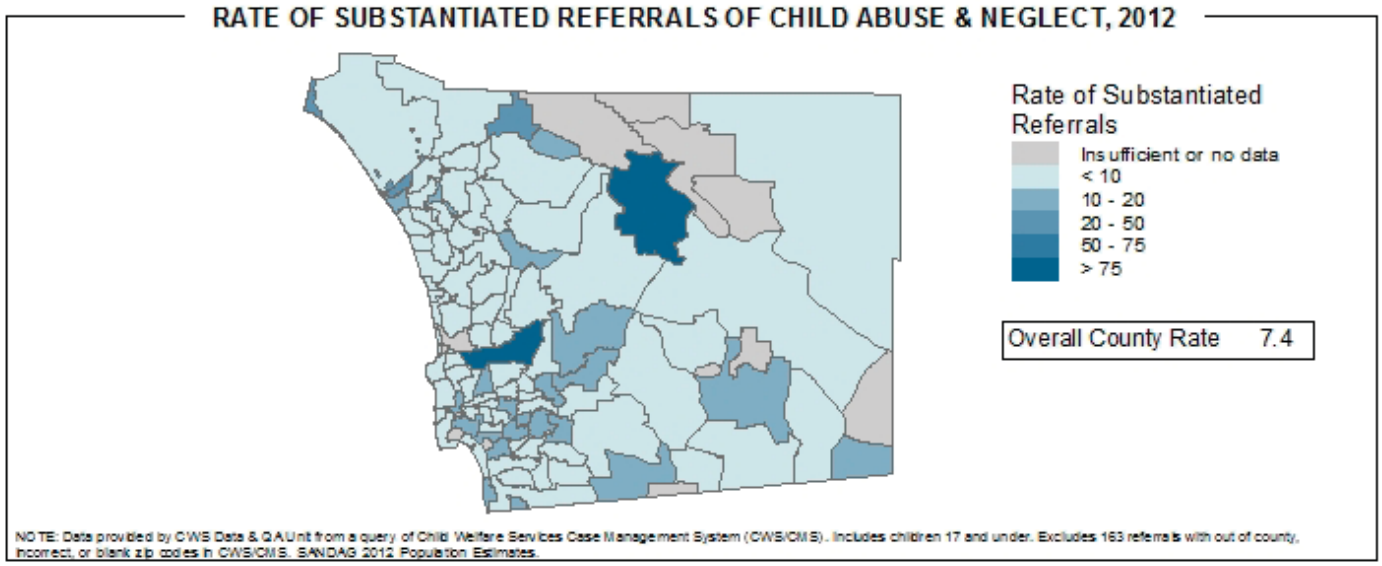
The Adverse Childhood Events (ACE) studies show that child abuse and neglect can have a lifelong impact on health and well-being, including increased risk of heart disease, obesity, and depression as an adult. Child abuse and neglect have profound and long-term effects on a child's physical, mental, and emotional health, as well as significant impact on brain and cognitive development. Physical effects include injury, disability, and even death; psychological effects include depression, anger, self-harm behaviors, anxiety, and aggression. Neglected children can suffer effects as serious as those who are physically abused.

## *How are we doing?*

**Rate of Substantiated Cases of Child Abuse and Neglect Per 1,000 Children Ages 0-17, San Diego County and California, 2000-2012**




*The trend is improving. In San Diego County, the rate of substantiated cases of child abuse and neglect dropped from 16.6 per 1,000 children in 2000 down to 7.6 per 1,000 in 2012. This is lower than the 2012 rate for California. (Note that due to a revision of county population estimates, this trend line has been modified from previous Report Cards).*




The population estimates by zip code vary slightly from the county average presented in the graph above. As a result, the overall county rate shown for this zip code map is slighly below the rate of substantiated cases of child above and neglect reported 7.6 per 1,000. The rate of 7.6 per 1,000 is correct in the multi-year trend.

## What strategies can make a difference?

Child abuse and neglect are preventable. They are associated with many factors, including parental substance abuse and mental health, unemployment, poverty, generational patterns of child abuse, and domestic violence. Effective interventions should be tailored to the individual family situation.

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

- Providing family interventions to strengthen parent-child relationship skills.
- Increasing supports and reducing economic stress for at-risk families, including enrollment in public assistance programs such nutrition, health, and income assistance.
- Providing high quality, evidence-based home visiting programs for at-risk families from prenatal to 5 years (e.g., Nurse Family Partnership, Healthy Families America, Parents as Teachers).
- Developing parenting classes and support groups to teach age-appropriate communication and positive discipline from birth (e.g., Incredible Years or Strengthening Families curriculum).
- Training health providers, teachers, and other care providers to recognize signs of abuse and neglect, as well as providing information regarding community resources available.
- Increasing financing for family (two-generation) treatments and interventions designed to reduce abuse and neglect.
- Implementing the Positive Parenting Program (Triple-P), shown to be effective in prevention of childhood social-emotional and behavioral problems and child maltreatment.
- Implementing programs such as 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 of maltreatment.
- Using efforts such as the Period of PURPLE Crying (an evidence-based shaken baby syndrome prevention program) to help parents and other caregivers.

## How can we improve the trend in San Diego County?

Supporting *2011 Report Card* recommendations, the First Steps program funded by First 5 San Diego offers intensive home visiting utilizing two evidence-based models, Healthy Families America and Parents as Teachers. First Steps assists with preventing child abuse and neglect in at-risk families including teen moms, low-income parents, military moms, and refugee and immigrant mothers. This program is offered county wide through Palomar Health, SAY San Diego, South Bay Community Services, and Home Start. In addition, Child Welfare Services is implementing Safety Organized Practice which is a strength-based child welfare approach that focuses on the safety of the child within the family system. Practices also include helping isolated moms form a safety network for community support.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with Health and Human Services Agency, United Way of San Diego County, First 5 San Diego, parents and parent associations, schools, courts, District Attorney, Probation Department, law enforcement, mental health providers, community-based organizations, and faith communities to:

1. Implement evidence-based, trauma-informed services and systems (e.g., child welfare, probation, mental health).
2. Expand intensive home visiting for at-risk families, including but not limited to teen parents, military families, and low-income parents.
3. Implement the Positive Parenting Program (Triple-P) in varied settings, including early care and education, schools, and family resource centers.

# *Community and Family (Cross Age):*
# CHILD VICTIMS OF VIOLENT CRIME

## *What is the indicator?*

**The rate of violent crime victimization per 10,000 children or youth ages 0–11 and 12–17.**

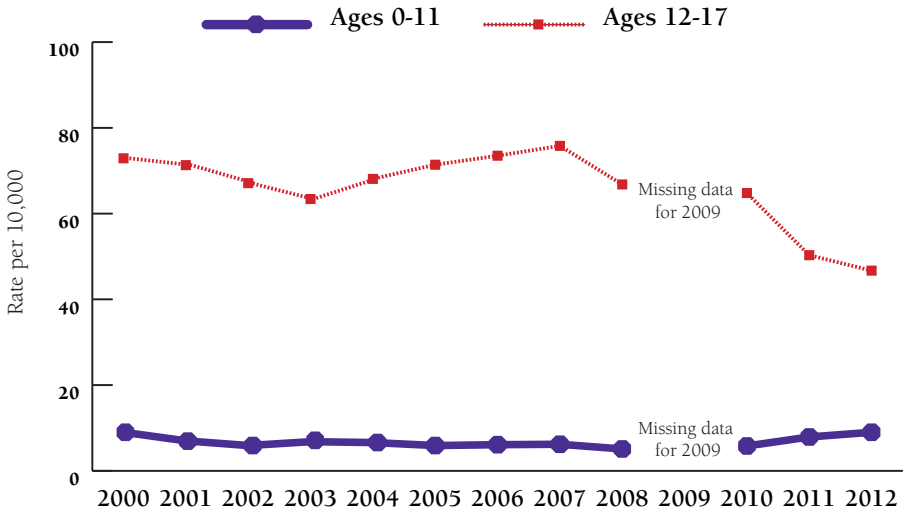
This indicator—the rate of violent crime victimization of children—reflects trends in four types of crime (homicide, rape/sexual assault, aggravated assault, robbery by force or threat). The data are from ARJIS, so only those incidents that result in an arrest report are represented.

## *Why is this important?*

Violent crimes perpetrated against children are a tragedy that have lifelong impact: impairing development, increasing mental health problems, affecting school success, shattering trust, and impairing healthy relationships. 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 by adult men. With the exception of assault, African-American children are more likely to be the victims of violent crime than those of any other race or ethnicity. The frequency of these crimes changes by time of day, peaking between the hours of 3 p.m. and 9 p.m., with implications for assuring safety after school.

## *How are we doing?*

**Rate of Violent Crime Victimization Per 10,000 Children, Ages 0-11 and 12-17, San Diego County, 2000-2012**




*The overall trend is improving. The rates for all ages birth to 17 were 22.7 per 10,000 in 2011 and 22.0 per 10,000 in 2012. However, this change is being driven by improvement in the rate among youth ages 12–17, the trend is moving in the wrong direction among children ages 0–11.*

## *Feature Box: Commercial Sexual Exploitation of Children*

The commercial sexual exploitation of children is a growing and significant but preventable problem in the United States, California, and San Diego. The FBI has identified San Diego as one of the top three metropolitan areas of the nation's thirteen High Intensity Child Prostitution areas for sex trafficking of children.

While there is currently no national or local data system that tracks the exact number of children and youth who are victimized, the U. S. Department of Justice estimates the range to be between 200,000 and 300,000 U.S. children annually. Commercial sexual exploitation of children encompasses a range of child sexual abuse acts including enticement of children for sexual acts, statutory rape, child sex trafficking, and child sex tourism. UNICEF defines commercial sexual exploitation of children as a commercial transaction that involves the sexual exploitation of a child for prostitution or pornography and involves coercion and/or violence against these children. Commercial sexual exploitation also includes forced labor, a form of contemporary slavery by offering the sexual services of children for compensation, financial or otherwise.

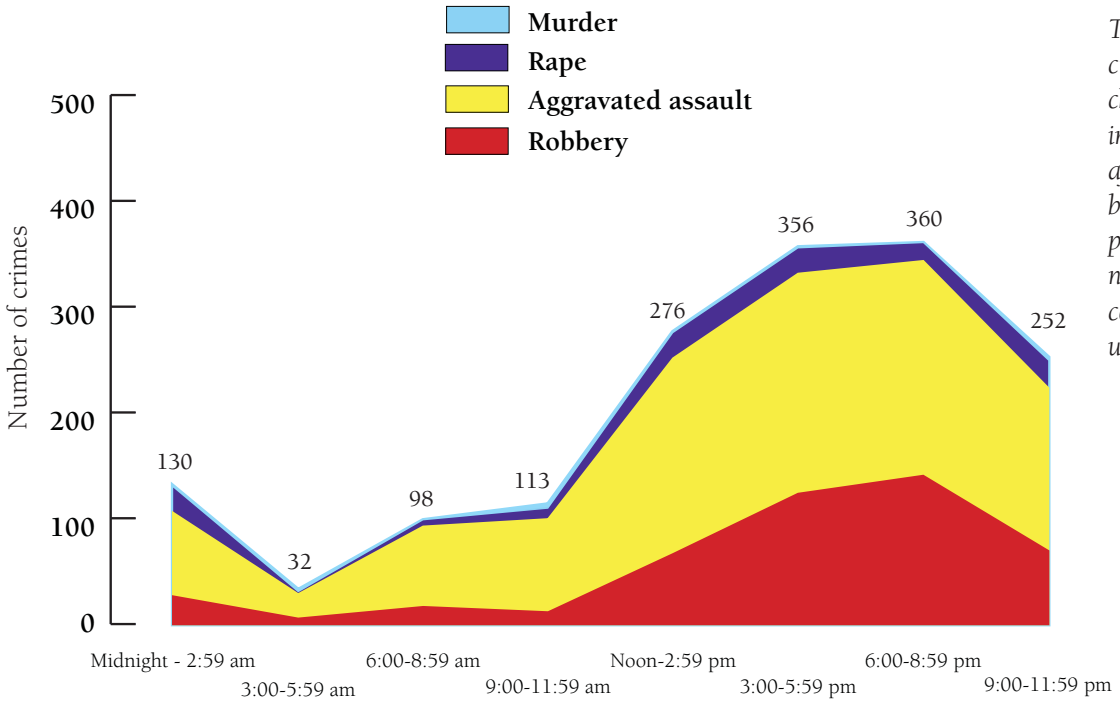
Nationally, girls and boys as young as eight years old have been confirmed as victims of commercial sexual exploitation. Those at increased risk include victims of earlier trauma from child sexual abuse or domestic violence, and those with histories of mental health and substance abuse. Homeless, throw-away, and runaway youth are especially vulnerable. An estimated 55% of homeless or runaway youth are involved in some type of forced prostitution.

According to the California Child Welfare Council, studies estimate that between 80% and 95% of children identified as being commercially sexually exploited had prior contact with Child Welfare Systems. Many had multiple child welfare referrals, and in many cases, the initial referrals for these youth occurred prior to the age of seven.

The list of the negative long-term impacts of sexual exploitation is extensive and includes: depression, acute anxiety, dissociation, increased aggression, somatic symptoms, delinquent criminal behavior, educational difficulties, and self-destructive acts including attempts and completion of suicide. Research has found that Post Traumatic Stress Disorder (PTSD) symptoms and sexualized behaviors have long- term negative effects on these victims' lives and health. The health risks for these children and youth are serious and can be life threatening including exposure to numerous infectious diseases such as HIV, HPV, Hepatitis B, gonorrhea, and other sexually transmitted diseases.

More evidence-based practices and programs are urgently needed both to prevent and intervene in this societal problem. Both nationally and locally, data systems are essential to accurately and consistently identify child victims of commercial sexual exploitation. In San Diego County, efforts have been underway to develop a more comprehensive, coordinated system to prevent, identify, and intervene for child victims of sexual exploitation. Leaders in San Diego support and recognize that it is crucial to bring together a very broad range of partners including law enforcement, education, health care, social services, families, and their advocates to develop effective measures for early identification, prevention, and intervention for child victims of commercial sexual exploitation.

## Number of Violent Crimes with Child Victims Ages 0-17, By Time of Day, San Diego County, 2012




*The number of violent crimes committed against children and youth increases dramatically after school, peaking between the hours of 3 p.m. and 9 p.m. High numbers of crimes continue into the evening until midnight.*

## What strategies can make a difference?

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 keep kids safer.

The following strategies have been used to reduce violent crime victimization of children and youth:

- Providing consistent, adequate adult supervision of children and youth in non-school hours.
- Educating parents, extended families, school personnel, and youth-serving organizations about Internet safety, including monitoring and restricting of use of Internet.
- Implementing gender-specific training for girls to help them protect against sexual assault, violence, and rape.
- Expanding programs aimed at keeping youth safe and reducing gang involvement, such as mentoring, after school programs, teen centers, community service, and job shadowing.
- Training parents, school personnel, after school staff, youth-serving organizations, health providers, and juvenile justice professionals in the identification and prevention of bullying, commercial sexual exploitation, racism, intimidation, sexual harassment, and hate crimes.
- Using schools as community hubs, including ball fields, libraries, and other common spaces.
- Supporting safe passages for children and youth to and from school.
- Implementing partnerships to identify and intervene in the commercial sexual exploitation of children.
- Developing anti-violence and anti-bullying prevention programs such as: Olweus Bullying Prevention; PeaceBuilders; Promoting Alternative Thinking Strategies (PATHS); and Resolving Conflict Creatively Program (RCCP).

## How can we improve the trend in San Diego County?

In line with the previous *Report Cards* recommendation to expand programs to prevent bullying, intimidation, harassment, and hate crimes, San Diego Police Foundation, in partnership with San Diego Internet Crimes Against Children Task Force, offers the SafetyNet: Smart Cyber Choices. This is an Internet safety program to raise awareness about: cyberbullying, computer/Internet safety, and on-line predators. In the last three years, this program has brought Internet safety awareness to more than 95,000 students, 10,000 teachers, parents, and community members, and 200 schools. Additionally, San Diego Unified Safe Schools Task Force distributed Safe Space Kits to all district middle and high schools. These kits help educators create safe places for lesbian, gay, bisexual, and transgender (LGBT) students. Safe Space Kits include a staff guide with action steps that schools can take to ensure a positive learning environment.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, parents and parent associations, community-based organizations, faith communities, community centers, neighborhood associations, municipalities, law enforcement, courts, District Attorney, and Probation Department to:

1. Increase adult supervision of 12- to 17-year-old youth in non-school hours, including after school programs and evening activities in low-income communities.
2. Strengthen partnerships with law enforcement, education, and families to effectively measure, prevent, and intervene with child victims of commercial sexual exploitation.
3. Expand programs to prevent bullying, commercial sexual exploitation, racism, sexual harassment, and hate crimes through schools, after school programs, community-based organizations, and juvenile detention facilities.

# *Community and Family (Cross Age):*
# UNINTENTIONAL INJURY

## *What is the indicator?*

**The rate of fatal and non-fatal unintentional injuries per 100,000 children ages 0–18.**

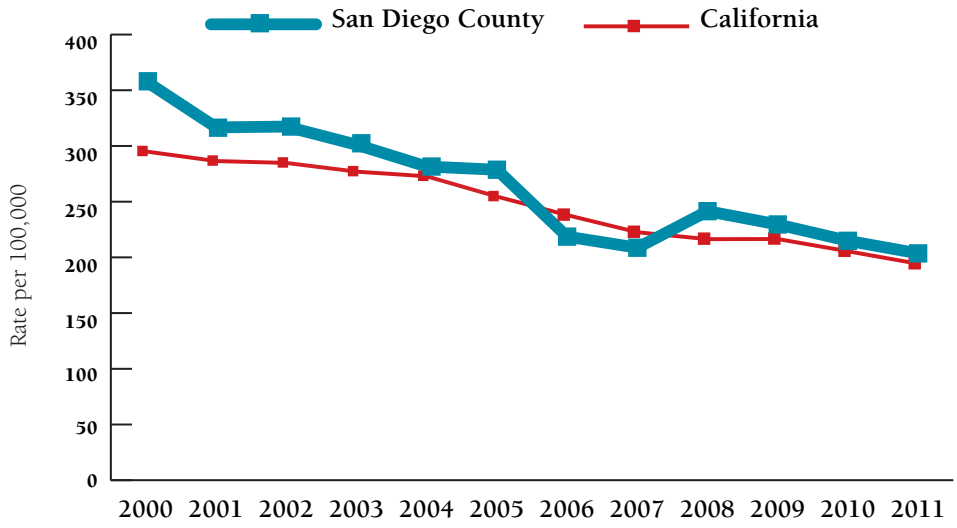
This indicator—the rate of fatal and non-fatal unintentional injuries per 100,000 children ages 0–18—shows the proportion of children who are injured severely enough to die or to require hospitalization. These data are routinely reported on hospital discharge reports and death certificates.

## *Why is this important?*

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

## *How are we doing?*

**Rate of Fatal and Non-Fatal Unintentional Injuries Per 100,000 Children Ages 0-18, San Diego County and California, 2000-2011**




*The trend is improving. The combined rate of fatal and non-fatal unintentional injuries dropped from 358 per 100,000 in the year 2000 to 241 in 2008 to 203 in 2011. (Note that due to a revision of San Diego County population estimates, this trend is not comparable to previous Report Card data).*

## What strategies can make a difference?

Specific prevention and intervention approaches may be needed to address each cause of injury. Legal mandates and public education about safety are the primary strategies for reducing unintentional injuries.

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

*Providing education, as well as equipment and supplies related to*:

- Firearm safety, including safe gun storage (e.g., Asking Saves Kids—ASK, gun locks).
- Protective restraints such as child car seats, booster seats, and seat belts.
- Signs and symptoms of head injury and appropriate follow-up actions.
- Protective gear such as helmets for biking, snowboarding, skiing, skateboarding, off-road vehicles, etc.
- Crib and bed safety for infants (safe sleep).
- Common causes of choking and suffocation.
- Common causes of drowning including swimming pools, buckets of water, and bathtubs.
- Home safety and child-proofing (e.g., outlet covers, cabinet locks, safety gates, and hot water 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.
- Environmental hazards (e.g., lead paint, access to poison).
- 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.
- Toy manufacturer safety standards.
- Use of helmets for all sport recreation activities (motorized and non-motorized).
- Graduated licensing for teens.
- Prohibitions on cell phone use (including hands-free) and texting among youth while driving.

## How can we improve the trend in San Diego County?

The Childhood Unintentional Injury Program, supported by First 5 San Diego and led by the Children's Initiative, combines *Report Card* recommendations to provide injury prevention education and tools. Families, childcare providers, and early education staff are trained about prevention for common types of unintentional injuries and resources available to them. Over a three year period, approximately 1,500 families will receive training on how to prevent unintentional injuries and receive safety products to reduce unintentional injuries. Additionally, with funds from the Kohl's Cares Foundation, Rady Children's Hospital provides child safety seat inspections, educates parents on car seat and helmet safety, and provides resources to make travel safer for everyone.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with Safe Kids San Diego, Injury Free Coalition for Kids, First 5 San Diego, parents and parent associations, schools and school districts, coaches and physical education teachers, local law enforcement, Health and Human Services Agency, Housing and Community Development, Environmental Services, landlords, property managers, County Board of Supervisors, and municipalities to:

1. Provide parents with education and no cost equipment to increase use of existing child vehicle restraint laws and helmet laws.
2. Develop policies and protocols to reduce sports- and recreation-related health injuries.
3. Increase County enforcement of safety regulations in rental properties and penalties for violations.

# *Community and Family (Cross Age):*
# CHILDHOOD MORTALITY

## *What is the indicator?*

**The mortality rate per 1,000 children ages 0–17.**

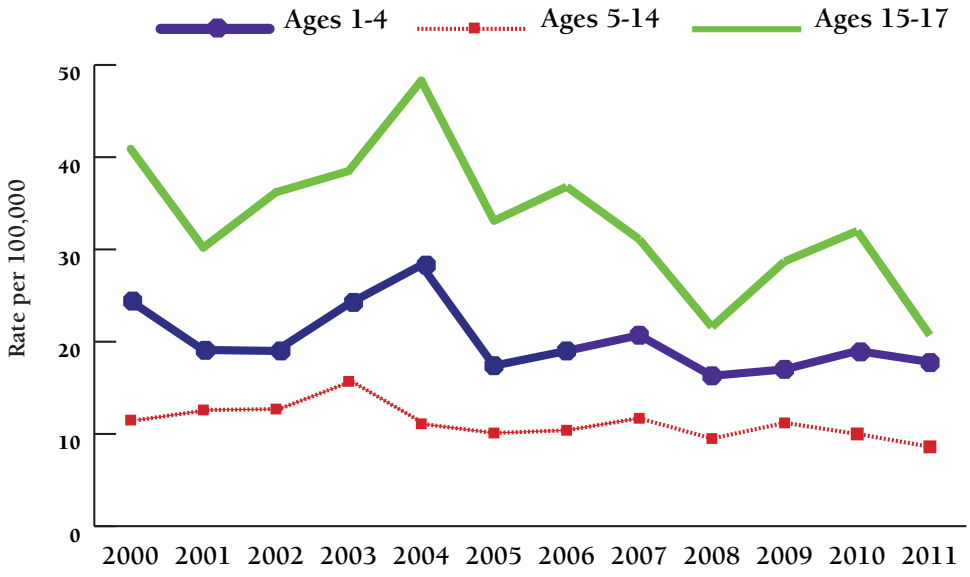
This indicator—the rate of mortality for children ages 0–17—monitors the rate of death for all causes among children, and youth. The infant mortality rate measures the number deaths in the first year of life per 1,000 live births. These data are recorded on death certificates and routinely reported as part of local, state, and federal vital statistics.

## *Why is this important?*

Child mortality is a fundamental indicator of a community's well-being. Child mortality is related to a variety of health factors (e.g., risk of disease, safety practices) and socioeconomic conditions (e.g., housing). The leading causes of death vary by age. About two-thirds of infant deaths occur in the first month after birth, primarily due to low birthweight, preterm birth, or birth defects. Almost twice as many deaths occur in the first year of life as in the next 13 years combined. Adolescence mortality rates also are high, compared to school age children. Youth are more likely to die of external causes such as motor vehicle crashes, drowning, suicide, and homicide. Many deaths among infants, children, and youth are preventable.

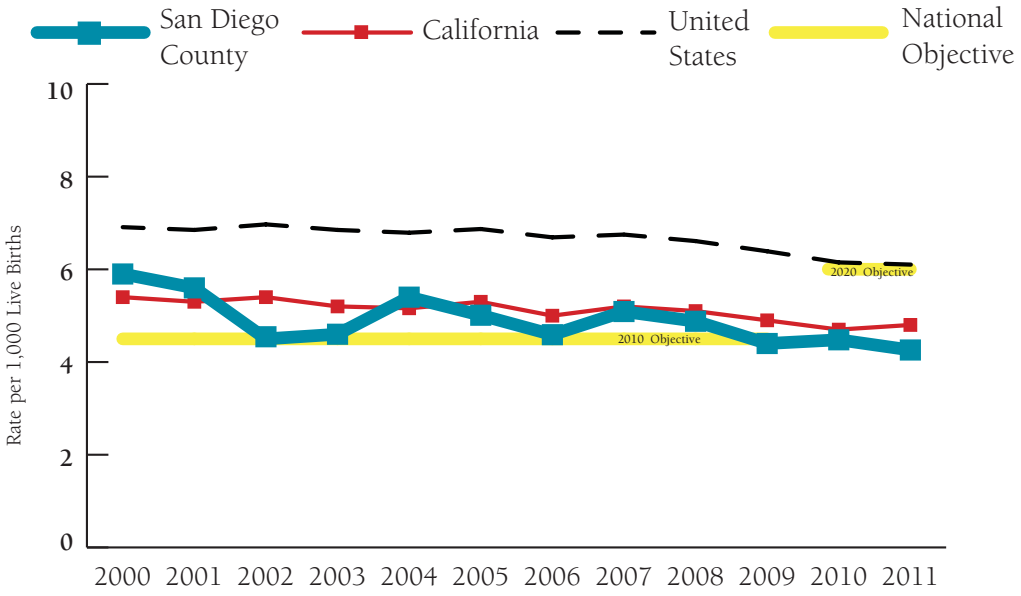
## *How are we doing?*

**Mortality Rate Per 100,000 Children Ages 1-4, 5-14, and 15-17, San Diego County, 2000-2011**




*San Diego County is improving, despite some variations, the trends in child mortality rates. However, nearly 300 children and youth died in 2011, many from preventable causes.*

## Infant Mortality Rate Per 1,000 Live Births, San Diego County, California, and United States Compared to National Objective, 2000-2011




*The trend in infant mortality is improving. The rate for San Diego, California, and the nation show small fluctuations but have declined. Still, 186 babies died in San Diego in 2011. The National Healthy People 2020 objective lowered expectations for improvement from 4.5 to 6.0 infant deaths per 1,000 live births.*

## What strategies can make a difference?

Infant and child mortality rates reflect an array of risks and conditions such as disease, poor maternal health, adverse living conditions, environmental hazards, lack of access to health services, risky behavior, 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. Many of the recommended actions throughout this *Report Card* are part of childhood mortality prevention.

The following strategies have been used to reduce childhood mortality:

- Ensuring access to services and supports that reduce the underlying causes of infant death, including preterm and low-birthweight birth.
- Educating parents before they leave the hospital about safe sleep practices to prevent sudden infant death syndrome (SIDS) and about shaken baby syndrome.
- Providing no cost or low cost car and booster seats for infants, toddlers, and young children.
- Educating parents and children about the risks of drowning at home and in the community.
- Promoting gun safety and safe storage of firearms.
- Using interventions, such as home visiting, for families at risk for child abuse and neglect.
- Requiring driver safety education programs, graduated licensing, and driving restrictions for teen drivers.
- Implementing suicide awareness and prevention programs.
- Supporting child death or fatality review teams to routinely and systematically identify risk factors and interventions that could prevent future deaths.

## How can we improve the trend in San Diego County?

In line with prior *Report Card* recommendations, efforts are continuing to educate parents and teen drivers about teen driving safety, graduated driving restrictions, and laws prohibiting driving while texting or using cell phones. For infants, the National Institutes of Health have put new emphasis on safe sleep practices. The American Academy of Pediatrics released *SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for the Safe Infant Sleeping Environment*. During home visits with pregnant women and families, San Diego public health nurses use this information to teach parents about the importance of safe sleeping environments for babies. The Health and Human Services Agency, in partnership with the Sheriff's Department, is developing a video to be released in late 2014 on Safe Sleep for infants. In addition, the Children' Initiative is continuing to distribute free gun locks to law enforcement agencies, community residents, and parents.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with Safe Kids San Diego, Injury Free Coalition for Kids, San Diego Child Fatality Review Team, Health and Human Services Agency, First 5 San Diego, United Way of San Diego County, parents and parent associations, schools and school districts, community clinics, American Academy of Pediatrics, faith communities, community-based organizations, local law enforcement, municipalities, and media partners to:

1. Inform and educate parents about new guidelines for infant safe sleep through public education and social marketing campaigns in multiple languages.
2. Continue and expand gun safety programs, particularly safe gun storage and free gun lock distribution.
3. Expand access to no cost or low cost car and booster seats for infants, toddlers, and young children, to be distributed along with parent education about seat belt and car seat use.

# ACKNOWLEDGEMENTS

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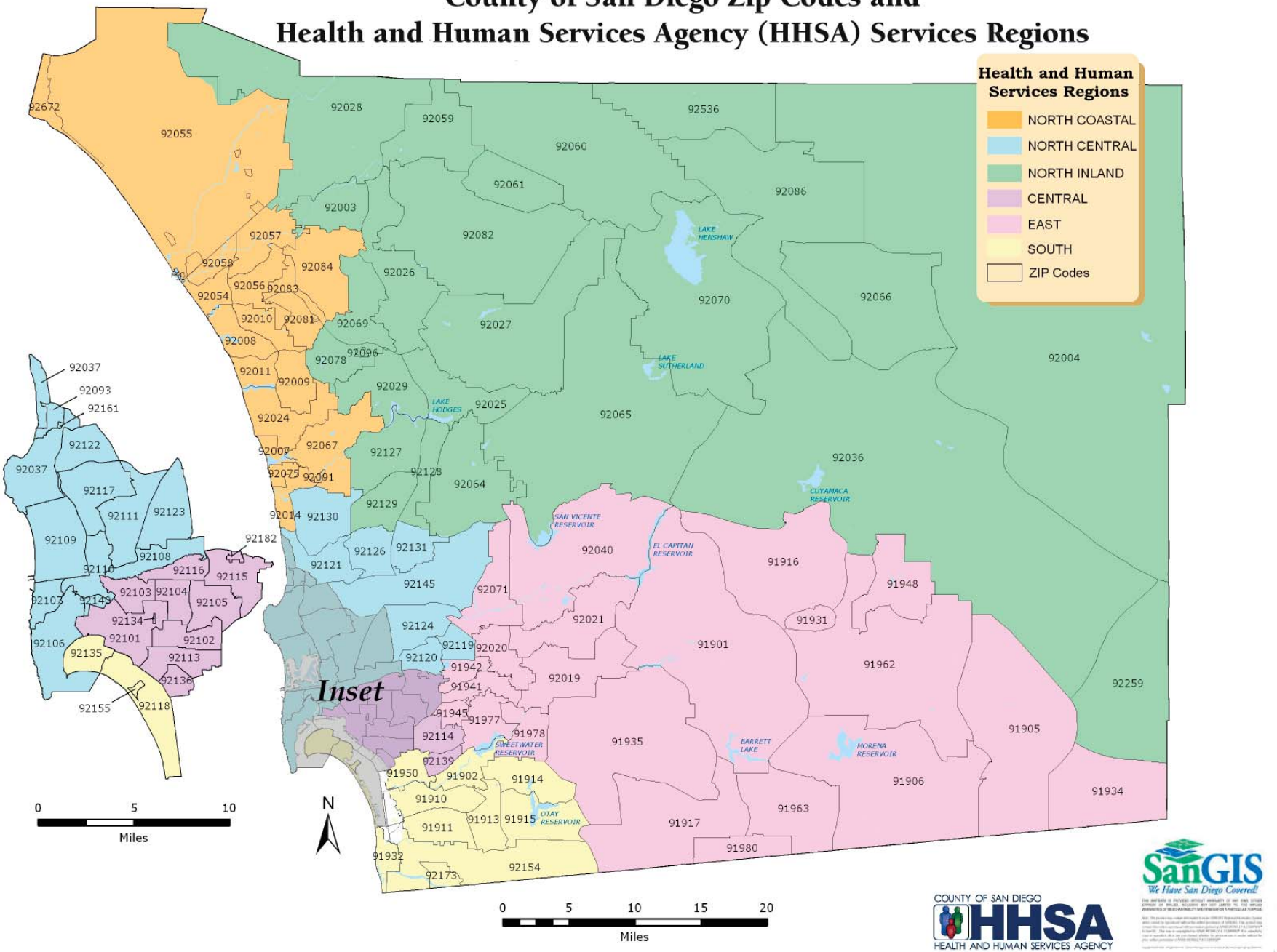
# County of San Diego Zip Codes and Health and Human Services Agency (HHSA) Services Regions




COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

SanGIS We Have San Diego Covered!

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