



2017

STATUS OF CHILDREN'S HEALTH

SANTA CLARA COUNTY

VOLUME 2

Dave Cortese

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To the Residents of Santa Clara County:

During my State of the County Address in January 2015, I called on the Santa Clara County Health and Hospital System to conduct a comprehensive assessment of the health of children in our county. A child's health plays a vital role in their development throughout their lifetime. Today's children are the future community leaders, elected officials, and workforce in Santa Clara County. The information we learn through this assessment will help us provide what our children need today to achieve their full potential in the future.

I am proud to present ***Status of Children's Health: Santa Clara County 2017***, the second part of a two-part report detailing the health and social needs of children in Santa Clara County.

This second volume of this assessment is a compilation of data collected through surveys in multiple languages, focus groups and interviews with key community stakeholders that focused on key priority areas of children's health and well-being: Structural racism and discrimination, access to health services, environmental and neighborhood conditions, educational system, family and social support, and economic inequality. There is a spotlight on select county programs, including child welfare system, juvenile probation and school wellness policy. Concluding, with findings from the community call to action, outlining the strategies and recommendations for addressing children's health concerns.

It is my goal that both reports will serve as valuable tools for policy makers, foundations, non-profits, researchers, elected officials, and government agencies to allocate resources, plan services, develop programs and policies to address structural and social inequities facing this county's most vulnerable residents.

I would like to acknowledge Dr. Sara Cody, Public Health Officer and Director, and her staff for their leadership on this project along with my office staff, Lara McCabe and The-Vu Nguyen. I also wish to acknowledge and thank all of the members of the Children's Health Assessment Advisory Committee who have helped guide this assessment.

The child health assessment is aimed at improving the overall health status of children in Santa Clara County. Together, we have the opportunity to support healthy families.

Dave Cortese
President, Board of Supervisors



To the Residents of Santa Clara County:

We are proud to present the **Status of Children's Health: Santa Clara County 2017**, the second part of a comprehensive assessment detailing the health and social needs of children's health in our county.

Our county has a long-standing commitment to the health and well-being of the children in our county. Results from this survey demonstrate how this commitment has translated to meaningful and positive achievements in the health of children. Data from Volume 2 of this report will be used to partner with stakeholders and help inform new service and policy areas. In addition, build on the success and support the evaluation of existing services and policies aimed at improving the overall status of children.

Children and youth experience patterns of health and illness that are different from adults. Although findings from Volume 1 of our assessment highlight that most children ages 0 to 17 in Santa Clara County have health insurance, racially disproportionate health outcomes persist. Volume two highlights the stories and narratives, as shared by youth, parents and children's health informants, detailing the daily challenges and undue burden placed on families navigating systems, and structures, and its impact on children's health, including discrimination, environmental and neighborhood conditions, barriers to accessing services, family and social support.

In the second part of this assessment, we present new data to inform the development of concrete next steps to execute the important action-oriented recommendations that resulted from the community call to action for improving children's health in Santa Clara County.

However, we strongly believe that in order to be successful, it will require individuals, organizations and agencies that serve our children to coordinate efforts, strengthen partnerships, develop new strategies, and align existing services and resources around identified priorities.

We wish to thank the members of the Children's Health Assessment Advisory Committee, and the Public Health Department staff for their dedication, commitment and leadership to elevate and address the needs of all children in Santa Clara County.

Sincerely,

A handwritten signature in blue ink that reads "René G. Santiago".

René G. Santiago
Deputy County Executive and Director
Santa Clara Valley Health & Hospital System

A handwritten signature in black ink that reads "Dr. Padmaja Padalkar".

Dr. Padmaja Padalkar
Assistant Chief of Pediatrics
Kaiser Permanente San Jose Medical Center

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INTRODUCTION

Healthy children are more likely to grow up to be healthy adults. In order to address the health and social needs of children in Santa Clara County, the Santa Clara Valley Health and Hospital System in collaboration with the Santa Clara County Public Health Department and Kaiser Permanente, under the direction of the Santa Clara County Board of Supervisors, undertook a two part assessment to examine the health of children in the county. The first part of the assessment, Volume 1 of the Children's Health Assessment released in early 2016, presented secondary data on the health status of children living in Santa Clara County. A significant finding from that report was that although many children in Santa Clara County experience good health, there are staggering disparities among various groups and by geographic area that persist. In the second part of the Children's Health Assessment, Volume 2, a broad picture of the health and social issues is presented through the experiences and collective wisdom of families, youth, professionals, and child advocates.

In an effort to enhance the county's capacity to address the needs of the children and youth living in Santa Clara County, this report examines the several facets of children's health through focus groups, key informant interviews, and survey data, shaping a collective narrative that is inclusive of the environmental, neighborhood and systemic conditions confronting families, such as housing, education and family support.

With that goal, this report is organized into 10 chapters, across the following domains: barriers to accessing services; early learning and the educational system; economic inequality and housing instability; racism and discrimination; family and social support; community safety and violence; healthy development; oral health; healthy eating and active living; and behavioral health. Each chapter begins with a brief overview of why the domain is important, followed by what the numbers tell us from survey findings, and what the community tells us from their perspective and experiences. There is also a spotlight on select county populations, programs, and partner agencies and community organizations providing services in Santa Clara County focusing on the existing successful efforts to improve the health of children, youth and their families. While this report is not all encompassing and comprehensive of all data sources that track the health and well-being of children in Santa Clara County, it does provide an in-depth profile of the salient issues facing children in this county. There is a strong foundation to build on, going forward.

Critical to the findings from both Volume 1 and Volume 2 of the Children's Health Assessment, is the community engagement and participation section, which describes the instrumental role of the advisory committee, and stakeholders in guiding, reviewing, and prioritizing the areas of concern impacting the health and well-being of the county's children and youth. In the Call to Action chapter, the top 7 strategies across the 4 priority areas are: [barriers to accessing services, early learning and the educational system, economic inequality and housing, and structural racism and discrimination](#).

The completion of the second volume of the Children's Health Assessment report, shifts the dialogue from assessment to action, moving towards a continued, collective commitment, and engagement of diverse community members, leaders and advocates in Santa Clara County. The strategies developed from the Call to Action community forum can aid the community, lead agencies identified, county agencies, and elected officials to achieve the goal of creating equitable, action-oriented programs, policies, and communities to improve the lives of children, youth, and their families in the county.

BARRIERS TO ACCESSING SERVICES

Children's access to healthcare is crucial to their overall health and development.¹ However, access to healthcare means much more than having health insurance coverage.² A number of financial and non-financial barriers may delay or prevent families from seeking healthcare for their children. Such barriers may be geographical access; transportation issues; cost of care; sociocultural, language and race/ethnicity related barriers; lack of healthcare providers; intricacies of navigating a complex healthcare system; and lack of knowledge and awareness about the services.^{2,3} Healthy People 2020, provides 10 year evidence based national objectives aimed at improving the health of Americans, has a goal to improve access to comprehensive, quality healthcare services for all.⁴ Research confirms that racial/ethnic minorities and people of low socioeconomic status are disproportionately represented among those with access problems.⁵

ACCESS TO HEALTHCARE

Why It's Important

Studies have shown that healthcare coverage leads to better health, higher educational attainment, and greater economic success.⁶ Children who have healthcare coverage report to be more successful in school and miss fewer days of school. Children with healthcare coverage are more likely to utilize primary healthcare services and are less likely to be hospitalized for conditions that could have been treated by a primary care physician.⁷ Children and families without healthcare coverage often delay medical care and resort to emergency care or hospitalization, which can lead to poorer health outcomes and increased healthcare costs.⁸ Poor access to healthcare results in both personal and societal cost. For example, if children do not receive vaccinations, they may get sick and spread disease to others; increasing the burden of disease individually and for society overall.⁵

In Numbers: Survey Findings

General Health Status

In Santa Clara County, 96% of the children were reported to be in excellent, very good, or good general health status; slightly lower than the percentage nationwide (98%).^{9,10} In the county, this percentage was lower among Vietnamese children and children from low income households compared to other children.⁹

PERCENTAGE OF CHILDREN WITH EXCELLENT, VERY GOOD, OR GOOD GENERAL HEALTH STATUS

		Percent (%)
Santa Clara County		96
Sex	Male	97
	Female	95
Age group	0-9 years	96
	10-17 years	94
Annual Household Income	Less than \$25,000	92
	\$25,000 – less than \$75,000	95
	\$75,000 and more	99
Race/ethnicity	Asian/Pacific Islander	96
	Latino	94
	White, Non-Hispanic	99
Asian subgroups	Asian Indian	99
	Chinese	99
	Filipino	98
	Vietnamese	88

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

Healthcare Coverage

In Santa Clara County, most children ages 0 to 17 (98%) had healthcare coverage, just slightly below the Healthy People 2020 target of 100% coverage.^{11, 4} Most children ages 0 to 17 (91%) in Santa Clara County had health insurance that usually or always allowed them to see the healthcare providers they needed. However, a lower percentage of males (87%) and children ages 0 to 9 (89%) had health insurance that usually or always allowed them to see the healthcare providers they needed.

PERCENTAGE OF CHILDREN WHO USUALLY OR ALWAYS HAVE HEALTH INSURANCE COVERAGE THAT ALLOWS THEM TO SEE THE HEALTHCARE PROVIDERS THEY NEEDED

		Percent (%)
Santa Clara County		91
Sex	Male	87
	Female	95
Age group	0-9 years	89
	10-17 years	93

Source: Santa Clara County Public Health Department, 2016 Child Health Telephone Survey

More than 4 in 5 children's (86%) health insurance plan offered benefits or covered services that always or usually meet their healthcare needs, while 14% of children's health insurance never or only sometimes covered services that met their healthcare needs.⁹ A higher percentage of Latino children

and children from low-income households reported having health insurance that never or only sometimes offered benefits or covered services that met their healthcare needs compared to children of other racial/ethnic groups and high-income households in Santa Clara County.⁹

PERCENTAGE OF CHILDREN WHO HAVE HEALTH INSURANCE THAT NEVER OR ONLY SOMETIMES OFFERS BENEFITS OR COVERS SERVICES THAT MEET THEIR HEALTHCARE NEEDS

		Percent (%)
Santa Clara County		14
Sex	Male	15
	Female	13
Age group	0-9 years	11
	10-17 years	17
Annual Household Income	Less than \$25,000	24
	\$25,000 – less than \$75,000	16
	\$75,000 and more	5
Race/ethnicity	Asian/Pacific Islander	8
	Latino	20
	White	10
Asian subgroups	Asian Indian	4
	Chinese	5
	Vietnamese	14

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

Healthcare Services Utilization

Children with a usual source of care are more likely to utilize primary care services and have better health outcomes.¹² More than 9 in 10 children (92%) in Santa Clara County were reported having a medical home; a place that a child usually go to when he/she was sick or parents needed advice about the child's health. A lower percentage of Asian Indian (82%) and Vietnamese children (88%) reported having a medical home compared to children of other racial/ethnic groups.¹²

PERCENTAGE OF CHILDREN WHO HAVE A MEDICAL HOME

		Percent (%)
Santa Clara County		92
Sex	Male	92
	Female	92
Age group	0-9 years	93
	10-17 years	93
Annual Household Income	Less than \$25,000	89
	\$25,000 – less than \$75,000	93
	\$75,000 and more	95
Race/ethnicity	Asian/Pacific Islander	89
	Latino	93
	White	97
Asian subgroups	Asian Indian	82
	Chinese	91
	Vietnamese	88
	Filipino	100

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

Children's access to primary healthcare is especially important in order to monitor healthy growth and development and prevent everyday illnesses from progressing into potential serious health issues.¹³ In the past 12 months, 94% of the children reported having at least one visit with a doctor, nurse, or other healthcare provider for preventive medical care such as well-child visits. A lower percentage of Latino children (93%) and children from low-income households (89%) reported having at least one preventive care visit with a doctor, nurse, or other healthcare provider in the past 12 months.⁹

PERCENTAGE OF CHILDREN WHO REPORTED HAVING AT LEAST ONE VISIT WITH A DOCTOR, NURSE, OR OTHER HEALTHCARE PROVIDER FOR PREVENTIVE MEDICAL CARE IN THE PAST 12 MONTHS

		Percent (%)
Santa Clara County		94
Sex	Male	95
	Female	93
Age group	0-9 years	95
	10-17 years	93
Annual Household Income	Less than \$25,000	91
	\$25,000 – less than \$75,000	97
	\$75,000 and more	96
Race/ethnicity	Asian/Pacific Islander	96
	Latino	93
	White	96
Asian subgroups	Asian Indian	97
	Chinese	95

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.
Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

What the Community Tells Us: Community Perspectives and Experiences

The following section presents findings from the Children’s Health Assessment key informants and focus groups participants, parents and youth, on barriers to accessing services.

Geographic Isolation of Impacts Service Availability

Key informants and focus group participants reported that services are difficult to access due to the large geographic size of the county and limited public transit options for families without personal vehicles. Most services are located in densely populated urban areas of the county. Families living in the southern parts of the county are not within close proximity to many needed services; consequently many families reported spending significant resources and time traveling to get to services. Key informants provided insights into the importance of locating services close to where families live, noting, "if you live in an under resourced area and that area has been under resourced for 20 or 30 years, and your closest community center, your closest health clinic is miles away, and transportation is a problem ... access is not just about knowing and knowing how to access [services]. It's also about being able to physically get places ... the key is really, you have to be able to go where people are and bring services to people."

Families Face Challenges Navigating the Healthcare System and Other Services

Even when families know about the available services and resources, many have trouble navigating the complex system of services in the county. Many focus group participants and key informants expressed concerns about families’ inability to understand eligibility requirements for services and the

steps necessary to enroll and access these services. Difficulty navigating a seemingly disconnected system of services is not just an issue for vulnerable families. Even caregivers with higher economic means and a greater understanding of how to access services struggle, as one focus group participant observed, "I'm a special-ed teacher. I have a masters doing special ed, I'm a union president, I'm a foster parent. I should know how to advocate and get things done. I know all the laws and I'm still scrambling all the time [to navigate the system and services for foster kids]."

Additionally, families noted that having health insurance does not always alleviate problems related to navigating and accessing services. Differences among various insurance plans add to the difficulties of finding adequate care that is covered under the plan. Focus group participant described having to spend a great deal of time understanding health insurance plan and coverage details for children, describing, "I went and switched [insurance plans], because I couldn't get appointments when I needed them. I went to the other health plan. They weren't covering here, they weren't covering there. I ended up having to do a whole switch over, within a two-month period. Back and forth. It was ridiculous ... I have five kids and they spread them all to different doctors ..."

Lack of Information about Available Services and Resources

Key informants and focus group participants described a lack of awareness of available resources as a barrier to families accessing needed services. Key informants described one of the challenges for families to make healthy choices is related to parent's education, awareness, and information about resources, such as healthcare and mental health services, and health education classes. Parents noted that many immigrant families are also not aware of the range of available services and resources that exist. A key leader explained that immigrant families do not often understand how to use healthcare services in the U.S., explaining that "[Recent immigrants are] not used to navigating the healthcare system. They don't know how to use it. They don't understand. ... Our lead times are fairly reasonable, but getting parents to understand how to use [the services is difficult]."

Lack of Culturally Relevant, Multilingual Services and Information

Focus group participants reported [a lack of services for non-English monolingual speakers living in Santa Clara County](#). They stressed the importance of providing information and services in multiple languages, in a culturally sensitive and responsive way, to help meet the needs of diverse communities and increase access to and utilization of services. As one key informant summarized, "... we were told by many people – the foundations, the county, the city – that Vietnamese don't access services and so because of that, they think the Vietnamese don't have any needs. When we started providing culturally sensitive parenting workshops, people came because it addressed their needs. It allowed them to ask questions in their language and in the way that they see the world and we understand that."

Participants also noted, in spite of the ongoing efforts for providing information and services in languages other than English, more work is needed to improve and expand the language accessibility of services and information materials throughout the county, especially for Vietnamese and other linguistically isolated communities. One key informant commented, "... the county's doing some good

work at language accessibility issues for materials but there's clearly a ton more work that needs to be done. I think one of the challenges of this county is while we may be pretty good at translating materials into Spanish, we were not quite as good as translating them into Vietnamese [or] ... other smaller populations here that need materials."

Some Providers Lack Knowledge and Competence to Provide Services to Diverse Sub-populations or Communities

Focus group and key informant's participants also discussed the need to train service providers about the cultural diversity of the families being served in the county. A provider noted that culturally sensitive practices will help improve the quality of care, explaining, "... just because you speak Spanish, or because you speak Vietnamese, it does not mean you understand the culture. ... Well, that's great for talking, but that doesn't mean [anything] when it comes to understanding the people you're talking to or talking about ..."

"There has to be a little bit of effort to understand the cultures and the nuances around the people whom you're dealing with. Because if you don't understand the cultures, you'll never really be able to truly serve the people that you profess to try to reach out to serve."

– Key Leader Informant

LGBTQ key informants and youth described providers' lack of knowledge and competence in providing a range of services to LGBTQ youth in Santa Clara County. Providers do not typically receive training for providing competent care for diverse sexualities and genders. Even when providers want to be supportive of LGBTQ youth, they often do not have the training to do so. A key informant described this issue in regards to mental healthcare explaining, "... in terms of mental healthcare, I think that it's not a required or standard practice for the clinicians in the field to receive in depth education or opportunities to develop cultural humility related to sexuality and gender ... so, even when they want to provide supportive care to trans or LGBT youth, they often do not have the tools readily available ... that leaves us with a very small pool of providers who ... have the competence to work with our community."

"... When I was younger I didn't feel safe approaching or trusting or communicating with an adult [staff] that didn't look like me or that had more money than me. ...You want me to trust you but your reality is different than mine. You live differently than I do."

– Focus group participant

Key informants and focus group participants emphasized the importance of service providers who can understand the life experiences of children of color and mirror the diverse backgrounds of the families they serve. They also expressed the difficulty for African American families in Santa Clara County to access service providers who they can identify with, "People need to know that there's some place that they can go if they have an issue where people will understand what the issue is. ... It's very difficult for a lot of African-American families, starting with parents all the way down to kids, to find somebody that they can identify with in a facility that has the ability to offer the services that they need."

Fear and Distrust of the Healthcare System

Santa Clara County has made strides in reducing obstacles to accessing services, but key informants and focus group participants agreed that despite continued efforts, gaps still exist. There are still many families throughout the county that do not access and receive needed services.

Families stated fear and lack of trust as some of the many obstacles to accessing the healthcare system and its services. Key informants explained that undocumented immigrant families report being afraid to access services, and often do not access services until the situation reaches crisis level, noting "I think all of those things play into health, because then families don't access services until it's a crisis." Another key informant further commented that immigration status is a driver of disparities, explaining that "when families don't feel safe contacting government agencies because of real or perceived fear, it doesn't matter how many services and programs you have, they're not going to come. They're not going to call law enforcement when they need help. They're not going to go to the emergency room, because they're afraid."

Focus group and key informant participants discussed that many members of Asian communities may not access mental health services due to stigma, preventing families from seeking care. Key informants described that stigma can be related to the belief that mental health problems reflect poorly on families. Explaining that, "[for] Vietnamese, the stigma related to mental health ... is very high because it goes all the way up to the ancestors. We believe in karma and because of that, if the children have problems today, that's because the ancestors did something bad and ... people are really scared to talk about it or even to ask questions." This belief contributes to a reluctance about acknowledging that there is a problem, seeking care, or talking about mental health issues. Another key informant noted that especially for the Asian community, mental health issues are big, and

urgent, adding, "We have seen this in some suicide clusters in Northern Santa Clara County. I think when you look at various health statistics, we sometimes forget about mental health issues, especially for the Asian community."

Shortage of Select Services and Service Providers Limit the Access to Services

Mental Health: Families who participated in the focus group described facing barriers when accessing needed mental healthcare. A caregiver commented that finding adequate mental health treatment for her son was difficult, even though depression and other mental health conditions are common among children and youth. She shared her experience about her seventeen year old son needing to be hospitalized with depression, explaining, "There's nothing here. There's no in-patient. There's no partial hospitalization. There's no real intensive outpatient. There's kind of a lighter outpatient [program but] that's it. I was shocked because it's so much easier to find something for a rare medical condition."

Specialty Care: Key informants also reported a lack of specialty healthcare providers (e.g., audiologists, mental health providers, and pediatric dentists) as a barrier to accessing services. The lack of healthcare providers in these fields disproportionately affect lower-income families' ability to receive needed services in a timely manner. Key informants observed that one reason for a lack of mental health services may be due to an insufficient number of mental healthcare providers that serve children and youth. The providers that are available are often at capacity and no longer accept additional patients, explaining, "I think we in this county have really lacked sufficient mental healthcare counselors ... often been told that they're no longer taking additional kids ... or they don't have any more psychiatrists that can see kids. There's a huge deficit of mental health access for pediatricians and families to get the appropriate care that they need."

Dental Care: Key informants have also pointed out that there are shortages of dentists and dental safety net clinics that serve low income families. In addition, dentists are not typically located near low income families. A key informant noted that that if more dentists accept Denti-Cal, there might be more services available to vulnerable families, "... if there were more providers ... who would accept [Denti-Cal], for example, [then] we might be able to have patients living next door to that office, a dental office." Another key informant added, "... we don't tend to have a lot of ... specialists. Like pediatric dental, anesthesiologists, pediatric dental surgeons ... We don't have a lot of these specialists, highly specialized for children."

Health Insurance Plans: Key informants also noted that providers have little incentive to serve low income patients due to low reimbursement rates for Medi-Cal, Denti-Cal, or plans under Covered California, which limit the number of providers available to vulnerable families. A key informant further described, "the reimbursement rate [for Denti-Cal] is so low ... that's a huge disincentive for anybody to want to take this insurance."

And, for those providers that do accept these insurance plans, there is often a long wait to get in for services, hence delays in receiving care, even for urgent health matters. One key leader explained that expanding health insurance coverage through the passage of the Affordable Care Act has succeeded

in increasing access to healthcare services for many families, but has also increased the demand for services which results in further stresses on the healthcare system.

COST OF CARE

Why It's Important

Health insurance coverage is supposed to protect individuals and families from the burden of high healthcare costs. However, even with health insurance coverage, the financial burden for healthcare can still be high and is increasing. High premiums and out-of-pocket payments can be a significant barrier to accessing needed treatment and preventive care.⁵ In 2014, rising costs were the main growth factor in children's healthcare spending.¹⁴

Prior to the Affordable Care Act (ACA), the Children's Health Insurance Program (CHIP) was established to provide coverage for uninsured children who were low-income but above the Medicaid eligibility cutoff. CHIP and Medicaid covered more than 1 in every 3 children in the U.S. In turn, this form of public insurance helped to reduce disparities in healthcare coverage that affected low-income children and children of color.¹⁵ The ACA further facilitated expansion of eligibility and enrollment among children and youth; examples of select ACA policies are required maintenance of the comprehensive CHIP program through 2019, youth and young adults can stay on their parent's health insurance plans until the age of 26, extending the Medicaid coverage to youth under age 26 if there were in foster care at age 18, children and youth cannot be denied healthcare coverage for pre-existing conditions, and most healthcare plans must cover a set of preventive health services for children at no cost.¹⁶

What the Numbers Tell Us: Survey Findings

In 2016, family finances emerged as one of the top concerns regarding their children's health among parents and caregivers living in Santa Clara County.¹⁷ Among the families who had a medical expense related to their child's healthcare in the past 12 months, nearly 1 in 8 families (12%) had problems paying or were unable to pay medical bills for their child's healthcare. This percentage was higher among Filipino, Vietnamese, and Latino families compared to families of other racial/ethnic groups; families seeking healthcare for older children ages 10 to 17 compared to those seeking healthcare for younger children ages 0 to 9; and low household income families than families with annual household incomes under \$75,000.¹²

Percentage of families having problems paying or were unable to pay medical bills for their child's healthcare in the past 12 months among those who had a medical expense related to their child's healthcare

		Percent (%)
Santa Clara County		12
Sex	Male	12
	Female	11
Age group	0-9 years	10
	10-17 years	15
Annual Household Income	Less than \$25,000	17
	\$25,000 – less than \$75,000	16
	\$75,000 and more	4
Race/ethnicity	Asian/Pacific Islander	8
	Latino	14
	White, Non-Hispanic	10
Asian subgroups	Asian Indian	3
	Chinese	4
	Filipino	18
	Vietnamese	17

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes. Medical bills may include bills for doctors, dentists, hospitals, therapists, medication, equipment, or home care.

Source: Santa Clara County Public Health Department 2016 Child Health Intercept Survey

What the Community Tells Us: Community Perspectives and Experiences

The following section presents findings from the Children's Health Assessment key informants and focus groups participants, parents and youth, on cost of care.

The Financial Barriers Associated with Healthcare Services

Parents and caregivers reported that health insurance is expensive, which can impact a family's ability to afford services at large. Focus group participants stated challenges of affording both the insurance premiums through their employer and the co-pays associated with seeing providers. They observed that these combined expenses can be prohibitive to seeking care.

Families also reported that dental care is expensive. For this reason, families have difficulty affording dental care and often prioritize one type of care over another (e.g., medical care over dental healthcare). Additionally, dental care is also not typically covered under health insurance plans, which means that many families often go without care.

Income Based Eligibility Requirements and the "Benefits Cliff" are Challenging

Many parents, caregivers, and key leaders identified challenges in understanding the eligibility requirements for services. Specifically, many key leaders described how the "benefits cliff" creates financial hardships that affect families' continued abilities to afford healthcare services. A *"benefits cliff"* refers to benefits decreasing as household income increases. For example, if families make an income just above the eligibility threshold, they no longer qualify for assistance for programs or services even if they are not able to afford the programs or services without assistance. Such gaps exist both for income assistance/safety net programs and for support services. Many families described challenges with eligibility in relation to Medi-Cal, speech therapy, and other kinds of government-funded assistance. Furthermore, the eligibility thresholds are set at a national level and do not adjust to the regional cost of living variations nationwide. Santa Clara County, being situated in the San Francisco Bay Area, has a much higher cost of living compared to the national average. This leads many families to pick between getting healthcare services and paying for housing and food for the family. A key informant described the problem, explaining, "The really crazy part is, if you make too much money, you go off the public support that might have been helping you. So there's an interesting problem that Santa Clara County has, and I think most of California has. Public benefits are set federally and they don't look at regional costs."

Focus group participants also acknowledged that eligibility requirements for services can prevent parents and caregivers from obtaining needed care for children. A focus group participant described her frustration with treatment for a child that was not progressing fast enough and who was not meeting predetermined milestones. As a consequence of not meeting these milestones, the child's treatment was reduced substantially, which, the focus group participant highlighted as counterintuitive. For example, a parent explained by describing, "sometimes with the speech language issue, if they are not progressing at a certain speed, they cut the child back, saying they are not progressing at the level they should be progressing – therefore we are not going to give you the hours a week anymore because [the child] cannot meet their milestones. Instead of increasing [services] they decrease [them]. How does that help the child? They're ... assuming this child will just never get it and it's so wrong."

REFERENCES

- ¹ Children's Access to Health Care. RAND Corporation. Accessed on 10/14/2016 at: <http://www.rand.org/topics/childrens-access-to-health-care.html>.
- ² Reducing Barriers to Health Care: Practical Strategies for Local Organizations: Covering Kids and Families Access Initiative Toolkit. Center for Health Care Strategies, Inc. http://www.chcs.org/media/CKF-AI_Toolkit.pdf. Published January 2007. Accessed on 10/15/2016.
- ³ Reaching the poor: Challenges for child health in the Western Pacific Region. World Health Organization. Accessed on 10/14/2016 at: http://www.wpro.who.int/publications/docs/ReachingthePoor_ChildHealthandPoverty_Part2.pdf.
- ⁴ Office of Disease Prevention and Health Promotion; Healthy People.gov. Accessed on 10/14/2016 at: <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>.
- ⁵ National Healthcare Quality Report, 2011. Agency for Healthcare Research and Quality. Access on 10/15/2016 at <http://www.ahrq.gov/research/findings/nhqrdr/nhqr11/chap9.html>.
- ⁶ Georgetown University Health Policy Institute. Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders. Published March 2016.
- ⁷ Bernstein J, Chollet D, Peterson S. How Does Insurance Coverage Improve Health Outcomes? Published April 2010. Available at: http://www.mathematica-mpr.com/~media/publications/pdfs/health/reformhealthcare_ib1.pdf.
- ⁸ United States Department of Health and Human Services. National Healthcare Disparities and Quality Report. Agency for Healthcare Research and Quality. 2010.
- ⁹ Santa Clara County Public Health Department, 2016 Child Health Intercept Survey.
- ¹⁰ Summary Health Statistics: National Health Interview Survey, 2014. Centers for Disease Control and Prevention 2016. Available at: http://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2014_SHS_Table_C-5.pdf. Accessed September 23, 2016.
- ¹¹ U.S. Census Bureau; American Community Survey, 2015 American Community Survey 1-Year Estimates, Table S2701; generated by Mandeep Baath; using American FactFinder; <<http://factfinder2.census.gov>>; (14 October 2016).
- ¹² U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2014. Rockville, Maryland: U.S. Department of Health and Human Services, 2014.
- ¹³ ChildStats.gov. America's Children: Key National Indicators of Well-Being. Usual Source of Health Care. Published 2015. Accessed 2016. <http://www.childstats.gov/americaschildren/care2.asp>.
- ¹⁴ Children's Health Spending Report: 2010-2014 | HCCI. <http://www.healthcostinstitute.org/childrens-report-2014>
- ¹⁵ The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us? Jul Paradise - <http://kff.org/medicaid/issue-brief/the-impact-of-the-childrens-health-insurance-program-chip-what-does-the-research-tell-us/>
- ¹⁶ The Affordable Care Act and Children's Coverage in California: Our progress and our future. The Children's Partnership. June 2016. Accessed on 11/07/2016 at: http://www.childrenspartnership.org/wp-content/uploads/2016/06/TCP_Children_and_the_ACA_Report_2016_1.pdf.
- ¹⁷ Santa Clara County Public Health Department, 2016 Child Health Online Survey

EARLY LEARNING AND THE EDUCATIONAL SYSTEM

In the U. S., the gradient in health outcomes by educational attainment has steepened over the last four decades, creating a larger gap in health status between Americans with high and low education.¹ The U. S. is the only industrialized nation where young people currently are less likely than members of their parents' generation to be high school graduates.²

Recent reports show that a person's level of educational attainment is a strong predictor of long term health and quality of life.³ There are several interrelated pathways through which education is linked with health such as health knowledge and behaviors; employment and income; and social and psychological factors, including sense of control, social standing and social networks.² People with more education are likely to live longer, experience better health outcomes, and practice health-promoting behaviors such as exercising regularly, refraining from smoking, and obtaining timely healthcare check-ups and screenings. Higher education is closely associated with financial security, social connections, and healthier working conditions. People who have at least a high school diploma have access to higher paying jobs; thus enabling them to afford basic necessities, such as healthy food, safe housing, and health insurance.⁴

Parent's educational level is strongly linked to their children's health and development. Babies born to mothers who have not finished high school are nearly twice as likely to die before their first birthdays as babies born to college graduates. Furthermore, children whose parents have not finished high school are more than six times as likely to be in poor or fair health as children of college graduates. Parents with lower educational attainment typically face greater obstacles – including lack of knowledge, skills, time, money and other resources – to creating healthy home environments and modeling healthy behaviors for their children. Children with less educated parents and low-income families face greater obstacles to succeed in school and are less likely to go on to receive college education.²

Studies show that the magnitude of association between parental educational level and birth outcomes varies depending on race of the parents. Higher parental education translates into better birth outcomes among Whites. However, for mothers who are not White, maternal educational level appeared to have little or no effect on birth outcomes such as low birth weight babies.⁵ The lifelong accumulated experiences of racial discrimination by African American women constitute an independent risk factor for poor birth outcomes. The association between maternal reported lifetime exposure to interpersonal racism and poor birth outcomes is strongest among college-educated women of color.⁶

The path to academic success and a professional career begins at birth. Children who receive high quality early learning from birth to age 5 have improved kindergarten readiness among children; which is associated with higher educational attainment and academic outcomes. Early education begins with a child's experiences at home, in child care, and other preschool settings. Along with child care, early learning can improve children's health and promote their social and cognitive development.⁷

What the Numbers Tell Us: Data Findings

School Enrollment:

In 2014, more than half of the children ages 3 to 4 (55%) were enrolled in a preschool in Santa Clara County with the following racial/ethnic composition: 2% African American, 38% Asian, 24% Latino, and 29% White children.⁸ During the 2013-14 school year, a total of 276,175 children were enrolled in public schools in kindergarten through 12th grades; encompassing the following racial/ethnic composition: 2% African American, 32% Asian/Pacific Islander, 39% Latino, 21% White children, and 5% children of other racial/ethnic groups.⁹

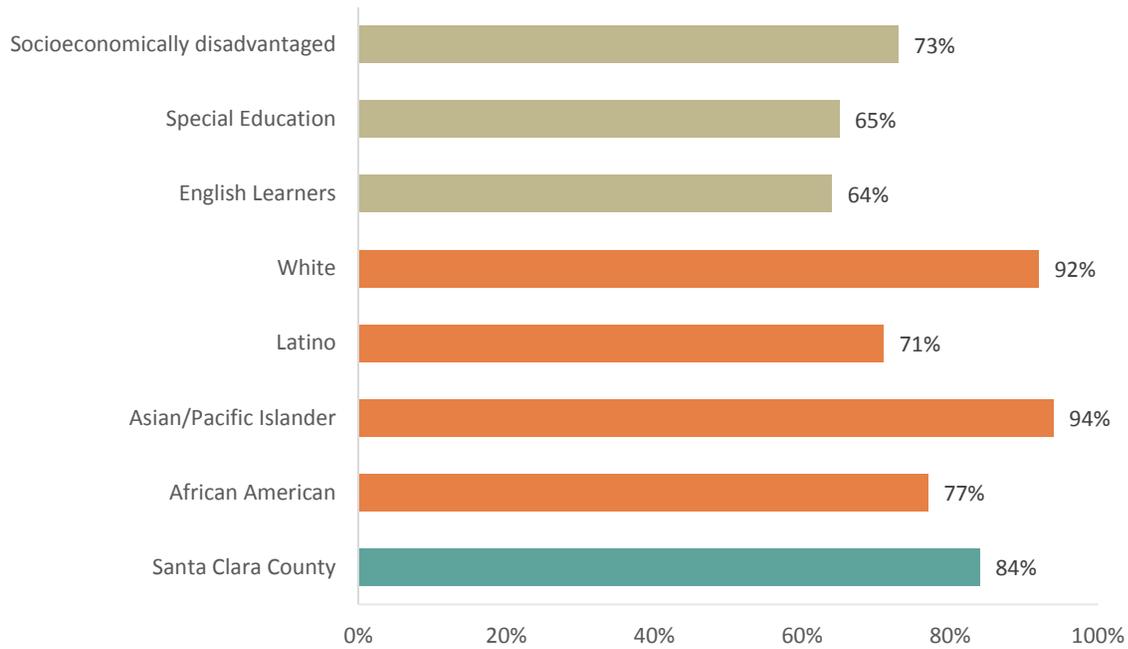
The term 'English language learners' describes students who have a primary language other than English and who do not have defined English language skills of listening, comprehension, speaking, reading, and writing that are needed to excel at school or in a school's program.¹⁰ One in 4 students (25%) enrolled in kindergarten to 12th grade were English language learners; the proportion of English language learners decreased with increasing grade levels.⁹

The term 'special education' describes information and resources available in the educational system to serve the unique needs of children and youth with disabilities so that each student will meet or exceed high standards of achievement in academic and nonacademic skills.¹¹ During the 2013-14 school year, 1 in 10 children and youth under the age of 23 (10%) were enrolled in a special education program in Santa Clara County, similar to the percentage in California (11%). Special education enrollment was highest among Latino children (50%) in the county, followed by 24% White, 18% Asian/ Pacific Islander, and 4% African American children and youth.¹²

High School Graduation:

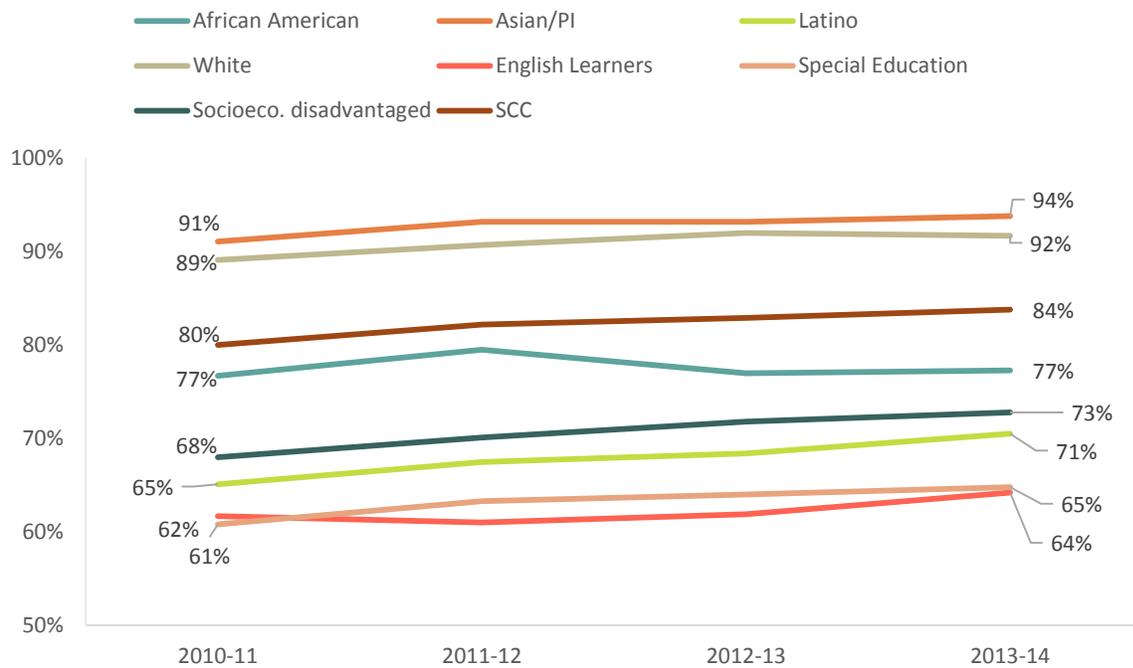
Although Santa Clara County (84%) had a higher high school graduation rate than the U.S. (82%)¹³ and California (81%) in 2013-14, racial/ethnic disparities exist. The graduation rate for Latino (71%) and African American students (77%) in the county was lower than White (92%) and Asian/ Pacific Islander students (95%). Graduation rates were even lower among students who were English language learners (64%); were enrolled in special education (65%); and were socioeconomically disadvantaged (73%).⁹ The gap in the graduation rate among various groups has been consistent over years: English learners students, students enrolled in special education, Latino, socioeconomically disadvantaged, and African American students constantly had graduation rates lower than the county average.¹⁴

PERCENTAGE OF HIGH SCHOOL 4-YEAR COHORT GRADUATION RATE AMONG PUBLIC SCHOOL STUDENTS



Source: California Department of Education, Data Quest, 2013-14

TRENDS OF HIGH SCHOOL 4-YEAR COHORT GRADUATION RATE AMONG PUBLIC SCHOOL STUDENTS

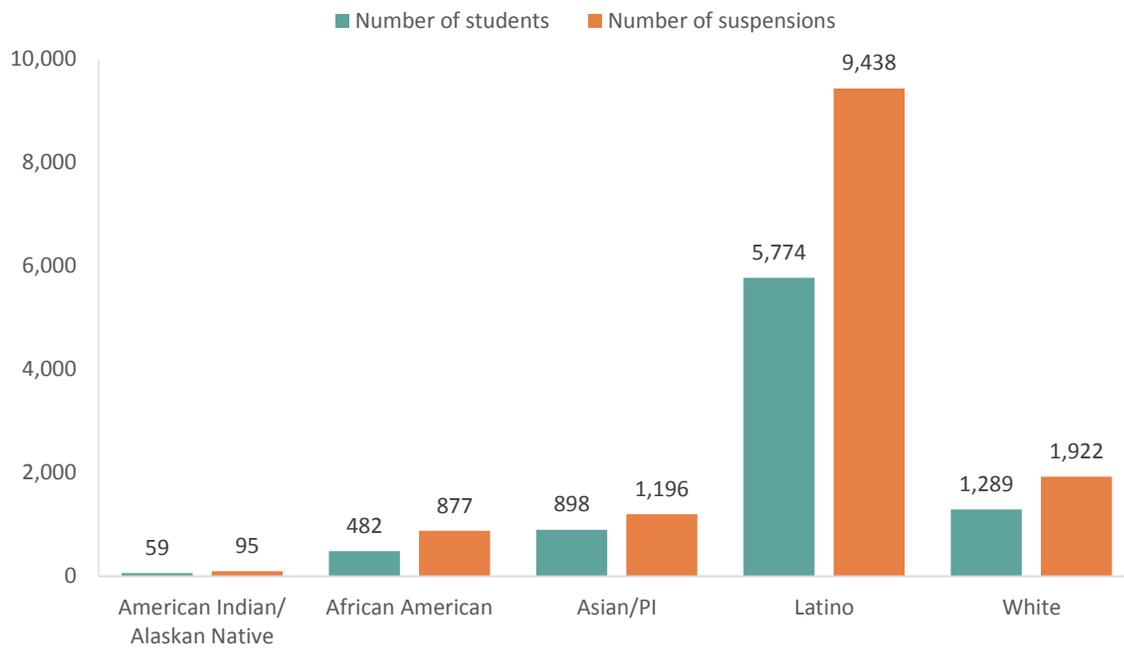


Source: California Department of Education, Data Quest, 2010-14

School Suspensions:

Suspension is a form of school discipline which temporarily removes a student from the class. Schools may prohibit a student from entering school grounds (out-of-school suspension) or a classroom, or a school may place the student in a supervised suspension room (in-school suspension) separate from other students.¹⁵ During the 2013-14 school year, 13,948 suspensions (including both in-school and out-of-school) were reported, affecting 8,773 studentsⁱ in Santa Clara County public schools. The suspension rate was 3% in the county, similar to that of California (4%). The highest number of suspensions were among Latino students. **However, African American students were suspended at disproportionately higher rates: 8 times higher than Asian/ Pacific Islander and 4 times higher than White students.**⁹

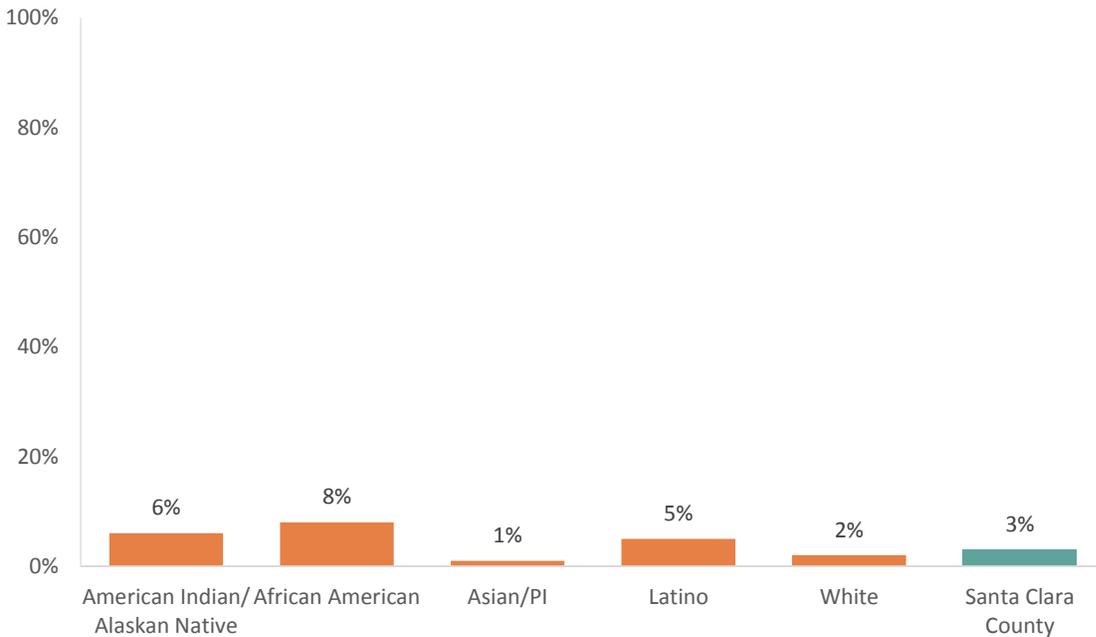
NUMBER OF SUSPENSIONS AND NUMBER OF STUDENTS WHO WERE SUSPENDED



Source: California Department of Education, Data Quest, 2013-14

ⁱ This data point represents the unique count of students who were suspended during the school year. Some students might be suspended more than once during the school year.

SCHOOL SUSPENSION RATE



Source: California Department of Education, Data Quest, 2013-14

What the Community Tells Us: Community Perspectives and Experiences

The following section presents findings from the Children's Health Assessment key informants and focus groups participants, parents and youth, on early learning and the educational system.

Barriers to Learning within the School Environment

Unequal Distribution of Resources Negatively Impact Students and Teachers

On a structural level, parents and key informants discussed how school funding and economic inequality affected the amount of money available per student, and in turn, the quality of education that exists in different school districts. One parent explained, "the more money they have, the better the schools, that's where it is ... It just depends on where you live at, the area where your district is." Key informants further echoed this inequity, highlighting additional details about school funding, "... there are schools in this county, public schools that have 15 or 16 thousand dollars to spend on a child. Then we have schools like in the Eastside that have 9 to 11 thousand dollars to spend. I don't think money solves all problems but I do think there's a leveling up that needs to take place." Another key leader explained the cumulative impact of funding inequities, "our lowest resourced kids go to our lowest resourced schools ... we still have kids that are entering 10th grade that had nine years of going to low resourced schools and it's not catching up that fast. We can have our lowest resourced kids concentrated and our children of color concentrated in our lowest resourced schools. There's a real opportunity gap that [happens] there."

Many parents also shared that teachers often had too many children per classroom, noting that there is an imbalance in the student-teacher ratio, "there are many kids for only one teacher," whereas the attention goes to the more advanced students, excluding the ones that are less advanced. A parent focus group participant further noted, that the separation perpetuates inequities in what, whom and how students are being taught.

Parents also expressed additional concerns about their children frequently having substitute teachers, including long-term substitute teachers. Parents noted that substitute teachers often did not understand the homework, did not have an established relationship with the students, and were not able to provide needed and tailored support to students. One parent explained, "there's always substitutes in the classroom because the teachers are in training or because teachers are taking tests or because they're in a meeting. Substitutes don't know what the kids are doing. 'Let's have a fun day.' It throws them way off."

Systematic Biases and Discriminatory Practices Affect Children of Color

Parents who participated in focus groups described how children of color continued to experience racism within school settings, from teachers and administrators as well as from peers. Institutional racism within the educational system may be reflected in the overall school climate (the foundation for many instances of bullying based on race and ethnicity), and both implicit and explicit bias from people in positions of authority (e.g., teachers, school administrators). Parents and youth participants in focus groups also discussed the ways that their opportunities (including their children's opportunities) had been limited by biased teachers, as well as how teachers had interacted with students.

Parents also identified the racially biased school curricula as an example of institutionalized racism. Parents in multiple focus groups described the damaging effects of youth not being taught history in ways that take into account perspectives and experiences of diverse populations. These participants

"... We have a history in this country, and we need to talk about it. I think it gives the kids perspective."

- Focus group participant

noted the importance of having historical role models and other knowledge that comes from learning about their historical origins (e.g., African/African American, American Indians/Native Americans). Many parents identified the lack of diverse teachers as contributing to this, with multiple parents noting that their children of color did not have an African/African American or Latino/a teacher until middle school and sometimes not until college. Parents reported that their children were frequently ostracized and bullied when youth of color were the minority within a school.

Parents in the African American focus group expressed concern that some teachers would teach about slavery in ways that minimized its history and importance in America, by framing it either as having happened a long time ago or as not being a "big deal." One parent further explained,

"Slavery is just not taught. ... I feel like as a society we just want to brush it away and act like it didn't happen. ... I'm even talking about [history lessons] going up into the Civil Rights era when I was born. It doesn't seem like they talk about Jim Crow that much. I'm saying, we have a history in this country, and we need to talk about it. I think it gives the kids perspective." There was also a concern that when Black history was addressed, it was done in a simplistic way and only during February, a designated month to celebrate Black History.

Parents in the American Indian focus group shared that teaching a more accurate version of history would benefit children's health by building their cultural pride and making them feel less isolated. Parents expressed frustration that their children were learning the same problematic history lessons they had received in their own childhood. One parent shared, "Even like my younger kids, they say, 'How come [teachers] don't teach us more about natives?' I said, 'It's always been that way.' It should have already changed. They [our children] learn the same thing we learned [as children]."

Parents in the American Indian focus group reported that the educational system overall continued to be discriminatory and that their children did not receive a fair chance. As a parent summarized, "[The education system sends the message to American Indian children that] 'You're not going to succeed,' so they pay less attention to [our children]. ... It hasn't changed ... it's not fair to our children that we grew up having the same stuff that they're [experiencing]." Some Latino and American Indian parents also shared that their children had been punished with detention for speaking up about unfair treatment. While another parent described experiences, in which teachers displayed their implicit biases by assuming—perhaps with the best intentions—that Latino students would benefit from specific vocational training, rather than being supported to continue into higher education. For example, one parent attended a school meeting where teachers were presenting information on the return of vocational classes, in which the teacher noted, "... 'That could be great for our Hispanic students, they can learn how to work in the hospitality industry' ... A lot of educators are unconscious[ly] biased. People just don't know what they're saying and how they're viewing things—and those are the educators."

Spanish-speaking parents also expressed frustration that their children were not allowed to speak Spanish in school settings, even at recess. They attributed this to the fact that most of their children's teachers do not speak Spanish and assume their children are saying bad things (e.g., using bad words, saying mean things). These parents also made the connection between this school policy and their children feeling ashamed of speaking Spanish. One parent explained, "sometimes children lie and say they don't speak Spanish. ... Children don't want to speak Spanish ... in school they must speak English, but if the child goes to recess and their classmates also speak Spanish, they want to communicate in Spanish. They shouldn't be completely limited."

Non-English-Speaking Parents Experience Barriers Engaging with their Children's Teachers, Service Providers, and Other Educational Gate-keepers

Overall, parents whose primary language is not English identified language barriers as a key factor that limited their communication with school staff (e.g., teachers, aides, administrators).

Parents and Youth Emphasized the Pressures on Children to Succeed Academically

Parents in both high and low socio-economic status groups shared concerns over young people's inability to address the multiple stressors young people encounter in school. Young people in Santa Clara County reported facing the burden of academic and parental pressures to succeed.

There is a lot of pressure on young people to succeed academically and focusing so much on academic success means less time is spent on the arts, playing, and with friends. In higher-income families, students are also experiencing extreme stress to create the perfect resume and to gain access to increasingly competitive schools and fewer university slots. One parent shared, "this generation is focused on studying, on getting a degree, because everything in this city is expensive—it's expensive to survive."

Children and Teens Lack Social-emotional Skills to Address and Cope with Stress in School

Parents identified the lack of social-emotional learning in elementary school as a reason why many teens lacked necessary coping skills. They also explained the critical importance of developing social and emotional skills to successfully address and deal with stress in school and elsewhere in their lives. For example, teaching a common language for children "to use to help identify if they're struggling, to recognize in one other [when] one of their peers is struggling, and to educate them about mental health and how to take care of themselves."

One key leader identified Positive Behavioral Interventions & Supports (PBIS) as one way to create a positive school climate and to focus on what students are doing well rather than punishing students who have behavioral issues. The same key leader explained that when schools provide teachers and students with mindfulness training to slow down, and focus, it "might help them pause and breathe and think about how to respond as opposed to just reacting."

Another parent emphasized the long-term benefits of incorporating mindfulness into the standard school curriculum for all aged children and youth explaining "[If] you start doing those classes in an elementary school and teaching kids about what is social-emotional [competence] ... you're going to prevent a lot of stuff from happening by the time they get to high school."

Children with Special Needs are Especially Vulnerable

Parents and key informants explained that children benefit from early identification of special needs and related support. Key informants, for example, noted the importance of having vision exams and hearing screenings as a way to address any early issues and support children's learning. Key informants continued by explaining that hearing impairments that go unaddressed can result in delayed speech and language. Many parents also discussed how challenging it was for them to get an individualized education plan (IEP) for their children, and to ensure that the IEP was then followed. One parent shared their experience, "I also noticed on their IEPs, [the school staff] don't always follow through—they are supposed to assess the child for speech/language and my kid never got assessed. ... I had to put her in private speech therapy because I didn't want to lose a whole school year. ... [Eventually, I got] reimbursed from the school district for my copays ... and they acknowledged they

dropped the ball. What is a parent who didn't have the insurance I had [to do]? They would have wasted a whole year not getting their child the help [their child] needed."

Barriers to Learning and Family Engagement

Family Barriers to Participating in Children's Education

The financial and housing-related difficulties faced by parents in their home and work life affect their ability to participate in their children's education. While parents report that involvement in their children's education leads to better student outcomes, they also noted the difficulties in doing this. In particular, parents whose primary language is not English explained that work schedules, commute times, and multiple jobs pose significant constraints on their involvement in the classroom. Additionally, these parents identified language barriers between parents and school staff (e.g., teachers, aides, etc.) as a key challenge. Parents reported making tremendous efforts to communicate with their children's teachers, and also highlighted that miscommunication can further hinder student's success. Another parent expressed that schools should teach the Common Core approach to parents so that parents can help their children with homework. Parents who were immigrants and who had low educational attainment themselves expressed that they wanted to support their children's education, but often did not know how to do so describing that "sometimes we as parents don't know very much about the education system. There is a lack of communication in telling the parents about the school system."

Key informants also identified financial barriers to parent engagement, as not all parents have internet at home, work at jobs with internet access, or have time off work when libraries are open. Despite the challenges, both parents and key informants emphasized the positive impact parent engagement has on academic outcomes. One parent further noted, "it is very important to have a good communication with the teachers, and that the kids see that you are involved, so they will work more."

Low Socio-economic Status Has Negative Impacts on Students' Learning Opportunities, Including the Quality of Education They Receive

Economic factors shape many aspects of children's lives, including their education. Children in low-income families are impacted in many ways by their socio-economic status, including the quality of education they receive. Parents and key informants noted that because of the high cost of housing, families have had to move further and further from where they work. Parents then find themselves having to choose between long commutes and having their children adjust to a new school, often mid-year. Some parents shared that they chose the long commute to ensure a higher quality of education or to maintain an already established IEP for their child. One parent shared that the long daily commute from Gilroy to San Jose, to take their children to school, resulted in being a burden the family couldn't bear, "it was so hard, we were burning gas, and sometimes we had to hop on the bus. A majority of the time, I just kept my kids out of school because I can't do that transition every day. Of course I got in trouble for it, but I really didn't care. I was like, 'Y'all ain't going to come pick us up every day and y'all ain't going to give me gas every day to keep going back and forth and have my kids out there in the cold and catching the bus back in the cold.'"

Focus group participants noted that many parents could not afford to miss work to stay home with their sick children and did not have alternate options for care, which translated into frequently sick and contagious children in preschool and elementary classrooms. These parents typically have low-wage jobs without sick leave, or have multiple part-time jobs. Taking time off to care for a sick child would translate into reduced income and could easily result in a lost job.

Poorer Children Lack the Opportunities for Extracurricular Activities

Both parents and key informants also identified the importance of having educational opportunities that go beyond traditional academics, explaining that "there's an opportunity gap. The number of kids who don't have ... The piano lessons, the sports activities, all of those things kind of help shape a child's health and overall wellbeing. If you don't have resources, you can't take advantage of all the opportunities that this Valley has." Many parents also expressed their concerns that schools were focused on standardized tests and often did not offer arts, athletics, music classes, or curricula that addressed social-emotional skills or nutrition.

Key informants identified that additional early learning and extended learning opportunities could help address the opportunity gap. A key informant suggested "universal preschool for kids or extended learning opportunities, including summer programming for low-income kid" as a strategy to mitigate educational inequities, supporting kids readiness, in particular zero to five.

REFERENCES

- ¹ Understanding the Relationship between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Healthcare Research and Quality, Rockville, MD. Accessed October 18, 2016. <http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html>.
- ² Education and Health: Exploring the Social Determinants of Health. Issue brief#5. Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447. Accessed on 10/18/2016
- ³ Janki Shankar, Eugene Ip, Ernest Khalema, Jennifer Couture, Shawn Tan, Roslynn T. Zulla, Gavin Lam. Education as a Social Determinant of Health: Issues Facing Indigenous and Visible Minority Students in Postsecondary Education in Western Canada. *Int. J. Environ. Res. Public Health* 2013, 10, 3908-3929; doi:10.3390/ijerph10093908.
- ⁴ Planned Parenthood Kids in Common. The Santa Clara County Children's Agenda: 2016 Data Book.; 2016. http://www.kidsincommon.org/storage/3283/TCA-Data-Book-2016_NEW.pdf.
- ⁵ Nicolaidis C, Ko CW, Saha S, Koepsell TD. Racial discrepancies in the association between paternal vs. maternal educational level and risk of low birthweight in Washington State. *BMC Pregnancy Childbirth*. 2004 Jun 17;4(1):10.
- ⁶ Collins JW Jr, David RJ, Handler A, Wall S, Andes S. Very low birthweight in African American infants: the role of maternal exposure to interpersonal racial discrimination. *Am J Public Health*. 2004 Dec;94(12):2132-8.
- ⁷ American Academy of Pediatrics. Quality early education and child care from birth to kindergarten. (2005). *Pediatrics*, 115(1), 187.
- ⁸ U.S. Census Bureau; American Community Survey, 2014 American Community Survey 1-Year Estimates, Tables DP02, B14007B, B14007D, B14007I, B14007H, B14001; generated by Mandeep Baath and Pamela Amparo; using American FactFinder; <<http://factfinder2.census.gov>>; (22 September 2015).
- ⁹ California Department of Education, DataQuest, 2013-14. <http://dq.cde.ca.gov/dataquest/>. Accessed on 10/19/2016.
- ¹⁰ California Department of Education, Specialized Programs, English Learners. <http://www.cde.ca.gov/sp/el/>. Accessed October 19, 2016.
- ¹¹ California Department of Education, Specialized Programs, Special Education. <http://www.cde.ca.gov/sp/se/> Accessed October 19, 2016.
- ¹² As cited on kidsdata.org, Special Tabulation by the California Dept. of Education, Special Education Division; Assessment, Evaluation and Support (Oct. 2015).
- ¹³ U.S. Department of Education, National Center for Education Statistics. ED Facts Data Groups 695 and 696, School year 2013-14; September 4, 2015. Accessed on 10/19/2016 at: https://nces.ed.gov/ccd/tables/ACGR_RE_and_characteristics_2013-14.asp.
- ¹⁴ California Department of Education, DataQuest, 2010-14. Accessed on 10/27/2016 at: <http://dq.cde.ca.gov/dataquest/>.
- ¹⁵ Know Your Rights: Suspensions, Expulsions, and Involuntary Transfers. American Civil Liberties Union of Northern California (ACLU). Accessed on 10/19/2016 at: <https://www.aclunc.org/our-work/know-your-rights/school-discipline>.

ECONOMIC INEQUALITY AND HOUSING INSTABILITY

ECONOMIC INEQUALITY

Why It's Important

Economic or income inequality refers to unequal distribution of household or individual income across the various groups in a society.¹ Poverty and income inequality are major contributors to lower life expectancies and are associated with many chronic diseases.² The gap between the poor and rich is sharply widening.³ Income inequality is even more stratified when race/ethnicity is considered due primarily to racial inequities.⁴ Economic growth in the Silicon Valleyⁱⁱ has failed to benefit low-income families, and the income gap within Santa Clara County has steadily increased.⁵

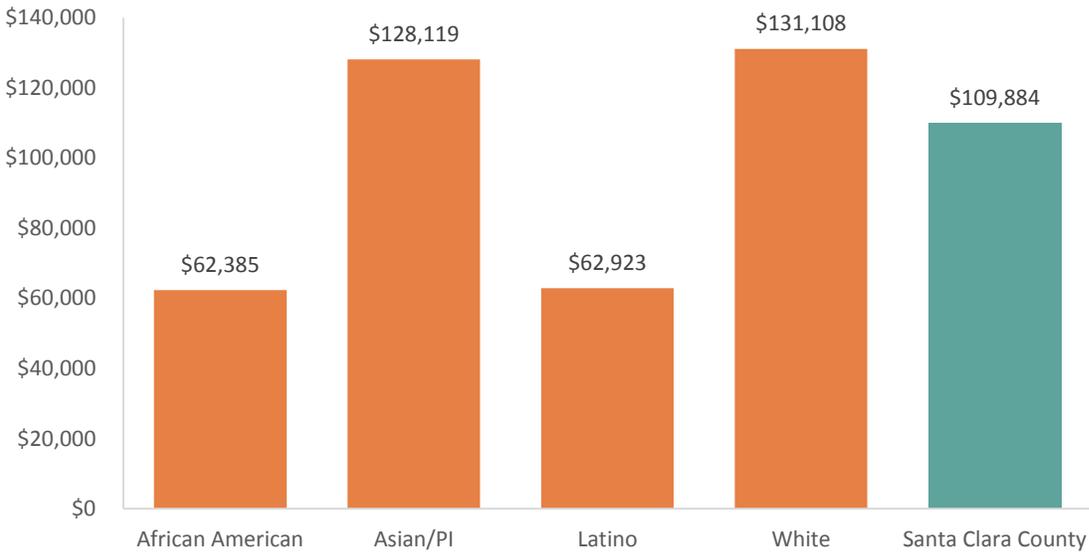
The link and effects of poverty on children's health is extensive, strong, and pervasive. Certain vulnerable segments of the population share disproportionately higher burden of income inequality and consequently worse health outcomes (e.g., poverty rates for African American and Latino children are higher than Asian and White children).⁶ Poverty is a multidimensional phenomenon affecting one's ability to provide basic needs as a result of limited resources and opportunities for education and access to high quality, affordable healthcare.⁷ Low socioeconomic status is related to higher likelihood of babies born premature, low birth weight, infant mortality, child mortality, poor physical growth, malnutrition, teen pregnancy, child abuse and neglect, infections, emotional and psychological problems.^{8,9} Children born to parents in poverty are likely to grow up and live in poverty. Childhood poverty limits the development path over one's lifetime and puts at risk future adult achievement. Children in poverty are less likely to achieve significant milestones such as graduating from high school and/or enrolling in and completing college.¹⁰ This in turn limits the lifetime earning potential, perpetuating a multi-generational cycle of poverty.

What the Numbers Tell Us: Survey Findings

Countywide, the median annual family income was \$109,884, higher than the state median annual family income of \$71,015 in 2014. However, racial disparities are wide and persistent: African American and Latino families had lower annual median family incomes, compared to Asian/Pacific Islander and White families.¹¹

ⁱⁱ Silicon Valley is the term used for the southern portion of the San Francisco Bay Area that includes Santa Clara County, San Mateo County, and parts of Alameda and Santa Cruz counties. (Source: Joint Venture Silicon Valley. 2016 Silicon Valley Index. <https://www.jointventure.org/images/stories/pdf/index2016.pdf>. Published 2016.)

MEDIAN FAMILY INCOME



Source: U.S. Census Bureau; American Community Survey, 2014 American Community Survey 1-Year Estimates

The Federal Poverty Level (FPL) is a measure of income used to determine eligibility for many assistance programs. In 2014, a total of 5% of families in Santa Clara County were living below 100% FPL.ⁱⁱⁱ This percentage sharply rose as FPL thresholds increased; 17% families were living below 200% FPL and 28% of families were living below 300% FPL. A higher percentage of single parent families were living below 100% FPL (15% female headed, and 8% male headed) compared to married couple families (3%).¹¹ Santa Clara County has a high cost of living compared to California and the U.S., but the FPL threshold does not take into account the regional cost of living in contrast to the Self-Sufficiency Standard. In 2014, the Self-Sufficiency Standard for a family of four with two adults, 1 preschool aged child, and 1 school aged child was \$81,774 in Santa Clara County compared to \$63,979 for California.¹²

ⁱⁱⁱ In 2014, for a family of 4, 100% of the Federal Poverty Level (FPL) was \$23,850; 200% FPL was \$ 47,700; and 300% FPL was \$71,550. Source: Office of the Assistant Secretary for Planning and Evaluation. Accessed on 10/18/2016 at: <https://aspe.hhs.gov/2014-poverty-guidelines>.

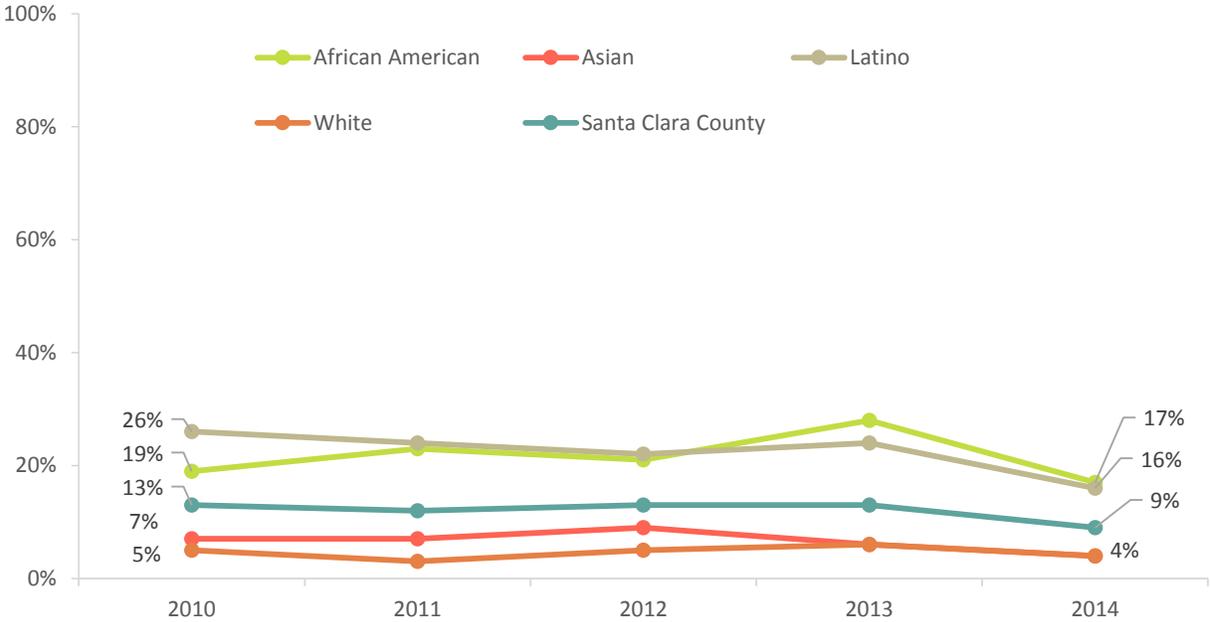
SELF-SUFFICIENCY STANDARD AND FEDERAL POVERTY LEVEL THRESHOLDS FOR A FAMILY OF FOUR



Source: Insight Center for Community Economic Development and Office of the Assistant Secretary for Planning and Evaluation and Office of the Assistant Secretary for Planning and Evaluation.

In 2014, 9% of children ages 0 to 17 were living in poverty in Santa Clara County. From 2010 to 2014, poverty rates among African American and Latino children were consistently higher compared to poverty rates among Asian and White.¹³

POVERTY STATUS AMONG CHILDREN (AGES 0 TO 17), 2010-2014



Source: U.S. Census Bureau, 2010-2014 American Community Survey 1-Year Estimates¹⁴

What the Community Tells Us: Community Perspectives and Experiences

The following section presents findings from the Children’s Health Assessment key informants, focus groups participants, parents, and youth on early learning and the educational system.

Persistent and Widening Disparities Exist in People's Income and Wealth

Family finances emerged as one of the top concerns among parents with children.

- 2016 Child Health Online Survey

Parents, youth, and key informants overwhelmingly identified economic inequality and the high cost of living as key factors that negatively impact children's health in Santa Clara County. One key leader articulated the connection by noting, "... if you're homeless or worried about housing all the time, you're going to be unhealthy ... if you can't have a stable place to live and a place that's safe, you're not going to be healthy."

Key informants reported that there are "pockets of poverty" throughout the county and that many communities have lived in poverty for multiple generations. These areas also typically lack key infrastructure and services, further disadvantaging the residents. Parents and key informants both identified that wages for low-income workers have remained modest while the cost of living has

risen dramatically. Key informants explained that there is a "major impact on the middle class because their wages have stagnated and housing costs keep going up, and they can't afford to buy housing. Both parents are working; they don't have a lot of time to spend with their kids. **I don't think it's just the poor ... there's the middle class too that I think is feeling incredibly stressed out trying to live here with long commutes and high housing costs.**"

Many Parents Are Working Multiple Jobs and Have Limited Time for Their Children

Many parent and youth focus group participants noted that even families in which multiple adults were working, and parents worked multiple jobs were still unable to afford basic necessities. This was true even when jobs were full-time and paid more than the legal minimum wage.^{iv} Parents who have low wage jobs often lack paid time off and benefits like employer sponsored health insurance. They are forced to make difficult choices related to when and for how long they can miss work either when they or their children are sick. Hence, key informants and parents reported that families in similar situations frequently delay or skip preventative healthcare. The lack of paid parental leave policies are also damaging to parent and child bonding and early childhood development.

Parents and key informants also explained that parents who worked multiple jobs were rarely able to prepare nutritious meals, engage in their children's school and homework, spend time with children after school and on weekends, exercising, or participating in other enrichment activities.

Families Face Daily Struggles to Meet Basic Needs

Key informants, parents, and youth all identified the increasing cost of housing and other necessities (e.g., food, clothing, healthcare, transportation) and low wages as having a negative impact on

^{iv} In summer 2016, the minimum wage in most parts of Santa Clara County was \$10.00/hour, although the City of San Jose had a minimum wage of \$10.30/hour, the City of Mountain View had a \$11.00/hour minimum wage, and the City of Santa Clara had a \$11.00/hour minimum wage. Source: UC Berkeley Labor Center, 2016. <http://laborcenter.berkeley.edu/minimum-wage-living-wage-resources/inventory-of-us-city-and-county-minimum-wage-ordinances/>

children's health. A parent shared, "The cost of living is just increasing, not just rent-wise but groceries, gas, all the amenities, electricity. It has such a huge impact on the stress levels of a family." When families do not have enough income to cover all necessities, parents find themselves making difficult choices. Because housing is so important, it is frequently prioritized before other basics.

Many key informants and focus group participants stated that healthy food and fresh produce were too expensive for low-income families. As a result, families reported eating less healthy food and skipping meals. Many parents also said that dental care was prohibitively expensive and that as a result, they (including their children) often went without dental care.

Since the cost of living in the county is so high, low-income families described how they often try to balance earning enough to pay for rent but not enough to disqualify them for CalFresh, Medi-Cal, Denti-Cal, and other benefits. This balancing act is a source of stress and prevents low-income families from saving money (as that could also make them ineligible for benefits, assuming they have enough room in their stretched-thin-budget to save anything).

Families Who Are Living Paycheck-to-paycheck Are Especially Vulnerable to Experiencing a Negative Domino Effect

Although most people in Santa Clara County have health insurance, those families who do not have health insurance, or are underinsured are particularly vulnerable. Many families who do not have insurance also lack savings or any financial resources to fall back on. Key informants reported that parents who are undocumented are ineligible for Medi-Cal but may not realize that their minor children are eligible. Undocumented parents may face additional barriers such as unstable income, lack of nearby family support or community networks that can help cover expenses, and lack of collateral or documentation to obtain emergency loans.

Key informants noted that the cost of emergency medical care can easily push low-income families who do not have insurance beyond their means. Similarly, if a parent loses a job, the family can quickly find themselves homeless, because of an inability to pay rent, "... families are just too close to that margins. ... There's just no room for things to go wrong."

Cumulative economic burdens were also identified by parents and key leaders. Parents who cannot afford to pay the fee to renew their driver's license or maintain car insurance may be burdened by fines for these lapsed payments, despite needing transportation to get to their employment or using their vehicle as their residence when unable to afford rent. One homeless parent described her experience, "we slept in our car and we were just staying there and [the police would] come and just start knocking. ... I told them, 'The keys are in the ignition. The reason why is because the heater's on. It's cold. I'm in the back with my daughter. I was sleeping.' Since I don't have my license, he's like, 'You're driving without a license. Here's a ticket.'... He saw me and my kid in the back, so he just went ahead and just did that. I'm not driving. I was just sitting in the car at the time."

Key leaders also identified the domino effect of lost income and benefits when incarcerated. Low income people who are arrested are frequently unable to post bail, and must therefore remain in custody for longer than those with resources. While incarcerated, people are unable to work and

often lose their jobs which might result in loss of health insurance and/or inability to pay rent. When people contributing to the household income are incarcerated (regardless of whether they have been charged or convicted), the entire family, and especially minor children, are affected.

CHILDCARE

Why It's Important

There are many barriers to participating in child care programs among low-income families.¹⁵ Quality child care allows parents to work or go to school, while providing their child with early childhood education experiences. In addition, child care subsidies make quality child care programs more affordable and accessible for low-income families.¹⁶

What the Community Tells Us: Community Perspectives and Experiences

Key informants identified the *"benefits cliff"* as a particular challenge for Santa Clara County given the difference between the self-sufficiency standard and the maximum income at which families are eligible for various benefits. Even a small increase in earnings can result in the loss of important subsidized programs. Parents consistently identified child care subsidies as an example, and explained that if they earn "too much," they will lose childcare subsidies. At the same time, without the childcare subsidies, they would have to work less because they cannot afford to pay for childcare without assistance. One parent drove an additional 2 hours every day to bring her children to a childcare provider whom she trusted and whom she could afford.

HOUSING INSTABILITY

Why It's Important

Housing is considered to be a strong determinant of health. Poor housing can be associated with negative health outcomes among children and adults. Child injury and mortality rates are strongly associated with both income inequality and housing instability.¹⁷ The Department of Health and Human Services has defined housing insecurity as a high housing cost in proportion to income, poor housing quality, unstable neighborhoods, overcrowding, and/or homelessness.¹⁸ High housing costs make it difficult to afford other necessities such as food, transportation, and healthcare.¹⁹

The cost of housing in California, particularly in the San Francisco Bay Area, is among the highest in the nation. This might be partly accounted for due to high cost of living and low housing inventory in the area. Furthermore, with increasing income inequality housing stability worsened.¹⁷ The shortage of available affordable and quality housing has made it increasingly difficult for low-income families to live in the Silicon Valley.²⁰

Homeless children can also be vulnerable to multiple health risks. In 2014, it was estimated that more than 1.6 million children in the U.S. were homeless. Children who are homeless suffer from many

negative health consequences and missed educational opportunities. In addition, children who are homeless are twice as likely to go hungry compared to children who are not.²¹

What the Numbers Tell Us: Survey Findings

The impact of housing insecurity is seen in the percentage of households that spend 30% or more of their total income on housing costs (the amount typically considered affordable).²² Nearly 4 in 10 (38%) owner-occupied households spent 30% or more of their income paying their mortgage. Half (49%) of renter-occupied households had a gross rent of 30% or more of their income.²³

HOUSING COST BURDEN OF 30% OR MORE OF HOUSEHOLD INCOME IN THE PAST 12 MONTHS



Note: Owner-occupied represents only those with a mortgage. Data represents only the occupied housing units.
Source: U.S. Census Bureau; American Community Survey, 2014 American Community Survey 1-Year Estimates

Homeless Families and Children

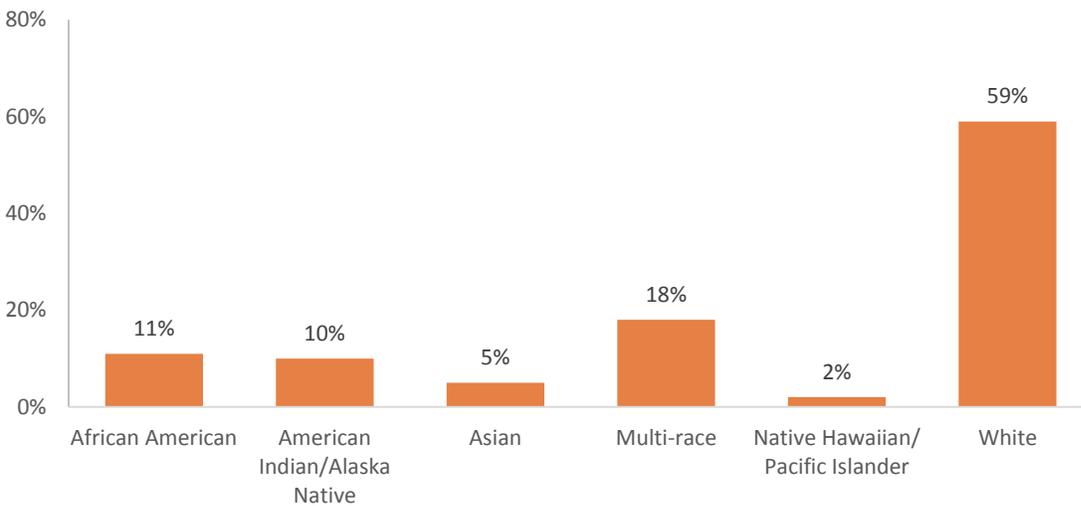
Children living in families experiencing homelessness have increased incidence of illness and are more likely to have emotional and behavioral problems than children living in families with consistent living accommodations. The risk of homelessness is highest among female headed single parent households and families with children under the age of 6.²⁴

According to the 2015 Homeless census, 587 children ages 0 to 17^v and 897 youth ages 18 to 24 were homeless in Santa Clara County, accounting for 23% of the total homeless population. While only 13% of the homeless children ages 0 to 17 were not in the county shelters, a higher percentage of transition age youth ages 18 to 24 (83%) were unsheltered. Four in 10 unaccompanied homeless children and transient age youth (40%) reported they had been in the foster care system. More than 3 in 10 unaccompanied homeless children and transient age youth (31%) reported they had spent at least one night in jail or prison in the past year.²⁴

More than 6 in 10 homeless families with children identified as Latino (63%). When considering race, the majority of homeless families with children were White (59%).²⁴

^v This count includes children ages 0 to 17 who are living with family and unaccompanied children.

RACE AMONG HOMELESS FAMILIES WITH CHILDREN



Note: Multiple response question. Percentages may not add up to 100 due to rounding.

Source: 2015 Santa Clara County Homeless Survey

What the Community Tells Us: Community Perspectives and Experiences

The High Cost of Housing Has Made the County Unaffordable

Parent and youth focus group participants reported that they and many of their peers had experienced sharp and sudden increases in rent. Some families said rent increases had forced them to move away (for example, from San Jose to Gilroy), which consequently lengthened their commute to jobs, school, and services, while simultaneously reducing the amount of time they could spend with their children or engaging with their children's teachers. Even families who had not directly experienced a rent increase reported that the threat of an increase was a major source of stress, as most knew other families who had had to move due to large rent increases. Some low-income youth focus group participants said they had considered dropping out (and some had) so that they could work and help their families pay for housing. Even parents with higher incomes expressed concerns about the high cost of housing, "I make \$18 an hour ... and I still can't make the rent," noting that they could not imagine how their children could ever afford to live in the area.

Multiple parents reported the high cost of housing as a huge issue, resulting in families dealing with homelessness and parents living in their cars with their children. A key informant explained, "if you just touch on the federal definition of homelessness, it's high, but then I think we have a lot of families that are couch surfing. ... It makes it harder to stay engaged in school." Parents and key leaders, alike also reported that there was an insufficient amount of rapid re-housing and affordable housing within the county, especially for families with children.

As an additional barrier, low-income parents stated that landlords often required proof that the total household income was at least two or three times the cost of rent, with one parent noting that,

"housing should be something that we're able to afford. I have friends that make \$12 to \$13 bucks an hour and that's not even enough because your income has to be twice as much as your rent, otherwise they won't give you the unit. They won't even consider you for the unit at all."

Overcrowded Living Conditions Have a Negative Effect on Children's Health and Academic Success

While overcrowding has often been a way for families to temporarily save money, parent focus group participants reported that families were living in overcrowded conditions so they could qualify to move into available units. Key informants identified that these conditions have numerous negative effects on children's ability to succeed academically and to be healthy. When too many people share a small space, it can be especially difficult for children to concentrate on homework or to get adequate sleep. Moreover, children living in overcrowded housing have higher chances of getting sick due to easy transmission of infectious diseases such as acute respiratory infections, meningitis, scabies, etc.²⁵ Key informants noted that immigrant families and families living in poverty were most likely to be affected by overcrowding. One key informant reported, "[Given that the cost of housing is] so exorbitant in our area, a lot of families live together. There can be health hazards in the form of one person getting an illness, [and then] pretty much every child gets an illness who lives there. ... A child being ill means that parents have to take time off of work to look after that child or is not able to attend school so [it] affects learning. We know that overcrowding is also a risk factor for things like asthma."

REFERENCES

- ¹ Income Inequality. Investopedia. Accessed on 10/16/2016 at <http://www.investopedia.com/terms/i/income-inequality.asp>.
- ² National Research Council (US); Institute of Medicine (US); Woolf SH, Aron L, editors. U.S. Health in International Perspective: Shorter Lives, Poorer Health. Washington (DC): National Academies Press (US); 2013. Summary. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK154469/>
- ³ S. V. Subramanian and Ichiro Kawachi. Income Inequality and Health: What Have We Learned So Far? *Epidemiologic Reviews* 2004;26:78–91. DOI: 10.1093/epirev/mxh003
- ⁴ Asante-Muhammed D, Collins C, Hoxie J, Nieves E. *The Ever Growing Gap*. Washington, DC; Published August 2016. Accessed 2016. http://www.ips-dc.org/wp-content/uploads/2016/08/The-Ever-Growing-Gap-CFED_IPS-Final-1.pdf.
- ⁵ Office of Human Relations and the Human Relations Commission of Santa Clara County. A Tale of Two Valleys: The Price We Pay for Living in Santa Clara County, Office of Human Relations and the Human Relations Commission of Santa Clara County. <https://www.sccgov.org/sites/ohr/Publications/Documents/HR-Report.pdf>. Published 2015. Accessed October 16, 2016.
- ⁶ Santa Clara County Public Health Department. Child Poverty in Santa Clara County, 2013. <https://www.sccgov.org/sites/sccphd/en-us/Partners/Data/Documents/child-poverty-reports/child-poverty.pdf>. Published 2013. Accessed 2016.
- ⁷ Poverty, social inequality and mental health. *Advances in Psychiatric Treatment* (2004), vol. 10, 216-224. Accessed on 10/15/2016 at <http://apt.rcpsych.org/content/aptrpsych/10/3/216.full.pdf>.
- ⁸ Eckenrode J. The link between child abuse and income inequality: Research brief. *Journalist's Resource*; Harvard Kennedy School Shorenstein Center on Media, Politics and Public Policy. <http://journalistsresource.org/studies/society/public-health/link-between-child-abuse-income-inequality-research-brief>. Accessed on 10/15/2016.
- ⁹ Reading R. Poverty and the health of children and adolescents. *Arch Dis Child* 1997;76:463-467 doi:10.1136/adc.76.5.463. Accessed on 10/15/2016 at: <http://adc.bmj.com/content/76/5/463.full>.
- ¹⁰ Fry CE, Langley K, Shelton KH. "A Systematic Review of Cognitive Functioning among Young People Who Have Experienced Homelessness, Foster Care, or Poverty." *Child Neuropsychology* (2016): 1-28. 21 Sept. 2016
- ¹¹ U.S. Census Bureau; American Community Survey, 2014 American Community Survey 1-Year Estimates, Tables B17010, B17001, B19101, B17024; generated by Mandeep Baath; using American FactFinder; <<http://factfinder2.census.gov>>; (poverty: 22 September 2015; family income: 23 October 2015).
- ¹² Self-Sufficiency Standard Tool for California. Insight Center for Community Economic Development. Accessed on 10/16/2016 at <http://www.insightccd.org/tools-metrics/self-sufficiency-standard-tool-for-california/>.
- ¹³ U.S. Census Bureau; American Community Survey, 2010-2014 American Community Survey 1-Year Estimates, Tables B17001, B17020, B17020B, B17020D, B17020H, B17020I; generated by Mandeep Baath; using American FactFinder; <<http://factfinder2.census.gov>>; (28 September 2015).
- ¹⁴ U.S. Census Bureau; American Community Survey, 2010-2014 American Community Survey 1-Year Estimates, Tables B17001, B17020, B17020B, B17020D, B17020H, B17020I; generated by Baath M.; using American FactFinder; <<http://factfinder2.census.gov>>; Accessed September 28, 2015.
- ¹⁵ Greenberg E, Adams G, Michie M. Barriers to Preschool Participation for Low-Income Children of Immigrants in Silicon Valley. Center on Labor, Human Services, and Population. January 2016.
- ¹⁶ Clasp: Policy solutions that work for low-income families. *Child Care Assistance: A Vital Support for Working Families*. June 2015.
- ¹⁷ Sengoelge, M., Hasselberg, M., Ormandy, D. and Laflamme, L. (2014), Housing, income inequality and child injury mortality in Europe: a cross-sectional study. *Child Care Health Dev*, 40: 283–291. doi:10.1111/cch.12027. Accessed on 10/16/2016 at <http://onlinelibrary.wiley.com/doi/10.1111/cch.12027/abstract>.

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- ¹⁸ Cutts DB, Meyers AF, Black MM, et al. US Housing Insecurity and the Health of Very Young Children. *American Journal of Public Health*. 2011;101(8):1508-1514. doi:10.2105/ajph.2011.300139.
- ¹⁹ Stahre M, Vaneenwyk J, Siegel P, Njai R. Housing Insecurity and the Association With Health Outcomes and Unhealthy Behaviors, Washington State, 2011. *Preventing Chronic Disease Prev Chronic Dis*. 2015;12. doi:10.5888/pcd12.140511.
- ²⁰ SV@Home. How do we tackle the affordable housing crisis? <http://siliconvalleyathome.org/wp-content/uploads/2016/05/how-do-we-tackle-the-affordable-housing-crisis-a-policy-roadmap.pdf>. Published May 2016. Accessed September 26, 2016.
- ²¹ McCoy-Roth M, Mackintosh BB, Murphey D. When the Bough Breaks: The Effects of Homelessness on Young Children. *PsycEXTRA Dataset*. February 2012. doi:10.1037/e501162014-001.
- ²² The Well-Being of Low-Income Children: Does Affordable Housing Matter? Insights from Housing Police Research. Available at: <http://www2.nhc.org/media/documents/WellBeingChildren.pdf>.
- ²³ U.S. Census Bureau; American Community Survey, 2014 American Community Survey 1-Year Estimates, Tables DP04, B25091; generated by Mandeep Baath; using American FactFinder; <<http://factfinder2.census.gov>>; (28 October 2015).
- ²⁴ Homeless Point-In-Time Census and Survey Comprehensive Report 2015, Santa Clara County. Published 2015. 2016 : https://www.sccgov.org/sites/opa/nr/Documents/SantaClaraCounty_HomelessReport_2015_FINAL.pdf. Accessed 10/18/2016
- ²⁵ What are the health risks related to overcrowding? World Health Organization. Accessed October 17, 2016. http://www.who.int/water_sanitation_health/emergencies/qa/emergencies_qa9/en/.

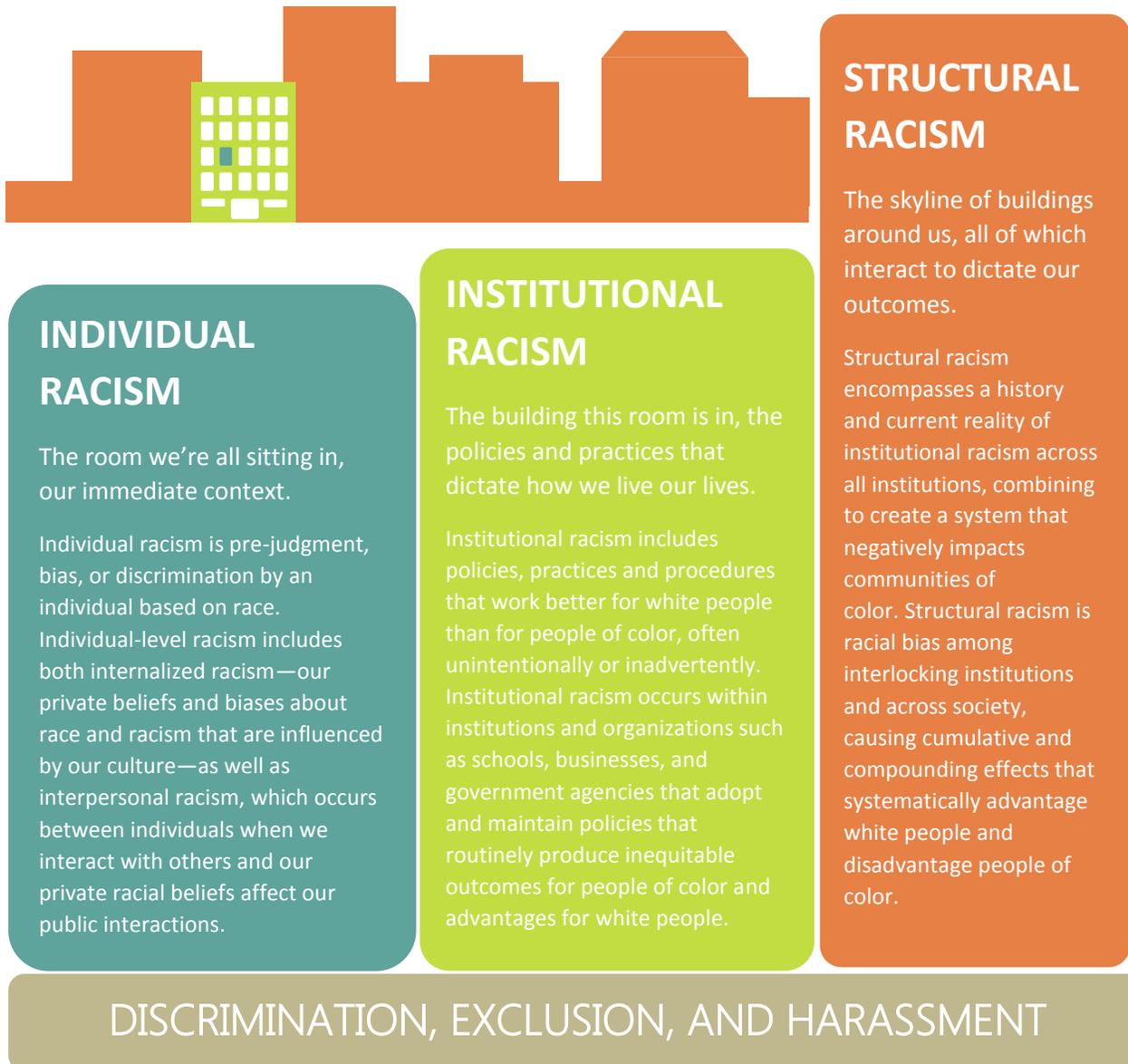
STRUCTURAL RACISM AND DISCRIMINATION

Why It's Important

The historical legacy and current reality of the multi-level forms of racism^{vi} in this country has contributed to the limited opportunities and resources that people of color, and other vulnerable groups can access.¹ This has led to cumulative, and multi-generational impacts, adversely shaping employment, housing, education, healthcare, and other parts of families' lives. Structural racism refers to the interplay of the structures and systems that perpetuate inequalities throughout the lifespan, contributing to an epidemic of racial disproportionality, as observed in poor health outcomes for the most vulnerable. Adverse exposure and experiences with racial discrimination are associated with illness irrespective of a life stage – childhood or adulthood.² Structural racism and discrimination, as social determinants of health, are examples of the factors and structures of inequality, beyond our genetic make-up that influence health outcomes, and exacerbate health inequities.

Health inequities are differences in health that are avoidable, unfair, and unjust. In order to combat health inequities and promote equity for all in Santa Clara County, the connection and drivers between structural racism and discrimination at multiple systemic must be acknowledged, named, and disrupted. A racial and health equity lens and vision is needed to make necessary system-wide improvements to provide all children living in Santa Clara County with the fair opportunity to achieve their full potential.

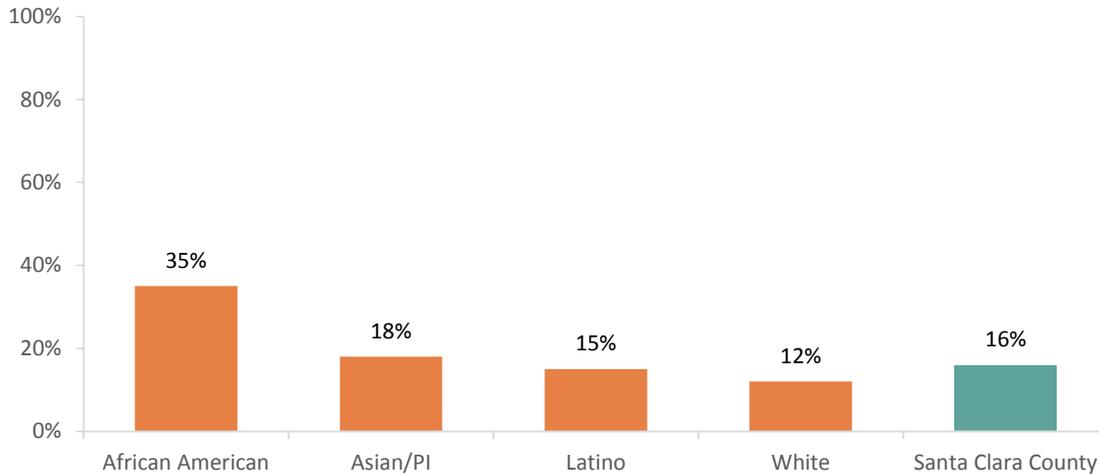
^{vi} Structural racism refers to the historical systems and institutions that work together to create the negative cumulative effects that systematically disadvantage people of color. Institutional racism refers to the policies and practices that exist in schools, businesses, and government agencies that result in inequities for people of color. Individual racism refers to the internal beliefs that people hold about race that are influenced by our culture, and are expressed between individuals. Discrimination, exclusion, and harassment are listed below the visual to illustrate that they relate to systems of oppression that operate in parallel to racism. People of color is often a preferred collective, inclusive and unifying term, across different racial groups that are not White, to address racial inequities. (Race Forward)



What the Numbers Tell Us: Survey Findings

Sixteen percent (16%) of middle and high school students in Santa Clara County were bullied due to their race, ethnicity, and/or national origin on the school property in the past 12 months; similar to the percentage of students statewide (17%).³ African American students reported a higher percentage of bullying due to race, ethnicity, and/or national origin (35%) than any other racial/ethnic group.³

MIDDLE AND HIGH SCHOOL STUDENTS WHO WERE BULLIED DUE TO RACE, ETHNICITY, OR NATIONAL ORIGIN IN THE PAST 12 MONTHS



Note: This indicator is defined as the percentage of students who reported being bullied due to race, ethnicity, or national origin 1 or more times on the school property in the past 12 months. See Santa Clara County Public Health QuickFacts for additional data and information. Source: California Healthy Kids Survey, 2013-14

What the Community Tells Us: Community Perspectives and Experiences

The following section presents findings from the Children's Health Assessment key informants and focus groups participants, parents and youth, on structural racism and discrimination.

Structural Racism

Interviews with key informants identified structural racism and historical injustices through which structural racism has functioned, as one of the top issues that drive inequities for children's health within Santa Clara County.

Key informants noted that the intersection of racism and poverty had negative effects on children's health within Santa Clara County. Redlining^{vii} ^{viii} was specifically identified as a factor with a legacy that continues to shape the infrastructure in poor neighborhoods. For example, neighborhoods that had historically been subject to redlining, continue to be low-income neighborhoods today, and often lack infrastructure that supports community safety and healthy lifestyles, such as street lights, parks, and sidewalks. One key leader identified the way in which different parts of City of San Jose had been annexed as an example of why neighborhood environments are so different, noting "... [The] historical

^{vii} Redlining refers to a discriminatory pattern of disinvestment and obstructive lending practices that act as an impediment to home ownership among African Americans and other people of color. Gaspaire Brent. Redlining (1937-). BlackPast.org. Accessed on 10/13/2016 at: <http://www.blackpast.org/aah/redlining-1937>.

^{viii} Madrigal AC. The Racist Housing Policy That Made Your Neighborhood. *The Atlantic*. May 2014.

<http://www.theatlantic.com/business/archive/2014/05/the-racist-housing-policy-that-made-your-neighborhood/371439/>.

poverty [that] existed in terms of redlining, those things that directed families to certain areas. I think that those are perpetuated in the way the community is currently structured."

Parents, youth, and key informants identified an important opportunity gap and disparities between young people who live in wealthier/higher resourced neighborhoods, and those who live in poor neighborhoods (where most residents are people of color). Specifically commenting on differences in educational quality, accessibility of recreational opportunities (such as safe and clean parks), city infrastructure (e.g., sidewalks, street lighting), and transportation system. A participant shared, "what makes me sad is that the areas in which people have more money, they do have lots of parks ... we are in a poorer area with more children and more people, more young kids who really need those parks, who live in apartments, who don't live in houses, and without parks."

Institutional Racism

Institutional racism functions within specific institutions such as schools or criminal justice system. Key informants recognized that systemic disparities resulted from how the systems and institutions are operated, rather than because of the actions of specific individuals working within any single institution. One key informant explained, "you see in the school system as well as the justice system this disproportionate representation of Latino and African American kids. I think that implicit bias in the system creates this racism. It is a racism that has impact on kids of color and I think poor kids, too."

One example to demonstrate unintentional institutional racism is in drug-related arrests. Although White people use illegal drugs at similar (and sometimes higher) rates than people of color, White people are more likely to use drugs in private settings (e.g., homes, dorm rooms), therefore they are less likely to be arrested for drug use.⁴ Research highlights that most individuals have implicit biases, implicit biases^x among law enforcement officials may contribute to racially inequitable policies and practices, including higher rates of traffic stops, searches, and arrests of people of color than White people.⁵

Youth, parents, and key informants all described the damaging effects of institutional racism on the resources that are available for communities of color. This idea is closely linked to the opportunity gap described earlier in this chapter, "there's ... institutional racism that affects the policies and planning of these services, where some [communities] have access to them and some [communities] don't."

^x Implicit bias refer to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness. The implicit associations we harbor in our subconscious cause us to have feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance. Kirwan Institute for the Study of Race and Ethnicity. "Understanding Implicit Bias." <http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/>. Published 2015.

Basic Service Delivery Systems Are Not Equipped to Serve Diverse Clients in a Respectful and Competent Manner.

Key informants and parents reported that healthcare and social services providers were often unable to provide consistently culturally competent care to people of color. Focus groups and key informants reported that this lack of competency was systemic.

Vietnamese parents and key informants agreed that mental health and social services providers often do not recognize the signs of mental health issues in the Vietnamese community. Since mental health resources are often allocated based on prevalence, the number of people affected by mental health, participants reported that there is a gap between actual community need and available resources (and further explained that prevalence is based on diagnoses, and stigma and this cultural disconnect underestimates prevalence rates). For example, one key leader shared, "... our tradition is 'don't air dirty laundry.' 'Don't show weaknesses to outsiders.' Keep the family honor, that kind of thing."

Individual Racism

Youth and parents described experiences they had with implicit and individual racism, primarily in educational settings. Individual racism occurs between individuals. Like institutional racism, individual racism may also manifest as implicit bias rather than explicit prejudice.

Parents and youth shared comments made by teachers to youth of color, indicating that the teachers did not view the student of color as capable or "worth as much time" as White students. In one case, when packets were handed out and there were not enough for every student, a teacher told one young Latino student that "it would be a waste of paper" for him to have a packet. Latino parents also shared that one of their children's teachers had "joked" with the Latino children in the class that they would not ever attend college.

Parents and youth also shared instances in which children and youth had experienced racism from their peers. A White teenager read racist comments on a school blog and shared them with the school to demonstrate how pervasive such comments were within the school. One parent said her child had been called "Chinese face" and other slurs. Parents also reported that their children's classmates often expected Asian children to be good at math and science, an example of the minority myth stereotype in action. Conversely, Latino children were treated as less academically advanced by their peers. One youth described this experience, "my sister takes an AP [Advanced Placement] class and [some of her classmates] were talking ... about their AP class, and me and my sister were sitting next to them and [my sister] just happened to say, 'Oh, what is the homework for [the AP class]?' [One of the classmates] looked at her and said, 'Oh, no. We're talking about the high class, the AP English,' [not realizing that they were both in the AP class]. ... Since we're mixed minorities, we just receive a lot of discrimination like we're less capable of taking certain classes or doing certain things."

DISCRIMINATION, EXCLUSION AND HARASSMENT

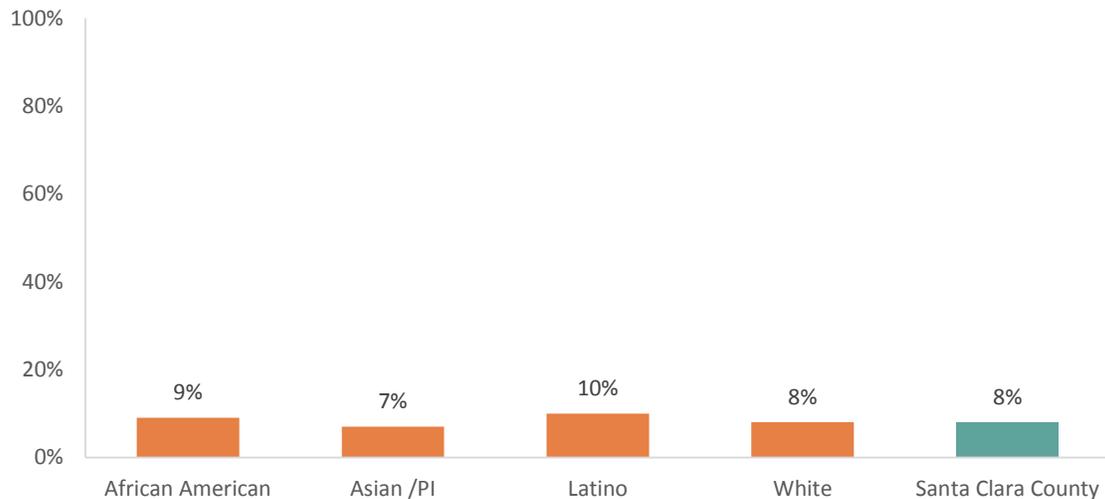
Why It's Important

Many population groups in the U.S. experience discrimination^x. Discrimination may be based on race/ethnicity, indigenous status, immigrant status, gender, sexuality, disability, and age.⁶ Discrimination has the potential to negatively affect a child's developmental or health trajectory.⁷ Discrimination can affect multiple dimensions of child's health: stress, cognitive and socio-emotional development, health behaviors, and ethnic identity. Discrimination can span across a person's life course and the effects can be amplified during critical developmental periods such as early childhood.³

What the Numbers Tell Us: Survey Findings

Among middle and high school students, 8% were harassed or bullied on the school property in the past 12 months because they were gay or lesbian or someone thought they were. The percentage is slightly higher among Latino students (10%), followed by African American (9%), White (8%), and Asian/Pacific Islander (7%) students.³

MIDDLE AND HIGH SCHOOL STUDENTS WHO WERE HARASSED OR BULLIED BECAUSE THEY WERE GAY OR LESBIAN OR SOMEONE THOUGHT THEY WERE IN THE PAST 12 MONTHS



Note: This indicator is defined as the percentage of students who reported being harassed or bullied because they were gay or lesbian or someone thought they were 1 or more times on the school property in the past 12 months. See Santa Clara County Public Health QuickFacts for additional data and information.

Source: California Healthy Kids Survey, 2013-14

^x Discrimination refers to the practice of unfairly treating a person or group of people differently from other groups of people; it can function as individual, institutional, or structural. Exclusion refers to the act of preventing another person or people from doing something or being a part of a group; it operates both at the individual/interpersonal level and within institutions such as schools. Harassment refers to the creation of an unpleasant or hostile situation through uninvited and unwelcome verbal or physical conduct; it is usually considered an interpersonal form of discrimination, although institutional and structural systems of oppression lay the foundation for the harassment of individuals.

What the Community Tells Us: Community Perspectives and Experiences

The following section presents findings from the Children's Health Assessment key informants, focus group participants, parents and youth on structural racism and discrimination.

Focus group participants and key informants identified specific subpopulations that experienced discrimination, exclusion, and harassment. Focus group participants identified how discrimination at various levels negatively affects children's health. Furthermore, focus group participants noted that children who were perceived as being different were often excluded from friend circles and social interactions. Focus group participants were concerned about discrimination, harassment, and exclusion experienced by children, youth, and parents due to the intersection of their marginalized identities (i.e., gender, race, sexual orientation, class). One key informant explained, "we often assume that a therapist or social worker did receive [culturally relevant] education, but on the whole they have not. ... That leaves us with a very small pool of providers who ... have the competence to work with our community."

LGBTQ Youth

Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) youth focus group participants expressed their concern about anti-LGBTQ hate violence, including being harassed in public spaces like the sidewalk and on public buses. Key informants and LGBTQ youth focus group participants both identified the lack of physical and mental healthcare providers who were able to provide competent and sensitive care to LGBTQ youth as a key barrier to healthcare for LGBTQ youth. Participants in the foster and adoptive parent focus group noted that LGBTQ youth in the foster/child welfare system were often excluded, harassed, and bullied about their sexual orientation or gender identity. Transgender youth were specifically noted as experiencing discrimination due to their gender presentation in employment settings and having legal documentation (e.g., driver's license, Social Security card) that does not reflect their gender identity. One key informant shared, "there's a lot of prejudice that our young folks face in trying to get jobs if they don't look like they're going to conform to gender norms. We've had a lot of – especially trans girls – really, really struggle to find employment."

REFERENCES

- ¹ Advancing Racial Equity and Transforming Government; A Resource Guide to Put Ideas into Action. Local and Regional Government Alliance on Race and Equity. Accessed on October 20, 2016 at: http://www.racialequityalliance.org/wp-content/uploads/2015/02/GARE-Resource_Guide.pdf.
- ² Gee GC, Walsemann KM, Brondolo E. A Life Course Perspective on How Racism May Be Related to Health Inequities. *American Journal of Public Health*. 2012;102(5):967-974. doi:10.2105/ajph.2012.300666.
- ³ California Healthy Kids Survey, 2013-14.
- ⁴ Edwards E, Bunting W, Garcia L. *The War on Marijuana in Black and White*. New York, NY; 2013. <https://www.aclu.org/files/assets/aclu-thewaronmarijuana-rel2.pdf>.
- ⁵ Fellner J. Race, Drugs, and Law Enforcement in the United States. *Stanford Law Pol Rev*. 2010;20(2):257-292. doi:10.1146/annurev.polisci.6.121901.085546.
- ⁶ Krieger N. Discrimination and Health Inequities. *Social Epidemiology*. 2014:63-125. Doi:10.1093/med/9780195377903.003.0003.
- ⁷ Walker SP, Wachs TD, Grantham-McGregor S, et al. Inequality in early childhood: risk and protective factors of early child development. *Lancet*. 2011; 378 (9799): 1325-1338.

FAMILY AND SOCIAL SUPPORT

PARENTING

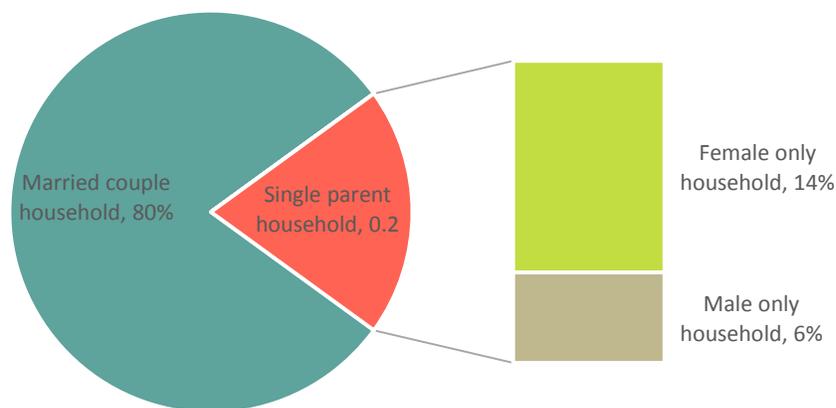
Why It's Important

Parental involvement is widely recognized as a key factor for children's academic achievement and development.¹ The Santa Clara County Bill of Rights for Children and Youth, which was endorsed by the Santa Clara County Board of Supervisors on February 9, 2010, includes the goal of supporting children and youth so that "they develop a healthy attachment to a parent, guardian or caregiver and an ongoing relationship with a caring and supportive adult."² Financial strain, family conflict, housing and food insecurity, family composition, academic demands are just a few of the factors that can have a negative effect on children's physical and mental health.³ Parental stress has also been shown to contribute to negative consequences for a variety of child and parental outcomes.⁴

What the Numbers Tell Us: Survey Findings

In 2014, 1 out of 5 family households (20%) were single parent households. Fourteen percent (14%) were female only households, and 6% were male only households in Santa Clara County.⁵

PERCENTAGE OF FAMILY HOUSEHOLDS BY FAMILY TYPE



Source: U.S. Census Bureau; American Community Survey, 2014 American Community Survey 1-Year Estimates.

Most parents of children (97%) ages 0 to 17 reported they were coping very well or somewhat well with the day-to-day demands of parenthood and raising children in Santa Clara County.⁶

PERCENTAGE OF PARENTS WHO SAID THEY FELT THEY WERE COPING WITH THE DAY-TO-DAY DEMANDS OF PARENTHOOD AND RAISING CHILDREN VERY WELL OR SOMEWHAT WELL

		Percent (%)
Santa Clara County		97
Sex	Male	95
	Female	100
Age group	0-9 years	97
	10-17 years	98

Source: Santa Clara County Public Health Department, 2016 Child Health Telephone Survey

Approximately 4 out of 5 (78%) parents of children ages 0 to 17 in Santa Clara County reported there was someone who they could turn to for day-to-day emotional help with parenthood and raising children.⁶

PERCENTAGE OF PARENTS WHO REPORTED THEY COULD TURN TO SOMEONE FOR DAY-TO-DAY EMOTIONAL HELP WITH PARENTHOOD AND RAISING CHILDREN

		Percent (%)
Santa Clara County		78
Gender	Male	76
	Female	81
Age	0-9 years	79
	10-17 years	77

Source: Santa Clara County Public Health Department, 2016 Child Health Telephone Survey

What the Community Tells Us: Community Perspectives and Experiences

The following section presents findings from the Children's Health Assessment key informants and focus groups participants, parents and youth, on family and social support.

Parents Face Challenges in Providing the Support all Children Need

Daily Pressures in Parenthood: Many parents who participated in focus groups expressed frustration about the daily sacrifices they make for their children, in their longing to give them the best opportunities and environments to grow up in and succeed. As one parent explained, "We want what's best for our children ... it's not easy because we work, we are mothers, we have a lot to do, but what's more important than our children?"

Work Demands Take Away From Family Time: Parents who work multiple jobs to afford housing and other basics have limited time to spend with their children. Many parents are forced to choose

between spending time at work, at home, and being involved with their children's school. The amount of time parents have outside of work limits whether parents can fix nutritious meals, have family dinners, engage in their children's education (including homework), meet and know their children's friends, and are not able to provide their children with support when they need it. A parent shared, "Since I had two jobs I had no time, [so recently] I quit one job because I want[ed] to be more involved with my son, my kids and with the teacher at school as well. ... I took the initiative to do this but I guess for many people, because of the economy they don't have enough money for food, rent, and other things, so they have to work. So they don't have time to be involved with their kids - because of the economy.

Systems Exacerbate Inequalities: Key informants described how economic inequality can affect everything from the ability to afford or qualify for high quality childcare, child custody and visitation rights, and housing instability. All of which can be damaging to parent-child relationships.

Cost of Childcare

Childcare is expensive, and the "benefits cliff" affects many families' ability to afford childcare. Caregivers described earning too much income to qualify for financial assistance for childcare; however, they still do not make enough to afford the high cost of childcare without it. Families also describe long wait lists for affordable childcare.

"Childcare ... it's a really big problem right now and to find the right person for your child ... because I work a swing shift, I'll work graveyard and day shift, so it gets harder to even find someone to watch our child ... they're like, 'There's a waiting list. You have to wait.' Its like, 'I'm about to lose my job.' ... It's really stressful with childcare as well and housing."

– Focus group participant

Not being able to secure affordable childcare impacts the ability of caregivers to work compounding to many families' already tenuous financial situation. One parent explained, "general assistance doesn't even help. They're like, "You make this amount of [money], you can't get childcare." It gets hard because one of us has to stay home with the kid while the other one works. It gets stressful."

Stable Housing is Important for Children in Welfare System

High cost of housing is stressing the budgets for all families in the county. Focus group participants described the stress they are under to manage financial hardships, explaining, "how can anyone afford [rental housing when it costs] so much?" Additionally, the cost of housing has repercussions for children and youth in the child welfare system in terms of being able to

maintain relationships with their family of origin. When the Department of Children & Family Services determines that a child cannot live with their parent or legal guardian, the child's relatives are the first to be considered for an out-of-home placement.^{xi} While relatives may be willing and otherwise well-suited to be legal guardians, the physical home needs to be "sufficient in size" to accommodate the needs of all people who live there and the child(ren) who need an out-of-home placement, and since many families may not be able to meet this requirement, they may not be able to provide the support children in the system deserve and need. The high cost of housing in the county also means that fewer families are able to become resource/foster families. A foster/adoptive parent focus group participant explained, "There was some family that was waiting because the grandparent couldn't find housing so that she could get her grandchild in her home."

Housing is a Major Challenge for Parents, Especially Families with Past/Present Exposure with the Criminal Justice System, and Homeless Parents

Families that have someone (parent, youth, or other relative) with a criminal record face additional challenges in finding and maintaining affordable and stable housing for their entire family. Families who have an adolescent on probation, for example, described being worried about being evicted if their child returned to live with the family. For this reason, many families feel like they are limited to either substandard housing in order to have their child live with them or not living with the adolescent (or other family member). Multiple focus group participants described this additional stress for the entire family, and a key informant emphasized this trend, noting, "I hear more and more that families are getting evicted because of [someone in the home has] low level criminal offenses. I think particularly from the juvenile perspective, which places such a strain on the familial relationship. We need parents to support their kids so that their kids stay on the right path when they're on probation. If there's a potential of being evicted because your kid has now committed a crime, that's a whole another level of stress, right?"

Family Leave Policies

The lack of paid parental leave policies are also very damaging to parent and child bonding and early childhood development. Focus group parents expressed discontent and frustration noting, "we don't have any really good leave policies for pregnant mothers so that they can stay home and bond with their kids ... without worrying about the fact that [they are] not getting paid for 12 weeks."

Chronic Stress Due to Economic Inequalities

Parents and youth both identified that children are aware of and are negatively impacted by parents who experience chronic stress due to economic inequalities (e.g., low wage jobs). Low-income parents and parents who were homeless shared how they tried to make the circumstances better for

^{xi} The County's policy for determining out-of-home placements is to give preferential consideration in the following order: 1) grandparents, aunts, uncles, and adult siblings, 2) other relatives, 3) "non-relative extended family members" (people who have an existing relationship with the child, such as mentors, teachers, clergy, or family friends), 4) licensed facilities that can meet the child's needs (i.e., a licensed foster family or a group home). Source: Santa Clara County Department of Family & Children's Services, Online Policies & Procedures, Handbook 7: Relative Home Approvals, 2009. <https://www.sccgov.org/ssa/opp2/07_relativehome/>

their children by working long hours and staying in the area so their children could continue attending the same school. A parent participating in a focus group noted, "I'm trying to make it less painful, but it's hard when they see mom or dad stressed out all the time, trying to work, and not spending enough time with their kids." Parents also consistently identified the lack of affordable housing as their biggest source of stress. One parent shared that she had limited contact with some of her children because she could not afford to rent a home and to care for all of them, reporting that "Housing is a big stress, definitely. ... I had to send my kids to Brentwood [in eastern Contra Costa County]. My other kids. I haven't seen them in two years because I had nowhere for them to go, and then I wound up having this one [indicating infant she is holding]." Some parents directly connected the cost of living to family support expressing their frustration with circumstances, such as custody agreements, "I'm basically stuck here. [Just because] his father can afford to live here doesn't mean I can afford to live here."

Lack of Knowledge Compromises Family Well-Being

Parents and key informants identified culturally and linguistically responsive parent education as an effective way to support parents, teach parenting skills, and educate parents about available resources. Key informants noted that parent education is an effective way to inform immigrant parents and parents who do not speak English about mental health services, Medi-Cal, CalFresh resources in particular. Parents who participated in focus groups also noted that parent education is an important form of outreach because, "many times us as parents don't know what to do, we don't know what resources are available to us." Parents who had attended parent education workshops and classes shared that they had found the education to be valuable, particularly in helping them to communicate more effectively with their children and in teaching them to prepare healthier meals. Parents emphasized that it is very important to have high quality teachers leading parenting classes, stressing that "it's about how people help us. If someone comes with a good program and they really teach us, and they are passionate about teaching us, that's important. How they approach you, how they treat you ... sometimes they think we are totally ignorant, and we are not. We just don't know."

Fragmented Services and Lack of Coordination Among Service Providers Hurts Families

Many key informants identified that having more coordinated systems and services would enable providers to treat the family more holistically and thus more effectively. This would also reduce the barriers that vulnerable families experience in accessing critical services. One key informant leader noted, "we don't have a common data system that tells the story about what's going on with our families ... the systems create barriers and the barriers become insurmountable for families. The families have good intentions, but the barriers are too insurmountable."

Another key informant discussed the concept of a "no wrong door" approach, in which a family would be connected to appropriate resources, regardless of whether they first connected with a school, homeless shelter, food pantry, or clinic. Because the services and systems would be coordinated, families would receive help in a range of areas, rather than needing time, knowledge, and other resources necessary to find each type of service on their own. A key informant explained, "[we need] a more robust safety net system so that people who are struggling with housing, who are

struggling with getting food, [have] an easier way. ... [We need to make] it so it's a lot easier to get from point A to point B without someone having [to have] the sophistication to navigate all the different systems." A connected, integrate system would enable families to be automatically enrolled in all benefits for which they were eligible, at the point of entry.

Services that Are Outside of Neighborhoods, Further Disadvantages Families with the Greatest Need

Parents expressed the importance of having affordable basic services available close to where they work and live. One key informant noted how existing community centers help connect parents and their children with critical healthcare, developmental screenings, and enrichment opportunities. They also serve as a place where parents can connect with other parents and form supportive peer relationships. A key informant leader described how, "the Family Resource Centers actually give the families a place to connect in their neighborhood, to get support from each other about whatever is going on. There's quality programming going out of them, like parenting and arts enrichment, language and literacy opportunities."

Many parents identified community centers as being especially important for youth. A young parent shared how she had benefited when she was a teen from having a community center within walking distance of her home, sharing "I used to go to the LGBT center when I was younger because me and my mom used to just bicker, go back and forth. I used to just go there and there was always somebody there to talk to me. It was just really close. It's actually down the street from where I used to live so I used to go there just to feel comfortable, to cool off, and then go back."

Another parent noted that youth centers should be co-located in and around neighborhoods. It is especially critical for parents(s) who work late, have two jobs, or are single-family homes with no caring and trusting adults available to provide the children and youth with food, shelter, and safe place to drop-in

"There's nothing more powerful than a quality mentor."

– Key Leader Informant

Lack of Role models that Reflect the Diverse Cultures and Experiences of Children in the County

Parents, key informants, and youth described the need for positive adult role models in the lives of young people in the county. They also emphasized the need for role models who look like them, who have had similar life experiences, and who can relate to the young people they are mentoring. Many key informants emphasized the important of diverse, positive role models for young people in leading mentally and physically

healthy lives. One key leader described the benefits of such role models and mentors, noting that "kids with healthy role models [are more likely to] have success in school [and to] mak[e] the right choices ... having a parent present at critical stages of their life is important. When a parent is not there, but a family member or a friend can step in, [that] can help alleviate that stress."

Many key informants identified positive role models as one of the key factors that help children and youth lead healthy lives, noting that the mentors model healthy behaviors that the children learn and embrace. One key leader shared, "if [children] see a grandparent eating fruits and exercising, that sends a positive message to kids that perhaps this is something that I should be doing. I think that's probably the most powerful influencer in a child's life. If they [learn in school] ... about nutrition and healthy choices that also certainly helps [but] if it isn't reinforced in the home that can only be so effective."

Many Young People Who Are Just Out of High School Do Not Have Appropriate Life Skills to Help Transition into Adulthood

Youth who participated in focus groups shared that many of their peers did not have important life skills and knowledge related to healthy eating, finances, and interpersonal skills. Youth identified that these skills used to either be incorporated into academic life or taught at home. One young person elaborated, "it was the expectation of the academic system or the family to teach these things but a lot of time, the family fails and expects that it's the responsibility of the schooling system, and the person is just stuck and lost." Another young person described a common theme about needing life skills as a young adult, "I recently graduated from high school and, you know, I learned nothing, like I know nothing about how to be an adult. I don't know what taxes are. I don't know how they work. I don't know like what my rights are at work. I don't know how to sew a button. I don't know how to cook. I don't know anything."

FOSTER CARE

Why It's Important

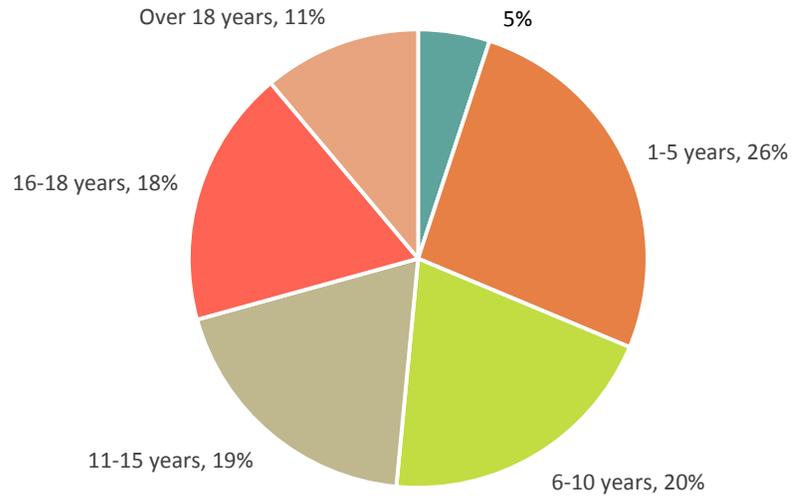
Foster care is meant to provide temporary living arrangements for children who cannot safely remain at home with their parents due to circumstances such as inadequate housing, child maltreatment, or neglect.⁷ Nearly two-thirds of children in foster care in the U.S. also have a sibling in the foster care. In addition, many of the siblings who are in foster care homes are not placed together initially or become separated over time. Sibling relationships are emotionally powerful not only in childhood but also over the span of a lifetime. The warmth in sibling relationships is associated with less loneliness, fewer behavior problems, and higher self-worth. For children entering foster care, being with their siblings can enhance their sense of safety and well-being and provide natural, mutual support.⁸

Children and youth in foster care often have complicated and serious medical, mental health, developmental, oral health, and psychosocial problems rooted in their history of childhood trauma. Due to the high prevalence of health problems among these children and youth, the American Academy of Pediatrics (AAP) classified children and youth in foster care as a population of children with special healthcare needs and recommended more frequent monitoring of their health status. Additionally, children and youth in foster care are more likely to have poor educational outcomes: high school dropout rates, be enrolled in special education, have a history of grade retention.⁹

What the Numbers Tell Us: Survey Findings

As of September 9, 2015, 1,262 children were in out-of-home placements (foster care) in Santa Clara County. More than 1 in 4 children in the system were children ages 1 to 5 (26%). Six in 10 children were Latino (60%).¹⁰

CHILDREN IN OUT OF HOME PLACEMENT (FOSTER CARE) BY AGE GROUP



Note: Percentages do not add to 100% due to rounding.

Source: Santa Clara County Social Services Agency, Department of Family and Children's Services, data as of September 9, 2015.

What the Community Tells Us: Community Perspectives and Experiences

Multiple Stressors for Children in Foster Care

"If you give a kid someone to look up to, it'll change their perspective. It'll make them feel like they're actually worth something instead of just some kid sitting, waiting to leave, or waiting for something to happen."

– Focus group participant

Caregivers described their desires to provide stability and a safe home for foster youth. A foster caregiver noted the importance of consistent presence of an adult in the lives of foster youth. Many foster youth often deal with constantly changing living situations and many times lack a positive support system comprised of adult role models. Foster youth described that adult mentors play an important role at key moments in a person's life, but can also be present across different life stages. A foster care youth described, "... when I was in my first group home, I had this mentor ... when I was thirteen years old, I still talk to her to this day. ... She was like my 'Big Sister,' you know what I mean? ... I had her for, like, a year and a half ... that, honestly, helped me through so much growing up, because it made the biggest impact." Foster youth also reported having difficulty coping with the stress and strain of being in foster care. A foster youth noted that some foster care youth disconnect from society because they are lonely or have a difficult time adjusting to foster care and "they don't have a social life."

Foster youth and parents emphasized the importance of maintaining connection and building a relationship with the children's birth family. A foster caregiver expressed how "... it's very important for [sibling groups] to be together. ... A lot of times babies are born and [DCFS] doesn't contact their [foster/adoptive] family to see if [the foster/adoptive family can] take that child ... I wish that ... if we had to split siblings up ... that we could have a relationship, where we could go to play dates, go to the park together."

Foster youth similarly expressed concern and sadness over the separation from their birth family, "you know how I reacted to ... being taken away from my mother, and my family? It hurt like hell. Nobody should have to be taken away from their parent." Similarly, foster youth described needing parent figures in their lives, "it's more like, when you're in foster home, you most likely tend to want more attention, because being told what to do by staff, you really don't get that. You really don't get attention. I'm not talking about trying to be a smart ass attention, you want a mom and dad, but instead [of] getting a mom and dad, you got a staff. That sucks."

Foster caregivers explained the importance of having supportive neighbors and other community members, especially when welcoming a new foster child into the family. Caregivers and foster youth, alike discussed protecting the foster care youth from abusive situations. Foster youth detailed the

mistreatment experienced in their foster care homes, "one day, I had an accident on myself, and this lady, the lady that I lived with ... literally threw me in the back of her barn, she literally just threw me and locked the gate, and she grabbed the hose and started hosing [me] down on the ground. That wasn't really ... parenting, you know? When I was trying to come open the gate, she kept spraying me even more. I was a little kid, I was mad ... You know what? A lot of foster parents aren't even, they should not even be foster parents."

Note: Please check 'Child Welfare System' program highlight section later in the report for more information.

REFERENCES

- ¹ County Health Rankings. Family and Social Support. <http://www.countyhealthrankings.org/our-approach/health-factors/family-and-social-support>. Published 2016. Accessed October 14, 2016.
- ² Planned Parenthood Kids in Common. The Santa Clara County Children's Agenda: 2016 Data Book. Published 2016. Accessed 2016. http://www.kidsincommon.org/storage/3283/TCA-Data-Book-2016_NEW.pdf.
- ³ Egerter S, Braveman P, Barclay C. How Social Factors Shape Health: Stress and Health; 2011. doi:10.1002/smi.1121. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70441.
- ⁴ Don BP, Chong A, Biehle SN, Gordon A, Mickelson KD. Anxiety across the transition to parenthood: change trajectories among low-risk parents. *Anxiety, Stress, & Coping*. 2014;27(6):633-649. doi:10.1080/10615806.2014.903473.
- ⁵ U.S. Census Bureau; American Community Survey, 2014 American Community Survey 1-Year Estimates, Tables DP02, B11003 ,B10051, C06001, B16007, B14003; generated by Mandeep Baath; using American FactFinder; <<http://factfinder2.census.gov>>; (22 September 2015). Accessed September 22, 2015.
- ⁶ Santa Clara County Public Health Department, 2016 Child Health Telephone Survey.
- ⁷ Foster Care. *Child Trends* 2014. Published 2015. Published 2015. Accessed November 19, 2015. <http://www.childtrends.org/?indicators=foster-care>
- ⁸ Sibling Issues in Foster Care and Adoption. <https://www.childwelfare.gov/pubPDFs/siblingissues.pdf>. Accessed September 21, 2016.
- ⁹ Szilagyi M, Rosen DS, Rubin, D., et al. Health Care Issues for Children and Adolescents in Foster Care and Kinship Care. *American Academy of Pediatrics. Council on Foster Care, Adoption, and Kinship Care, Committee on Adolescence, and Council on Early Childhood. Pediatrics* 2015, 136 (4) e1131-e1140; DOI: 10.1542/peds.2015-2655. Accessed on 11/7/2016 at: <http://pediatrics.aappublications.org/content/136/4/e1131>.
- ¹⁰ Santa Clara County Social Services Agency, Department of Family and Children's Services, data as of September 9, 2015.

COMMUNITY SAFETY AND VIOLENCE

NEIGHBORHOOD SAFETY AND ENVIRONMENT

Why It's Important

Safe neighborhoods are important to positive child and youth development. Unsafe neighborhoods are associated with high rates of infant mortality and low birth weight, juvenile delinquency, high school dropout, child abuse and neglect, and poor motor and social development among preschool children. Conversely, children who live in highly supportive neighborhoods have positive outcomes such as stronger connections with family, peers and community, and greater participation in out-of-school time programs, volunteering, and religious services.¹

Neighborhoods with high levels of crime often have concentrated poverty, and a high proportion of single parent households. Children and adolescents living in high crime neighborhoods are more likely to become victims of violent crime and to perpetrate acts of violence. Children who witness crime and violence are more likely to experience social and emotional problems such as aggression, stress, and withdrawal, as well as delinquency and low school achievement. Children of parents who believe their neighborhood is unsafe may also be less likely to engage in physical activity and more likely to be overweight.

What the Numbers Tell Us: Survey Findings

Nine in 10 parents (91%) of children ages 0 to 11 in Santa Clara County agree or strongly agree that their closest park or playground is safe. The percentage is lower among Latino parents (83%) and parents of male children (88%).²

PERCENTAGE OF PARENTS OF CHILDREN AGES 0-11 WHO PERCEIVE THE CLOSEST PARK OR PLAYGROUND IS SAFE

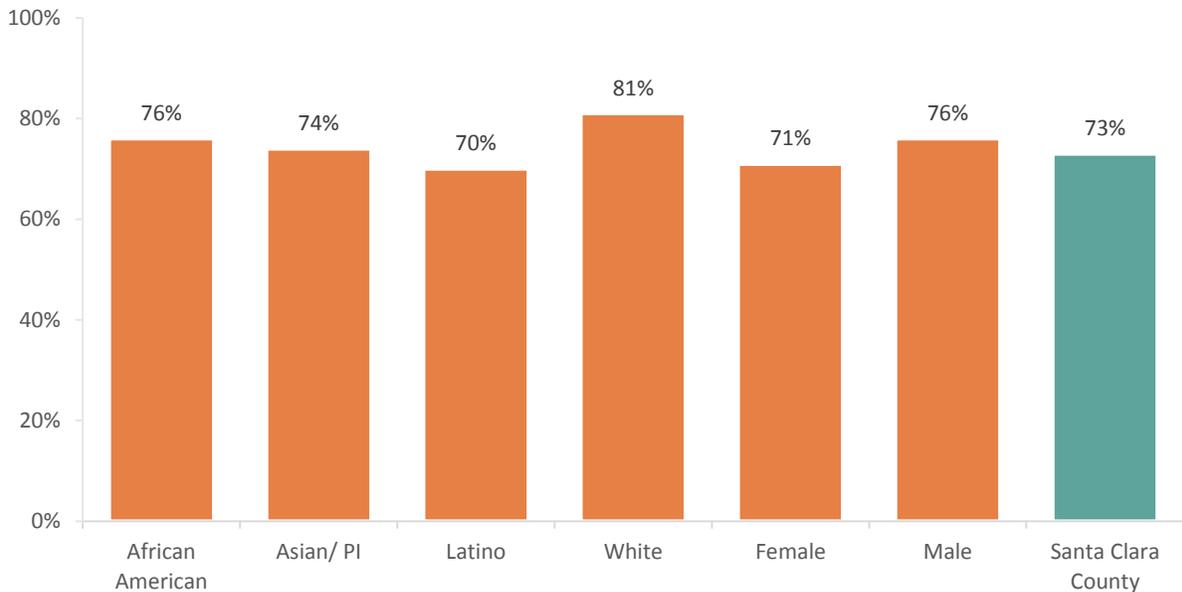
		Percent (%)
Santa Clara County		91
Gender	Male	88
	Female	93
Race/ethnicity	Asian/Pacific Islander	96
	Latino	83
	White	91
Age group	0-5	90
	6-11	91

Note: Data not presented for African American and select Asian subgroups due to small numbers.

Source: Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey

Nearly three-quarters (73%) of middle and high school students reported feeling safe or very safe in the neighborhood where they live. The percentage was lower among females than males (71% vs. 76%). Latino (70%) and Asian/Pacific Islander (74%) students reported lower percentages of feeling safe or very safe in the neighborhood where they live than African American (76%) and White (81%) students.³

PERCENTAGE OF MIDDLE AND HIGH SCHOOL STUDENTS WHO FEEL SAFE OR VERY SAFE IN THE NEIGHBORHOOD AND SCHOOL



Source: California Healthy Kids Survey, 2013-14

What the Community Tells Us: Conversations with Community Members and Informants

The following section presents findings from the key informants and focus groups participants, parents and youth.

Community Violence and Trauma Are More Prevalent in Some Areas of the County

Concerns over neighborhood safety and violence negatively affect the health and well-being of children and entire communities. Key informants, youth, and parents discussed their concerns and personal experiences with violence, especially within low-income neighborhoods. One key informant noted, "... violence is something that has been particularly endemic in certain communities." While another key leader noted that such consistent violence negatively effects children's social and emotional skills, and perceptions of the world, explaining that, "violence seems to be a way of life, particularly for people who come from depressed areas ... people learn to accept violence as part of their daily lives, and somehow it's like that ... You expect it. You get desensitized to it." Parents and

key informants shared this sentiment, as articulated by a key informant, "parents of children of color ... are in fear of this violence. It affects their [children's] ability to concentrate at school and other places." Another key informant identified gangs and trauma as factors that damage the functioning of family units, and thus negatively affect children's physical and mental health, noting, "we have a lot of families that aren't really well equipped to raise kids, because of a lot of trauma related things, and also just a lot of generational issues. We have a lot of generational gang issues in our community in East San Jose."

Recognizing the difference between perception and reality, and progress that has been made, another key leader noted, "[Violence is] not as prevalent as it used to be. I think when people think about Mayfair, they think about it in the 1980s and they think gang violence is rampant and happening on the streets every single day. I think there's been a vast improvement since those days. We still continue to be a city hot spot [for violence]—that's important to note."

Poor Design and Neighborhood Planning Links to Violence

The design of low-income neighborhoods was identified as contributing to the people's perceptions of safety and violence. The presence of numerous liquor stores in low-income neighborhoods was identified as a sign of disinvestment, and a factor driving substance abuse and associated violence. One young person shared, "In my neighborhood, there's a liquor store on every corner. They sell pipes, tobacco. Some liquor stores sell liquor ... when I go to other places, to other cities, like Santa Rosa ... I don't see all of those liquor stores there on every corner ... in a nutshell, they open these stores [here], kids start drinking when they are too young."

When asked what made them feel safe, parents and youth identified surveillance (e.g., cameras), locked doors, and having other people with them. Some parents and youth said that having guns made them feel safe, one parent explained, "I carry a knife everywhere I go with my kids ... there's always men looking at my daughter and actually one was trying to call her over, 'Hey babe, come over here.' ... It's scary to think one of these days one of these guys [is] going to follow her home or something." Another parent noted that gang members sometimes act as neighborhood protectors, sharing, "there's a lot of gang members [who think], 'Oh, you live in our neighborhood ... something happens to you, it happens to us, so we'll give you a head's up.' ... People look out for one another, right, and so do gangs. If they know you live there, most of the time they [gangs] don't mess with them [other residents]. [Gang members] are part of our neighborhood as well."

Distrust, Racial Profiling and Safety Concerns Contribute to Poor Relations with Police

Parents living in low-income neighborhoods throughout Santa Clara County voiced concerns about police. Many youth, parents, and key informants identified that the pervasive racial profiling of Latino, African American, American Indian, and Pacific Islander young men made youth of color feel a constant threat of violence – and made their parents worry about their safety. A young man in

Juvenile Hall shared, "what concerns me is that people like the police abuse their power. There have been lots of incidents and they've just been lightly punished, [the courts] don't send them to prison, and when [the courts] do, they get less time than we [youth in Juvenile Hall] do. Those are things that concern me. One of my friends was shot in the head because he was driving a stolen vehicle. And the police, 'they are doing their job.'"

Parents in the southern parts of the county felt that when police engaged in high speed chases, the neighborhood was unsafe for their children to play. Other parents agreed with the statement made by one focus group participant, "... it's not safe for the cops to do that, but they're allowed to do that. I understand they're going after a criminal so they think [it's OK], but what about the rest of the people's safety?"

Parents also shared that police were less responsive to property crimes in low-income neighborhoods. Rather than solving a crime and responding to resident needs, parents and youth expressed that the time police spent engaging in racial profiling shifted their focus away from assisting residents who needed help. Some parents noted their skepticism that more police would decrease crime or make people feel safer, "I don't think increased policing would help to inhibit crime, personally. That's just leading to further criminalization of our society. We already have full prisons."

Some parents reported that they relied on their neighbors to help and to watch out for them more than they relied on the police. Some parents and youth noted that police were not called because community members did not want to be labeled "snitches."

Social Cohesion Makes Parents Feel Safer

Parents identified that having strong neighborhood bonds has many benefits. In particular, parents noted many positive social interactions with their neighbors, and pointed out the many benefits of social cohesion and community connectedness on the health and development of their children. When asked, "What helps make you and your children feel safe or safer in your neighborhood?" many parents expressed that building a community, and knowing and trusting their neighbors helped, "since it's so small people, we pretty much look out for everybody. Everybody knows everybody."

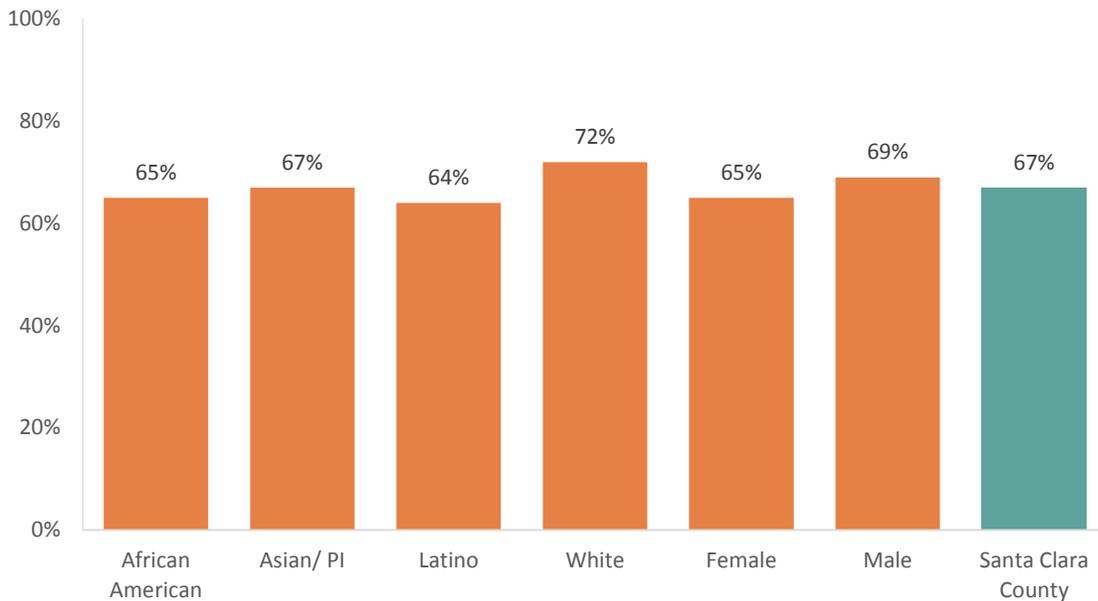
These sentiments were also expressed by foster and adoptive parents, who noted that foster and adoptive children benefited by being welcomed by their neighbors and community members.

SCHOOL ENVIRONMENT

Two-thirds (67%) of middle and high school students in Santa Clara County reported feeling safe or very safe at school. The percentage was lower among females than males (65% vs. 69%) and among Latino (64%) and African American (65%) students than other racial/ethnic groups. The countywide percentage was slightly higher than the percentage of students who felt safe or very safe in California (63%).^{3, 9}

Nearly 1 in 2 middle and high school students who identified either as gay/lesbian/bisexual (49%) or transgender (49%) reported feeling safe or very safe at school. This percentage was lower than the heterosexual students (68%).³

PERCENTAGE OF MIDDLE AND HIGH SCHOOL STUDENTS WHO FEEL SAFE OR VERY SAFE AT SCHOOL



Source: California Healthy Kids Survey, 2013-14

BULLYING/PEER VIOLENCE

Why It's Important

Bullying in adolescence can manifest in many forms: physical (i.e., assault), verbal (i.e., threats or insults), relational (i.e., exclusion or rumor spreading), and cyber (i.e., aggressive texts or social network posts.)⁴ Bullying can threaten a youth's well-being both in school and in their neighborhood. Bullying can result in physical injury, social and emotional distress, and even death.⁵ Victims of bullying perform poorly in school and have a negative view about school. Victims of bullying are more likely to report feelings of anxiety, backaches, headaches, stomachaches, dizziness, injuries, irritability, depression, sleep problems, low self-esteem, and isolation than those who are not bullied.^{6,7}

What the Numbers Tell Us: Survey Findings

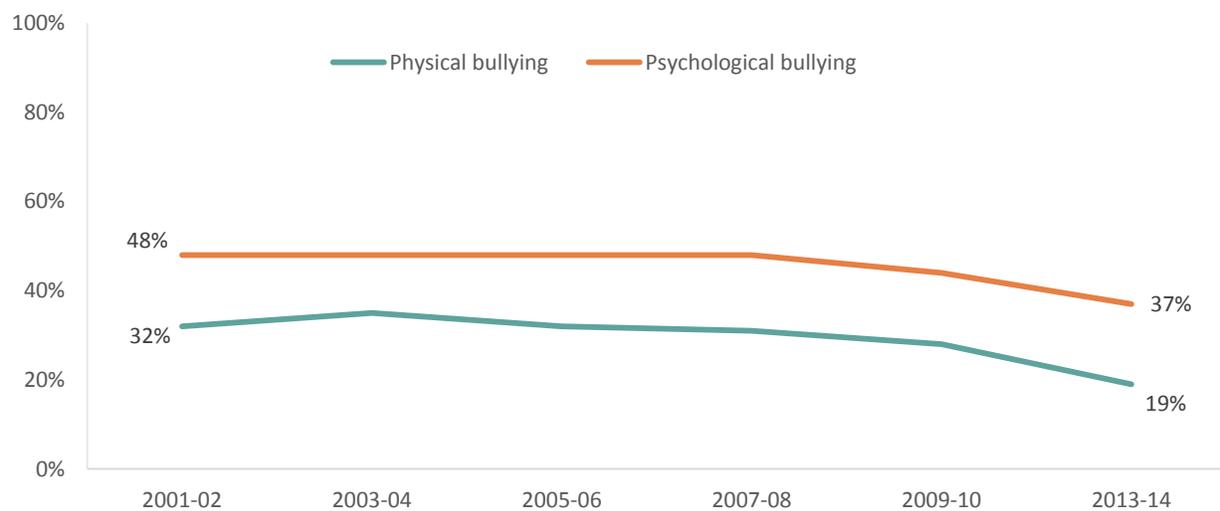
One in 5 (19%) middle and high school students in Santa Clara County were physically bullied on school property in the past 12 months, higher than the Healthy People 2020 target of 17.9%.^{8,3} Thirty-seven percent (37%) of middle and high school students were psychologically bullied on school property in the past 12 months. Eighteen percent (18%) of middle and high school students reported

they were cyberbullied (bullied online) in the past 12 months in Santa Clara County; lower than statewide (22%).^{3,9}

While higher percentage of male students (23%) were physically bullied than female students (15%), female students were psychologically bullied and cyberbullied at higher percentages (41% and 22%, respectively) than male students.³

Reported bullying has steadily declined in the last ten years. The percentage of middle and high school students who were physically bullied on school property in the past 12 months declined from 32% to 19% since 2007. The percentage of middle and high school students who were psychologically bullied on school property in the past 12 months declined from 48% to 37% since 2007.¹⁰

BULLYING IN SCHOOLS AMONG MIDDLE AND HIGH SCHOOL STUDENTS IN THE PAST 12 MONTHS



Note: Physical bullying is defined as the percentage of students who reported being pushed, shoved, hit or kicked by someone who wasn't kidding around 1 or more times in the past 12 months. Psychological bullying is defined as the percentage of students who reported being afraid of being beat up or had mean rumors or lies spread about them on school property in the past 12 months.

Source: California Healthy Kids Survey, 2013-14

What the Community Tells Us: Community Perspectives and Experiences

Bullying within Schools is a Serious Problem and a Barrier to Learning

When asked what their primary concerns were for their children, many parents talked about bullying. Some parents noted that principals and teachers were more aware of bullying than they have been in the past, and that some schools have policies declaring that bullying is unacceptable. They also noted the challenge in enforcing a "no bullying" policy, and described how children and youth were often reluctant to tell adults that they were being bullied. Some parents explained that their children were concerned about being perceived as "snitches" and therefore avoided using confidential or anonymous bullying tip boxes.

One parent shared that their child's doctor and principal had suggested that the child either stop participating in speech therapy or wait to begin school for a year to keep her from being bullied. Another parent explained that the school did not believe that his child's child was bullied and had his/her hair pulled by a classmate. Once the parent reported the situation to the school, the school responded by protecting the accused student explaining to the parent, "oh, [the accused classmate is] a straight-A student. She doesn't do that. She's so nice, she's so kind." The bully was subsequently caught pulling the daughter's hair. After sharing more instances of how their child had been bullied, the parent continued to share the impact of bullying, "my daughter ended up in the psychiatric ward because of it. She was bullied for 3 years. It's very serious. It's no game to play."

Parents of children of many ages—kindergarten through high school—identified bullying as a serious issue. Bullying appeared to be present across all school grades. One parent shared, "my girl went through [being bullied] many times. When she was in kindergarten she didn't want to go anymore, and when I asked why, she said they called her things. You think they won't hold on to that but they do. Because my girl is older now, she still says 'Mom, do [you] remember when ... ?' and I say 'Oh, child, forget about it.' But they do hold on to that or remember things, even if they are young they do."

Parents also shared some proactive strategies that their children's school have employed to reduce bullying. One parent described an elementary school's approach explaining, "there's this bench, it's called a "buddy bench." Now a lot of schools have this system, so if you feel lonely or sad as a kid, you know where to go. The rule is, if you see a student sitting there, everybody should come to [your] attention [asking]. 'What's wrong? Are you okay? Do you want to come play with us?' They encourage that and the kids are supposed to help the kid out. It could be they're being bullied or they've just been made fun of or they got pushed out, they want to sit or they're sad, right?"

Another parent shared the approach taken by the middle school their child attends, which they said helped build relationships and respect between students by assigning lunch partners at the beginning of the school year, noting that "once you know someone, and you had lunch with them for a week, you're a lot less likely to tease that person or judge them than if you've never bothered to talk to them before. ... The girls did feel much safer going to school every day and more accepted."

Many Parents Expressed Concerns About Bullying In and Outside of Schools.

Parents expressed concerns about bullying both on the school campus and in the streets. Many parents emphasized that bullying needs to be addressed in both settings and across the broader community.

One parent described a second time that the school was unwilling to respond appropriately to how her daughter had been treated, "the boys were scooping her boob and slapping her butt and all this stuff while she was waiting to go into the classroom—when I found out, I took it to the school. They said, 'Well, they [the boys] are suspended for 3 days. They're going to come back to the school. There's no need to move them around. We'll move her because they're straight-A students.' Wait a minute, this is an assault on my daughter for 2-3 weeks, and you're telling me that it's okay for boys

to do that to girls? I felt that I was forced to take it to the San Jose [Police Department] ... and then things got done."

LGBTQ Youth Often Felt Threatened by Violence in Public Spaces

LGBTQ youth and key informants reported feeling a threat of violence when being at school, taking public transportation, being out in public (e.g., using bathrooms, walking on the sidewalk). One key informant shared, "... our gender nonconforming youths definitely experience a pretty consistent risk of violence, especially accessing restrooms or any sex segregated facilities. We're in downtown San Jose, it's not uncommon that a young transgender person would come to the [Name of business] and tell us that they received threats or threatening comments just on a walk of a few city blocks related to their presentation of gender."

CRIMINAL JUSTICE

Why It's Important

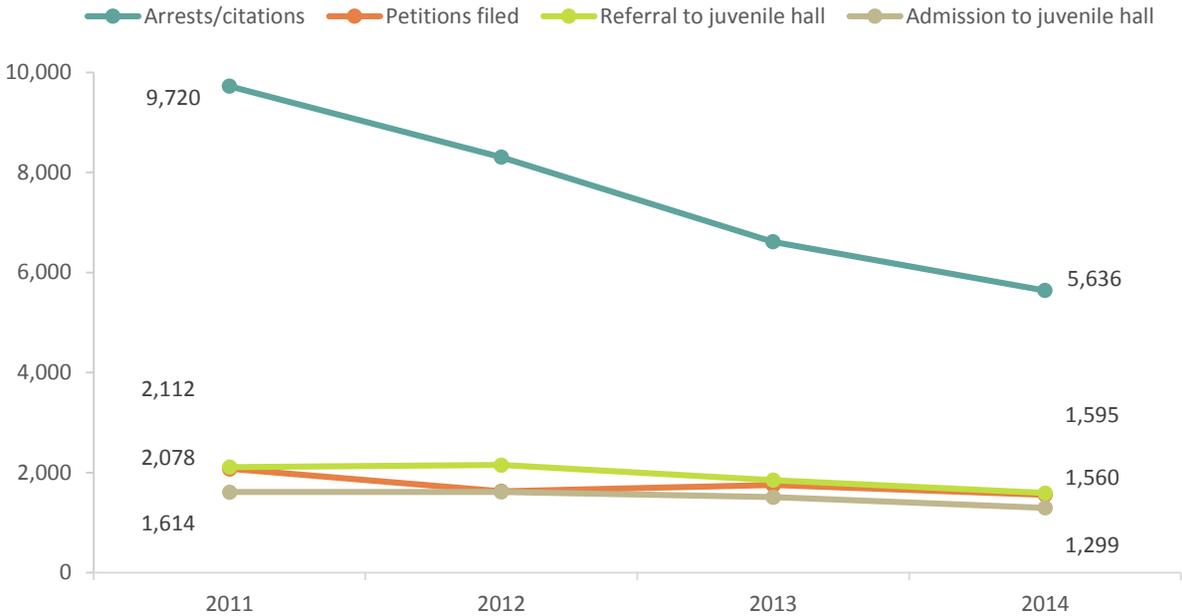
California's juvenile justice system deals with children under the age of 18 at the time of their offense. The system is set separate from adults with intentions to emphasize guidance, education, treatment, and rehabilitation over punishment among juveniles. The juvenile justice system includes local law enforcement, county probation department (includes juvenile hall, camp and ranch), juvenile court, local school districts, child welfare, and behavioral health departments.¹¹

Youth in the juvenile justice system are a high-risk population who usually have unmet physical, developmental, and mental health needs. Often, these youth do not have access to healthcare in their community on a regular basis. Continuity of care, both on entering the facility and when transitioning back to the community, is crucial for youth; however it is a challenge.¹²

What the Numbers Tell Us: Data Findings

Juvenile arrests and citations among youth in Santa Clara County declined from 2011 to 2014 with 15% fewer arrests and citations in 2014 versus 2013 (5,636 and 6,612, respectively).¹³

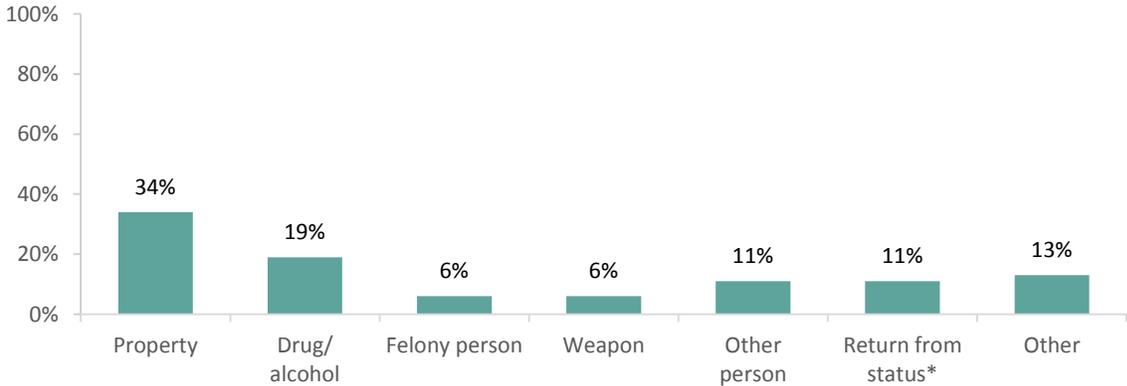
JUVENILE JUSTICE SYSTEM ARRESTS/CITATIONS, 2011-2014



Note: The following definitions are courtesy of the Santa Clara County Probation Department’s annual report: Arrest/citation - An arrest or citation marks the initial contact a youth will have with the juvenile justice system (this includes paper tickets, such as citations and summons to appear, and actual arrests); Petition – Petitions are brought to a juvenile court judge once a youth has been accused of a status offense or crime; Referred to juvenile hall – Some arrested youth are booked at Santa Clara Juvenile Hall; Admission to juvenile hall – At juvenile hall intake, a detention risk assessment instrument (RAI) is administered by the Probation Screening Officer through the Juvenile Records Service (JRS) to determine whether or not the youth should be admitted to pre-adjudication secure confinement.
 Source: Santa Clara County Probation Department, Santa Clara County Juvenile Justice System Annual Report, 2014¹³

In 2014, one-third (34%) of all juvenile arrests/citations were for property crimes followed by drug/alcohol (19%) related offenses.

JUVENILE ARRESTS/CITATIONS BY OFFENSE CATEGORY



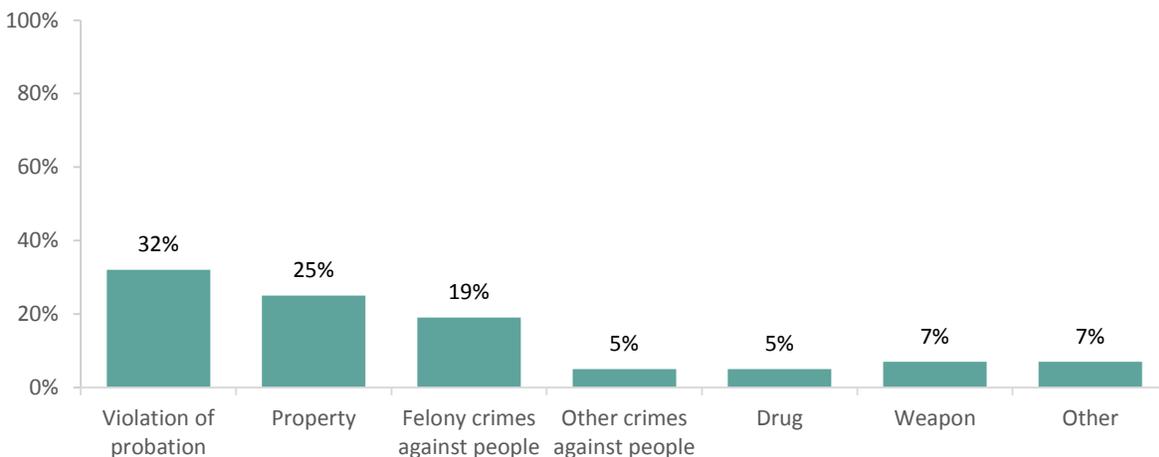
Note: [*] Return from status / courtesy hold / other admits. Return from status includes probation violations.
 Source: Santa Clara County Probation Department, Santa Clara County Juvenile Justice System Annual Report, 2014¹³

The majority of juvenile arrests/citations in Santa Clara County were among youth ages 16 to 17, with a higher percentage among males (78%) than females (22%). Latino youth (67%) comprised a higher percentage of arrests/citations than African American (9%), Asian/Pacific Islander (4%), and White (15%) youth.¹³

However, African American youth were arrested/cited at a higher rate of 101 per 1,000 youth, or 6 times that of White youth (16). Latino youth (56 per 1,000 youth) were 3.5 times more likely than White youth (16) to be arrested/cited.¹³

In 2014, 1,595 county youth (28% of those arrested) were booked at juvenile hall and of those youth, 1,299 (81%) were detained. Most youth were admitted for violation of probation (32%), property crime (25%), and felony crimes against people (19%).¹³ The number of violations of probation filings has declined from 1,117 in 2010 to 306 in 2014.¹³

JUVENILE INTAKE/ADMISSIONS BY OFFENSE CATEGORY



Source: Santa Clara County Probation Department, Santa Clara County Juvenile Justice System Annual Report, 2014

Similar to arrests/citations, the majority of admissions to juvenile hall were youth ages 16 to 17 (68%), with a higher percentage of males (85%) compared to females (15%). More than three-quarters (78%) of the youth detained at juvenile hall were Latino youth, followed by African American (10%), White (9%), and Asian/Pacific Islander (3%) youth.¹³

African American youth were approximately **12** times more likely than White youth to be detained (24.5 vs. 2.1 per 1,000 youth, respectively). Latino youth were **7** times more likely than White youth to be detained (15.1 vs. 2.1 per 1,000 youth, respectively).¹³

Violations of probation, the most common cause for admission to juvenile hall, occur when a youth has violated the terms of his or her probation status, has a technical violation, or has committed a new law violation. In 2014, there were 306 violations of probation filed.

What the Community Tells Us: Community Perspectives and Experiences

Youth in the juvenile justice system discussed concerns about community safety and violence. Several participants brought up that they do not feel safe around street gangs and fear getting caught in the gun crossfire of gang violence. Some youth spoke about the amount of liquor stores in their neighborhoods compared to those in more affluent areas.

Youth Complained of Racial Profiling and Neighborhood (Dis)Trust

Racial profiling and disproportionalities in the juvenile justice system are so systemic that they shape the daily lived experiences of youth of color (especially African American and Latino youth), and as such function as structural racism. Youth focus group participants shared their experiences with being racially profiled and witnessing racial profiling. Many youth described it as a regular occurrence and therefore live with the ongoing threat of being racially profiled. African American parents also described their own experiences with being racially profiled and how they must prepare their children for these (inevitable) experiences, "Even though my son hasn't experienced overt discrimination, I'm trying to prepare him to expect it, because it's going to come."

Focus group participants also shared personal experiences with racial profiling that involved police, neighbors, residents in neighboring communities, teachers, social services staff, and retail workers. In other words, they described experiencing racial profiling in all aspects of their daily lives – and across institutions. One parent described how she tries to avoid being profiled, while also noting that it is inevitable, "what hurts my heart is having to talk to my son about [this]. He loves his little action figures, and I make him leave them in the car when we go inside of a store. I'm like, 'You leave everything here. We're not going to go in and have any sort of conversations with anybody in Target or wherever that you took this.' It breaks my heart even just talking about it. Those are the conversations we've been having since he was 7-years-old. It's just the reality. 'Hands out of your pockets.' All of these little things that you have to teach your child."

Young people, parents, and key informants expressed fear for themselves, their friends, and their children regarding racial profiling, police harassment, and death in the hands of police. Latino and African/African American youth in Juvenile Hall expressed deep concern about witnessing police misusing/abusing power. Youth of color also shared many personal experiences when police had racially profiled them or their friends and how they felt harassed by police, as police often stopped them. This sometimes had a negative impact on the ability for youth to be in school—one parent shared this experience about their nephew and nieces, "they went to McDonald's before they were going to school and the cop stops them and says, 'Where are you going? Why aren't you in school?' 'Well, we're going to school right now.' He detains them and he's questioning them, and because of that they were late to school. ... If you don't believe them, park your car and watch them go to school. Literally they were across the street. ... He felt the need to ask them questions and make them feel like they were doing something wrong and they weren't. They got breakfast and they were going to school. That's it."

Residents of low-income neighborhoods with a predominant number of residents of color also reported inequities in the amount of attention police paid to crime in those areas. Parents shared that they relied on themselves and their trusted neighbors to monitor burglaries and other crimes, and explained that when police were called they regularly took a long time to arrive and did not appear to be concerned about the victims.

Note: Please see the "Juvenile Probation: Juvenile Justice" program highlight section for additional information.

REFERENCES

- ¹ Neighborhood Safety: Indicators on children and youth. Child Trends Data Bank. http://www.childtrends.org/wp-content/uploads/2012/08/107_Neighborhood_Safety.pdf. Accessed October 17,2016.
- ² Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
- ³ California Healthy Kids Survey, 2013-14
- ⁴ Litwiller BJ, Brausch AM. Cyber Bullying and Physical Bullying in Adolescent Suicide: The Role of Violent Behavior and Substance Use. *J Youth Adolescence Journal of Youth and Adolescence*. 2013;42(5):675-684. doi:10.1007/s10964-013-9925-5.
- ⁵ Understanding Bullying Factsheet. Division of Violence Prevention. https://www.cdc.gov/violenceprevention/pdf/bullying_factsheet.pdf. Published 2015.
- ⁶ Frieden TR, Sosin DM, Spivak HR, Delisle DS, Esquith DG. Bullying Surveillance Among Youths: Uniform Definitions for Public Health and Recommended Data Elements. Center for Disease Control and Prevention. Published 2014. Accessed 2016. <http://www.cdc.gov/violenceprevention/pdf/bullying-definitions-final-a.pdf>.
- ⁷ The Clinic for Health Problems Related to Bullying. Children’s National Health System. Accessed on October 17, 2016. <http://childrensnational.org/departments/bullying-related-health-risks>.
- ⁸ U.S. Department of Health and Human Services, Healthy People 2020. Accessed February 26, 2016. <http://www.healthypeople.gov/2020/topics-objectives>.
- ⁹ Kidsdata.org, California Student Survey, 2011-13. Available at: <http://www.kidsdata.org/>. Accessed September 22, 2016
- ¹⁰ California Healthy Kids Survey, 2007-14.
- ¹¹ Tafoya S, Hayes J. Juvenile Justice in California. Just the FACTS. Published May 2014. Accessed 2016. http://www.ppic.org/main/publication_show.asp?i=1100.
- ¹² Braverman PK, Murray PJ. Health Care for Youth in the Juvenile Justice System. Committee on Adolescence; Pediatrics Dec 2011, 128 (6) 1219-1235; DOI: 10.1542/peds.2011-1757.
- ¹³ Santa Clara County Probation Department, Santa Clara County Juvenile Justice System Annual Report, 2014.

HEALTHY DEVELOPMENT

DEVELOPMENTAL SCREENINGS

Why It's Important

Developmental screening is the practice of systematically looking for and monitoring signs that a young child may be delayed in one or more areas of normal development. It is one of the many tools available to ensure a child's success in life. Studies have shown that the earlier detection of a delay and prompt intervention improves the child's chances of substantial improvement.¹ Early identification should lead to further evaluation, diagnosis, and timely treatment of the cause of developmental delay. This is critical for the well-being of children and their families. However, many children with developmental delays are not being identified early enough resulting in delay in intervention/ treatment that is needed for the children to do well in social and educational settings (e.g., in school).²

Developmental screening can be done by doctors and/or nurses in healthcare, and other professionals in community, or school settings. Developmental screening is an integral function of the primary care medical home.³ Well-child visits allow healthcare providers to have regular contact with children to keep track of or monitor a child's health and development through periodic developmental screening. In the U. S., about 13% of children 3 to 17 years of age have a developmental or behavioral disability such as autism, intellectual disability (also known as mental retardation), and attention-deficit/hyperactivity disorder. Additionally, many children have delays in language or other areas that can affect school readiness. However, many children with developmental disabilities are not identified before age 10, by which time significant delays already might have occurred and opportunities for treatment might have been missed.² Currently, diagnosis rates of developmental delays are lower than their actual prevalence, suggesting need to expand efforts for universal screenings. The American Academy of Pediatrics (AAP) recommends that developmental screening/surveillance should be incorporated at every well-child visit. Any concerns raised during surveillance should be promptly addressed. Furthermore, school-readiness screening before the child's attendance at preschool or kindergarten might prove beneficial. *Title V* of the *Social Security Act* and the Individuals with Disabilities Education Improvement Act (IDEA) of 2004 reaffirm the mandate for child health professionals to provide early identification of, and intervention for, children with developmental disabilities through community-based collaborative systems. The medical home is the ideal setting for developmental surveillance and screening of children and adolescents.³ Timely screening and treatment of these developmental, social-emotional, and behavioral concerns can help prevent learning and behavioral issues from becoming a pervasive problem that can affect long term behavior and learning.⁴

What the Numbers Tell Us: Survey Findings

In 2016, nearly 1 in 4 parents (26%) reported that their child’s doctor or other healthcare provider asked about their concerns regarding their child’s learning, development, or behavior. This percentage was higher among Latino and White (28% each) parents compared to Asian/Pacific Islander (20%) parents. A higher percentage of Chinese (24%) parents reported that their child’s doctor or other healthcare provider asked about their concerns regarding their child’s learning, development, or behavior compared to Vietnamese (20%), Asian Indian (18%), or Filipino (18%) parents. A higher percentage of parents with annual household incomes of less than \$25,000 (30%) reported that their child’s doctor or other healthcare provider asked about their concerns regarding their child’s learning, development, or behavior compared to parents with higher annual household incomes.⁵

PERCENTAGE OF CHILDREN AGES 0 TO 17 WHOSE DOCTOR OR OTHER HEALTHCARE PROVIDER ASKED PARENTS ABOUT ANY CONCERNS REGARDING CHILD’S LEARNING, DEVELOPMENT, OR BEHAVIOR

		Percent (%)
Santa Clara County		26
Sex	Male	27
	Female	24
Age group	0-9 years	26
	10-17 years	25
Annual household income	Less than \$25,000	30
	\$25,000 – less than \$75,000	27
	\$75,000 and more	25
Race/ethnicity	Asian/Pacific Islander	20
	Latino	28
	White	28
Asian subgroups	Asian Indian	18
	Chinese	24
	Filipino	18
	Vietnamese	20

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

VISION SCREENINGS

In 2016, more than 4 out of 5 parents of children ages 3 to 17 (81%) reported their child ever having their vision tested with pictures, shapes, or letters. This percentage was higher among parents of children ages 10 to 17 (89%) compared to parents of children ages 3 to 9 (77%), and among White (88%) parents compared to Latino (82%) and Asian/Pacific Islander (77%) parents.⁵ Santa Clara County has a higher percentage of parents reporting their children getting vision screening than California (61%) and the U.S. (68%).⁶

PERCENTAGE OF PARENTS WHO REPORTED THEIR CHILD AGES 3 TO 17 EVER HAD THEIR VISION TESTED WITH PICTURES, SHAPES, OR LETTERS

		Percent (%)
Santa Clara County		81
Sex	Male	83
	Female	80
Age group	3-9 years	77
	10-17 years	89
Annual household income	Less than \$25,000	82
	\$25,000 – less than \$75,000	81
	\$75,000 and more	83
Race/ethnicity	Asian/Pacific Islander	77
	Latino	82
	White	88
Asian subgroups	Asian Indian	77

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

What the Community Tells Us: Community Perspectives and Experiences

Children Do Not Have Regular Vision Care

Focus group participants reported not having vision care coverage, as part of their health plan. A Spanish focus group parent noted, "We have to wait a year; my daughter needs glasses again but she was to wait until next year to be given glasses again." An African American parent further explained, "That's the thing. We didn't have vision, and he was just like, 'Mom, I really need to get my eyes checked.' Hold on. Wait until I find a job. Hold on to them glasses."

Key informants reported vision problems as the "biggest problem in healthcare in terms of how underserved it is" that it often goes undetected, and can have serious long-term repercussions on learning. "The problems with kids' vision –and specifically how certain vision problems that kids have – are missed. Kids basically have no symptoms. They don't complain. The parents don't know that their kids have a vision problem." In some cases, key informants reported that child and parent alike, were unaware of any vision problems, rather attributing a child's "squinting," for example, as part of their children's normal behavior. A key informant explained further, "I would ask the child, 'Do you have any vision problems?' 'No.' Asked the mom, 'Do you think your child has any vision problems?' 'No.' 'Why are you here?' Usually at that point they were sent by a teacher, but also they might have been sent by a pediatrician, and then, 'How are they doing in school?' 'Terrible.'

Additionally, key informants noted that certain vision conditions affect some populations more than others, explaining, "that occurs with hyperopia, which is farsightedness, and astigmatism. For whatever reasons, hyperopia and astigmatism are many, many times more ... far, far more prevalent in Hispanics." While Myopia, or nearsightedness, which causes distance blur, was described by a key

informants "far more prevalent in Asians. We don't know why. That's just the way it is." Another key informant concluded that "children in general below the federal poverty level were twice as likely to have vision problems as those who were greater than 200 percent above poverty level. Those are just three conclusions from the eye care study [from the] Center for Disease Control and Prevention from 2002."

Vision Care Professionals Are Not Set Up to Meet the Needs of Children and Insurance Reimbursement is a Challenge

Key informants also noted the importance of ensuring that eye doctor's offices are set up to see children, explaining, "Kids are tough to examine, right? So eye doctors, like I said, their offices aren't set up for it, so most of them would prefer just to avoid it. Another key informant discussed the need to ensure that eye exams are reimbursed appropriately for low-income children because as he noted, "the truth is most kids don't need glasses [which is what doctors get paid for]. ... If all you see are kids, [and] that is a prevailing undervalued eye exam rate. You can't make [the money] up."

Need to Identify Strategies to Mitigate Barriers to Early Detection and Treatment

"I will say, in the schools they still use the eye chart which was developed during the Civil War. We use photo optic cameras that take 15 seconds."

– Key Leader Informant

Increased education for parents, teachers and pediatricians about eye exams, in particular the differences between eye exams and eye screenings, were described by a key informant as an important strategy to early detection and treatment for all children, "here's what's happening. They're falling down in school. They're losing [important time in school] ... and this is all detectable and treatable if we get them early enough. ... Education sounds easy, but it's hard."

Key informants and focus groups participants also suggested investing in effective eye screening technology, mandating eye exams for all children entering kindergarten, offering vision exams where families live and go to school, and increased transportation options to appointments, as important strategies to mitigate barriers to early detection. Participants from an American Indian focus group, in particular shared that "resources such as dental care and

vision are hard to come by in the community," describing timely vision exams as part of an early screening process at existing resource centers and other trusted community sites. "[You have] that early learning system and you have an early screening system with the developmental health, the oral, the vision, the hearing. ... All of those together and then you have over here the high quality early learning and the Family Resource Centers. The Family Resource Centers actually give the families a place to connect in their neighborhood, to get support from each other about whatever is going on."

HEARING SCREENINGS

What the Numbers Tell Us: Survey Findings

Early diagnosis of hearing loss is crucial to the development of speech, language, cognitive, and psychosocial abilities. The most important time for a child to be exposed and learn language is in the first three years of life.⁷ Besides a hearing screening at birth, more than half of the parents (53%) reported their child ever having their hearing screened or tested using headphones, audio probe/electrodes, or a sound booth. This percentage was higher among parents of children ages 10 to 17 (70%); parents with annual household incomes of less than \$25,000 (60%) and \$25,000 to less than \$75,000 (59%); and White parents (60%) compared to other groups.⁵

PERCENTAGE OF PARENTS WHO REPORTED THEIR CHILD AGES 0 TO 17 EVER HAD THEIR HEARING SCREENED OR TESTED BESIDES HEARING SCREENING AT BIRTH

	Percent (%)
Santa Clara County	53
Sex	
Male	56
Female	51
Age group	
0-9 years	47
10-17 years	70
Annual household income	
Less than \$25,000	60
\$25,000 – less than \$75,000	59
\$75,000 and more	46
Race/ethnicity	
Asian/Pacific Islander	43
Latino	58
White	60
Asian subgroups	
Asian Indian	40
Chinese	37
Filipino	55
Vietnamese	43

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.
Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

What the Community Tells Us: Community Perspectives and Experiences

The need for audiologists, specifically pediatric audiologists in Santa Clara County was a concern among key informants, citing "a real shortage of audiologists ..." and understaffed offices as barriers to care, this is further compounded if a child is on Medi-Cal. Key informants further described the need for increased number of audiologists in Santa Clara County, explaining, "what we really need is more trained people in audiology, more trained people in early education, more staff in regular

"There's a real shortage of audiologists, and to try to screen everyone [or] ... do a diagnostic on everyone would almost be impossible."

- Key leader informant

education. Especially pediatric audiology. It's very, very different working with the zero to three population than it is. ... When you're in audiology, you either work with really young kids or really old people. Most audiologists work with older ones. It's less time-intensive, they can dispense hearing aids. The younger ones, it's a lot of technical testing, where you're doing a test that's almost like an EEG, where you're recording brain waves and stuff. It's much more time-intensive. It takes specialized training to work with kids."

Key informants also expressed the need for removing barriers to audiology appointments, in particular for low income families to ensure access to timely, and high

quality care, such as increased transportation options to appointments for families, "there are a lot of no-shows on some of these appointments because this mother has to take her baby on three buses to get somewhere." A key informant suggested providing care for siblings during audiology appointments, noting "The other factor is that [families] don't always have daycare. They come with their baby, and they come with their two-year-old and their four-year-old to the appointment. There's no place, and you have to have a quiet. ... There's no place to take care of these other kids. ..." Key informants also recommended supporting parent to parent peer networks to assist families navigate services in culturally appropriate ways.

Timely Hearing Assessments

Early intervention, especially for children with mild to moderate hearing loss, to avoid delayed speech and language, is of paramount importance and as noted by a key informant, one of the many reasons why the Early Start Program is important. A key informant noted "if they [children] don't pass on the second screen (when a child has an ear infection), then that child's referred to California Children's Services to get a diagnostic hearing test. It's important to do that, because they may need Ear/Nose/Throat (ENT) services if they continue to retain fluid behind the ear drum. An ENT will not see a child until they know if there's any hearing loss. The important thing is to get them to a diagnostic hearing evaluation before they get the referral, before they see the ENT person."

However, for kids that are sent to Santa Clara Valley Medical Center for a hearing test/evaluation, they are confronted with a three-month waiting period, which key informants cite as another problem to accessing timely care.

CHILDREN WITH SPECIAL NEEDS

What the Numbers Tell Us: Survey Findings

A majority of parents reported that their child does not have any current physical, behavioral, or mental conditions that limit or prevent them from doing childhood activities usual for the age (93%). However, 7% of parents reported their child to have at least one of these conditions that limit or prevent him/her from doing childhood activities usual for his/her age: 3% have a physical condition, 2% have a behavioral condition, 1% have a mental condition and 1% have multiple conditions limiting or preventing the child from doing childhood activities usual for the age. A higher percentage of parents who were Filipino, had children ages 10 to 17 and had low annual household incomes reported their child has a current physical, behavioral, or mental conditions that limit or prevent him/her from doing childhood activities usual for the age compared to parents in other groups.⁵

PERCENTAGE OF PARENTS WHO REPORTED THEIR CHILD HAVE AT LEAST ONE PHYSICAL, BEHAVIORAL OR MENTAL CONDITION LIMITING OR PREVENTING HIM/HER FROM DOING CHILDHOOD ACTIVITIES USUAL FOR THE AGE

		Percent (%)
Santa Clara County		7
Sex	Male	8
	Female	5
Age group	0-9 years	5
	10-17 years	10
Annual household income	Less than \$25,000	9
	\$25,000 – less than \$75,000	7
	\$75,000 and more	5
Race/ethnicity	Asian/Pacific Islander	5
	Latino	8
	White	7
Asian subgroups	Asian Indian	2
	Chinese	3
	Filipino	14
	Vietnamese	7

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

What the Community Tells Us: Community Perspectives and Experiences

Several caregivers participating in focus groups expressed concern for the future of their children, such as their ability to hold down a job, succeed academically, keep up in school, take care of themselves, or make friends and be social. Caregivers shared their concern with the stress levels and high rates of suicides and mental health issues that exist among youth, some of which, attributed this to the intense academic pressure to succeed and unhealthy levels of competitiveness in schools. Caregivers also expressed frustration with the quality of and access to educational support at school

to help their children address, and resolve daily pressures. Additionally, caregiver focus group participants reported that families also lack access to timely, affordable care for their children.

Racism & Discrimination

A caregiver who has a child with mental health issues spoke about another family's struggles with racism within the school system. She reported that children of color are placed into special education classrooms, even though they do not have special needs, because of the lack of remedial classes and the stark gap in education outcomes. "If you look in Palo Alto, the percentage of black and Hispanic families ... they're being [bussed in] because of that law from East Palo Alto. They don't really live in the community. They're a very small percentage and a lot of them are put into special education. ... We put kids of color into special education because we don't know what else to do with them, because [the quality of education they received] before they came to the district [was poor]. ... How do we make that up? We're going to put them in special education because we don't have remedial classes. We don't even know what that means. I've seen this because of my daughter being in special education, having these kids with no special needs in her special education classes."

Economic Inequality & Housing Stability

Caregivers of children with disabilities raised serious concerns about their children's future, especially their children's ability to care for themselves financially. A caregiver of a 25 year old child with disabilities shared her experience; "... when is she going to move out and stay out for good on her own? That is my concern. Developmentally she feels like she is 15, she is 25, she is missing a lot of stuff in the real world of how to do things yet she is resistant to learning that stuff. How is she going to get to her chronological age in life to accept responsibility of somebody her age? How is she going to realize that she needs to be monetarily responsible for a lot of her own expenses being that she is 25?" A similar sentiment was shared by another caregiver of a child with disabilities "... the more my son grows up the more I have concern about his ability to handle things, the ability to socialize and to live in the community ... he is in high school now ... I'm thinking about what he can do after he finishes high school. Will he be able to handle himself and manage his life by himself, will he be able to handle a job? ... I am not sure if he will be able to handle a job or be responsible for himself."

Barriers to Accessing Services

Caregivers brought up the difficulty of navigating the system of care and handling their children's changing diagnosis and treatment options. A caregiver shared her experience noting, "... I am also very confused about all those diagnosis changes. She had autism and so then she was getting some therapy, she was getting speech and ABA (Applied Behavior Analysis) for that, and then once they removed the diagnosis because she improved and they said 'you know she no longer qualifies for it' and they gave her instead ADHD anxiety and speech and language. But just because that thing was gone, the diagnosis of autism was gone, the services all went with it."

Caregivers also relayed their frustrations with delays in receiving an accurate diagnosis for their children, "I think [at] 3 months, six months, nine months, they always have ... autism screening, but they could never figure out that he could be somewhere on the spectrum ... when I was speaking

[with the] day care playschool teacher and we thought something could be off, I took him to the pediatrician again and still nothing came out in her screening and that delayed us at least six to nine months ... Even if you start the procedure, the appointments and everything is long [and] you can lose one and a half year in just getting diagnosis." Delays in receiving a diagnosis also delays treatment.

A caregiver noted that **services and resources should not be solely based on diagnosis**. Relying solely on a diagnosis for treatment increases the chance that children will "fall through the cracks" of the system and not receive the help they need to be healthy. A caregiver of a child with disabilities noted, "... when they need something, when you see them having social deficits, when you see them have language deficits, they should get that help ... It shouldn't be based on a diagnosis and only if they could have this diagnosis then agencies will help them – that makes a lot of kids fall through the cracks ... I know a few [children] who have a diagnosis and who are getting the help, and my daughter isn't ... I know she has all these other things, but she probably doesn't meet the criteria exactly."

Some caregivers described **difficulties with health insurance coverage**, noting that without coverage, families have few options, which impacts their children's care. Caregivers also noted difficulties with qualifying for services, "sure, my son has a medical diagnosis [of] fragile syndrome -- it's well known and documented but types of issues he may encounter and what types of therapies they should proceed, but our health insurance won't cover any of this ... we can get [therapies] through the regional center after ... our health insurance rejection, but then he has to have a certain delay in order to [receive treatment] so ... if he is not showing the thirty percent delay now he can't get any services, which could help bridge the gap sooner ..."

Caregivers also reported a **low rate of reimbursement to providers**. This, combined with the high cost of living in the county, impacts the number of providers practicing in the area. A caregiver of child with mental health issues, expressed his frustration, sharing "Trying to get treatment through a covered and in-network provider, through a therapist or psychiatrist in this area, I would say is close to impossible. The reason that they don't bill insurance is because the amount that the insurance cover will pay is not sufficient for them to run a practice ... The reimbursement rate is ridiculous. For an in-network psychiatrist, it's like sixty bucks an hour and out-of-network is \$300 to \$400 an hour in this area. There's a real issue of cost and availability. I think there are fewer people practicing in the area because of the cost of living and the lack of reimbursement, and they're not filing for insurance for that reason."

Caregivers also noted that the lack of providers leads to **long wait times for care**, "there are [also] very, very few child psychiatrists ... [And] so it's ... like you know a 45 days wait ... there's just not enough providers." Another caregiver discussed the long wait time for dental appointments for his child with disabilities, noting that he sometimes has to register "six months in advance to make an appointment."

Other caregivers worried that their children will not be able to advocate for themselves for medical services when they become adults, and worry about their children's ability to care for themselves. A caregiver with a daughter with mental illness shared that **"mental illness is going to be a part of her life. I don't have mental illness and I have invested so much energy in trying to find her care, timely**

care, affordable care. Fortunately, we can pay out of pocket, but for her to self-advocate and have the energy that's going to be required to find her own care as an adult, I don't know how she's going to do it. The lack of access to timely, affordable care in this area, maybe in the country is, I think a huge concern."

One caregiver described positive experiences with providers and the level of service provided to their child with disabilities, "I asked my pediatricians for the service for my son at that time, and the insurance says that they cannot do it, so I called the regional center and they provided the service for my son. So, I haven't had any bad experience with anything at all. Anything I need, I call my pediatrician, call regional center and I got approval. So I have had all good experiences."

Educational System

Caregivers worried about their children academically and their ability to keep up with their peers in school, one caregiver noting, "I have a 10-year-old and she has ADHD [and] she has a speech delay ... So that is a lot of the concerns I have, I am worried about her academically. She can read, but she can't comprehend what she is reading so she does not read because reading is hard for her ... so she just avoids that."

Some caregivers also discussed difficulties with receiving educational support for their children in schools, one caregiver of a child with disabilities explaining, "I also noticed on their IEPs they don't always follow through like they are supposed to access the child for let's say for speech language and my kid never got assessed and so I had to just go put her in private speech therapy [because] I didn't want to lose a whole school year."

Caregivers reported that the pressure to perform academically in a competitive environment, combined with social and peer pressures and lack of healthy coping skills, can result in devastating consequences for children in Santa Clara County (i.e., increased rates of suicides). A caregiver of a child with mental health illness noted, "I hear somebody tell me something new every day about the pressure that their high school kids feel with academic and social pressures, and the diagnoses that are coming out of that, the lack of coping skills that each of these kids have, and that why isn't it taught at a much younger level? [There are] people [who are] cutting [themselves], [there are] people who are suicidal, there's eating disorders, there's all these strange things that people are developing all because of high-performing districts. The ability to want to please your parents and want to please teachers that are crippling these high school students. Why aren't we teaching our kids and making it more important to be happy instead of making the focus on academics?" Some caregivers stated that the pressure to succeed is much more pronounced in Asian families.

Caregivers reported that all of this competition and pressure to succeed creates a toxic environment for children, "not just the classes, but every club, every sport, everywhere they turn, it's a competition to see who's getting the award, who's adding this to their CV, who's the best everywhere. Nothing is for just enjoyment or fun."

Recommended Solutions

Caregivers recommended early education on social and emotional learning "as part of the school curriculum starting in preschool all the way through the public school where they are taught a language to use to help identify if they're struggling and to recognize in one other, where one of the peers is struggling ... I think [teach them about] mental health and how to take care of themselves." They also recommended more counselors in schools to offer support to children with special needs.

Some caregivers also recommended that schools should work to address the high levels of stress and pressures to succeed academically. They suggested that mental health issues seen during this phase of life is related to the stress that children experience.

Family & Social Support

Caregivers expressed concern for their children's abilities to make friends and lead socially fulfilling lives. A caregiver of child with disabilities shared her daughter's experience "It is hard for her to make friends and she always comes back saying, 'I don't have any friends, nobody plays with me.' So, it's been years and years of hearing that ..." Caregivers also expressed fear that their children will be lonely and become depressed as a result, "she is getting more aware ... before ... if she was lonely and alone she seemed okay with that. She would just do things herself, but now she is becoming more aware and she is seeing that other kids are invited to other parties and other kids have all these things and people don't like her as much. They don't prefer to be with her. She is realizing these things, and she is just so hurt, and you know I'm also afraid of her getting depression or you know other things like that. So I am concerned about what preventive solutions there can be to help her out."

Many caregivers worried about their children's quality of life, one caregiver described her fear, "once he becomes part of the real world, I am scared that he might be lonely and that he would want to connect, but he won't be able to ... I want to know how best to help him through this ... and what services are there so that socially he can be involved in the community through work, through education, through activities."

Caregivers also expressed concern about their children's ability to handle stress and rebound from adversity, "for my daughter, my major concern is a mental health concern. It is about stress ... [and] resilience, the ability to handle all that I know that life is going to throw at her. I wouldn't say come out of it unscathed, but come out of it or be able to deal with it in a way that works for her overall in the long run." Another caregiver discussed the need to provide their children with healthy coping mechanisms, "if you have negative emotions which is normal to have those negative emotions, how can you work through them, so that you don't go and punch Johnny in the face because you're mad at Johnny? ... Don't punch yourself because you're depressed. Deal with your negative feelings in a healthy manner, how do you work through those. All emotions are necessary. We all have them. It's fine."

Caregivers expressed frustration with the lack of understanding from others (i.e., parents of other children) about their children's disabilities and recommended that the public should be educated about disabilities. One caregiver recalled when her daughter was in first grade, "used to bang her head on the desk when she was a head banger, and she had a friend at that time and then her

mother heard about it because her mother volunteered and maybe saw [that]. She told her daughter that she couldn't hang with my daughter anymore because she was too weird. That was just you know all of a sudden this girl would say I can't hang with her anymore. I saw her mother and I remember approaching her and [she said I needed to get] help [for] my daughter ... she was so naïve."

Caregivers recommended that all children in school be taught about children with special needs, which could lead to more understanding and acceptance of children with special needs. "We had ... the program called Kids Corner. It's been to the school and [the program] educates ... children about special needs and what is special needs and they understand that some children were born with a different development, so they [can] understand that and they accept them. I wish that ... we still had that program ... we [can] educate our children in the school about other children with special needs, so it's much better, so they can gather together and accept them as a friend."

Most caregivers noted that their own health issues impact their children's health, one caregiver shared, "I think our own health impacts our kids' health. Like ... dealing with all of this seriously added to my depression ... I don't know I think you can't speak of a child's health without [considering] maternal health ..." Several caregivers recommended respite care or specialized childcare, which allows caregivers opportunities to recuperate from the stresses of caring for children with special needs, but "respite care is, it's kind of narrow when you have kids with special needs. On top of that, [it's] pretty expensive [and there's not that much] availability. Another caregiver shared his family's experience, "when we go for a walk, we see adults having dinner on the table together and I don't remember having sat at a table having dinner with an adult. I never have adult time."

Caregivers described that they too need education and support about how to best care for their children with mental health needs, noting "... no one's perfect and [mental health issues don't] come with a handbook. When you have kids that have mental health issues, parents really do need as much counseling as the kid does to figure out how you're going to parent that child. Your parenting style has got to change. It's not the same ... Your parenting is so different."

One parent described differences in their children's ability (one with mental health issues and one without) to cope with social pressures and stress, "for my daughter, so I got the twins. One is on the spectrum, so she has Asperger's, anxiety, and depression. She's had a much more difficult time than her twin brother who's doing fine. What's the difference? It's biochemical. It's her brain. Her brain is wired differently. Everything is more difficult for her. ... Her brother is doing great. He's going to go off to Hofstra in September. We're gearing him up for that. He's very excited ... he's got a lot of friends, he's popular ... He's having almost the perfect high school experience. His twin sister, not so much ... I can see how my son is able to thrive and he's more resilient among all these pressures that have been placed on him, and is in almost the exact same situation. But with his sister, having all the mental health issues and Asperger's, everything's more difficult and it's her brain that's different."

Some caregivers also described how social media has a negative influence on children's self-perception. They suggested that school should not allow children to use social media or to access their phones while at school.

Other caregivers were concerned that transition periods in a child's life (i.e., graduating from high school and going to college) can create stress and anxiety for children noting that "kids without coping skills that don't know how to deal with big transitions internalize that and can make people sad or depressed, or they get sad or depressed." In particular, this was noted as a huge problem by a caregiver of teen with mental illness transitioning from high school to college, I know my daughter, for example, she's gay. She's a lesbian. During high school, she had a boyfriend. She said, she felt the pressure to be fit to that mold and it wasn't until she went away to school that she could really identify. She struggled with that at her freshman year in college. It's really the first chance they have to have an identity."

Healthy Eating, Active Living

Caregivers shared that although the focus on healthy eating is important, increased awareness of nutrition and diet (i.e., calories consumed) can also have unintended consequences of fostering eating disorders. A caregiver of a child with mental illness noted that this concern is especially true for young girls and discussed her daughter's friend, who was going through anorexia, "my daughter, I remember, she said to me, 'Mom, the fact that they keep on saying it in school to don't eat high calorie and stuff, and everyone was so super conscious.' There's that balance of what was on one hand, yes, you want to eat healthy, but how much is advocating too much of it, and especially ... for girls in this environment and this culture over here where they get really worked up about all of this."

REFERENCES

- ¹ ASQ Ages & Stages Questionnaires. Developmental screening. ASQ Ages & Stages Questionnaires. <http://agesandstages.com/research-results/why-screening-matters/developmental-screening>. Accessed October 20, 2016
- ² Centers for Disease Control and Prevention. Developmental monitoring and screening. Centers for Disease Control and Prevention. <http://www.cdc.gov/ncbddd/childdevelopment/screening.html>. Updated February 23, 2016. Accessed October 20, 2016.
- ³ Bright Future Steering Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*. 2006;118;405. doi: 10.1542/peds.2006-1231.
- ⁴ FIRST 5 Developmental Screening & Behavioral Health. http://www.first5kids.org/sites/default/files/download/f5_one_pager_kcn_2015_eng.pdf. Accessed September 27, 2016.
- ⁵ Santa Clara County Public Health Department, 2016 Child Health Intercept Survey
- ⁶ National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 09/23/16 from <http://www.childhealthdata.org>
- ⁷ T American Academy of Otolaryngology-Head and Neck Surgery. The necessity of early intervention in hearing. American Academy of Otolaryngology-Head and Neck Surgery. <http://www.entnet.org/content/necessity-early-intervention-hearing>. Accessed September 28, 2016.

ORAL HEALTH

Why It's Important

Good oral health is an integral part of overall health and well-being throughout the lifespan. Although oral health status among Americans has generally improved over time, tooth decay in primary teeth has increased slightly among young children.¹ More than half of children ages 6-11 have primary tooth decay, and among them, 1 in 4 has untreated decay.² In spite of being totally preventable, tooth decay (cavities) is one of the most common chronic conditions of childhood in the U.S. Nationwide, 1 in 5 children ages 5-11 (20%) and 1 in 7 children ages 12-19 (13%) have at least one untreated decayed tooth. The percentage of children ages 5-19 with untreated tooth decay is twice as high for those living in low income families (25%) compared to children from high income families (11%). If left untreated, cavities can cause pain and infections that may lead to health problems with eating, speaking, playing and learning.³ Healthy People 2020 has a target of decreasing untreated tooth decay among children (HP2020 target: ages 3 to 5 years – 21.4%, ages 6 to 9 years – 25.9% and ages 13 to 15 years – 15.3%).⁴

Good self-care, such as brushing with fluoride toothpaste and daily flossing is key to good oral health. Many barriers to accessing preventive care and treatment exist, such as limited access to and availability of dental services as well as cost.³ The Healthy People 2020 objectives that focus on oral care include: increase the percentage of children and adolescents who had a dental visit in the past year to 49%, and increase the percentage of low income children and adolescents who received preventive dental service in the past year to 33.2%.⁴ Healthy People 2020 has the following objective in development: increase the percentage of persons including children who have access to dental health services (dental insurance).

Research supports that sealants are an effective and economical measure to prevent or halt the progression of tooth decay. This prevents the development of caries (or cavities) in permanent teeth and helps avoid future invasive treatment.² The Healthy People 2020 objective that supports this important preventive measure underscores the importance of increasing the percentage of children and adolescents who have received dental sealants on their permanent molar teeth (target: ages 3 to 5 years – 1.5%, ages 6 to 9 years – 28.1% and ages 13 to 15 years – 21.9%). In an effort to expand the benefits of preventive interventions at the community level, Healthy People 2020 created objectives to increase the percentage of school-based health centers which have an oral health component and to increase the percentage of the U.S. population served by community water systems with optimally fluoridated water.⁴

What the Numbers Tell Us: Survey Findings

In Santa Clara County, more than 1 in 5 parents of children ages 1 to 17 (21%) reported their child having a toothache, decayed teeth, or unfilled cavities in the past 12 months. This percentage was higher among children from low income families.⁵

PERCENTAGE OF CHILDREN AGES 1 TO 17 WHO HAD A TOOTHACHE, DECAYED TEETH OR UNFILLED CAVITIES IN THE PAST 12 MONTHS

		Percent (%)
Santa Clara County		21
Sex	Male	19
	Female	22
Age group	1-9 years	20
	10-17 years	21
Annual household income	Less than \$25,000	26
	\$25,000 – less than \$75,000	23
	\$75,000 and more	14
Race/ethnicity	Asian/Pacific Islander	22
	Latino	22
	White	12
Asian subgroups	Asian Indian	5
	Chinese	20

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

In 2016, 14% of parents of children ages 1 to 17 reported their child never visited a dentist or dental clinic. However, more than 3 in 4 parents of children ages 1 to 17 (78%) reported their child visited a dentist or dental clinic in the past 12 months. A higher percentage of parents of older children (ages 10 to 17) reported their child visited a dentist or dental clinic in the past 12 months compared to others. The percentage was lowest among Chinese and Asian Indian parents of children ages 1 to 17.

PERCENTAGE OF CHILDREN AGES 1 TO 17 BY DENTAL VISITS IN THE PAST 12 MONTHS

		Percent visited a dentist or dental clinic in the past 12 months (%)	Percent never visited a dentist or dental clinic (%)
Santa Clara County		78	14
Sex	Male	78	16
	Female	78	13
Age group	1-9 years	73	20
	10-17 years	90	1
Annual household income	Less than \$25,000	82	8
	\$25,000 – less than \$75,000	75	15
	\$75,000 and more	76	21
Race/ethnicity	Asian/Pacific Islander	72	22
	Latino	82	10
	White	80	16
Asian subgroups	Asian Indian	64	26
	Chinese	62	25

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes.

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

What the Community Tells Us: Community Perspectives and Experiences

Barriers to Accessing Services

Key informants and focus group participants reported multiple reasons why children and youth do not access oral healthcare including cost, limited or no dental insurance coverage, providers that do not accept specific insurance such as Medi-Cal, lack of time, or lack of transportation. Many focus group parents expressed concerns about affordability, "if you can't afford medical [care], why do they think you can afford dental [care] – which is just as expensive, if not more?" Parents also shared their frustration caused by, financial stress and the personal trade-offs related to accessing oral services. One parent commented, "you have to qualify with paycheck stubs and if you do qualify, you only pay 40% and they cover the rest, but even so we are talking about 300-400 dollars, and you pay half. ... Where am I going to find that money? Between paying that and feeding your children, it's best not to go to the dentist." For low-income children, in particular, that may qualify for services due to state funded insurance or sliding scale programs, key informants still reported issues with children trying to access dental care. One key informant explained, "[children might not come in] because either they lack an adult to bring them or have transportation issues. Different things play into whether the child actually might end up seeing you."

"... there aren't many dentists that want to take the [insurance we have] ... it is very difficult for us to find a dentist for our kids. We waited 4 months to get an appointment and then it is postponed 3 more months... when a kid has a toothache that is an emergency...it is difficult to find a dentist that can help him the next day."

– Focus group participant

Scarcity of Oral Health Providers and Specialists

Key informants reported a lack of providers who accept Denti-Cal because reimbursement rate is very low, explaining that "access is an issue because of certain policies and the way some insurance companies do practice. I'll give you an example. In California, in general, there is no child left without insurance. Again, how Medicaid is compensating private practices [is the problem.] No private practice would like to work with them." Focus group participants also shared the challenges involved with accessing orthodontic care for their children, due to the perception of the care being a "luxury." One parent shared her experience, "I have my daughter and her teeth are very bad, not because they have cavities, but because they are crooked. So they don't see it as a necessity, they think it's a luxury. Because I think that it's not a luxury, braces, because sometimes your teeth are very bad, very crooked, and you need that."

Key informants also reported a lack of oral health specialists for children, as an access issue. Noting that general dentists do not often feel equipped or trained to treat children for root canals, for example, many opt to send them to a specialist. The scarcity in oral health specialists for children, places children with special needs at a further disadvantage because the oral health specialists that are available, lack the needed resources to serve special needs populations. For example, one key informant explained that they are not fully equipped to care for special needs children, "to a certain degree autistic patients or patients who have [developmental disabilities] or who are in a wheelchair, we might be able to treat them to a certain extent, but we do not provide hospital dentistry. We do not provide sedation dentistry." Funding and lack of resources were noted as barriers to contracting with hospitals, and conducting staff training to address the gap in service delivery for children with special needs.

Educational Strategies Are Needed to Promote Oral Health

Key informants reported the need for education related to oral health, explaining "there are lots of things that we could educate people about. That's why I'm emphasizing education because if you know that this [gum] can harm you when you're a child, maybe you would [stop] doing certain things." Key informants further noted that children and teen's behaviors are influenced by their peers, "they are modeling behavior based on their peers or an adult who they might be living with ... [Behavior choices] go in hand in hand with what they think and what choices they are making." Thus stressing the importance of prevention messaging in diverse venues, such as grocery stores, schools, and other public places to remind parents to take their children to the dentist every six months, were noted as key.

"All child[ren] should be seen by a dentist by the time they enter kindergarten. This is a good step forward, but I like what Head Start is doing. They are making sure that each child has a dentist ... They follow up with all of this."

– Key Leader Informant

Key informants also mentioned the need for educating parents about the link between sugar and tooth decay, noting that "one of the changes that we can make is in nutrition ... Sugar sweetened beverages for example, they should not even be in the picture. Get rid of those juices, flavored and sweetened milk for example. I mean, why are we serving chocolate milk to our kids in school?" Key informants recommended targeted and coordinated policy change efforts explaining, "... the biggest impact would be if we have the right kind of legislation to ... provide the right nutrition, provide the right housing, provide the right environment for the kids to grow and have physical activity. I think it needs to be 360 degrees working towards addressing these issues. [The issues] cannot be addressed at just one level or the other. Everybody needs to buy into

[them]." One key informant also suggested focusing on one thing, such as sugar sweetened

beverages, "whether we do it in terms of messaging, an [educational] campaign, a [soda] tax or having a warning label on [them]. Whichever way it works. If you can do that that would be effective and hopefully get the message across to parents."

REFERENCES

- ¹ Dye BA, Thornton-Evans G, Li X, Iafolla TJ. Dental Caries and Sealant Prevalence in Children and Adolescents in the United States, 2011–2012. NCHS data brief, no 191. Hyattsville, MD: National Center for Health Statistics. 2015.
- ² Dong F, Ablah E, Hines R, Lazar A, Johnston J. Disparities in oral health among school-aged children in Kansas. *Open Journal of Preventive Medicine*. 2015;5:291-298. http://file.scirp.org/pdf/OJPM_2015063014374019.pdf. Accessed 2016.
- ³ Centers for Disease Control and Prevention. Children’s oral health. Centers for Disease Control and Prevention. http://www.cdc.gov/OralHealth/children_adults/child.htm. Updated November 10, 2014. Accessed October 23, 2016.
- ⁴ Office of Disease Prevention and Health Promotion. Oral health. Office of Disease Prevention and Health Promotion. <https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health>. Accessed October 23, 2016.
- ⁵ Santa Clara County Public Health Department, 2016 Child Health Intercept Survey.

HEALTHY EATING AND ACTIVE LIVING

OVERWEIGHT/OBESITY

Why It's Important

Childhood obesity is a complex health issue in the United States and remains a serious issue among all children. It occurs when a child is well above the normal or healthy weight for his or her age and height.^{xii} ¹ One in 3 children in the U.S. is overweight or obese.² Between 2003 and 2007, obesity rates increased by 10 percent for all U.S. children ages 10 to 17; however the rate increased by 23 percent for low-income children. Children living in lower-income households have more than two times higher odds of being obese than children living in higher-income households.³

Behaviors like dietary patterns, family mealtimes, and physical activity/inactivity are among the many causes of excess weight in children and youth. Additional contributing factors in our society include the food and physical activity environment, education and skills, as well as food marketing and promotion.¹ Obesity is among the easiest medical condition to recognize but most difficult to treat.⁴ Childhood obesity is causing a wide range of health problems that were not previously seen until adulthood.² Obesity in children is associated with greater risk of high blood pressure, high cholesterol, type 2 diabetes, sleep apnea, asthma, joint problems and musculoskeletal discomfort, gallstones, fatty liver disease and heartburn. Additionally, there are psychological effects of obesity in children: psychological stress, depression, behavioral problems, problems in school, low self-esteem, low self-reported quality of life, negative body image, and impaired social, physical and emotional functionality. Childhood obesity is associated with earlier and severe risk of obesity-related disease and death in adulthood such as heart disease, diabetes, cancer and metabolic syndrome. Obese children are more likely to be obese adults.^{1, 2} Children who maintain a healthy weight have a lower risk of developing health issues such as cancers, heart disease and stroke, and joint problems.⁵

What the Numbers Tell Us: Survey Data

Fourteen percent (14%) of Santa Clara County middle and high school students were classified as overweight, while 11% were classified as obese. Overweight and obese percentages were higher among African American (19% and 12%, respectively) and Latino (18% and 19%, respectively) students than other racial/ethnic groups. A higher percentage of male students (15%) were classified as obese than female students (8%).⁶

^{xii} Body mass index (BMI) of children and youth is used to categorize overweight and obesity. Children and youth whose BMI is between the 85th and 95th percentile are classified as overweight and BMI equal to or greater than the 95th percentile is considered obese

MIDDLE AND HIGH SCHOOL STUDENTS WHO WERE OVERWEIGHT/OBESE

	African American	Asian/PI	Latino	White	Male	Female	Santa Clara County
Overweight	19%	12%	18%	11%	15%	14%	14%
Obese	12%	7%	19%	7%	15%	8%	11%

Note: See Santa Clara County Public Health QuickFacts for additional data and information.

Source: California Healthy Kids Survey, 2013-14

FITNESSGRAM, an assessment of physical fitness of 5th, 7th, and 9th graders in the county, measures aerobic capacity and body composition.⁷ Students were classified as obese or in the "health risk" zone based on the body composition. A higher percentage of students in the "health risk" zone for body composition were in the [Gilroy Unified School District \(24%\)](#), [East Side Union High School District \(18%\)](#) and [San Jose Unified School District \(18%\)](#) in 2013- 14.⁸

PHYSICAL ACTIVITY

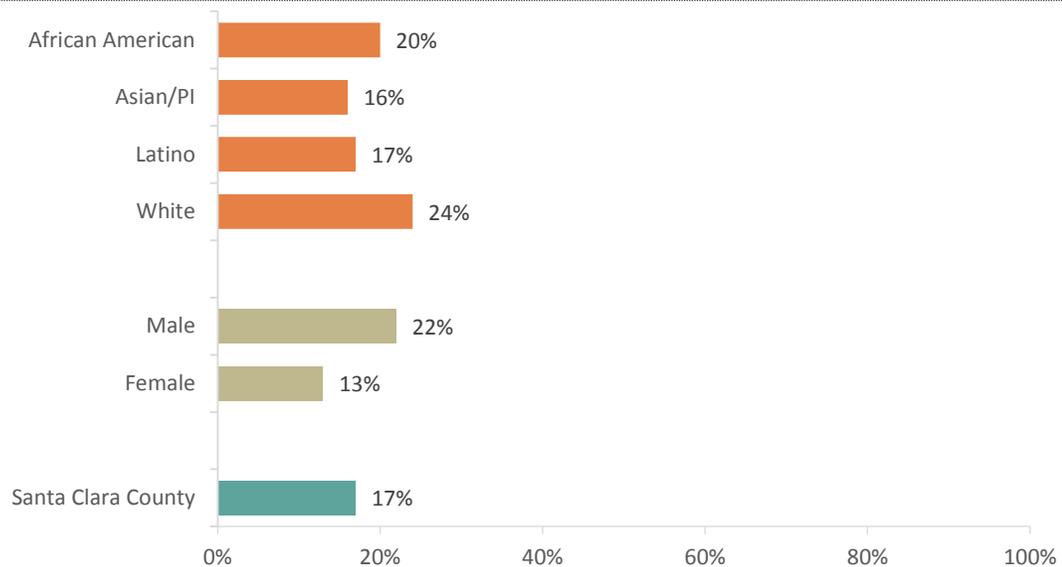
Why It's Important

The U.S. Department of Health and Human Services recommends that children ages 6 to 17 spend a minimum of 60 minutes each day engaged in physical activity.⁹ Participating in regular physical activity is associated with many positive outcomes among children and youth including: short- and long- term health benefits, improved academic performance, and a lower likelihood of engaging in risky behaviors. In addition, regular physical activity can be associated with reducing anxiety and stress and increasing self-esteem.¹⁰ Several factors determine the physical activity levels among children: personal behavior choices and physical environment are two of these. Many communities are built in ways that make it difficult or unsafe to be physically active. For some families, getting to parks and recreation centers may be difficult, and public transportation may not be available. For many children, safe routes for walking or biking to school or play may not exist. Half of the children in the U. S. do not have a park, community center, and sidewalk in their neighborhood.¹

What the Numbers Tell Us: Survey Data

More than 1 in 4 children ages 5 to 11 (27%) in Santa Clara County were physically active for at least 60 minutes each day in the past 7 days.¹¹ Seventeen percent (17%) of middle and high school students were physically active for at least 60 minutes each day in the past 7 days.⁶ The percentage was lower for female children than male children (26% vs. 29% for ages 5 to 11; 13% vs. 22% for middle and high school students).

MIDDLE AND HIGH SCHOOL STUDENTS WHO WERE PHYSICALLY ACTIVE 60 MINUTES PER DAY DURING THE PAST 7 DAYS



Note: See Santa Clara County Public Health QuickFacts for additional data and information.
Source: California Healthy Kids Survey, 2013-14⁶

What the Community Tells Us: Community Perspectives and Experiences

The Physical Environment Contributes to Lower Physical Activity Levels

Safe places for children to play is important. Many caregivers discussed how the built environment affects perceptions of safety as well as comfort with allowing children to play outside. In particular, they reported concerns over safety around moving vehicles. Because of concerns for their children's safety, many caregivers restrict outdoor play. Focus group participants explain: "[People in the neighborhood] like to speed It is a street of 25 miles per hour and they speed at 60 or 70 miles per hourFor example, ... I am crossing the street with my kid in a stroller, the car is not going to be able to stop [when going] at that speed, and that is another reason why I don't let my kids to play outside. If the ball rolls to the road, they run to grab it and a car might come and run him over. We don't want to let our kids to play outside but because it is dangerous."

Other caregivers also noted that a lack of visibility around parking garages and structures makes it unsafe for children to walk on or play near the street. Parents described their fears about drivers not seeing children playing when they exit and enter these structures. For these reasons, caregivers reported not wanting their children to walk on the street near parking garages.

Focus group participants and key leaders highlighted that other elements of the built environment, such as the presence of liquor stores and the lack of adequate lighting, also greatly affect children's safety and ability to engage in outdoor physical activity. Caregivers and key leaders further reported that the presence of liquor stores in neighborhoods is associated with increased crime, violence, and substance abuse. For these reasons, children are often not allowed to play outside when there are

liquor stores nearby. The lack of adequate street lighting was also a common safety concern that limited children's physical activity ... "It's quite dangerous to bring my kids for a walk here at night because the lighting here is quite dim and the visibility is not good when they drive at night. Normally we will go for a walk at the school or garden but I worry about the cars on the road."

Additionally, caregivers described how unsafe streets limit walking or biking to local destinations, such as a neighborhood park, thus having to drive their children when their neighborhoods felt unsafe, which they described as inconvenient and time consuming. Another participant reflected on her experience as a child, underlining that it is no longer safe for children today to play outside, "... when we grew up, we would play outside, we could play outside safely. We could exercise, we could run, we could hang out on the street until 10-11 pm during summer breaks. Now ... that's no longer possible."

Key informants also noted important differences between higher-income and lower-income neighborhoods, particularly related to the number of people exercising in public spaces. These interviewees continued by emphasizing that when people feel unsafe, they will not engage in outdoor physical activity. One key informant summarized, "you can walk down the street in Los Gatos and you're going to see ... people running around and jogging and riding bikes. You very rarely see that in East San Jose. You don't see anybody, you may see some people running but you don't see it like you see in ... the more affluent areas. A lot of it is environmental."

Key informants observed that adequate funding for streets and parks in all neighborhoods is important for safety and regular use. One key informant explained, "investing in infrastructure ... could be one thing, just making sure we have streets that are safe to walk because they are well lit and we're not going to trip on holes in the sidewalk and having parks that are good and fun and clean, investing in their upkeep."

Physical Activity is Limited by Inaccessible Recreational Areas

I take my daughter to the park, and most parks don't have bathrooms. We have to leave the park if she has to go to the restroom.

- Focus group participant

A child's physical activity is severely limited when parks or recreational areas are not safe, clean, or need basic facilities and infrastructure. Focus group participants identified the need for bathrooms in parks in order to increase use. In one focus group, caregivers shared that the lack of restrooms makes it more difficult for their children to play in parks, "a lot of the parks, places they play soccer, don't have bathrooms. It's very, very difficult, because you want them to be outside, and there are no bathrooms."

Another focus group participant continued by highlighting the lack of operating water fountains as a constraint for their children to play in parks, "... even the water too. They don't have fountains for them. Working fountains."

Lack of Access to Neighborhood Parks

Parks and other recreational areas are often not close to where families live (especially in low-income neighborhoods), which means that children are not able to easily access these spaces for physical activity. A key leader recommended creating more parks and allowing shared use of school facilities after school hours, especially in areas where access is limited. Caregivers and key informants also reported that the lack of access to public transportation in the County limits opportunities for physical activity many destinations are far apart and are difficult to get to without a vehicle.

Living Near High-Traffic-Volume Roadways Affects Children's Health

High-traffic-volume roadways, contributes to poor air quality and higher rates of asthma. A key informant described how traffic in certain neighborhoods is impacting air quality and asthma rates among children, "Air quality is huge in this neighborhood. We're the only neighborhood where the freeway actually drives over us. It goes right over us in San Jose. We have a very large population of children with asthma, and we're finding that that is one of the number one factors of why they're not attending school, which is mind-blowing. Yes, air emissions from the traffic is huge." (Please see volume 1 report for more information on asthma among children)

FOOD AND NUTRITION

Why It's Important

Eating a healthy diet promotes optimal growth and development among children and reduces their risk of chronic disease. Regularly consuming fast food or drinking sugar-sweetened beverages puts children and youth at a higher risk of unhealthy weight gain, which can lead to obesity.¹²

More than 6 million children nationwide live in low income neighborhoods with restricted access to healthy food and proper nutrition, including the recommended daily amounts of fruits (2+ servings per day) and vegetables (3+ servings per day).¹³ There might not be a supermarket or grocery store close to low income neighborhoods restricting the access of fresh and health food options. Food affordability also plays a role in access to healthy food. Besides, high calorie and low nutrient foods are highly advertised and marketed by media targeting children and adolescents. Nearly half of the U.S. middle and high schools allow advertising of less healthy foods, which impacts students' ability to make healthy food choices.¹

What the Numbers Tell Us: Survey Data

The majority (80%) of children ages 2 to 11 in Santa Clara County consumed 2 or more servings of fruit the previous day, while 10% ate 3 or more servings of vegetables the previous day.¹¹ Among middle and high school students, more than 1 in 2 (53%) consumed fruit 2 or more times in the past 24 hours, while more than 1 in 4 (28%) ate vegetables 3 or more times in the past 24 hours.⁶

FRUIT AND VEGETABLE CONSUMPTION AMONG CHILDREN

	African American	Asian/ PI	Latino	White	Male	Female	Santa Clara County
Fruit consumption							
Children (ages 2-11)	NA	73%	83%	85%	77%	84%	80%
Middle and high school students	49%	53%	52%	59%	52%	54%	53%
Vegetable consumption							
Children (ages 2-11)	NA	9%*	6%*	17%	11%	9%	10%
Middle and high school students	26%	32%	24%	29%	28%	29%	28%

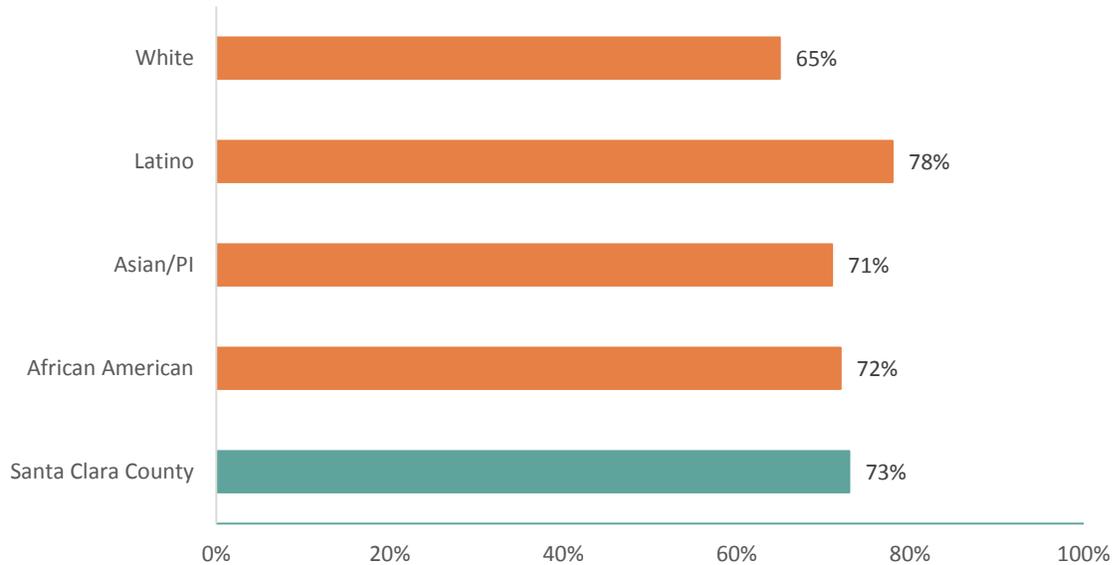
Note: Fruit and vegetable consumption data on African American children (ages 2-11) were not available due to a small sample size. [*] indicates estimate is statistically unstable due to a relative standard error of greater than 30% or less than 50 respondents in the denominator. These estimates should be viewed with caution and may not be appropriate to use for planning or policy purposes. See Santa Clara County Public Health QuickFacts for additional data and information.

Source: Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey¹¹; California Healthy Kids Survey, 2013-14⁶

Three in 5 (61%) children ages 2 to 11 in Santa Clara County ate fast food 1 or more times in the past 7 days. The percentage was higher among Latino children (74%) than Asian/Pacific Islander (55%) and White (53%) children.^{xiii, 11} Among middle and high school students, approximately 7 in 10 students (73%) had consumed fast food 1 or more times in the past 7 days. The percentage was higher among Latino students (78%), followed by African American (72%), Asian/Pacific Islander (71%), and White (65%) students.⁶

^{xiii} Data on African American children were not available due to small sample size.

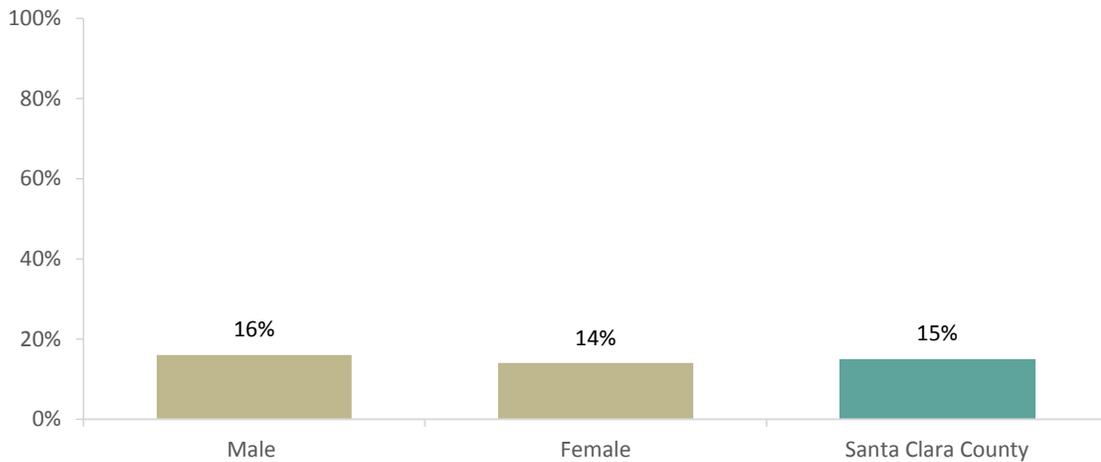
MIDDLE AND HIGH SCHOOL STUDENTS WHO ATE FAST FOOD 1 OR MORE TIMES IN THE PAST 7 DAYS



Note: See Santa Clara County Public Health QuickFacts for additional data and information.
 Source: California Healthy Kids Survey, 2013-14⁶

Fifteen percent (15%) of children ages 2 to 11 in Santa Clara County drank 1 or more sugar sweetened drinks (including soda) the previous day.¹¹

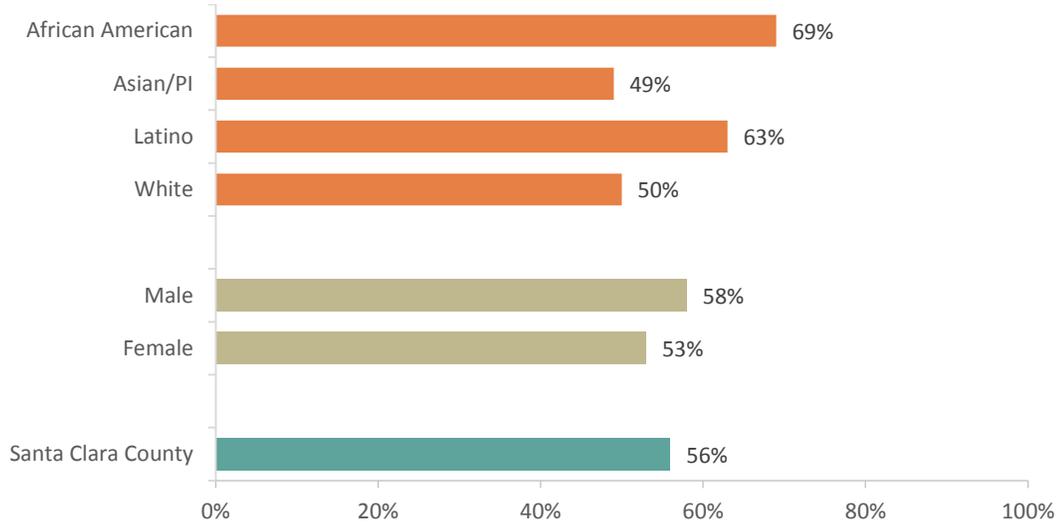
CHILDREN (AGES 2-11) WHO DRANK 1 OR MORE SUGAR SWEETENED DRINKS (INCLUDING SODA) THE PREVIOUS DAY



Note: See Santa Clara County Public Health QuickFacts for additional data and information.
 Source: Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey¹¹

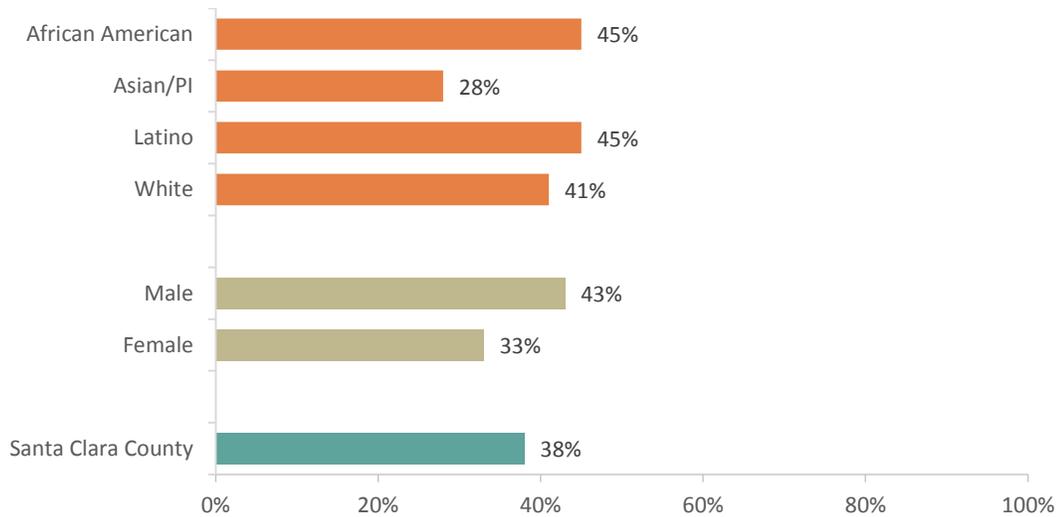
Among middle and high school students, more than half (56%) drank sweetened fruit drinks, sports, or energy drinks 1 or more times in the past 24 hours, while 38% drank soda pop 1 or more times in the same time period. For both indicators, African American and Latino students reported higher percentages than other racial/ethnic groups.⁶

MIDDLE AND HIGH SCHOOL STUDENTS WHO DRANK 1 OR MORE SWEETENED FRUIT DRINKS, SPORTS, OR ENERGY DRINKS 1 OR MORE TIMES IN THE PAST 24 HOURS



Note: See Santa Clara County Public Health QuickFacts for additional data and information.
 Source: California Healthy Kids Survey, 2013-14⁶

MIDDLE AND HIGH SCHOOL STUDENTS WHO DRANK SODA POP 1 OR MORE TIMES IN THE PAST 24 HOURS



Note: See Santa Clara County Public Health QuickFacts for additional data and information.
 Source: California Healthy Kids Survey, 2013-14⁶

What the Community Tells Us: Community Perspectives and Experiences

Accessing Affordable Healthy Food is Challenging, and Access Varies Across the County

One of the most challenging issues for parents is the **cost of healthy food**. For many families, fruits and vegetables are too expensive, and the cost of organic foods is often prohibitive. Parents discussed the need for more farmer's markets to accept CalFresh.

In addition, parents described how the convenience and availability of fast foods also affects their decision not to buy and cook healthy foods. In fact, the presence of low-cost, fast food restaurants was identified as a common reason for not spending money on the higher cost of fresh fruits and vegetables. A key informant expressed the perspective of many of her clients, related to challenges they encounter with accessing healthy food, "How do you expect me to eat healthy when there's a fast food restaurant on every corner? ... I can't afford farmer's markets, fresh vegetables, you know? Even with my EBT stamp card, I can't afford it."

In some cases, the local convenience store may be in close proximity, but have limited healthy food offerings. One parent participant identified the issues with quality, "Where I live, there's 7-Eleven, and that's it. [The only fresh fruit is] some watermelon that's been sitting there two weeks that's already cut."

In other cases, however, having the ability to afford healthy food does not always mean that parents have the time to buy and cook fresh food and healthy meals, or that children will eat the food. Parents described challenges they face in buying fresh fruits and vegetables, including limited budgets and that fresh fruits and vegetables spoil more quickly. Parents described that they stop buying fresh fruits and vegetables for these reasons. One parent summarized her challenges, "the fruit doesn't last very long. Then if you buy a kilogram of fruit, you are going to eat some and in a few days it goes bad. You cannot go to the store all the time to buy [more because] what is at home is rotten. Because of this you stop buying because you are throwing away your money."

Youth participants in the juvenile justice system reported that poverty affected their eating habits on a daily basis. One participant brought up how their parent's food choices for their family was a reflection of their limited budgets, "I didn't know this, but my mother, she made broth, she made soups, soups with water, food made with water. Lentils, spaghetti, things like that, and I was always asked, "Mom, why do you always make things with water? Why do you make soups? I want beef, I want bread, I want turkey, I want something better." And, until now she hasn't been able to tell me, but now I know that soup fills you up faster and is cheaper. Until now she hasn't said anything but I know. I know why. And there's nothing wrong with that, it's what families have to do so they can all eat"

Parents Reported That School Lunches Are Often Not Healthy or Appealing to Kids

Parents emphasized the need for healthy lunches that taste good. Many parents shared experiences of kids coming home hungry because they did not eat the food at school, referring to it as "packaged," "not healthy," "disgusting," and "tasting the abnormal-ness in it." Among parents, there are mixed ideas about what constitutes a healthy meal, "to me, what's healthy are home cooked meals, fresh foods including vegetables. School does offer some vegetables but they are optional,." While another parent

described her concerns about what is offered regularly at school for lunch, "[The school] tells us, 'we are offering healthy meals,' but they are really not so healthy. They are offering burgers, they are offering pizzas, they are offering corn dogs, and in my home that's not considered healthy."

The quality of food at schools can have important effects on students' learning. For many parents, the quality of food at school can translate into poor grades or poor performance. Lower-income parents talked about the importance of high-quality lunches that are appealing for their children, explaining, "a lot of them, they won't eat [lunch]. Sometimes there's nothing else, so they just go without. If you're hungry, you don't do your best. That'll translate into poor grades or even just acting up in class because you're hungry. You can't focus."

In contrast, parents from a higher-income focus group reported having healthy, appealing lunches that students eat, "I feel like the school offers really healthy foods. When you buy lunch, there's a sign that says you have to pick a fruit. They're having milk. It's very balanced."

All parents expressed concerns about healthy foods, and the type of food available at schools. Parents acknowledge that children sometimes choose unhealthy, but tasty food, if that is what is available. One parent explains "there's crap in [the school vending machines]. A lot of times there's not any good, quality snacks. The kids who have change to get something out of the vending machines will just get candy. [We need] more quality snacks in the vending machine and water. A lot of the sugary drinks are in there. Even Gatorade has a lot of sugar in it even though it's a sports drink."

Parents Lack Time and Resources to Prepare Healthy Meals for Their Children

Many parents talked about their interest in preparing healthy meals for their children, but also identified that long work hours and low incomes prevented them from spending additional time on food preparation. A parent focus group participant shared, "I'm also guilty of just being so busy myself that by the time we get home sometimes, I just want to order a pizza versus cook something healthy. I know I'm part of the problem."

In some instances, parents take the time to prepare healthy foods, but their children did not eat the food ("You can lead a horse to water, but can't make it drink"). For these parents, it is important to know how to prepare simple, quick, appealing, and healthy foods for children.

There is a Need for Increased Education About Healthy Eating

Key informants, parents, and young people explained that if young people better understood the importance of eating healthy foods, they would be more open to eating the foods, and the parents might be more proactive about taking the time to prepare healthy meals. Parents expressed interest in education related to preparing easy, fast, affordable, and healthy meals for their families. One parent explained "we need to focus more on doing a better job of teaching kids how to be healthy, realizing that they're then going to become adults who want to be healthy. So I feel like that is something that tends to get missed and children tend to get overlooked – a lot."

Overall, key informants, parents, and young people noted that both adults and children need more information and education about what is healthy, as well as the consequences of not eating a healthy diet, including the risks of chronic diseases. A key informant explained, "... I think we have to first quantify how many of our kids in Santa Clara County are now pre-diabetic and how many are diabetic from obesity-related causes or Type 2 diabetes. I don't think I've seen that quantified and until we can quantify that, we can't really try to start to address that. But I feel like that these children are becoming adults with diabetes and we can stop it when it when they're kids and put more focus children's health because if we can teach them when they're young, we can prevent them from being unhealthy adults."

Parents also expressed the need to **focus on prevention**, and emphasized that a focus on prevention could inform early habits and transform behavior at an early age. As described by multiple focus group participants, "And I feel like the system sometimes is reversed, like it waits for them to be unhealthy adults to then treat them and we have to go back and correct things that were taught or mis-taught or not learned as children."

Parents Expressed Concerns About Rates of Obesity, and How to Address the Epidemic

Parents shared many concerns about obesity, and expressed multiple ways to address the epidemic. Some parents, for example, pointed to the importance of consistent messaging at home and at school. A parent focus group participant shared, "children are children, if you provide them with healthy nutrition..., it has to happen everywhere. That's why it's also important for schools to do the same. I can give him the healthiest things, but if they have different choices at school they will lean towards sweets. That's just the way it is."

Other parents see the need for a more proactive approach to shaping their children's eating habits. As shared by one parent focus group participant, "they should teach those [nutrition classes] to children in school, so [the children] know how much sugar there is in sodas. They should be aware and go 'wait a minute, what's happening?' Then when they are offered a soda they'll go 'Oh, no, there's too much sugar in that.'"

Participants in multiple focus groups expressed an interest in having more community gardens, specifically identifying them as a way to build community and improve access to affordable, healthy food. Many focus group participants pointed to both education and locally grown food as a way to build community and have access to affordable, healthy food.

Participant also noted the importance of learning how to garden, as well as needing the space and time to make it happen. Other focus group participants suggested having fruit trees in public places and community gardens. They noted that this would also allow a range of community members, including homeless people, to access free, fresh produce.

REFERENCES

- ¹ Centers for Disease Control and Prevention. Childhood obesity causes & consequences. Centers for Disease Control and Prevention. <https://www.cdc.gov/obesity/childhood/causes.html>. Updated July 19, 2015. Accessed October 23, 2016.
- ² American Heart Association. Overweight in children. American Heart Association. http://www.heart.org/HEARTORG/HealthyLiving/HealthyKids/ChildhoodObesity/Overweight-in-Children_UCM_304054_Article.jsp#.WA1qzIMrLIU. Published August 2014. Accessed October 23, 2016.
- ³ Food Research & Action Center (FRAC). Relationship between poverty and obesity. Food Research & Action Center (FRAC). <http://frac.org/initiatives/hunger-and-obesity/are-low-income-people-at-greater-risk-for-overweight-or-obesity/>. Accessed November 16, 2016.
- ⁴ American Academy of Child & Adolescent Psychiatry. Obesity in children and teens. American Academy of Child & Adolescent Psychiatry. http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Obesity-In-Children-And-Teens-079.aspx. Published April, 2016. Accessed October 23, 2016.
- ⁵ World Health Organization. Obesity and overweight. World Health Organization. <http://www.who.int/mediacentre/factsheets/fs311/en/>. Published June 2016. Accessed November 10, 2015.
- ⁶ California Healthy Kids Survey, 2013-14
- ⁷ California Department of Education. FITNESSGRAM performance standards 2015-16. California Department of Education. <http://www.cde.ca.gov/ta/tg/pf/documents/pft15hfststd.pdf>. Published October 2015. Accessed November 30, 2016.
- ⁸ California Department of Education, FITNESSGRAM 2013-14. Generated using communitycommons.org, September 2015
- ⁹ Centers for Disease Control and Prevention. Physical activity facts. Centers for Disease Control and Prevention. <http://www.cdc.gov/healthyschools/physicalactivity/facts.htm>. Updated June 15, 2015. Accessed September 23, 2016
- ¹⁰ Child Trends. Vigorous physical activity by youth. Child Trends. <http://www.childtrends.org/?indicators=vigorous-physical-activity-by-youth>. Published August 2014. Accessed November 4, 2015.
- ¹¹ Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey
- ¹² Centers for Disease Control and Prevention. Nutrition and the health of young people. Centers for Disease Control and Prevention. <http://www.cdc.gov/healthyschools/nutrition/facts.htm>. Updated August 28, 2015. Accessed November 30,
- ¹³ Let's Move. Promote affordable, accessible food. Let's Move. <http://www.letsmove.gov/promote-affordable-accessible-food>. Accessed November 16, 2015.

BEHAVIORAL HEALTH

MENTAL HEALTH AND ACCESS TO SERVICES

Why It's Important

Mental health is a state of well-being in which an individual recognizes the ability to cope with the normal stresses of life, works productively, and is able to contribute to the community.¹ Mental health during childhood means reaching developmental and emotional milestones, and learning healthy social skills and learning to cope with problems. Good mental health status ensures that children have a positive quality of life and function well at home, in school and in their communities. Mental health is a key component in a child's healthy development and overall health. Mental health problems are often chronic in nature and can continue into adulthood. Without early diagnosis and treatment, children with mental health conditions can have problems at home, in school and in forming friendships; interfering with their healthy development.² Children with untreated mental health issues tend to struggle in life and have lower educational achievement and greater involvement with the criminal justice system. When treated, children and youth do better at home, in schools, and in their communities.³

What the Numbers Tell Us: Survey Findings

In Santa Clara County, 1 in 7 parents (15%) of children ages 0 to 17 reported that their child ever have experienced any difficulties with their emotions, concentration, or behavior or experienced some other mental health condition. A higher percentage of parents of male children (19%), children ages 10 to 17 (21%) and children from low-income households (20%) reported their child to ever have experienced any difficulties with their emotions, concentration, or behavior or experienced some other mental health condition.⁴

More than 1 in 10 parents (12%) reported that their child ever have received any treatment or counseling from a mental health professional. A higher percentage of children ages 10 to 17 and children from low-income households were reported to ever have received any treatment or counselling from a mental health professional.⁴

PERCENTAGE OF PARENTS REPORTING THEIR CHILD EVER HAD ANY DIFFICULTIES WITH THEIR EMOTIONS, CONCENTRATION, OR BEHAVIOR OR EXPERIENCED SOME OTHER MENTAL HEALTH CONDITION

		Percent (%)
Santa Clara County		15
Sex	Male	19
	Female	12
Age group	0-9 years	13
	10-17 years	21
Annual Household Income	Less than \$25,000	20
	\$25,000 – less than \$75,000	15
	\$75,000 and more	16
Race/ ethnicity	Asian/ Pacific Islander	11
	Latino	17
	White, Non-Hispanic	19
Asian subgroups	Asian Indian	9
	Chinese	6
	Vietnamese	14

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

PERCENTAGE OF PARENTS REPORTING THEIR CHILD EVER HAD ANY RECEIVED ANY TREATMENT OR COUNSELING FROM A MENTAL HEALTH PROFESSIONAL

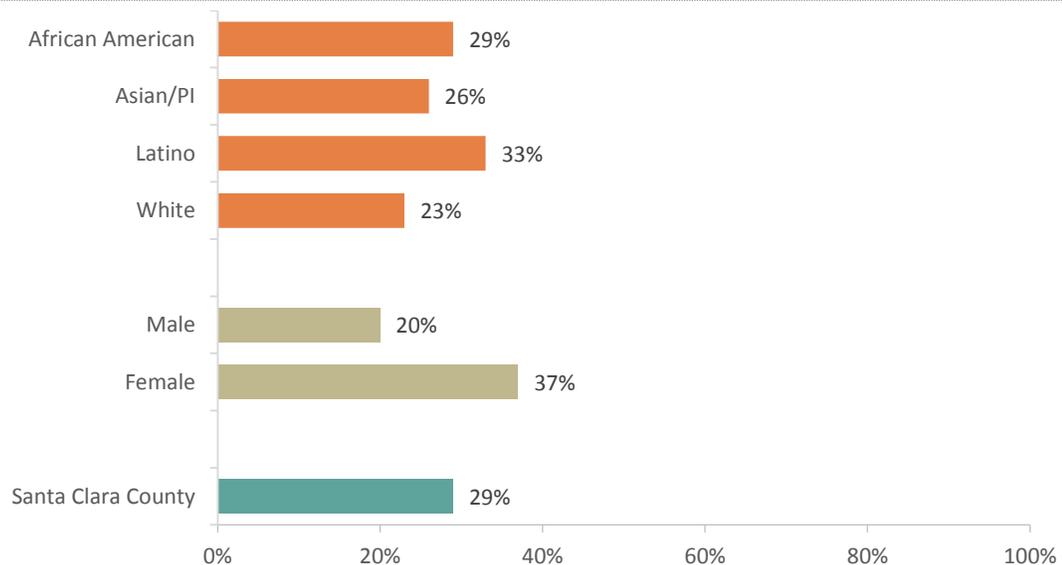
		Percent (%)
Santa Clara County		12
Age group	0-9 years	8
	10-17 years	22
Annual Household Income	Less than \$25,000	16
	\$25,000 – less than \$75,000	13
	\$75,000 and more	9
Race/ ethnicity	Asian/ Pacific Islander	5
	Latino	14
	White, Non-Hispanic	13
Asian subgroups	Asian Indian	3
	Chinese	4
	Filipino	14
	Vietnamese	3

Note: Data are not reported for African Americans and select Asian subgroups due to small sample sizes

Source: Santa Clara County Public Health Department, 2016 Child Health Intercept Survey

More than one-quarter (29%) of middle and high school students in Santa Clara County reported that they had felt sad or hopeless 2 or more weeks in the past 12 months, on par with the state (30%).⁵ This percentage was higher among female students than male students. Latino and African American middle and high school students reported higher percentages than all other racial/ethnic groups.⁶ The percentage of middle and high school students in the county who experienced depressive symptoms (felt so sad or hopeless almost every day for 2 or more weeks in the past 12 months that they stopped doing usual activities) fluctuated slightly from 29% in 2007-08 to 27% in 2009-10 to 29% in 2011-12 and 2013-14.⁷

MIDDLE AND HIGH SCHOOL STUDENTS WHO FELT SAD OR HOPELESS TWO WEEKS OR MORE IN THE PAST 12 MONTHS

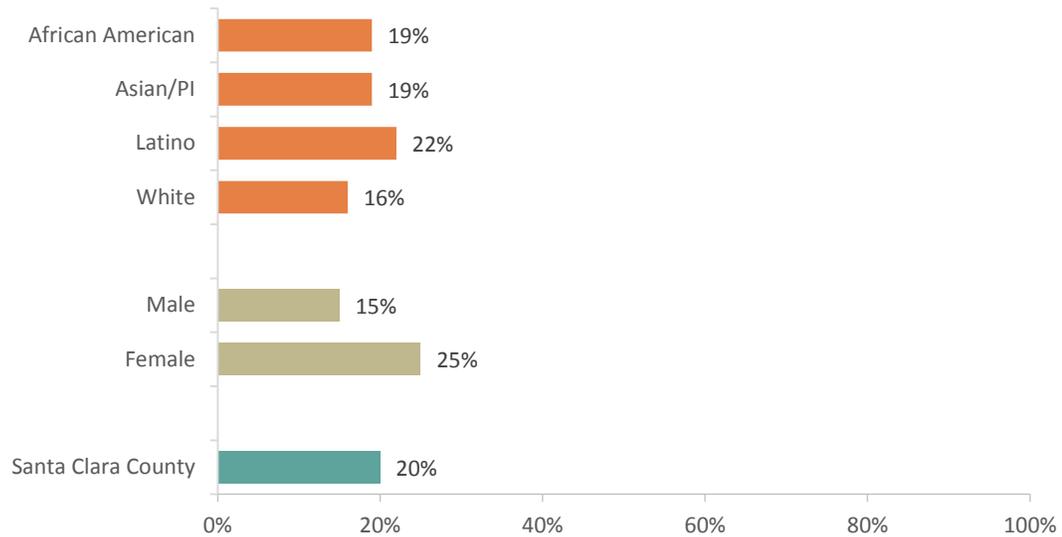


Note: See Santa Clara County Public Health QuickFacts for additional data and information.

Source: California Healthy Kids Survey, 2013-14⁶

One in 5 (20%) high school students in Santa Clara County seriously considered attempting suicide in the past 12 months in 2013-14 compared to 19% statewide.⁵ Female students reported higher percentages than male students (25% vs. 15%, respectively) as did Latino high school students (22%) compared to students in other racial/ethnic groups.⁶ The percentage of high school students in the county who have ever seriously considered attempting suicide in the past 12 months increased from 17% in 2008-10 to 20% in 2013-14.⁷

HIGH SCHOOL STUDENTS WHO HAD SERIOUSLY CONSIDERED ATTEMPTING SUICIDE IN THE PAST 12 MONTHS

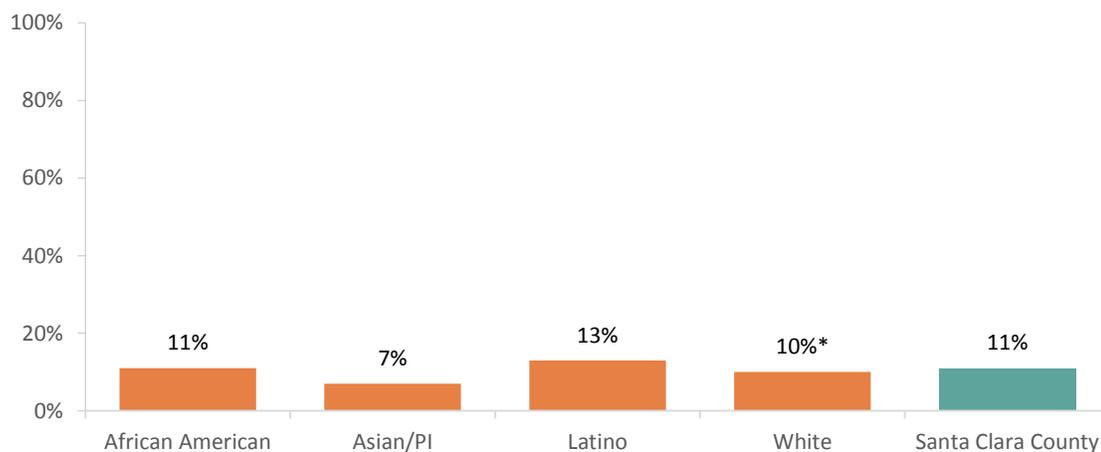


Note: See Santa Clara County Public Health QuickFacts for additional data and information.

Source: California Healthy Kids Survey, 2013-14⁶

Among middle and high school students in the county, 1 in 10 (11%) reported that they had attempted suicide 1 or more times in the past 12 months. This percentage was higher among Latino middle and high school students (13%).⁶

MIDDLE AND HIGH SCHOOL STUDENTS WHO ATTEMPTED SUICIDE IN THE PAST 12 MONTHS



Note: [*] + indicates estimate is statistically unstable due to a relative standard error (*) of greater than 30% or less than 50 respondents in the denominator (+). These estimates should be viewed with caution and may not be appropriate to use for planning or policy purposes. This indicator is defined as attempting suicide 1 or more times in the past 12 months. See Santa Clara County Public Health QuickFacts for additional data and information.

Source: California Healthy Kids Survey, 2013-14

CHRONIC STRESS

Why It's Important

Stress^{xiv} is often described as a feeling of being overwhelmed, worried or run-down. Stress can affect people of all ages, genders, and circumstances.⁸ Stress can be a natural part of development and of adaptation to a changing environment. Yet the implications of stress for children and youth can be far-reaching, depending on its level and persistence.⁹ While the body's natural defense mechanisms provide defense against short term stress, excessive chronic stress can be psychologically and physically debilitating.⁸ Prolonged and poorly managed stress can result in negative physical, mental, and cognitive outcomes for children and youth.¹⁰ Experiencing high levels of stress or chronic stress can undermine physical health, e.g., by increasing the likelihood of a weakened immune system, heart disease, obesity, and diabetes.¹¹ Other negative outcomes include anxiety, depression, poor memory and language skills, and lower academic achievement.^{12,13} Children and youth from high-conflict families and those who live in high-crime, low-resource neighborhoods may be even more likely to experience chronic and/or high levels of stress. It is important for families, schools, and program providers to be able to recognize and help children cope with stress in order to minimize the risk for negative health and behavioral development.

What the Community Tells Us: Community Perspectives and Experiences

Stress Adversely Impacts the Whole Family

Parents described the negative affect their stress had on their children, and youth described that they were stressed if their parents were stressed. The cost of housing and other basic living expenses was identified as an enormous stress for low-income and middle-income parents and youth. Parents and youth agreed that the stress faced by parents also impacts their children, explaining "... any problem that we have as adults, the kids feel it." Stress also impacts students with special needs and can magnify emotional and behavioral changes. The anxiety of having to deal with challenges at home can compound stress in other areas of young people's lives. One parent shared their experience, "They see the struggle I'm going through, so many [things] all at once. The kids see how their parents are and how they're trying to do it [all]. They don't see [their parents] happy because they're trying to work or they barely see them ... It gets stressful on the kids too."

Children Are Under Constant Stress from the Pressure of Performing Well Academically

Students face constant pressure in their schools and communities to perform academically. Their performance in school is linked to being able to get into college and professional success after that. A

^{xiv} Stress is defined as any uncomfortable "emotional experience accompanied by predictable biochemical, physiological and behavioral changes." Acute stress reflects short-lived stress or eventful experiences that occur once or multiple times; e.g. changing homes or schools, school exams. Chronic stress is an ongoing form of stress that occurs as a part of one's daily life and that continually taxes one's physical and mental resources; e.g. frequent parental arguments, chronic illness, neighborhood crime, caregiving for a parent or sibling, and trying to adapt to another culture.

parent further explained, "... it's really the society that puts the pressure on these kids can't just relax because they're constantly competing ... and they've got to keep up with that."

Success is narrowly defined and both parents and youth describe intense pressure on youth to be academically successful (from their parents, teachers, and peers) rather than being well rounded, or recognized for individual strengths, or having a balanced life. One parent summarized it by noting, "That's what their day is like – who really looks forward to that kind of a day where you feel slammed? These forty-five minute classes, six, seven different teachers; six, seven different sets of kids; six, seven different things to cope with every day, I think this is pretty overwhelming."

There is an understanding that unless students are high performing, young people will not be able to afford to live in the area. And for students with special needs, meeting expectations can be especially challenging, "... it's really hard for anybody, but especially a kid who's anxious, to transition to six different classes a day with five minutes to get from one class to another. I think about my work days where I have meeting after meeting after meeting after meeting, and to constantly having to shift and refocus, you don't have time to go to the bathroom."

Key informants and parents also described cultural differences that young people experience when moving between cultures. Vietnamese and Mandarin key informants and parents explained that Vietnamese and Mandarin youth navigate expectations placed on them from U.S. culture as well as expectations specific to the Vietnamese and Mandarin cultures. Key informants and parents underlined the additional challenges and difficulties their children face at times when transitioning from one environment to the next, including the home, neighborhood, and school. One key informant described his experience, explaining, "I have students, young adults, who told me that they cross oceans every day the minute they walk out the door, because when they leave the house, they operate in one way. When they come home, they operate in a different way. Some are able to navigate that. Some are not."

REFERENCES

- ¹ World Health Organization. Strengthening Mental Health Promotion. Geneva, World Health Organization (Fact sheet no. 220), 2001.
- ² Centers for Disease Control and Prevention. Children's Mental Health; Basics. Accessed on 10/31/2016 at: <http://www.cdc.gov/childrensmentalhealth/basics.html>.
- ³ Children's Mental Health. What Every Policymaker Should Know. Available at: http://www.nccp.org/publications/pub_929.html
- ⁴ Santa Clara County Public Health Department, 2016 Child Health Intercept Survey
- ⁵ Kidsdata.org, California Healthy Kids Survey, 2011-12
- ⁶ California Healthy Kids Survey, 2013-14
- ⁷ California Healthy Kids Survey, 2007-14
- ⁸ Understanding chronic stress. American Psychological Association. Accessed on 10/25/2016 at: <http://www.apa.org/helpcenter/understanding-chronic-stress.aspx>.
- ⁹ Assessing stress in children and youth: A guide for out-of-school time program practitioners. Available at: http://www.childtrends.org/wp-content/uploads/2010/10/Child_Trends-2010_10_05_RB_AssessingStress.pdf
- ¹⁰ Steinberg L. *Adolescence* (7th ed.). New York, NY: McGraw-Hill; 2005.
- ¹¹ Rosmond R. Role of the pathogenesis of the metabolic syndrome. *Psychoneuroendocrinology*. 2005;30(1):1-10. doi: 10.1016/j.psyneuen.2004.05.007.
- ¹² Farah M, Nobel K, Hurt H. The developing adolescent brain in socioeconomic context. In: Romer D, ed. *Adolescent psychology and the developing brain: Integrating brain and prevention science*. New York, NY: Oxford University Press. 2007:373-387.
- ¹³ Evans GW, Schamberg MA. Childhood poverty, chronic stress, and adult working memory. *Proceedings of the National Academy of Sciences*. 2009;106(16):6545-6549. doi: 10.1073/pnas.0811910106.

SPOTLIGHT ON SELECT POPULATIONS AND PROGRAMS

The following section of the report presents data compiled by various programs and partner agencies/organizations that serve the children, youth and their families living in the Santa Clara County:

CHILD WELFARE SYSTEM

CHILDREN IN FOSTER CARE

Children enter into the child welfare system primarily due to reasons of neglect and abuse. A foster care placement is given to some children if there are any safety concerns at their own home. Neglect is generally defined as the failure of the caretaker to provide needed food, clothing, medical care, or supervision to the degree that the child's health, safety, and well-being are threatened with harm. Abuse can be physical, emotional or sexual.^{xv} This section describes caseloads and trends for children and youth in the foster care in Santa Clara County from calendar years (CY) 2011 to 2015.

What the Numbers Tell Us: Survey Findings

Case Openings¹

Each year, an average of 13,000 children and youth are referred to the Santa Clara County Department of Family and Children Services due to allegations of maltreatment.^{xvi} A case^{xvii} is opened and supervised by a children's social worker for approximately 12% of the children referred annually.

Between 2011 and 2015, the number of cases opened in a year fluctuated from a high of 1,749 in 2013 to a five year low of 1,456 in 2015. The majority of cases (66%) did not involve dependency court intervention. Approximately 1 in 3 cases was supervised by dependency court (32%).

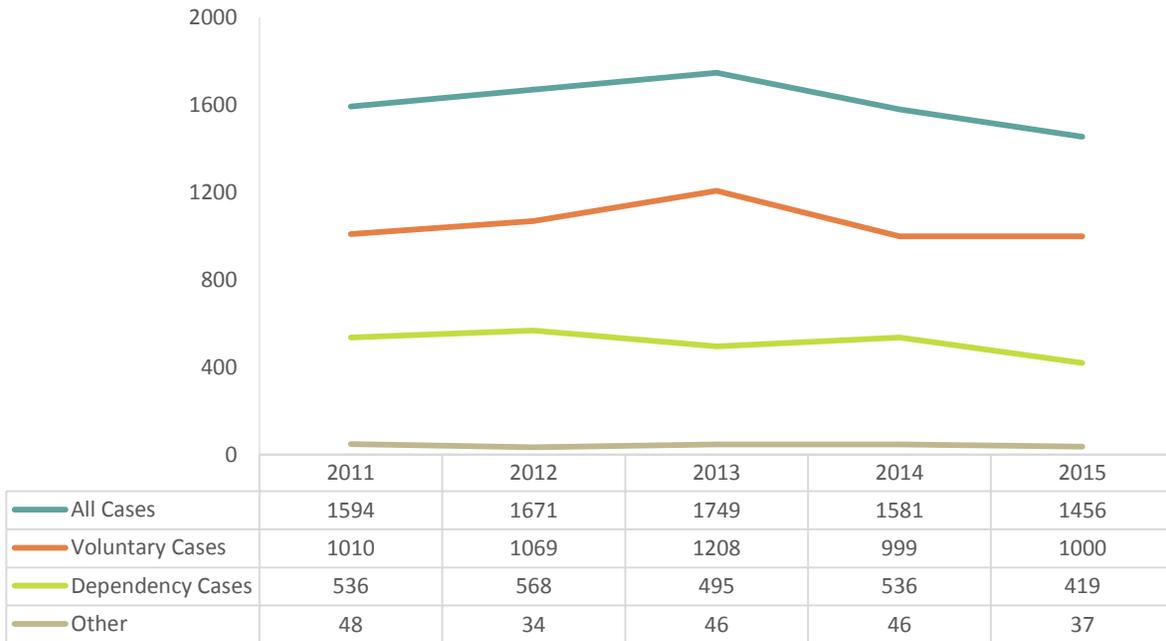
In 2015, children ages 0-5 comprised the majority of the cases opened representing 47% of the dependency cases and 39% of the voluntary cases.

^{xv} Physical abuse includes any bodily injury inflicted by other than accidental means on a child. Sexual abuse is the victimization of a child by sexual activities and includes molestation, fondling, rape, and sexual exploitation. Emotional abuse includes injury to the psychological capacity or emotional stability of the child as evidenced by substantial change in behavior. For more information, please see: [https://www.childwelfare.gov/pubPDFs/define.pdf#page=2&view=Types of abuse](https://www.childwelfare.gov/pubPDFs/define.pdf#page=2&view=Types%20of%20abuse)

^{xvi} Based on an average number of youth involved in a maltreatment referral from Calendar Years 2011 to 2015. Resource: http://cssr.berkeley.edu/ucb_childwelfare/Allegations.aspx

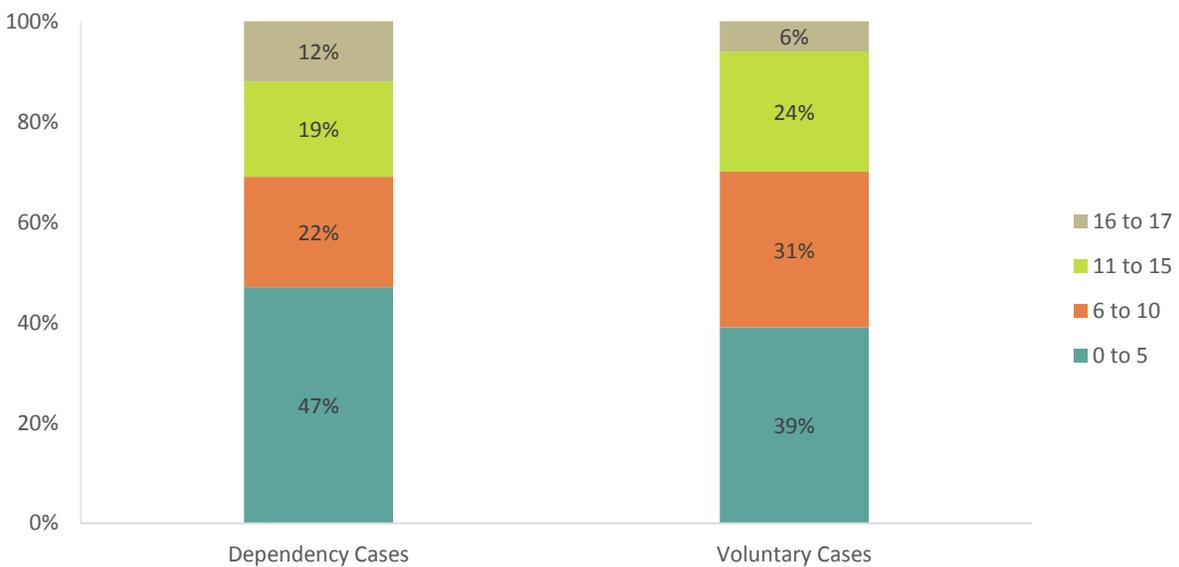
^{xvii} A case can either have voluntary or dependency status. In voluntary cases, children usually remain at home while the family engages in time-limited services designed to strengthen and support the family environment. In dependency cases, the allegations of maltreatment are viewed as severe enough to warrant court intervention. Due to safety concerns, children are generally placed in foster care while parents engage in services designed to address challenges so children can safely return home.

CASES OPENED BY VOLUNTARY AND DEPENDENCY STATUS, CY 2011 TO 2015



Note: Other category includes incoming ICPC and unknown status cases.
 Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

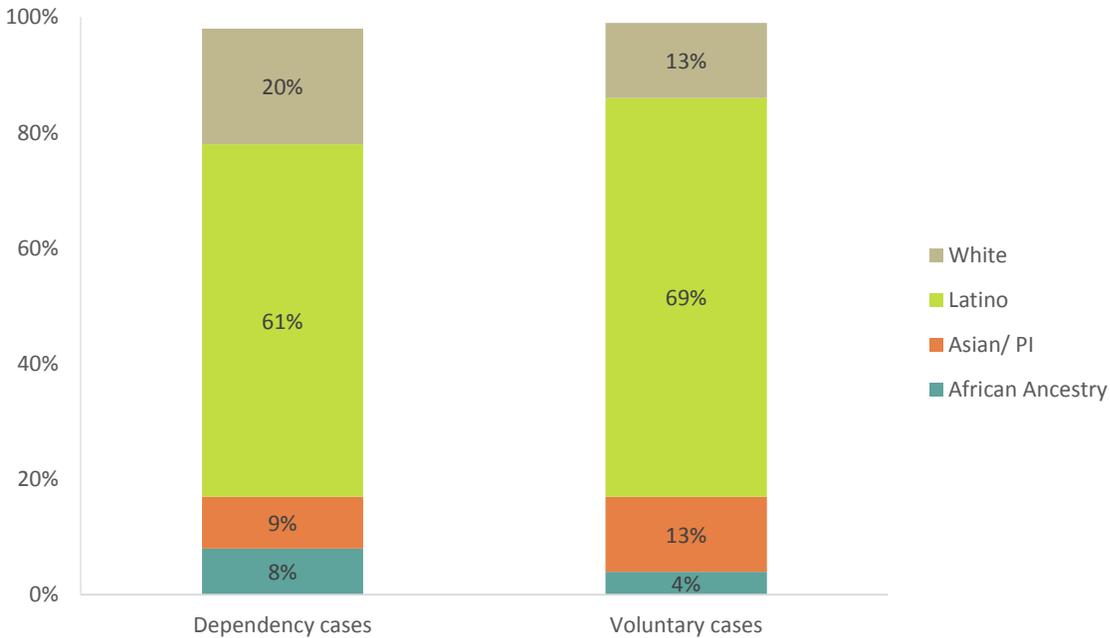
DEPENDENCY AND VOLUNTARY CASES BY AGE AT THE TIME OF CASE OPENING



Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Over 60% of all the cases opened in 2015 were for Latino children. More than 6 in 10 children with dependency cases were Latino, while nearly 7 in 10 children with voluntary cases were Latino.

DEPENDENCY AND VOLUNTARY CASES BY ETHNICITY, CY 2015

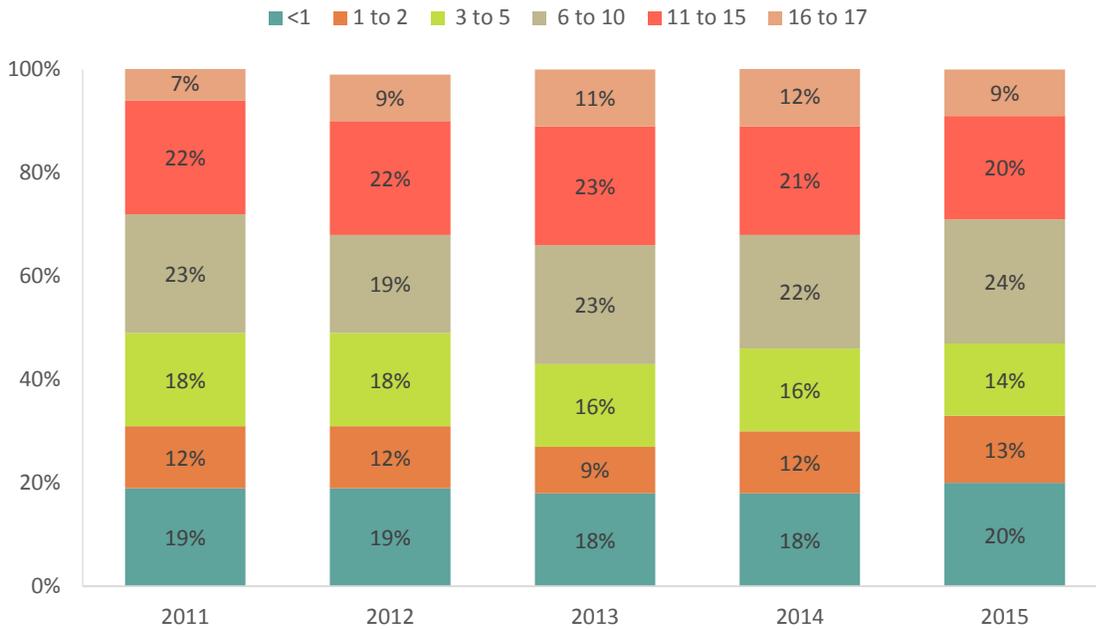


Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Children Entering Foster Care¹

During 2011-2015, 2979 children ages 0 to 17 entered the foster care system. Nearly 1 in 2 children who entered foster care were children ages 0-5; infants representing a higher proportion among this age group. Children ages 6-10 and 11-15 represented similar proportions of children who entered into a foster care placement; children ages 6-10 represented 19-24% and children ages 11 to 15 comprised 20-23%. Older children represented the smallest proportion of children entering foster care. Approximately 1 in 10 children who entered into a foster care placement were ages 16 to 17.

AGE OF THE CHILD AT THE TIME OF ENTRY INTO FOSTER CARE PLACEMENT



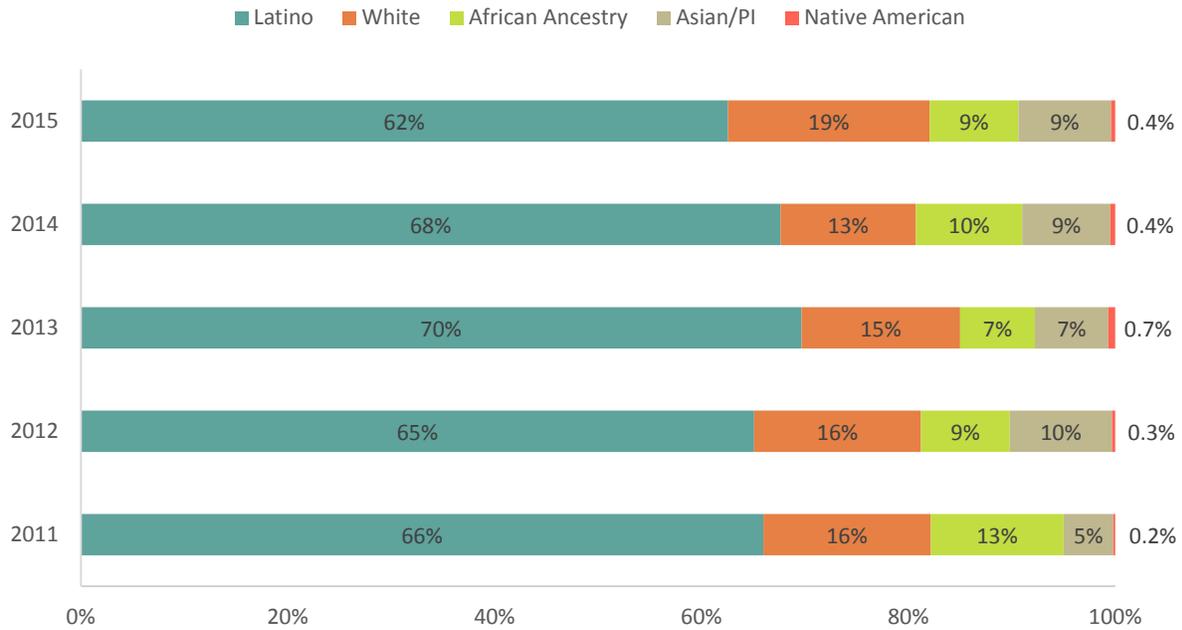
Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Ethnicity

During 2011-2015, 2 in 3 children ages 0 to 17 entering foster care were Latino.

During 2011-2015, 2 in 3 children ages 0 to 17 (66% average) who entered foster care were Latino, disproportionately higher than their population distribution in the county (36% of total child population). The proportion of Latino children entering foster care decreased from a high of 70% in 2013 to 62% in 2015. On an average, the proportion of Latino children in the foster care was 4 times the proportion of White children, 7 times the proportion of African Ancestry children and 8 times the proportion of the Asian/ Pacific Islander children in the foster care. On an average, 16% of the children ages 0 to 17 who entered foster care were White; followed by 10% African Ancestry and 8% Asian/ Pacific Islander children. The proportion of Native American children entering foster care was consistently low and encompassed less than 1% of all entries into foster care.

RACIAL/ETHNIC COMPOSITION OF CHILDREN AGES 0 TO 17 ENTERING FOSTER CARE



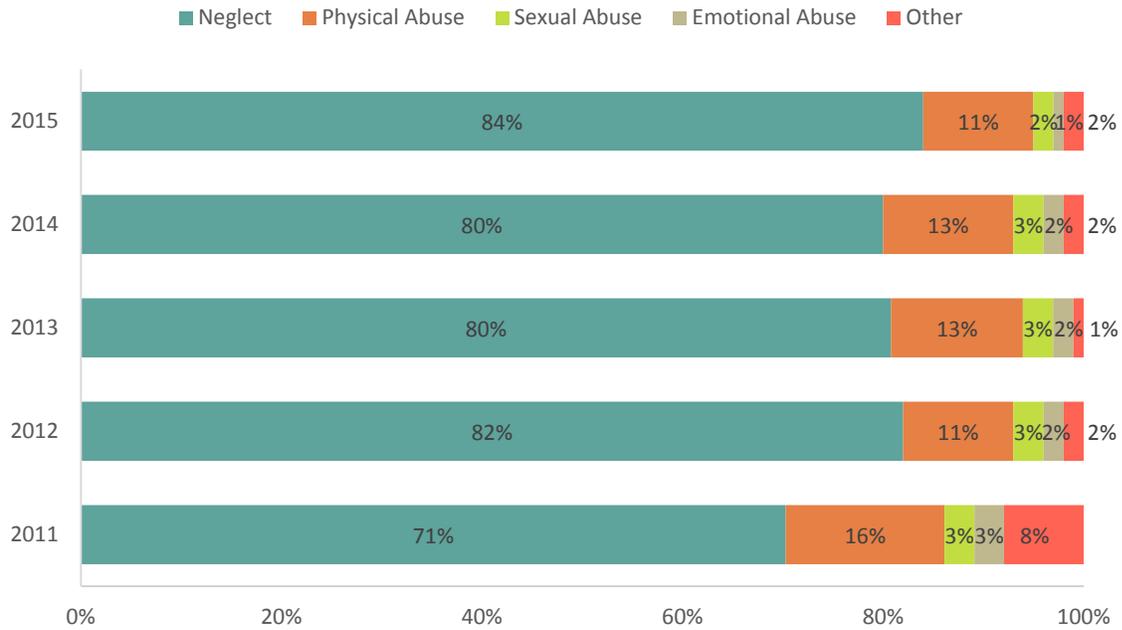
Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Reasons for Foster Care Placement

During 2011-2015, the reason for foster care placement for approximately 4 in 5 children was neglect^{xviii}. Physical abuse was the primary reason for an average of 13% of the children entering foster care. Approximately 3% of the children were removed from family due to substantiated allegations of sexual abuse and less than 2% of all entries into foster care were due to reasons of emotional abuse.

^{xviii} Neglect includes categories of general neglect, caretaker incapacity/ absence and severe neglect.

REASONS FOR FOSTER CARE PLACEMENT

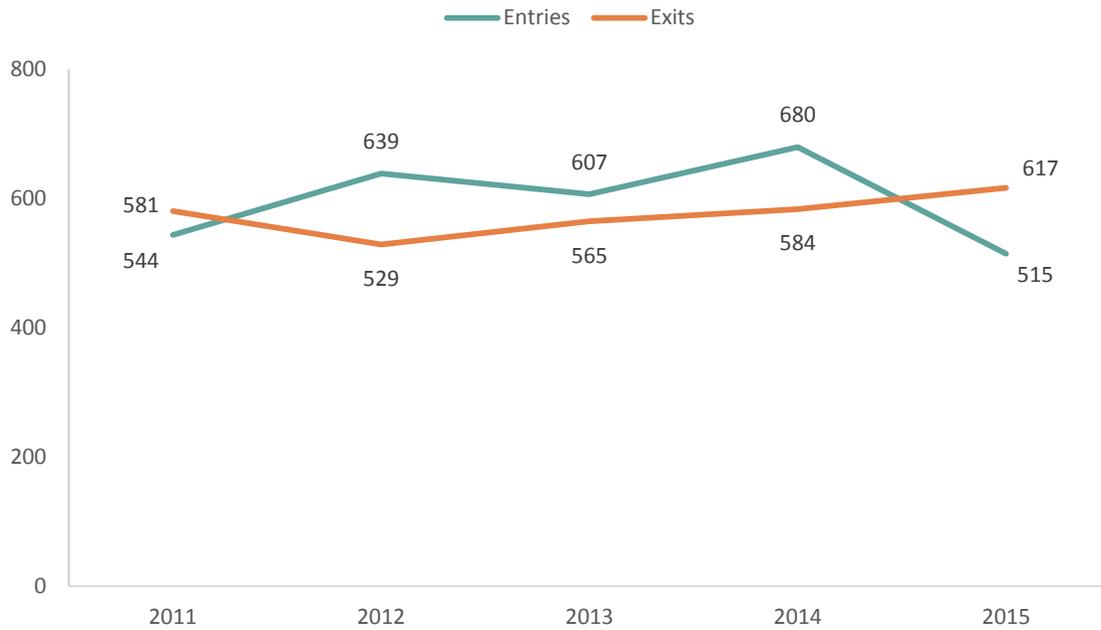


Note: Other category includes reasons of law violation, relinquishment, safely surrendered baby, child's disability, and unknown reasons.
 Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Trends in Foster Care Entries and Exits

The number of foster care entries among children increased from 544 in 2011 to a high of 680 in 2014, and then decreased to 515 in 2015. During the same time period, the number of children who exited the foster care gradually increased from 581 in 2011 to 617 in 2015. From 2011 to 2014, the number of children who entered foster care was larger than the number who exited the foster care. However in 2015, the trend reversed; with the number of children leaving the foster care system surpassed the number of children who entered into a foster care placement.

CHILDREN ENTERING AND EXITING THE FOSTER CARE SYSTEM



Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Children Exiting Foster Care¹

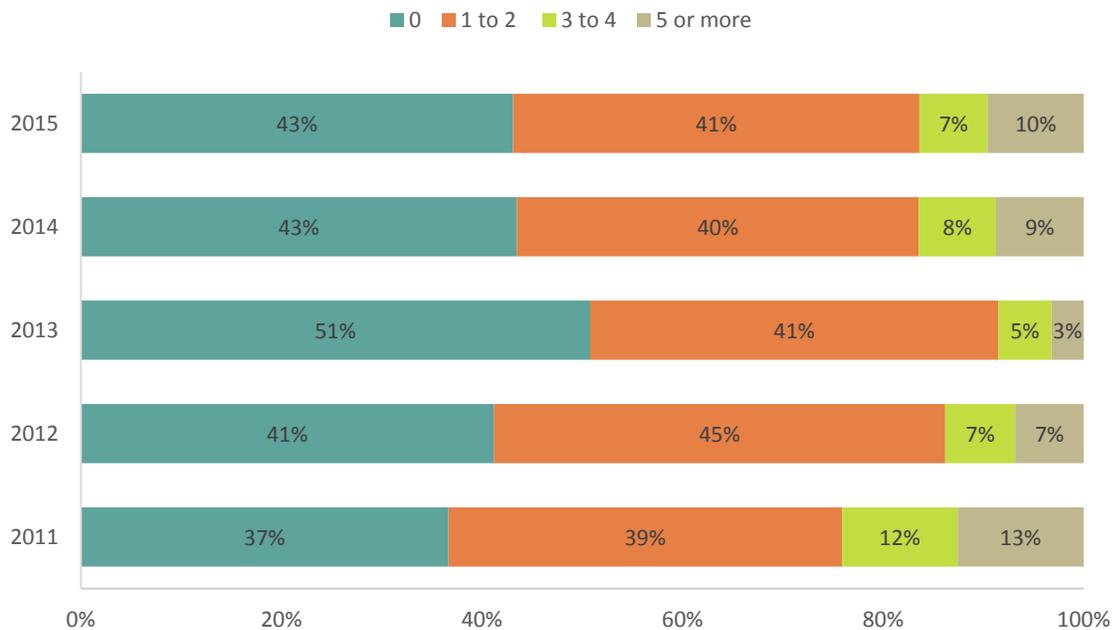
An exit from the foster care to a permanent and safe living situation is the primary outcome for children entering the foster care. Reunification with family is the most preferred outcome for children removed from their homes and placed in foster care. Other acceptable outcomes may include permanent residence with relatives, adoptive families who obtain legal custody, or guardians. Less acceptable non-permanent exit types include emancipation or 'aging-out' of foster care.^{xix}

Placement Changes

More than 4 in 5 children who exited foster care between 2011 and 2015 changed their foster care placements 2 times or less while they were in the system. The proportion of children who changed their placements 3 or more times was highest in 2011 (25%); decreasing to 8% in 2013 and then increasing again to 17% in 2015.

^{xix} For more information please see: <https://www.childwelfare.gov/topics/permanency/overview/>

CHILDREN WHO EXITED THE FOSTER CARE SYSTEM BY NUMBER OF PLACEMENT CHANGES WHILE THEY WERE IN THE FOSTER CARE



Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

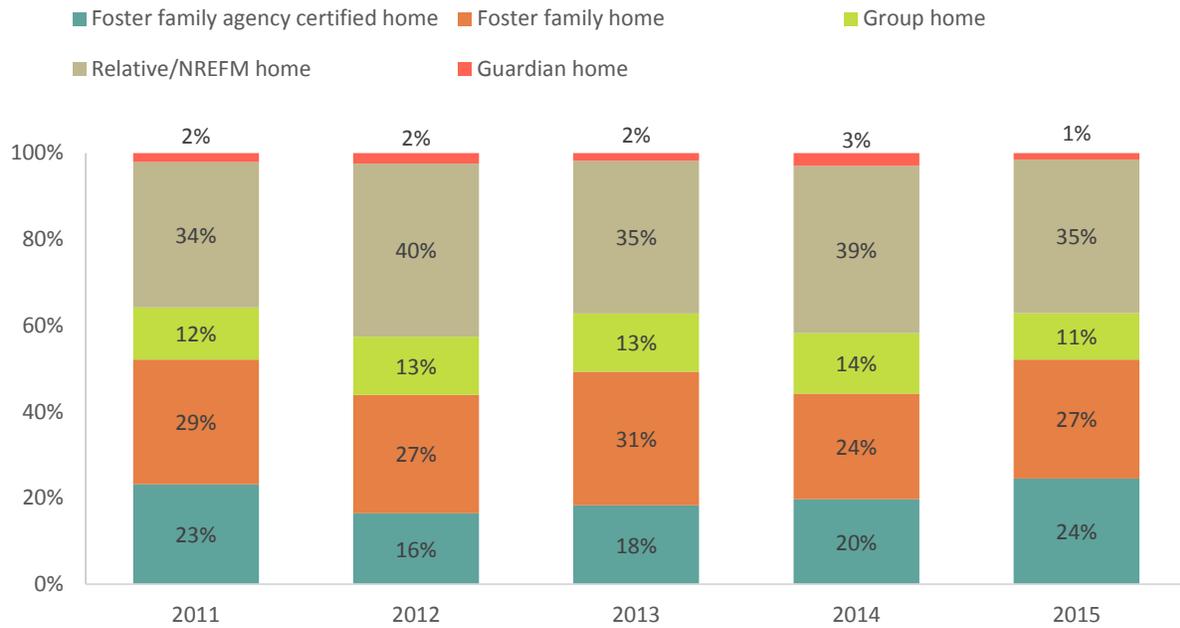
Placement Type

For more than 85% of the children who exited foster care between 2011 and 2015, the placement type where they spent the longest period of time was in a 'family centered home'. A 'family centered home' includes placement with relatives, extended family members, in foster family homes, or with guardians. The largest proportion of children, ranging from 34% to 40%, were placed with relatives or non-related extended family members (NREFM). On an average, nearly 1 in 2 children spent the longest time in a Foster Family Agency home (FFA)^{xx} or Foster Family Home.^{xxi} Less than 3% of the children who exited foster care spent the most time in a Guardian Home. Nearly 1 in 8 children (13% average) were in a group home placement for the longest time.

^{xx} Foster Family Agency homes are supervised by Foster Family Agencies. FFAs are organized and operated on a non-profit basis and are engaged in the following activities: recruiting, certifying, training, and providing professional support to foster parents. For more information, please see: <http://www.childsworld.ca.gov/pg1346.htm>

^{xxi} Foster family homes are certified and supervised by the California Community Care Licensing Division: <http://cclcd.ca.gov/>

LONGEST PLACEMENT TYPE FOR CHILDREN WHO EXITED THE FOSTER CARE SYSTEM



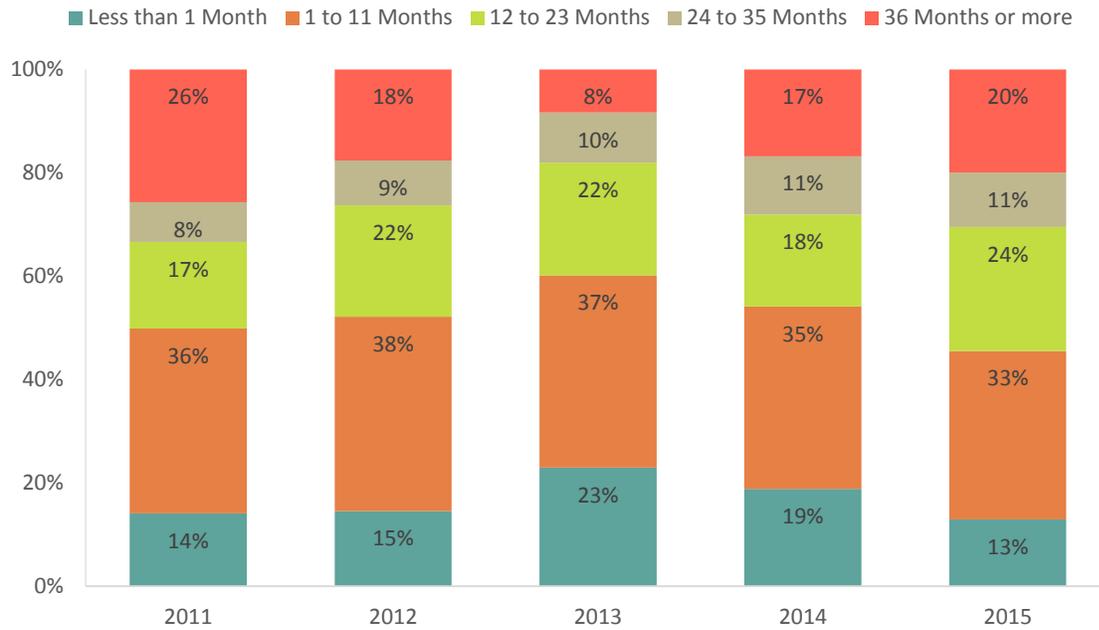
Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Length of Stay in Foster Care

Over half of the children in the foster care system exited within 1 year.

During 2011-2015, on average, more than half of children who exited foster care (52%) did so within 1 year. On average, 1 in 5 children (20%) remained in foster care for 12 to 23 months (ranging from 17% to 24%). A small proportion of children were in foster care for 24 to 35 months (ranging from 8% to 11%). The proportion of children whose length of stay in foster care was 3 years or more varied from 8% to 26%.

LENGTH OF STAY FOR CHILDREN WHO EXITED FOSTER CARE



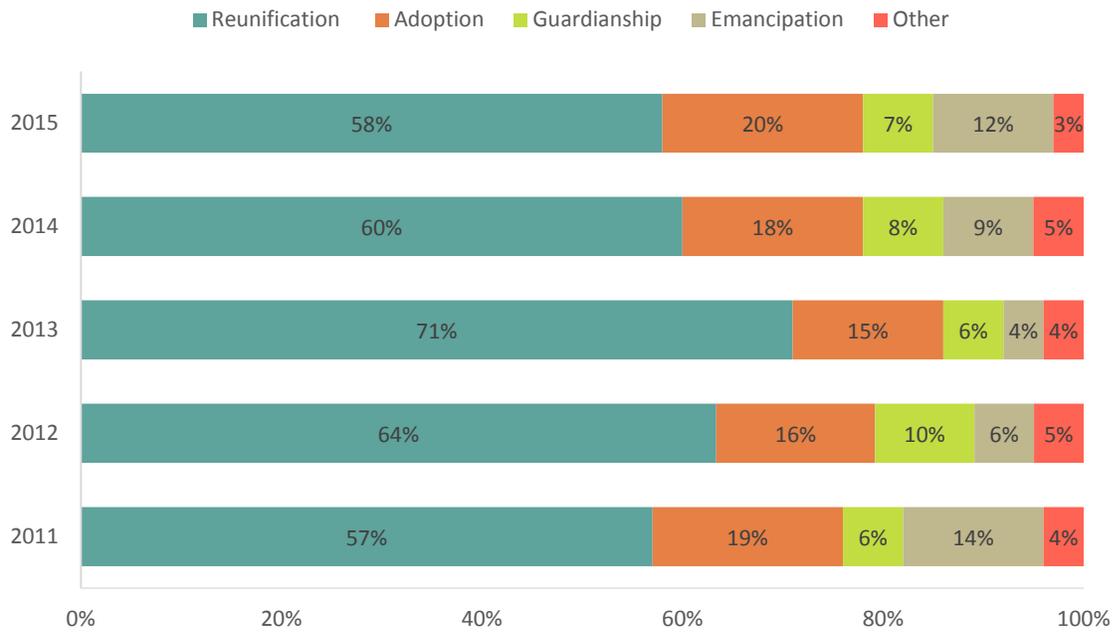
Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Reason for Foster Care Exit

On an average 8 in 10 children (80%) exited from foster care to a permanent home (parent, guardian or adoptive parent) during 2011-2015. In all five years, the primary reason for leaving foster care was reunification with parent/guardian, ranging from 57% to 71%. During the same time period, exits to adoption averaged 18%. The proportion of children who exited via guardianship ranged from 6% to 10%. The proportion of children who exited due to emancipation ('aged-out' of foster care) varied widely during this time period, ranging from 4% to 14%. Additional 3% to 5% of the children exited foster care due to other reasons.^{xxii}

^{xxii} Other reasons include child was under the jurisdiction of another Child Welfare System (CWS) agency, child was adjudicated under Welfare and Institutions Code (WIC) § 601/602, child incarceration, and death of the child.

REASONS FOR EXITING FOSTER CARE



Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Non-Minor Dependents²

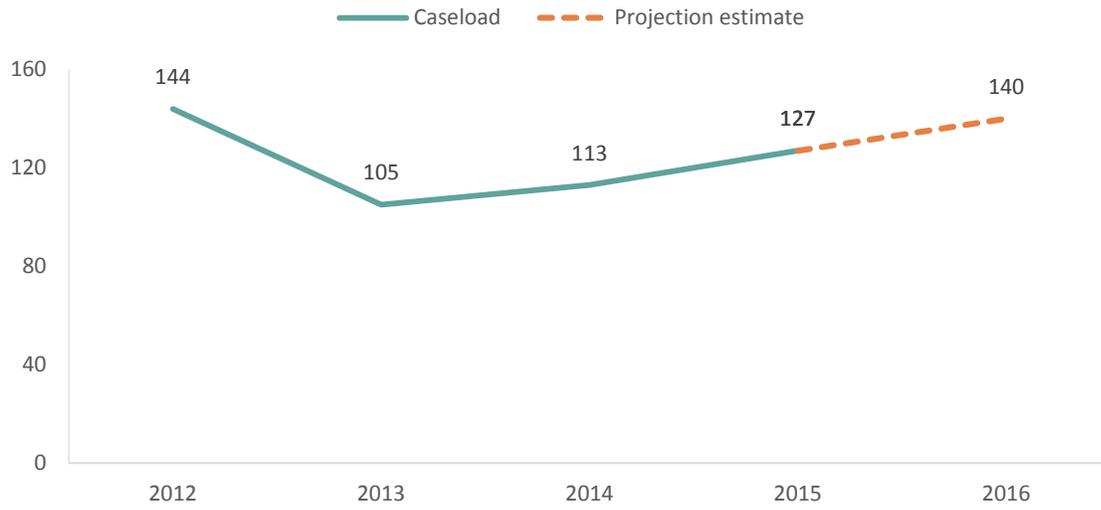
The California Foster Connections to Success Act, commonly referred to as AB12, was signed into law in 2010. Enacted in January 2012, the legislation allows eligible youth to remain in foster care until age 21 as Non-Minor Dependents (NMD). The voluntary program provides foster youth with a supportive environment to acquire the necessary tools they need to succeed in life and become self-sufficient.^{xxiii}

Trends in Non-Minor Dependent Caseload

The Non-Minor Dependent (NMD) caseload decreased from 144 in 2012 to 105 in 2013. From 2013 to 2015, the number of NMD youth gradually increased. In the same way, NMD caseload is projected to increase by 10% from 2015 to 2016.

^{xxiii} For more information about the California Connections to Success Act (AB12) please review: Independent Living Program Policy Unit Fact Sheet: After 18 Program (2015) available at: <http://www.childsworld.ca.gov/res/pdf/AB12FactSheet.pdf> and California Fostering Connections to Success Act: Assembly Bill 12 Primer (2014) available at: http://www.cafosteringconnections.org/wp2/wp-content/uploads/2014/10/AB-12-Primer_Updated-1-1-14.pdf

NON-MINOR DEPENDENT CASELOAD AND PROJECTION ESTIMATE

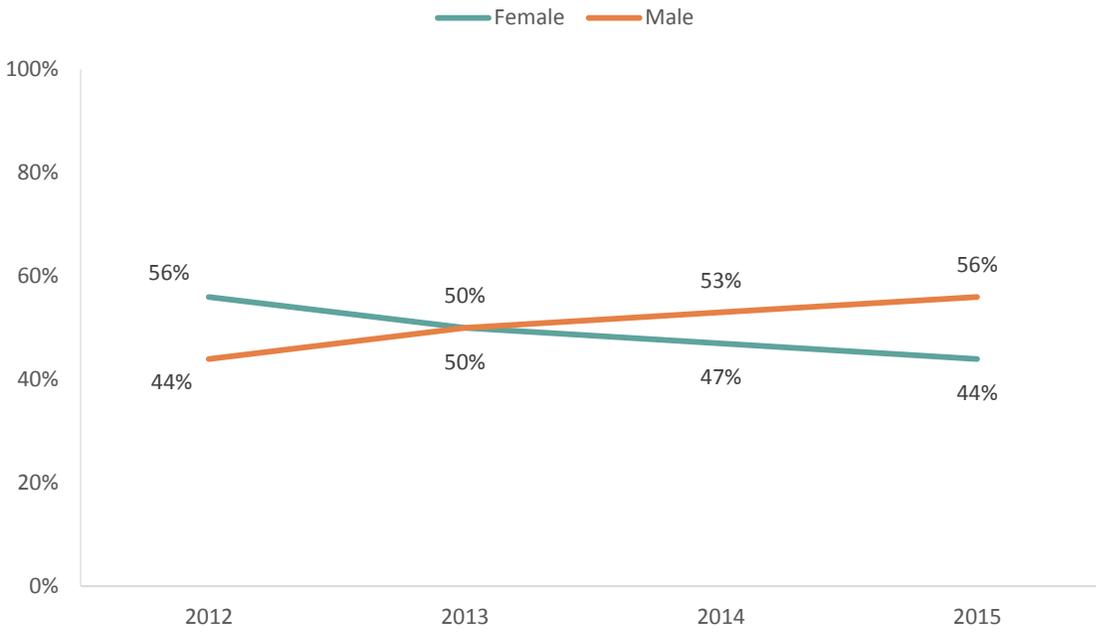


Source: Santa Clara County Department of Family and Children Services, calendar year 2012-2015

Gender

During 2012-2015, the proportion of female NMD decreased while that of male NMD youth increased. In 2012, the majority of NMD youth were female (56%). Since then, the proportion of female youth who entered into the NMD program gradually decreased to 44% in 2015. The proportion of males who entered the NMD program increased from 44% in 2012 to 56% in 2015.

NON-MINOR DEPENDENT YOUTH BY GENDER

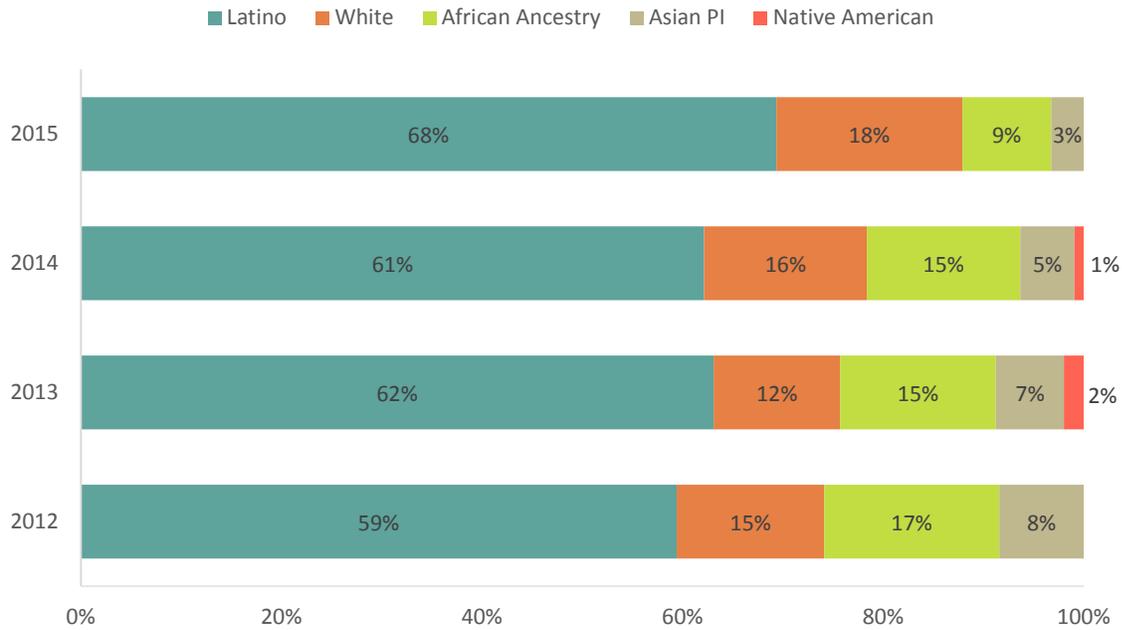


Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Ethnicity

During 2012-2015, on an average, more than 6 in 10 NMD youth (63%) were Latino. The proportion of Latino NMD youth increased from 59% in 2012 to 68% in 2015. On an average, 15% of the NMD youth were White. The percent of African Ancestry NMD youth decreased from 17% in 2012 to 9% in 2015. Similarly, the proportion of Asian/ Pacific Islander NMD youth decreased from 8% in 2012 to 3% in 2015. Native American youth represented an average of 1% of the NMD population.

NON-MINOR DEPENDENT YOUTH BY ETHNICITY

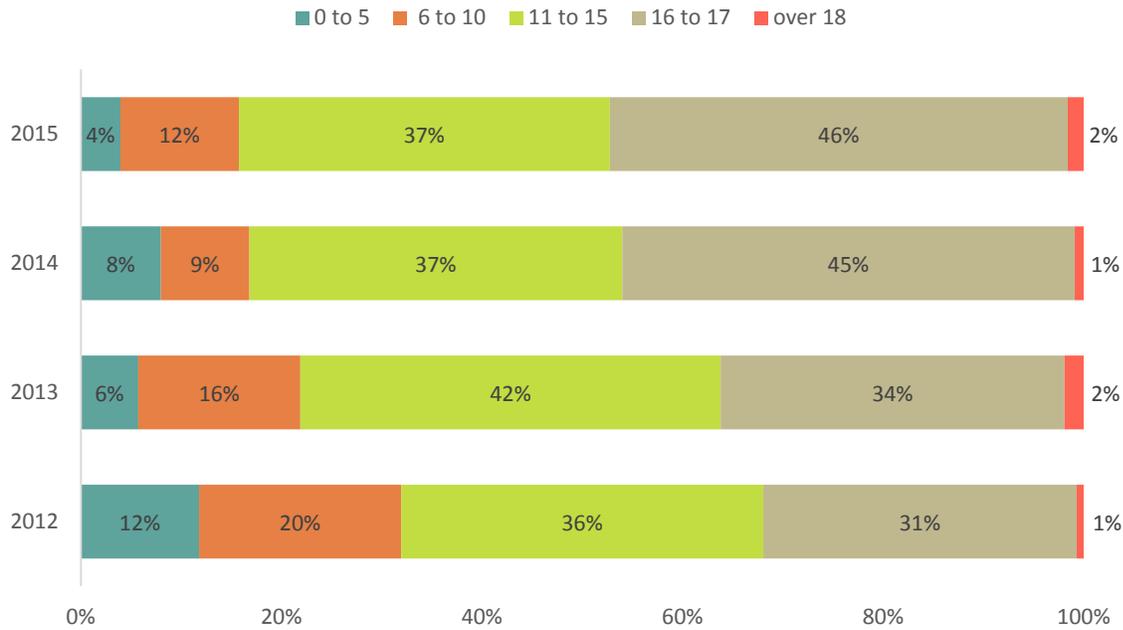


Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Age at Case Opening

During 2012-2015, approximately 98% of NMD youth were already an open foster care case prior to the transition to the NMD program (upon turning 18 years of age). On an average, more than 1 in 5 NMD youth (22%) were ages 10 or younger when a foster care case was opened for them. Nearly 4 in 10 NMD youth were 11 to 15 years of age (38%) when they entered foster care; similar to those who were 16 to 17 years of age (39%) at the time of foster care entry. Nearly 2% of NMD youth entered the NMD program at age 18 or older.

NON-MINOR DEPENDENT YOUTH BY AGE AT THE TIME OF FOSTER CARE CASE OPENING



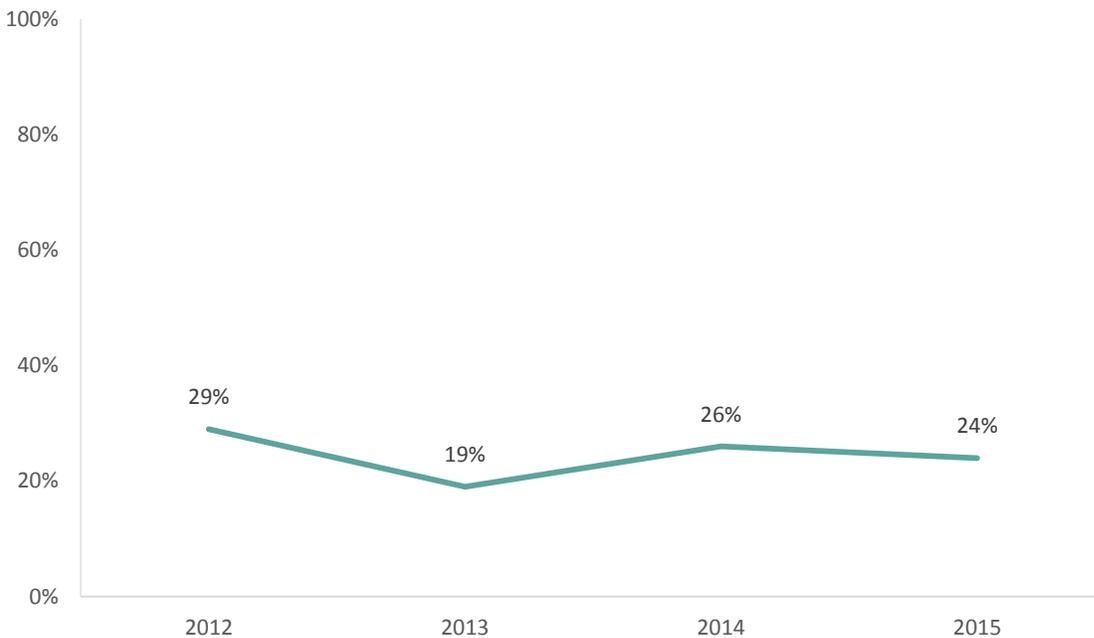
Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Psychotropic/Psychiatric Medication

During 2012-2015, 1 in 4 NMD youth (25%) were authorized for a psychotropic or psychiatric medication while in foster care. The proportion decreased slightly from 29% in 2012 to 24% in 2015. A higher proportion of NMD youth (25%) had authorization for a psychotropic or psychiatric medication while in foster care compared to an average of 11% for all children ages 0 to 17 in foster care during the same time period.^{xxiv}

^{xxiv} Based on estimates from UCB CWS/CMS website, Measure 5F: http://cssr.berkeley.edu/ucb_childwelfare/CDSS_5F.aspx

NON-MINOR DEPENDENT YOUTH AUTHORIZED FOR A PSYCHOTROPIC OR PSYCHIATRIC MEDICATION WHILE IN FOSTER CARE

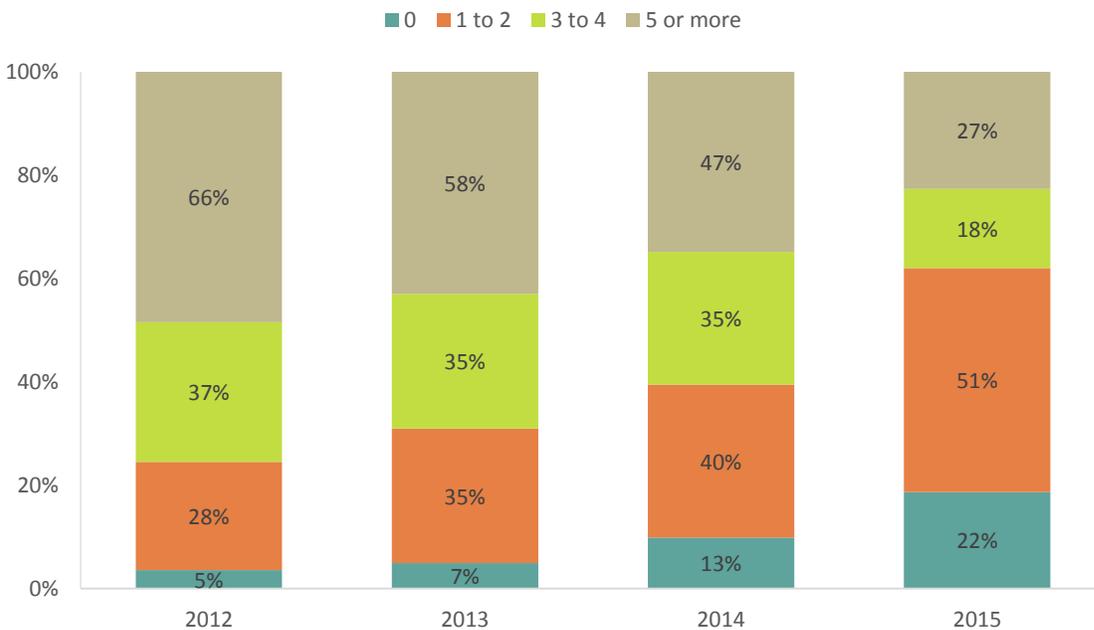


Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

Placement Changes

During 2012-2015, more than 1 in 10 NMD youth (12% average) had no placement change while they were in the NMD program. The proportion of the NMD youth who had 1 to 2 placement changes increased from 28% in 2012 to 51% in 2015. The proportion of NMD youth who had 3 to 4 placement changes decreased from 37% in 2012 to 18% in 2015. Similarly, the proportion of NMD youth who had 5 or more placement changes decreased from 66% in 2012 to 27% in 2015.

NON-MINOR DEPENDENT (NMD) YOUTH BY THE NUMBER OF PLACEMENT CHANGES WHILE IN THE NMD SYSTEM



Source: Santa Clara County Department of Family and Children Services, calendar year 2011-2015

FosterVision Program

A unique partnership between the Santa Clara County Office of Education (SCCOE), the Department of Family and Child Services (DFCS) and the Santa Clara County Juvenile Probation Department (JPD) is focused on improving the educational outcomes among the children and youth in the county’s foster care and juvenile justice system. The FosterVision database developed by the SCCOE houses health and education information for all children and youth in the foster care and those under the jurisdiction of the Juvenile Division of the Santa Clara County Superior Court. FosterVision is used to provide authorized caseworkers, probation officers and school services personnel with information about the health and educational needs of these children and youth. Through automated, nightly transfers of key information, those who serve children and youth in foster care and/or Juvenile Justice System have the most current information to guide their support services. As of the first year of the program, 14 of the county’s 31 school districts, DFCS and JPD can easily determine who is most at risk and why. For example, of the 1,303 foster care children and youth currently identified in FosterVision, 32% had multiple placements during the 2015-16 school year and 14% were designated as truant; both are high risk factors which can jeopardize positive school outcomes. Access to this additional shared information is allowing more timely interventions with identified high risk children and youth, and better coordination of services among the stakeholder agencies.

What the Community Tells Us: Community Perspectives and Experiences

Foster youth identified the **high cost of transportation and housing, education, trust and friendship, and stress and emotional health as top concerns**. Caregivers reported stressors associated with ensuring that the basic needs of foster children are met, and addressed the challenges with accessing and navigating services, such as medical experts not having expertise to deal with foster care youth. They also reported their concerns with ensuring the safety of foster children from abusive situations.

Economic Inequality & Housing Stability

Foster caregivers noted that the high housing costs in Santa Clara County affects the ability of birth families to maintain stable housing and to stay with their children. Without stable housing, foster caregivers maintained that many children have to enter or remain in the foster system for longer periods of time. A foster caregiver shared, "I think it's [housing] affecting the birth families, the children that we have. I think it's very difficult for them which puts a lot of extra stress [on] finding places. There was some family that was waiting because the grandparent couldn't find housing so that she could get her grandchild in her home. So I think we see it affecting the birth family to deal with."

Foster youth also described how the cost of living in the area, combined with economic instability, leads to uncertainty, such as being worried about their housing situation or whether they will have enough food to eat. The youth in foster care reported that this volatility and uncertainty is very stressful. Several youth also expressed concerns about the myriad of responsibilities related to personal finances, explaining, "there's also other types of stressors, like physical stressors, mental stressors, but mostly in life, you're going to stress about having a house or having a roof over your head, or having food in your stomach, when are you going to get your next bite? Are you going to be homeless tomorrow?"

Foster youth parents also described the stressors associated with money, "I worry about if I'm spending too much money, although every week I get a check, but sometimes they hold off checks, so it's like you got to save money, you got to remember to save, you got to remember that everything is not just for you. You have a son, you got to make sure that he's eating too, you got so much things. A lot of liabilities and responsibilities that must be taken care of before myself is something that I think about a lot."

Barriers to Accessing Services

The Need for Accurate Diagnosis and Services: Many foster caregivers reported that a primary concern is ensuring that the needs of their foster children are being met. Specifically, many spoke about receiving the correct diagnosis for their foster children in order for them to assess appropriate services, "well, my major concern, not just speaking of my daughter, is to make sure that their needs are met. Say for an example the diagnosis, hopefully she's being diagnosed correctly and hopefully if anything happened to me she would be taken care of. That's my main concern, her welfare." This is further compounded for a foster child with disabilities, as explained by a caregiver, "The flip side of that is if you have a child that has different disabilities or [is] acting up and they're not diagnosed,

then they don't get any services. You want your child to have some sort of level or some sort of diagnosis so you can access the services that they are entitled to."

The Stigma of Diagnosis: Although many caregivers noted that it is important for foster youth to receive a correct diagnosis in order to ensure that they receive the services and treatment they need to be healthy, several caregivers also observed that a diagnosis can also lead to stigma. Caregivers reported concern over how a diagnosis can **unfairly label a child**, which can affect them throughout their life, "I've ran into [this] with the babies that [have been] labelled. They get diagnosed and they're labelled and then that's really difficult for them to move on ... because that's stamped on a piece of paper and it never leaves. So if they're diagnosed with fetal alcohol, that's in their file for the rest of their lives ... we want a diagnosis, we need to know something, but on the flip side of it we have to be really careful and if your doctors aren't [careful] ... they just stamp that label and then that child just has that brand for life."

Challenges Navigating Healthcare System: Caregivers also reported difficulty with navigating the system of care and finding service providers that can provide foster children with the care they need, noting "It's hard to navigate getting them help. If you're going to regular pediatricians who don't understand children who have been neglected or have trauma, you're jumping through five million hoops." Foster caregivers further reported that many mental health providers do not have the expertise to serve with foster-adopt youth, explaining, "I will say even mental health providers with young kids that are trying to diagnose our young kids or they're trying to be their friends or whatever they're trying to do through therapy and it's just not working. I have a huge concern over that."

Foster caregivers described that streamlining services, or bundling services, is an effective way for foster youth to receive the support and care they need, "so that no matter where he goes or if he stays here it's all taken care of.' If they look at that child the same way, we would get so many more of those children who get diagnosed or they could get the support that they needed. That will go throughout their lives."

Data Sharing Critical for Caregivers to Help Support Children in Foster Care: Additionally, foster caregivers noted that they need as much information as possible to provide the foster youth the care they need. They observed that it is important to have the full scope of the child's health in order to provide adequate and timely care. One foster caregiver summarized, "I think that social workers should be honest when they're placing the kid and give you more information so you can help the child because a lot of times the kids come and you have the binder and they say, 'It's a good kid,' and this kid has so many mental health issues and you don't know who to turn to and then you have to wait forever to get a therapist. I think the social worker should give foster parents more information and more history so we can work a lot better."

Educational System

Many Teachers Help Support Children in Foster Care and be Their Role Models: Foster youth spoke about education as an important and positive force in their lives, explaining, "I didn't want to walk away and be like my parents, you know, and not get my diploma and not succeed. I

wanted to prove everybody wrong. I told myself that I was going to graduate before I was twenty, and I wasn't going to break my own promise to myself, because what's that telling me? That I break promises and I don't keep my word?"

Foster youth noted that low student to teacher ratios and effective teachers can have a positive impact in their lives. They spoke about forging a special bond with teachers, in the absence of their parents, "If you have ... more students, [this] equals less one to one time. If you have a lot less students, you [will] be able to have that more one to one ... and you could have that special bond like you had with your mother, father. Even though the teacher's not like that to you, it's close."

Foster youth were also emphatic about the need for an educational system that can teach to different types of learners (e.g., tactile and visual learners), "you can actually learn more standing up doing presentations and whatnot in person. It works both ways. It just depends on how much patience you actually got." Another foster youth further explained, "Yeah ... I'm one of those kids that are hands-on. You can give me a crescent wrench right now, and I [would] be able to go and probably change most of the, I could probably take [thing] apart with it. I could ... do oil changes ... If a teacher could ... show me, like a project or something ... I'd be able to learn a lot more."

Some Medications Create Learning Challenges for Children: Many foster youth described how many of the medications they are prescribed affect their learning and ability to concentrate and perform in school. One in particular, described his experience, "When I was in school, I was on medication, and ... I couldn't concentrate for nothing because I'd be falling asleep halfway through the class, because they overmedicated me. After that, that's when I realized, like, the medication wore off. My junior or senior year in high school, I wasn't taking medication at all. That's why I graduated. You know, I got motivation, and I was like, you know what? Because after I turned eighteen is when I stopped taking medication. I was like, hell no. I'm not going to take any more medication, because this doesn't help at all. If I'm going to be talking to my therapist and falling asleep halfway through our conversation, then it's not working. It's supposed to keep me focused, it's supposed to keep me from messing up, but that's exactly what medication did. I've been off medication for four years now."

The Need for Advocacy Rights for Foster Parents in School Settings: One of the more notable educational challenges that foster caregivers discussed was that they, as foster parents, do not usually have the ability to advocate on behalf of their foster children. This lack of "educational rights" hampers many foster parents' ability to ensure that their foster children receive the educational support that they need. Foster caregivers also discussed the lack of accurate educational data on foster children, which impacts targeting foster youth, mentioning, "they don't count the foster kids because they don't know how to count them. They have all the numbers wrong, there's no database and we're not able to get the things that we need for them. They need more tutoring ... They need different kind of mental health services [for] the trauma. Nothing happens and the state government came up with this new funding model and yet I never see it trickle down and I sit at board meetings."

Family & Social Support

Many Foster Families Work Hard to Provide Stability and Positive Environments for Children in Foster Care, Along with Connections with their Birth Families: Foster caregivers described their desires to provide stability and a safe home for foster youth. They also described their concerns navigating systems and overcoming challenges to ensure that their foster children receive the care and services they need. One notable recommendation from a foster caregiver was the consistent presence of an adult in the lives of foster youth. A foster caregiver noted that many foster youth oftentimes deal with constantly changing living situations and many times lack a positive support system comprised of adult role models.

A foster youth noted that some foster care youth disconnect from society because they are lonely or have a difficult time adjusting to foster care, "they don't have a social life" another foster youth further emphasized, "people react to foster care different ways. Some people, you got people that fight, people that just don't talk about it.

Many foster caregivers spoke about the need for respite care for themselves, which would provide temporary care for their foster children and allow foster caregivers to take much needed time off, describing, "I've had almost nine years and I've never been on a vacation because I can't find anybody to keep her but now thank God, I think that I have and I'm going on a vacation which I deserve."

Foster youth and parents alike emphasized the importance of maintaining connection with the family of origin. In some instances, this support means building a relationship with the children's birth family, "... it's very important for [sibling groups] to be together ... A lot of times babies are born and [DCFS] doesn't contact their [foster/adoptive] family to see if [the foster/adoptive family can] take that child ... I wish that—if we had to split siblings up— ... that we could have a relationship, where we could go to play dates, go to the park together." Foster youth similarly expressed concern and sadness over the separation from their birth family, "You know how I reacted to ... being taken away from my mother, and my family? It hurt like hell. Nobody should have to be taken away from their parent ..."

Foster caregivers also explained the importance of having supportive neighbors and other community members, especially when welcoming a new foster child into the family, explaining "they're starting to understand like my neighbor [does] that I am a foster parent and they're ... a little more understanding of the kids and what they might do playing outside. It's nice in the community [when you have] neighbors to support you."

Foster caregivers also noted wanting to assist their foster children in dealing with their grief and sadness openly, "it sinks in if they're feeling it, they're experiencing it ... Then I think allowing them to grieve openly and understand that their grief and loss [is] okay."

Important Role of Role Models and Mentors: Foster youth described that adult mentors play an important role at key moments in a person's life, but can also be present across different life stages, "When I was in my first group home, I had this mentor, whom actually just texted me ... when I was thirteen years old, I still talk to her to this day. She's going to be 30, she met me when she was 21. She was like my 'Big Sister,' you know what I mean? ... I had her for, like, a year and a half, about a good

year and a half, and that, honestly, helped me through so much growing up, because it made the biggest impact ... *if you give a kid someone to look up to, it'll change their perspective. It'll make them feel like they're actually worth something instead of just some kid sitting, waiting to leave, or waiting for something to happen.*" Another foster youth added, "... kids need mentors ... They need advocates that they can look up to. You got to take them out, you got to show them things." Similarly, foster youth described needing parent figures in their lives, describing, "it's more like, when you're in foster home, you most likely tend to want more attention, because being told what to do by staff, you really don't get that. You really don't get attention. I'm not talking about trying to be a smart ass attention, you want a mom and dad, but instead [of] getting a mom and dad, you got a staff. That sucks."

Foster Youth Experience Mistreatment at the Hands of Some Foster Parents: Foster youth detailed the mistreatment experienced in their homes, *"one day, I had an accident on myself, and this lady, the lady that I lived with ... literally threw me in the back of her barn, she literally just threw me and locked the gate, and she grabbed the hose and started hosing [me] down on the ground. That wasn't really ... parenting, you know? When I was trying to come open the gate, she kept spraying me even more. I was a little kid, I was mad ... You know what? A lot of foster parents aren't even, they should not even be foster parents."*

Stressors Associated with Foster Care Placement: Foster youth reported having difficulty coping with the stress and strain of being in foster care. Some youth described acting out in destructive ways. "It's like, trouble, everyone's been through that one foster home or one group home where they end up doing property damage or end up beating the [crap] out of somebody, just because of anger, you know? You don't know their story, you know, but they probably have their reason at that time [for] why they did it, but it's way deeper than that. At the moment, no one's thinking that. Everybody just thinking, in a foster home or a group home, yeah, fight. Let's [mess stuff] up. You know? Let's give staff a hard time. That's what people are thinking. I think people in a group home right now, they're probably, they're thinking that right now, about destroying and getting kicked out of their own group homes."

Drug Use and Prescription Medications: Several foster youth described using marijuana as a coping mechanism, "I feel like ... with foster youth should smoke weed, like, legalize it for foster youth, it's because we've been through a hard time. I don't know, it's like, not only talking about that, when you're high, I feel like when you have weed around, you could bring friends over. It helps you bring more friends together, because they kind of talk about their story." Another foster youth added, "I was basically always high. That was basically my medication besides those pills. I have always refused my pills, you know? When I stopped doing medication, I started smoking weed, and that was my medication."

Many youth also described their experiences with taking prescription medications and frustrations with being overmedicated, "what I was going to say is that the ... When foster youth are put into the system, generally, most foster youth are put on some sort of medication because of something that happened during maybe their first foster home [or group home]." Other foster youth described being placed on medication for no reason, *"in a group home, they go, oh, this kid's acting up, and it's almost exactly the same, and they have the same diagnosis, let's put them on the pills. But, eventually, later on down the road, it's a different symptom that they're trying to cope [with], thinking that this dude*

and that dude have the same symptoms, but he [has] different symptoms, but ... a lot of foster kids are put on medication for no reason. If anything, it's the medication that makes them ... unruly."

Foster youth described the lack of emotional support to cope with the traumatic experience of being separated from their parents, "... what I hate is that just because ... they're your foster kid and your foster parents decide that you are too fed up [for the foster caregiver] to handle, why in the holy hell do you think your kid is too tough to handle? Because they got ripped away from their ... parents. That pisses me off, because it's just like, why don't you just talk about it with that kid, and so, assuming they need medication. Maybe they just need to talk about it. Maybe they just need to vent, instead of frigging' putting a friggin' top on what they feel. That's what medication is ..."

Racism & Discrimination: Foster caregivers described how their foster children receive different types of instruction and treatment at school based on their race or ethnicity. Some of the caregivers discussed the implicit bias that educators have towards youth of color. "We've talked to foster parents who might live in a community that's heavily Caucasian and they bring Hispanic foster children and they get treated differently ... It's hard because a lot of educators are unconscious[ly] biased. Like I went to a meeting the other day, a high school prospect [meeting] and they were talking about these vocational classes coming back and you could learn vocational skills and they're like, 'That could be great for our Hispanic students, they can learn how to work in the hospitality industry.' We're all like, 'Did you just really say that?' People just don't know what they're saying and how they're viewing things and those are the educators."

A caregiver reported interpersonal racism (between children) that led to bullying and teasing, and as a result, the child needed to withdraw from school, "... the other kids did tease him and they would call him names. It was very difficult, we ended up homeschooling him since."

Caregivers also described having to deal with foster child's experiences of internalized racism. They asked for assistance from other people because they did not feel they were equipped to handle the situation appropriately. "One of my kids, she's half African American and when she came she hated her skin color. She's like, 'I'm ugly, I wish I was like you.' This isn't right, and it broke my heart. I was calling my friends who are African American. I'm like, 'You need to help me out here. I don't understand this, I don't get it so you need to help me.' I had so many people coming in and be like, 'No, you're beautiful.' ... I had to have people who could identify with it come in and give her that kind of support. It broke my heart, she's seven. You shouldn't feel like that at seven."

Healthy Eating, Active Living: Foster youth described wanting more programming in parks, "I do go to the park a lot to skate. What I've noticed about the parks in town is there's not a lot to do, for kids. They have the skate parks, but not a lot of people skate. If they were to put in a handball court, a lot of people would be there."

Foster caregivers reported that many foster children lack a healthy diet. They also discussed that is a challenge to get foster youth to eat healthier foods, "As far as eating healthy I would say the majority of children that came into my home they never had healthy food in the past. They had all junk food, chips, soda and all that stuff. It's a shock ... and they come with a mouth full of cavities, at least 15 on ... average I would say."

REFERENCES

¹ Santa Clara County Department of Family and Children Services, Child Welfare System, calendar year 2011-2015

² Santa Clara County Department of Family and Children Services, Child Welfare System, calendar year 2012-2015

JUVENILE PROBATION

JUVENILE JUSTICE SYSTEM

Why It's Important

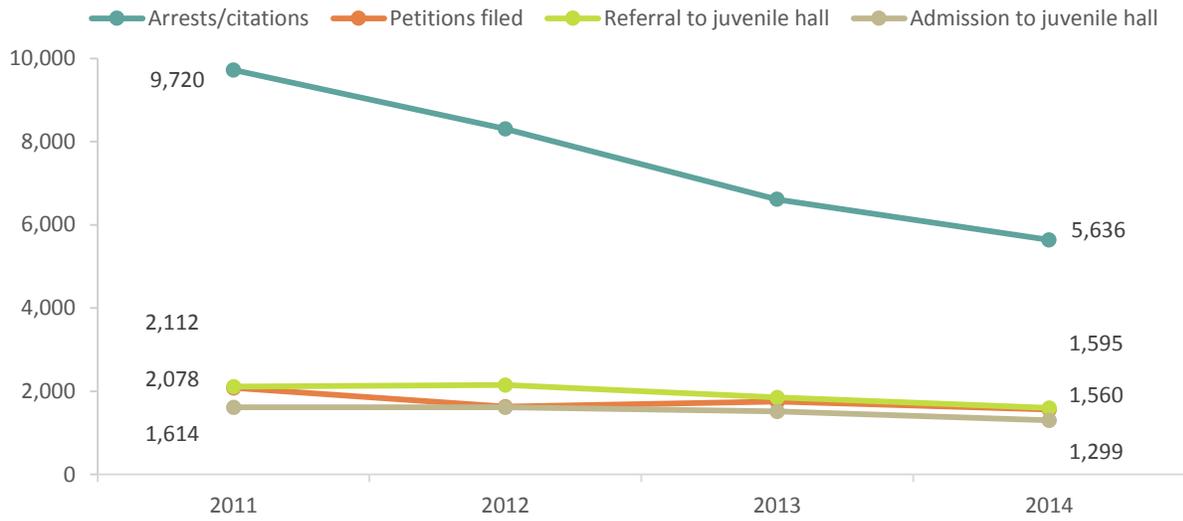
California's juvenile justice system deals with children under the age of 18 at the time of their offense. The system is set separate from adults with goals of emphasizing guidance, education, treatment, and rehabilitation over punishment. The juvenile justice system includes local law enforcement, county probation department (includes juvenile hall, camp and ranch), juvenile court, local school districts, child welfare, and behavioral health departments.¹

Children and youth in the juvenile justice system are a high-risk population who usually have unmet physical, developmental, and mental health needs. Often, these children and youth do not have access to healthcare in their community on a regular basis. Continuity of care, both on entering the facility and when transitioning back to the community, is crucial for children and youth; however it is a challenge.² Additionally, children and youth in the juvenile justice system are at increased risk for substance abuse, injury, and worse educational outcomes. Many factors have been noted as contributing to crime among youth, including: poverty, exposure to violence, maltreatment, substance abuse, and mental illness.³ Children and youth who have spent time in detention are more likely to engage in criminal behavior as adults and experience increased rates of recidivism, attempted suicide and other mental health disorders.⁴

What the Numbers Tell Us: Data Findings

Juvenile arrests and citations among youth in Santa Clara County declined from 2011 to 2014 with 15% fewer arrests and citations in 2014 versus 2013 (5,636 and 6,612, respectively).⁵

JUVENILE JUSTICE SYSTEM ARRESTS/CITATIONS, 2011-2014

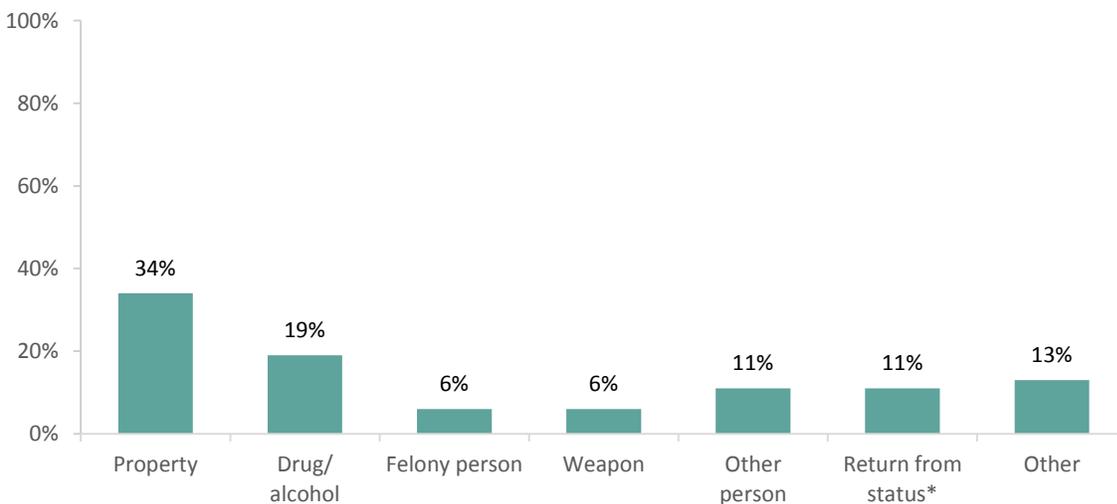


Note: The following definitions are courtesy of the Santa Clara County Probation Department’s annual report: Arrest/citation - An arrest or citation marks the initial contact a youth will have with the juvenile justice system (this includes paper tickets, such as citations and summons to appear, and actual arrests; Petition – Petitions are brought to a juvenile court judge once a youth has been accused of a status offense or crime; Referred to juvenile hall – Some arrested youth are booked at Santa Clara Juvenile Hall; Admission to juvenile hall – At juvenile hall intake, a detention risk assessment instrument (RAI) is administered by the Probation Screening Officer through the Juvenile Records Service (JRS) to determine whether or not the youth should be admitted to pre-adjudication secure confinement.

Source: Santa Clara County Probation Department, Santa Clara County Juvenile Justice System Annual Report, 2014

In 2014, one-third (34%) of all juvenile arrests/citations were for property crimes followed by drug/alcohol (19%) related offenses.⁵

JUVENILE ARRESTS/CITATIONS BY OFFENSE CATEGORY

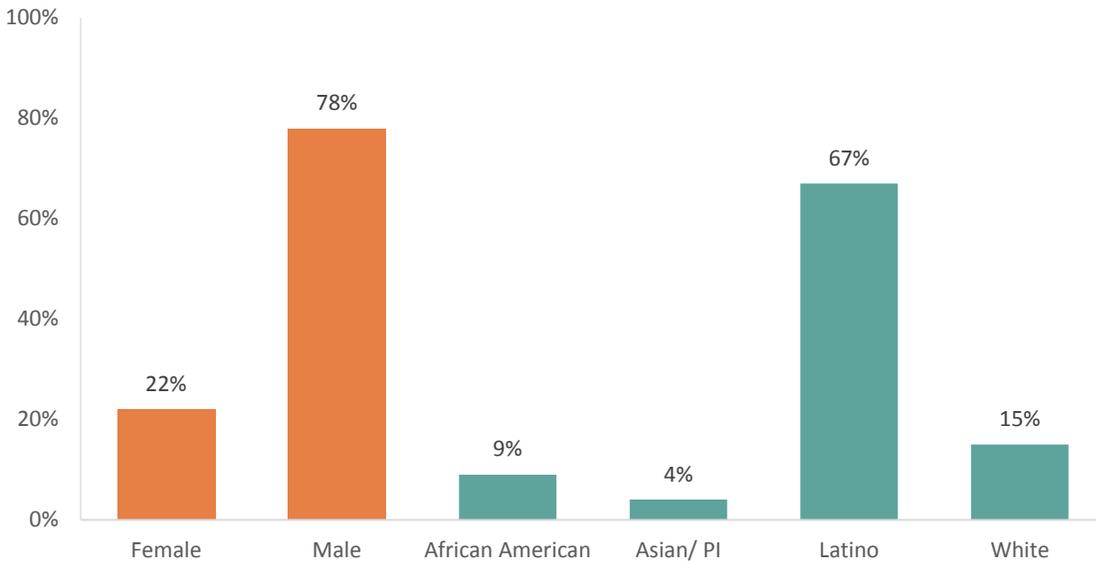


Note: [*] Return from status/courtesy hold/other admits. Return from status includes probation violations.

Source: Santa Clara County Probation Department, Santa Clara County Juvenile Justice System Annual Report, 2014

The majority of juvenile arrests/citations in Santa Clara County were among youth ages 16 to 17, with a higher percentage among males (78%) than females (22%). Latino youth (67%) comprised a higher percentage of arrests/citations than African American (9%), Asian/Pacific Islander (4%), and White (15%) youth.⁵

JUVENILE ARRESTS/CITATIONS BY GENDER AND RACE/ ETHNICITY

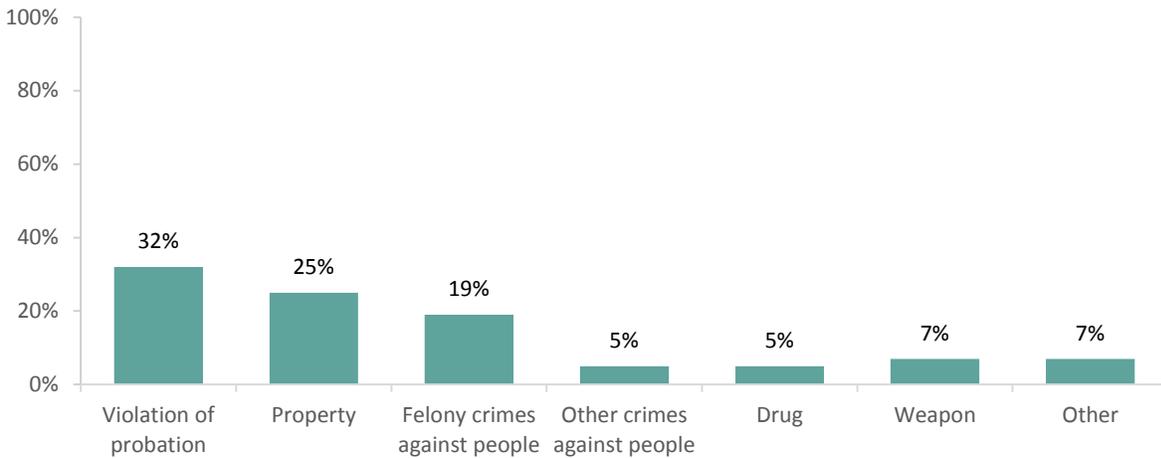


Source: Santa Clara County Probation Department, Santa Clara County Juvenile Justice System Annual Report, 2014

However, African American youth were arrested/cited at a higher rate of 101 per 1,000 youth, or 6 times that of White youth (16). Latino youth (56 per 1,000 youth) were 3.5 times more likely than White youth (16) to be arrested/cited.⁵

In 2014, 1,595 county youth (28% of those arrested) were booked at juvenile hall and of those youth, 1,299 (81%) were detained. Most youth were admitted for violation of probation (32%), property crime (25%), and felony crimes against people (19%). The number of violations of probation filings has declined from 1,117 in 2010 to 306 in 2014.⁵

JUVENILE INTAKE/ADMISSIONS BY OFFENSE CATEGORY



Source: Santa Clara County Probation Department, Santa Clara County Juvenile Justice System Annual Report, 2014

Similar to arrests/citations, the majority of admissions to juvenile hall were youth ages 16 to 17 (68%), with a higher percentage of males (85%) compared to females (15%). More than three-quarters (78%) of the youth detained at juvenile hall were Latino youth, followed by African American (10%), White (9%), and Asian/Pacific Islander (3%) youth.⁵

African American youth were approximately 12 times more likely than White youth to be detained (24.5 vs. 2.1 per 1,000 youth, respectively). Latino youth were 7 times more likely than White youth to be detained (15.1 vs. 2.1 per 1,000 youth, respectively).⁵

Violations of probation, the most common cause for admission to juvenile hall, occur when a youth has violated the terms of his or her probation status, has a technical violation, or has committed a new law violation. In 2014, 306 violations of probation were filed.⁵

Program Highlights

This section lists some of the salient programs in the Santa Clara County Probation Department for children and youth:

EDGE/PEAK

The Encouraging Diversity Growth Education (EDGE/PEAK) Program is a community-based treatment center, in partnership with the County Office of Education that serves as an alternative to detention for youth in the Juvenile Justice System. At the core of the EDGE/PEAK program is a cognitive based behavior management program. The program philosophy has an emphasis on a holistic and multifaceted approach to individual academics success, cognitive restructuring and making positive choices. Additionally, this 6 to 9 month long program also focuses on positive peer support, with individual, group and family counseling. In 2015, 63 youth were ordered to participate in the EDGE/PEAK program, of those 82% were Latino, 8% were African American, 8% were White and 2%

were Asian/ Pacific Islanders. Nearly 1 in 5 youth (19% percent) were 14 to 15 years old, 8% were 16 to 18 years old. Majority of the youth participants were males (90%) while 10% were females.

Gang Unit

The Juvenile Gang Unit is responsible for the supervision of gang related juvenile cases and for the investigation of juvenile offences that are gang related. The unit has 83 youth assigned to seven supervision probation officers. The maximum caseload is 25 cases per Probation Officer. Supervision services provided to clients are intensive and intervention is done on a proactive basis. The Probation Officers assigned to this unit receive specialized training including but not limited to, gang awareness, crisis intervention techniques, and other evidence based practices to support the unit's work.

One of the many services available for youth assigned to the Gang Unit is the Probation-Gang Resistance Intervention Program (Pro-GRIP), through Catholic Charities, a local non-profit organization. Pro-GRIP, is a collaborative effort that provides intensive case management services, with integrated vocational and educational services, counseling, and support services to eligible, gang-involved youth offenders throughout Santa Clara County. The objective of the intensive case management system is to make youth cognizant of their behavior, hold them responsible for their actions, and provide them with opportunities to develop pro-social competency skills, empathy, and resiliency through family, school, and community involvement. All youth receive intensive case management services, which may include mental health case management services. Youth also receive additional counseling and support services, as identified in their Transformational Care Plan (TCP) to address the individualized needs of youth.

Re-Entry Services Unit

Re-Entry/Aftercare is an innovative six month program, which focuses upon the success of children and youth re-entering the community from the James Ranch Enhanced Ranch Program. This program utilizes a client-centered and family-focused approach which emphasizes the support of the children/youth and their families for successful transition into the community from a custodial setting. Through a highly collaborative team-oriented approach, transition plans for education, vocational training, mental health and/or substance abuse services are coordinated by probation staff and community based organizations at the Multi-Disciplinary Team meetings (MDT) 60 and 30 days prior to the child's/ youth's release. This ensures a seamless transition when the children and youth return to their families and communities.

The three primary program goals are to: (1) reintegrate youth into pro-social community life through independent living, (2) eliminate delinquency and self-defeating behaviors, and (3) promote pro-social self-sufficiency through healthy behaviors in employment, school, and social activities, etc.

In fiscal year 2015, a total of 53 children and youth exited the Re-Entry Services program. Among those, 78% were Latino, 8% were African American, and 8% were White. The majority of the children and youth were males (90%). Nearly one-third of program participants (32%) recidivated, mostly within 6 months of the program exit, which is a decrease from 40% recidivism the prior year.

What the Community Tells Us: Community Perspectives and Experiences

Priorities for This Population

Police Abuse

Youth focus groups in juvenile justice system identified police abuse/ police attitudes and behaviors toward youth of color as top concerns. Youth in the juvenile justice system spoke emphatically about harassment and mistreatment by the police. Many spoke about being racially profiled and discussed how assumptions and accusations are made by the police because of how youth looked or where they were when they were approached by police officers.

Housing

Youth participants also discussed how rentals and the cost of housing are too high in Santa Clara County. This impacts the ability of families to afford clothes, food, and other basic necessities. Many youth reported that their families are struggling financially, and as a result, many families live in overcrowded situations and are stressed.

Education & Employment

Although focus group participants spoke about the importance of education, they also discussed how schools and teachers are not serving their interests or teaching them useful information or skills. Participants agreed that having a felony or a criminal record makes securing employment more difficult. They also spoke about difficulties with obtaining employment generally, and many stated the need for more resources for job training. When speaking of their future, one participant stated that a top concern was knowing where they would be in 15 years.

Racism & Discrimination

Mistreatment and abuse of power by police officers were major topics of concern by focus group youth participants in the juvenile justice system. Participants discussed this concern in terms of racial profiling and assumptions made or stereotypes used by police officers based on their appearance (e.g., race or presence of tattoos). Many youth participants reported feeling unsafe and powerless around police officers, describing, "what concerns me is that people like the police abuse their power. There have been lots of incidents and they've just been lightly punished, they don't send them to prison, and when they do they get less time than we do. Those are things that concern me. One of my friends was shot in the head because he was driving a stolen vehicle. And the police, they are doing their job."

Youth participants also reported that police officers arrest or harass them because of their race, or because they fit the description of a suspect or "look suspicious," even if they are not engaging in any illegal activities, "they arrest [young people] just because they are hanging out on the streets, not doing anything." Another youth participant described, "policemen are racist ... They just look at you and if you are dressed in a certain way, or if you are in a certain place ... they stop you just because of

what you look like, what you're wearing, and they start asking questions. 'Did you rob a house? Did you steal this? Did you steal that?'"

"But the thing is the police, the police make me feel unsafe."

- Focus group participant

As a result of harassment and racial profiling, many youth participants do not feel safe around the police, "and [the police] get there, with their blue car. And I run, why? Not because I have anything that's going to get me in trouble, not because I have drugs. I run because I already know how they are. Because I know that if they do something to me, I can't do anything back, because then I'll be done."

A participant also noted that their appearance limits their ability to get a job and reported that many employers discriminate based on how the applicant looks, such as the presence of tattoos, "If you have tattoos you can't get a job. They judge you

because of what you look like and what you're wearing. That shouldn't be a problem to find a job. They should focus on if you are a good worker or not, if you work hard."

Consequences of Gang Affiliation

Assumptions based on appearance also extend to gang affiliations, which can have consequences on sentencing. Participants noted that gang enhancements, or additional charges to existing crimes for participating in or assisting street gangs, can lengthen prison sentences. Focus group participants reported that some youth receive longer sentences because of gang enhancements even if they are not gang affiliated simply based on assumptions made about them, like their appearance, "like I feel like we could cut it down [stop gang enhancement] because like some people are not even like in ... gangs and stuff, [but they are] getting charged with gang enhancement."

Youth participants also reported that racial profiling, early involvement in the criminal justice system, and prison sentences can have devastating impacts on the lives of young people, "[The system is corrupt.] ... Like I know people that ... just ... barely turn 19 and they're going away for ... 17 years. And like you're still, you're still a teenager. [Their] mind's not even fully developed."

Youth also discussed racism and stereotyping based on their appearance by neighbors in their communities, "I don't know with ... my long hair and stuff ... they pick on me and call the cops. Like because they say ... 'Oh, you match the description.'" Another youth participant shared his experience, "I got White neighbors and they look at me all weird every time I step out of my house. Yeah. They look at me like I'm so bad like I'm going to hurt them or something." While another expressed the fear he feels, "It's like every time I step out of my house, I got to watch my back."

Economic Inequality & Housing Stability

Focus group participants discussed their concerns about the high cost of housing and housing instability. Youth reported that many of their families had to move in order to find more affordable housing, and as a result, caregivers and other family members needed to commute long distances to

their jobs. Several participants expressed a desire to move because of the financial strain of living in Santa Clara County. Several youth described overcrowded situations with multiple families sharing one apartment. In the words of one youth participant, "I can say about the housingand the few relatives we have ... are ... in my apartment I can say that we share it, around 8 people in an apartment of 3 bedrooms. For example, I have my cousins, my mom, my uncle, my dad, my two brothers, my sister and me. So I'd like to have my own bedroom, but I sleep on the couch like a dog. It's the truth. I don't like to hangout in my house much, I spend time in other places, I travel by myself, because I'd rather not be there ... In any case, housing is difficult, we all need our own space and not all of us can afford it, a bedroom, a house."

"Because housing went pretty high, and if the costs [were] lower your mom [would have more] money to buy you clothes, food."

- Focus group participant

As a result of high housing costs, participants reported that many families are not able to afford basic necessities, or have very little money for other expenditures which adds stress to caregivers., "you pay for your house and then at the end of the month ... [our parents are] stressed about the bills, so they are all stressed about having enough money to pay. And then they pay the housing and since they have children and want to take them somewhere to eat or something,... they don't have enough money to buy clothes for them, or take them out, they just have enough money for school supplies, housing, phone bills, car bills, that's it."

One participant articulated that when parents or caregivers are stressed, their children are stressed as well. Youth participants also reported that in the best of circumstances obtaining employment is challenging, but it is especially difficult with a criminal record, "It's hard to get jobs ... when you have like

felonies, so like ... I said, whether or not you have a felony or not, it's kind of hard to get a job."

Participants reported that many jobs require a computer in order to apply, which many participants do not own. Some jobs also require that employees need a computer in order to work. Several participants recommended that more job programs, job fairs, and training are needed to support young people to apply and obtain jobs.

Educational System

Many youth participants spoke about the importance of education. As one participant observed, "to get far in life, education is power ... You need an education to do everything in life."

Although important, participants also noted that the quality of education is lacking. Specifically, many youth reported that teachers are not engaging or are not teaching them needed information and life skills, such as job training. "More help, like, helping us find jobs. They already have some job programs, you know? ... But they should integrate more what we want to do, how to do it, people [should] come here and scout." Many stated that they were unhappy with the quality of teaching and

that better teachers are needed, "... some teachers don't give you the answers to your questions. And I think, I want them to explain, not just give the answers. Not just give you an easy answer." **Youth participants recommended that classes should be more interactive and relevant.**

Family & Social Support

Several youth focus group participants discussed the importance of family and social support. Specifically, many spoke of lacking a stable home, and their experiences with poverty and family members struggling with substance abuse or dying. Many youth reported the lack of adult role models in their lives, "being [raised on] your [own], know what I mean? You have to ... take care of yourself and ... learn everything by yourself and stuff." While another youth shared, **"Not all of us have parents who can look after them, not all of us have dads in our lives, not all of us have our mothers."**

Some participants also noted the lack of a robust support system in their lives. A participant commented, that they do not have anyone in their lives that they can talk to or confide in about their problems, "[I'm not] attach[ed] to anyone much. Not even to my mom, [I'm not] attach[ed] because when you have a weak spot everyone knows that, and I don't want to have a weak spot. So who do I go to, to talk about my problems? No one. I keep them within me." **Participants highlighted the need for more adult role models.**

Several participants also reported that the deportation of family members as a destabilizing factor in their families' lives, which can have enormous consequences on young people, "my cousin is hanging around my house, I tell him, 'Why don't you go to your house?' 'Oh, because my mom is working.' One day I was talking to him, I forgot that his dad had been deported, I asked, 'Where's your dad?' and he said, 'I don't have a dad.' That's sad. And all of this, why? Because the government is always deporting these people."

Additionally, youth participants reported that family members were deported because they were not able to find legal ways to financially support their families, "that's why people do illegal things, just to have money, and the cops are just pestering. You're trying to make money for your family, to support your family. My uncle, my godfather, they were deported in different years. Different years, different charges to deport them."

Community Safety & Violence

Youth participants discussed concerns for community safety and violence. Several participants brought up that they do not feel safe around street gangs and fear getting caught in the gun crossfire. Other youth reported that the prevalence of liquor stores in their neighborhoods, compared to other more affluent areas, is concerning. A youth participant described that more liquor stores lead to increased alcohol and substance use by youth, "in my neighborhood, there's a liquor store on every corner. They sell pipes, tobacco. Some liquor stores sell liquor; they sell many things ... So, when I go to other places, to other cities, like Santa Rosa. There are other neighborhoods, not the same neighborhood as mine. I don't see all of those liquor stores there in every corner. I don't see those shops on every corner ... My point is that you find neighborhoods where everything's a mess, in a nutshell, they open these stores, kids start drinking when they are too young. They start drinking too young ... Or smoking or using drugs."

REFERENCES

¹ Tafoya S, Hayes J. Juvenile Justice in California. Just the FACTS. http://www.ppic.org/main/publication_show.asp?i=1100. Published May 2014.

² Healthcare for Youth in the Juvenile Justice System. Committee on Adolescence; Pediatrics Dec 2011, 128 (6) 1219-1235; DOI: 10.1542/peds.2011-1757.

³ Juvenile Arrests Summary - Kidsdata.org. Kidsdata.org. Available at: <http://www.kidsdata.org/topic/30/juvenilearrests/summary#jump=why-important>. Accessed November 23, 2015.

⁴ Prevent Juvenile Delinquency. Policy For Results 2015. Available at: <http://www.policyforresults.org/youth/preventjuvenile-delinquency>. Accessed November 23, 2015

⁵ Santa Clara County Probation Department, Santa Clara County Juvenile Justice System 2014 Annual Report.

SCHOOL WELLNESS POLICY

Why It's Important

A local school wellness policy is a written document that guides a local educational agency's^{xxv} (school districts or schools) efforts to create supportive school nutrition and physical activity environments.¹ The policy guides schools and school districts in developing programs for students and their families to support better lifestyle choices such as healthy eating and physical activity. The policy may include practices such as improving availability of fresh fruits and vegetables in school lunches, restricting sugar sweetened beverages on campus, implementing health education classes and hours.

Providing established and well-formulated policies regarding physical education and nutritional content helps foster healthy eating and lifelong physical activity habits.² In 2013-14 school year, nearly 4 in 10 students in Santa Clara County public schools (39%) were enrolled in the free and reduced price meal program³, which incorporated some components of the wellness policies varying by the schools and school districts. Therefore, it is important that schools and school districts provide opportunities in preventing obesity and encourage healthier lifestyle choices for children.⁴

In an effort to understand the awareness about and implementation of the school wellness policies in the county public schools and school districts, key informant interviews were conducted. The key data findings from these interviews are presented in this section:

School Wellness Policies in Schools and School Districts

The practices and components of school wellness policies varies among different schools and school districts in Santa Clara County. Most of the school administrators, teachers, and staff noted they were aware of or had participated in ensuring that school wellness policies are being implemented or coordinated. Yet, there were some discrepancies in the awareness about the policy components and varying levels of implementation between schools and school districts. Some schools had engagement coordinators or school-linked service providers that were designated in ensuring school wellness policies were being enforced. Some schools have morning recess and administered strict policies surrounding food and beverages for classroom celebrations. Some schools developed regular communication channels between faculty, staff, parents, and students about wellness policies and practices, such as newsletters, morning recess announcements, and easy access to documentation of policy components and practices for teachers and aides, e.g., food and beverages for classroom

^{xxv} The local education agencies participating in federal Child Nutrition Programs, including the National School Lunch Program or the School Breakfast Program, are required to develop and implement a wellness policy as established by the Child Nutrition and WIC Reauthorization Act of 2004, and recently enhanced by the Healthy, Hunger-Free Kids Act of 2010 (HHFKA). Wellness policies can be integrated into the Whole School, Whole Community, Whole Child (WSCC) model for school health, and can help put into action several provisions of the Every Student Succeeds Act, including Title I and Title IV.

celebrations. On the other hand, there were some schools that solely relied on nutrition services and physical education instructors on providing both mandated physical activity and education.

Although there have been some successes for schools and school districts in developing awareness and implementation of wellness policies, there continues to be **inconsistencies** between schools within districts. Some schools were unaware or unsure of which policies currently exist. A staff member highlighted the information disseminated to district administrators is disconnected when it reaches the school level. Also, key informants noted that the **school's administration play a major role in determining whether the school wellness policy will be prioritized and effective.**

Partnerships with Public Health

Key informants mentioned that collaborating with the county's Public Health Department (PHD) has been helpful in implementing school wellness policies. For example, nutrition classes and interactive tastings were popular among parents and students. Staff and providers mentioned that having resource fairs with the PHD in conjunction with community-based organizations have been effective in reaching out to the community at-large. In addition, healthy eating campaigns such as "rethink your drink," have been noted as effective campaigns in teaching families to lessen the consumption of sugary beverages.

Opportunities for Collaboration and Recommendations

Key informants mentioned that the PHD can strengthen its advocacy role by supporting school staff and administrators. An example, public health can be a potential collaborator in ensuring that training is provided to all staff and administrators in a consistent and appropriate manner. Another opportunity is to encourage workplace wellness and workshops for school and district employees.

Most importantly, key informants stressed the significance of continuing school wellness education at all levels: students, parents, staff, and administrators. Key informants mentioned that even if students are made aware, it is ideal that parents practice the same healthy eating behaviors at home to ensure a sustainable, healthier lifestyle. An interviewee noted that "... the more we educate the kids and the parents, then they're going to have more of the expectation of the district and food service department [of] what they're giving my children ... And I know it's not okay because I've learned that it is not ... it's an education piece, [and] more education would help change things around."

REFERENCES

¹ Centers for Disease Control and Prevention. Healthy Schools; Local School Wellness Policy. Accessed on 11/16/2016 at: <https://www.cdc.gov/healthyschools/npao/wellness.htm>.

² Brissette, I., Wales, K., & O'connell, M. (2013). Evaluating the Wellness School Assessment Tool for Use in Public Health Practice to Improve School Nutrition and Physical Education Policies in New York. *Journal of School Health, 83*(11), 757-762. doi:10.1111/josh.12091

³ California Department of Educations, Data Quest, 2013-14 school year.

⁴ Story M, Nannery MS, Schwartz MB. Schools and Obesity Prevention: Creating School Environments and Policies to Promote Healthy Eating and Physical Activity. *Milbank Quarterly*. 2009;87(1):71-100. DOI:10.1111/J.1468-0009.2009.00548.X.

SELECT PROGRAM HIGHLIGHTS

Santa Clara County is home to many agencies and organizations that serve the diverse needs of children in the county. This section highlights a small sample of programs and services that are working to improve the health of the children. The narrative provided below, was compiled by the individual programs, agencies and organizations that serve children.

PUBLIC HEALTH DEPARTMENT

Black Infant Health Program

The goal of this program is to improve African American infant and maternal health, as well as decrease Black/African American and White health inequities and social inequities for women and infants. Within a culturally affirming environment and honoring the unique history of African American women, Black Infant Health (BIH) aims to help women have healthy babies. The BIH program uses a group-based approach with complimentary participant-centered case management conducted by multidisciplinary teams of Family Health Advocates, Mental Health Professionals and Public Health Nurses. The program staff assists pregnant and parenting women to develop life skills, set and attain health goals, learn strategies for managing stress and build social support. Since 1991, the BIH program has served over 8,500 African American women and their families.

BIH participants report stronger and positive connections to their heritage and other African American women in their community which work by preventing isolation and building a mechanism to access necessary services.

BIH participants report increased empowerment to make behavior changes leading to a healthier life and to understand the impact of racism on their health while encouraging effective stress-reduction strategies to better handle the negative effects of racism on their health.

California Children's Services Program

Children with complex health conditions who live at or near poverty are less likely to receive care within a medical home and have several unmet needs.¹ The California Children's Services (CCS) program is a state program for children under 21 years old who are residents of California and who have specific diseases, physical limitations, or chronic medical conditions. CCS aims to address the needs of children and youth by providing diagnostic and treatment services, medical case management, and physical and occupational therapy services. CCS also coordinates the children's medical care and refers them to Medical Therapy Programs and/or other agencies as needed. CCS children are a subset of the nationally defined Children with Special Health Care Needs (CSHCN).

Examples of CCS eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious diseases resulting in major sequelae.² CCS' Medical Therapy Program (MTP) provides physical therapy and occupational therapy to children with certain physical (neuromuscular or orthopedic) conditions or diseases.

CALIFORNIA CHILDREN'S SERVICES PROGRAM ELIGIBILITY REQUIREMENTS

Child is under 21 years old
Child has a health problem that is covered by CCS
Child is a resident of California
Child has one of the following:
Family income of \$40,000 or less
Out-of-pocket medical expenses expected to be more than 20 percent of family's adjusted gross income
A need for an evaluation to find out if there is a health problem covered by CCS
Adopted with a known health problem that is covered by CCS
A need for the Medical Therapy Program
Medi-Cal, with full benefits

Source: California Department of Health Care Services, California Children's Services

More than 180,000 of California's children and youth were active enrollees in the California Children's Services (CCS) program in 2012; and almost 6% were under the age of 1 year. Of the active enrollees statewide, nearly 5,600 children and youth were residing in Santa Clara County (3%).³

Child Health and Disability Prevention Program

The Child Health and Disability Prevention (CHDP) program provides complete health assessments for the early detection and prevention of disease and disabilities among low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, the CHDP program began using the "CHDP Gateway," an automated pre-enrollment process for non Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or the Healthy Families program. The CHDP Gateway is based on federal law found in Titles XIX and XXI of the Social Security Act that allows states to establish presumptive eligibility programs for children and youth.

Childhood Lead Poisoning Prevention Program

The Santa Clara County Childhood Lead Poisoning Prevention Program (CLPPP) is dedicated to both the identification and case management of children identified as at risk and those who have raised blood lead levels (BLL) and the prevention of lead poisoning through education to various target

groups and the community at large. The goal of program is to lower blood lead levels among children in the county, and thus achieve the Healthy People 2020 objective.

Parents of children, who are identified as having a reportable raised blood lead level, receive case management services throughout the course of their treatment from a multidisciplinary team.

The program staff provides outreach and education about the effects of childhood lead poisoning and ways to prevent it by attending health fairs, collaborating with community agencies (e.g. Head Start), and businesses (e.g. Kelly Moore). In addition, Santa Clara County Department of Environmental Health handles tips and complaints with regards to lead poisoning and provides educational material to several city planning departments regarding how to avoid the hazards of lead.

Maternal, Child, and Adolescent Health Program

The Maternal, Child & Adolescent Health (MCAH) program is responsible for the planning, implementation and evaluation of services that address the health priorities and primary needs of women of childbearing age, infants, children, adolescents and their families. The program staff provide a broad range of services, including participating in and/or facilitating collaborative partnerships, to address the ongoing needs of the MCAH population in Santa Clara County.

A top MCAH priority is to help ensure that pregnant women have timely access to quality prenatal care, thus supporting the health of infants. The MCAH program helps to provide timely access to quality prenatal care by overseeing a state run, enhanced prenatal care program called the [Comprehensive Perinatal Services Program \(CPSP\)](#). Pregnant women who participate in this program receive individual case coordination, referrals, and ongoing assessment and follow up in the areas of nutrition, health education and psychosocial services in addition to routine obstetric care.

The MCAH program also addresses mental health and substance use among pregnant women which can directly impact infant health. The MCAH program started a [Universal Prenatal Screening Pilot](#) project using a validated screening tool called the '4P's Plus[®]', screening all pregnant women (regardless of insurance status) for substance use, mental health, and domestic violence. Women who screen positive for any substance use, mental health or domestic violence issues are provided a brief intervention, and referred to a public health nurse for case management and linkage to services.

The MCAH program also leads a collaborative of key stakeholders and community partners working with youth of reproductive age, called the [Adolescent Pregnancy Prevention Network \(APPN\)](#). APPN works throughout the county to provide other agencies with best practices, and strategies to help prevent teenage pregnancy.

The MCAH program coordinates the [Child Passenger Safety Program](#) that provides education and services to ensure that children are properly secured in car seats in order to prevent major injuries in case of a motor vehicle crash.

Public Health Nursing Regional Services Program

The Public Health Nursing Regional Services program provides case management services by qualified Public Health Nurses (PHN) to clients of all ages who are experiencing a wide variety of health issues and concerns. The services are generally provided in the client's home setting. Often times, PHN case managers visit clients along with a public health assistant who provides translation services and performs other tasks under the direction of the PHN case manager (e.g. weighing infants). PHNs prioritize all referrals within the Santa Clara Health and Hospital System, according to presenting concerns, to assure a timely response.

Clients who are eligible for PHN case management services include:

- High risk infants: premature, substance-exposed, and/ or who have complex medical problems (Targeted Case Management (TCM))
- Children and adolescents who have chronic health problems or those with "special needs" (TCM)
- Children with elevated blood lead levels
- Women who are enrolled in the Comprehensive Perinatal Services Program (CPSP)
- Pregnant and post-partum teens and women who have high risk medical conditions, complex social situations, and/or current/past history of substance abuse (TCM)
- Adults and seniors who have complex medical problems and/or chronic diseases for medication management, education about medical conditions, and linkage/referrals to community resources (TCM)

Public Health Nursing Home Visitation Program

The Public Health Nursing Home Visitation program is a collaboration between the Santa Clara County FIRST 5, Santa Clara County Public Health Department (PHD), and Department of Family and Children's Services (DFCS). The program aims to provide public health nursing assessment and home visitation services for children from birth through age five, and foster youth or non-minor dependent who are pregnant and/or parenting a child under one year of age. The public health nursing services are provided to the families and children receiving DFCS services and are county residents. The public health nurses (PHN) provide developmental and social/emotional assessment using the Ages and Stages Questionnaire (ASQ), and Ages and Stages Questionnaire for Social-Emotional (ASQ:SE); postpartum health assessment and depression screening; evaluation of home safety; domestic violence screening; car seat linkage; pregnancy education including newborn care and parenting; health and immunization status health education to parents and foster parents/caregivers linkage and follow-up with medical, dental, mental health and community resources. The PHNs provide monthly home visits for infants up to age six months and wrap up PHN services after ensuring needed follow-up and linkages are complete. For children ages 6 months through 6 years, PHNs provide a minimum of 2 home visits and ensure that the client gets the needed follow-up and linkages to services.

Public Health Nursing – Health Care Program for Children in Foster Care

The Health Care Program for Children in Foster Care (HCPCFC) is a public health nursing program located at the Department of Family and Children's Services (DFCS). HCPCFC follows guidelines mandated by federal and state funding for the Child Health and Disability Prevention (CHDP) program and the California Welfare and Institution Code, Section 16501.3. PHNs provide case management and care coordination for foster care children/youth and foster parents/caregivers to ensure that medical needs of children and youth, including immunization, dental, mental health and developmental needs, are met during their foster care placement.

Childhood Feeding Collaborative

The Childhood Feeding Collaborative provides information and training on the recognized best practice model, *Division of Responsibility in Feeding*, to more than 300 pediatric health, mental health, nutrition, childcare, and parent education providers. More than 30 organizational partners use this model to help prevent chronic diseases, such as obesity and diabetes. Through the "*5 Keys to Raising a Healthy, Happy Eater*" free parenting class (which highlights this model), thousands of parents since 2008 have adopted positive feeding and parenting behaviors preventive of obesity and picky eating such as having more consistent routines for meals and snacks, and turning off the television during meals.

Safe Routes to School Program

Safe Routes to School (SRTS) is a nationwide program intended to increase walking, bicycling and other active forms of transportation in a safe and healthy environment amongst school age children and their families. The Santa Clara County SRTS program utilizes the *5 E's model*, bringing together key partners for providing traffic safety education; encouragement activities, such as *Walk and Bike to School Day* and walking groups; needed traffic engineering enhancement, such as crosswalks or signage; enforcement of traffic laws; and evaluation and assessment of the walking and bicycling environment as well as tallies of the students using active forms of transportation. With funding from the Valley Transportation Authority (VTA) and Caltrans, Santa Clara County SRTS program reached more than 67,000 students during the 2013-14 school year.

Nutrition Education and Obesity Prevention Program

Nutrition Education and Obesity Prevention (NEOP) is funded by the United States Department of Agriculture (USDA) Food and Nutrition Service. NEOP provides nutrition and physical activity education designed to promote healthy eating, food literacy, food resource management/food security, and physical activity to at least 24,825 of Santa Clara County's Supplemental Nutrition Assistance Program – Education (SNAP-Ed) eligible population. Collaboration with more than 31 community agencies and 10 school districts extends the reach and consistency of the educational messaging and activities.

NEOP activities are directed to SNAP-Ed eligible individuals and the various organizations that serve them such as churches, elementary schools, Head Start, community centers, and housing complexes.

Tobacco-Free Communities Program

The Community Advocate Teens of Today (CATT) Coalition is a youth advocacy group aimed at decreasing the harmful effects of smoking in Santa Clara County. CATT plans and implements tobacco prevention projects in schools and the community; engaging and encouraging youth to lead healthy lifestyles through education, outreach, and civic engagement. The coalition also raises awareness among community leaders, policymakers, and elected officials on issues related to tobacco control. CATT utilizes the framework called *"5 Cs of Positive Youth Development."* This research-based framework embraces psychological, behavioral, and social characteristics that youth develop, helping them grow into healthy responsible adults. Those *"5 Cs"* are competence, confidence, connection, character, and caring/compassion. In 2015-2016, 5,500 youth attended CATT coalition activities.

OFFICE OF MEDICAL EXAMINER-CORONER

Santa Clara County Child Death Review Team

Unsafe Sleep Practices

Sudden infant death syndrome (SIDS) is not a common occurrence in Santa Clara County and has continued to remain almost non-existent since 2010. The majority of the infant deaths are attributed to unsafe sleep practices and environment, including overlay and accidental suffocation.

Of the 40 infant deaths occurring during the 2013-2015 period and were reviewed by the Child Death Review Team (CDRT), there were 17 infant deaths that occurred due to either unsafe sleep practice (overlay, etc.) (n=4) or in an unsafe sleep environment (n=13). There were an additional 12 cases in which the infant died in an unsafe sleep environment in combination with other factors for sudden death (undetermined cases).

A safe sleeping environment for an infant is to be routinely placed on his or her back in a crib or bassinette. There should be a firm mattress, no toys or stuffed animals, and the clothing should be light to avoid overheating. Bed sharing^{xxvi} with an adult puts the child at risk and is not recommended. Deaths due to bed sharing are preventable by using the bassinet or crib for the child's first year. By placing the bassinette next to the bed, breastfeeding can occur without the mother rising from bed. She should be encouraged to return the infant to the bassinette on his or her back after feeding.

Unsafe sleep environment entails the infant either died alone on an adult bed, couch, or pillow or in an unsafe sleep environment shared with a parent. The babies either rolled and became wedged between the bed and wall, or rolled to a prone position (face down) with the face pressed into the couch, bed pillows or linens. A safe sleeping environment should be used each time an infant is placed down for a nap or for a night's sleep.

^{xxvi} Bed sharing is defined as parent and infant sharing the same sleep surface. Co-sleeping is defined as parent and infant sharing the same room (i.e. parent in the adult bed and infant in the crib placed in the same room).

The diagnosis of Sudden Infant Death Syndrome (SIDS) has traditionally been applied to unexpected infant deaths of previously healthy infants with no findings of injury or disease on autopsy, and no recognizable cause of death revealed by scene investigation. SIDS had been a leading cause of infant mortality around the world, but decreased sharply over the past 15 years. In the early 1990s, a public campaign to place infants in a safe sleep environment was instituted. The American Academy of Pediatrics' *Back to Sleep* campaign emphasized supine sleep position (i.e. putting infants to sleep on their backs) along with the use of a crib or bassinette. Since then, SIDS rate in the United States has declined by more than 50%.⁴

The diagnosis of SIDS in Santa Clara County is far below the national average, mainly attributed to the recognition of sleep position as a risk factor and to the detailed death investigation performed by the Medical Examiner. Since 2008, the Medical Examiner-Coroner (MEC) Office has instituted conducting baby doll re-enactments for sudden unexpected infant death investigation wherever possible. It is explained to the parents/caregivers that this portion of the investigation allows the Medical Examiner to obtain a better understanding of the infant's body position when last seen alive, and to compare it to the position of the infant when found unresponsive. In a bed sharing situation where an infant dies, the baby doll re-enactment also allows the Medical Examiner to not only assess the infant's last body positions, but also the parent's or caregiver's body positions in relation to the infant.

Over the past 8 years, the CDRT has acknowledged the risk of infants dying due to unsafe sleep environment and support the recommendations set forth by the American Academy of Pediatrics (AAP). The team collaborated with First 5 during 2011-2013 to launch a public awareness campaign to educate the community about safe sleep practices.

The CDRT continues to recommend and to participate in efforts to increase the public's awareness of the dangers of placing a child to sleep on any surface other than a crib or bassinette. Furthermore, the team continues to assist families grieving the loss of a child. With the loss of every child in Santa Clara County who falls under the jurisdiction of the Medical Examiner, grief packets continue to be sent to families, along with a cover letter from the CDRT Chair and Coordinator to express condolences and provide additional grief support resources during the difficult times.

The CDRT as well as the Medical Examiner continue to approach the sudden and unexpected death of an infant in the county as Sudden Unexpected Infant Death (SUID) instead of SIDS given the above data emerging from the MEC Office and data which is being collaborated by other Medical Examiner Offices across the country.

BEHAVIORAL HEALTH SERVICES

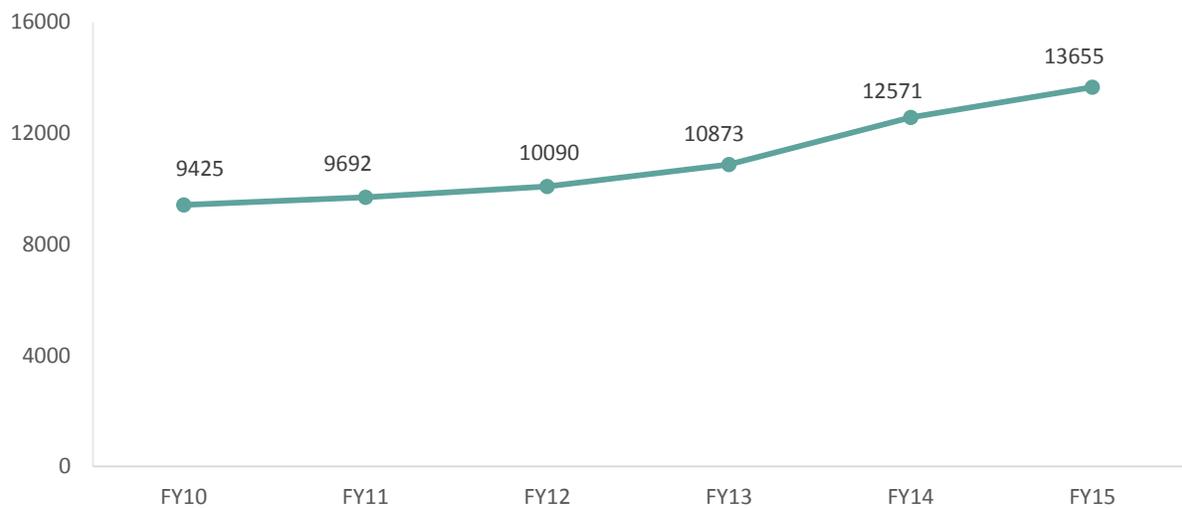
Family and Children's Services Division

Data are provided courtesy of the Behavioral Health Department. Data are presented by fiscal years.

The Family and Children's Services Division (F&C) serves children, adolescents, young adults (ages 0 to 25) and their families who are experiencing social, emotional and behavioral concerns. Services are

provided at five county-operated sites and by 20 contract agency programs located throughout the Santa Clara County. The Family & Children's Services Division provides outpatient care and programs specific to the unique needs of children and their families. Services that are provided respect cultural values and the natural support systems of youth and families and address behavioral health problems among children and families in the least restrictive, most family-like context possible. These services are offered within a continuum of care ranging in intensity and duration based on the needs of the individual child/youth.

NUMBER OF TOTAL CLIENTS SERVED



During fiscal year 2010 to 2015, the F&C division served an average of 11,000 clients per fiscal year in the county. There is a 44% increase in the number of clients served from 2010 to 2015. This increase can be attributed to the new programs developed by F&C division; many of these program being funded through the Mental Health Services Act (Prop 63) that included prevention and early intervention services to meet the increasing needs of the diverse population of Santa Clara County residents. Some of the new programs started by the F&C division that are ongoing are: School Linked Services (SLS), Outpatient Ethnic Services and Full Service Partnership Programs.

The F&C system serves clients based on their age, and social, emotional, and behavioral health needs. The standard age breakdown used is:

- 0 to 5 years old (First 5)
- 6 to 11 years old
- 12 to 17 years old
- 18 to 25 years old (Transient Age Youth (TAY))

The largest age group served from 2010 to 2015 was the 12 to 17 age group, representing 24,403 clients (37% of clients served). For each of these age groups, there are specific programs within the F&C system of care designed to address their behavioral health issues by using age appropriate

assessment and evidence-based practices. In addition, these programs also offer training and support for the parents/guardians of these clients. One of the major training initiatives for the past several years is the *Triple Parenting Program (Triple P)* and *Strengthening Families*. Both programs are designed to establish a foundation for fostering resiliency and good social skills among children and youth, and confidence and positive relationship among parents during the early stages of a child's development.

Demographics

Consistently, the largest ethnic population served from fiscal year 2010 to 2015 is the Hispanic population. In 2015, 62% of the clients were Hispanic. This is a 75% increase in Hispanic clients from 2010 to 2015. Asian/Pacific Islander client counts increased by 15% while client counts for Blacks/African Americans declined by 15% during the same time period. Client counts for Whites remained stable throughout this time period. More than half of the clients within the F&C treatment system were males (55%) and 45% were females.

DISTRIBUTION OF CLIENTS, FISCAL YEAR 2015

		Percentage (%)
Gender	Male	55
	Female	45
Ethnic groups	Asian/Pacific Islander	8
	Black/African American	5
	Hispanic	62
	Native American	1
	Other	4
	Unknown	7
	White	14

In order to serve the diverse and growing population of Santa Clara County, the F&C system continually trains staff in cultural sensitivity and recruits bilingual staff representing the population served. There are 39 languages spoken by clients in the F&C mental health system. The five threshold languages (English, Spanish, Chinese, Tagalog and Vietnamese) account for 95% of the clients' languages. English and Spanish are the two most common languages spoken by the clients. The number of clients speaking English increased by 30%; from 7,550 clients in 2010, to 9,787 clients in 2015. The client counts of Spanish speakers increased by 106%; from 1,340 clients in 2010 to 2,386 clients in 2015. Chinese, Tagalog and Vietnamese account for 2% of the threshold languages; however, the number of clients speaking these three languages increased during this time period (Chinese: 61%, Tagalog: 11% and Vietnamese: 17%).

Program Outcomes

The Full Service Partnership (FSP) program has been operating for over five years. This is one of the intensive outpatient programs designed to treat clients with the highest needs. Emergency Psychiatric Services (EPS) admissions decreased by 20% among children and youth enrolled in FSP after one year

of enrollment in the program. Similarly, the arrest rates decreased by 85% among children and youth after enrolling in the FSP program.

FSP PROGRAM OUTCOMES

Outcomes		Percent change (+/-)
Change in EPS admissions	Children/youth	-20%
	TAY	27%
Change in arrests	Children/youth	-85%
	TAY	-91%

In the biannual state mandated Consumer Perception Survey (CPS) of the F&C system, clients were asked about their satisfaction level of the service and treatment they received. For the May 2015 survey, consumers gave the F&C system a high rating, especially for the culturally relevant treatment system.

CONSUMER PERCEPTION SURVEY RESULTS, MAY 2015

Domain	Average score	Rating
Access	4.41	Good
Treatment planning	4.28	Good
Services provided	4.39	Good

Substance Use Treatment Program

In 2015, the Behavioral Health Department's substance use treatment services provided services to 792 youth residing in the county. Evidence-based outpatient treatment is offered at 22 schools and 7 clinic sites. Nearly half of the referrals (49%) were from the Probation Department, followed by 25% from the Truancy Court, and 6% from Social Services Agency. Two percent of the referrals were youth self-referrals, and 18% were referred by various community sources such as schools, pediatricians and community organizations. Seventy two percent of youth reported they were Hispanic/Latino, 12% were White, 9% were Asian/ Pacific Islander, 5% were African American, and 2% were American Indian.

The age range of youth served was from 13 to 21 years. Nearly 3 in 4 youth (74%) were male, and 26% were female. More than 4 in 5 youth (82%) self-reported at intake that their primary drug of choice was marijuana while 12% described alcohol as their primary drug. Four percent of youth stated methamphetamines was their primary drug, followed by 1% reporting crack or cocaine, less than 1% reporting prescription drugs and less than 1% reporting heroin as their primary drug. Less than half of the youth (46%) reported using more than one substance.

Youth are assessed using the nationally recognized American Society of Addiction Medicine (ASAM) assessment tool which guides the placement of each youth in the appropriate level of treatment. Licensed and waived therapists, as well as multi-disciplinary teams, provided developmentally appropriate individual, family and group treatment based on each youth's individualized needs. Evidence-based modalities of treatment include *Seeking Safety* and *The Seven Challenges*.

Based on the ASAM assessment, youth needing residential care are placed in one of three substance use specific group homes that provided a recovery-oriented environment for youth with more serious symptoms. Twenty-six adolescent males and sixteen females received residential care in 2015, staying in treatment for an average of 45 days. Thirty-two residential youth self-identified as Hispanic, six as Caucasian, two as Hispanic-mixed, and one each as African American and Pacific Islander. Each youth is connected to aftercare treatment prior to leaving the residential program and re-entering the community.

School Linked Services

Research shows that high levels of parental and community involvement is strongly associated with improved student learning, attendance and behavior. The Santa Clara County School Linked Services (SLS) initiative, managed by the Behavioral Health Services Department, aims to systematically support some school districts in Santa Clara County in fostering family and community engagement in the schools. The SLS Coordinators, located at the school districts or school sites, develop partnerships with schools and community-based organizations to improve protective factors (e.g., family relationships), decrease risk-factors (e.g., behavioral and emotional problems), enhance service accessibility and resource linkage, and support children's success in school and life.

Within the first three quarters of fiscal year 2015-2016 (i.e., July 1, 2015 to March 31, 2016), over 16,954 services and referrals were provided to families at the SLS school districts. The services and referrals are categorized into four domains: family engagement, behavioral health services, resource referrals/linkages and social skills groups.

Family engagement include school-based workshops and events, such as parenting skill workshops, nutrition education classes and coffee with the principals. **Behavioral health services** include evidence-based modules such as the Prevention and Early Intervention (PEI) services (e.g., Strengthening Families, Triple P, Brief Family Therapy and Trauma-Focused Cognitive Behavioral therapy). **The social skills group education**, intended for students, focused on topics such as drug prevention and respecting each other.

In terms of the PEI behavioral health services, program evaluation is conducted annually where parents and teachers of the child receiving behavioral health services complete a pre and post survey. The most recent program evaluation in FY 2014-2015 showed a statistically significant improvements in a child's behavior (i.e., pre average score of 53.1 to post average score of 47 from parent surveys; and pre average score of 51 to post average score of 33.8 from teacher surveys) and the degree to which a child's behavior is problematic (i.e., pre average score of 56.5 to post average score of 49.7 from parent surveys; and pre average score of 49.4 to post average score of 33.2 from teacher surveys).

SANTA CLARA VALLEY MEDICAL CENTER

Santa Clara Valley Medical Center Pediatric Primary Care

Santa Clara Valley Medical Center (SCVMC) has served as a regional pediatric center for more than 50 years. With more than 80 board certified specialists in pediatrics and neonatology, the Pediatrics Department provides quality care in nearly every pediatric sub-specialty. The table below provides the number and percentage of SCVMC pediatric primary care patients who are overweight or obese. Approximately 1 in 5 (18.12%) patients are overweight and 23.13% are obese. Male patients are more likely to be obese (24.97%) than female patients (21.20%), but the percentage is similar for overweight. Hispanic/Latino patients are more likely to be either overweight (18.88%) or obese (25.21%) than other racial/ethnic groups. The percentage overweight or obese increases with age, with patients ages 12 to 17 most likely to be overweight (20.57%) or obese (27.24%). Patients in foster care are less likely to be overweight or obese than patients who are not in foster care.

PERCENTAGE OF SCVMC PEDIATRIC PRIMARY CARE PATIENTS WHO ARE OVERWEIGHT OR OBESE (JANUARY 1, 2015-JUNE 30, 2016) (N=22,544)

		Overweight	Obese
		85th to <95th percentile	>95th percentile
		% (N)	% (N)
All pediatric patients ages 2-17	All	18.12% (4086)	23.13% (5215)
Gender	Male	18.29% (2113)	24.97% (2884)
	Female	17.95% (1973)	21.20% (2331)
Race/ethnicity	African American	17.66% (119)	17.80% (120)
	Asian/Pacific Islander	13.67% (245)	13.67% (245)
	Hispanic/Latino	18.88% (3390)	25.21% (4526)
	White (non-Hispanic)	15.53% (194)	16.09% (201)
	Two or more races	10.39% (8)	12.99% (10)
	Unknown/refused/other	16.35% (128)	13.79% (108)
Age group	2-5	14.86% (1087)	16.22% (1187)
	6-11	19.11% (1741)	25.92% (2362)
	12-17	20.57% (1258)	27.24% (1666)
In foster care [^]	Yes	15.50% (62)	20.75% (83)
	No	18.17% (4024)	23.18% (5132)

Note: Table includes only pediatric patients whose height and weight were measured during a visit to a pediatric primary care department from January 1, 2015 to June 30, 2016. The calculation of overweight and obesity among pediatric primary care patients requires that both height and weight be measured on the same day during a primary care visit from January 1, 2015 to June 30, 2016. A significant number of primary care patients had either height or weight measured during a visit in this time period, but not both. Given this, the actual number and percentage of patients who are overweight or obese may differ from the data presented here.

^Definition of "in foster care" includes those pediatric patients who have an ICD-10 diagnosis of z62.1 in their HealthLink record. Although these diagnoses are regularly updated, the diagnosis may not have been removed for some patients who are no longer in foster care. The total number of patients who met this definition was 1,634. Of these patients, 400 had had their height and weight measured in a pediatric primary care department from January 1, 2016 to June 30, 2016.

Source: Santa Clara Valley Health and Hospital System, HealthLink, January 1, 2016 to June 30, 2016 (data extracted on 8/31/16)

Silicon Valley Medical-Legal Partnership Clinic at Santa Clara Valley Medical Center Pediatrics

Founded in 2009, the Santa Clara Valley Medical-Legal Partnership Clinic (MLPC) is a collaboration between Santa Clara Valley Medical Center (SCVMC) and Legal Advocates for Children and Youth (LACY), a non-profit legal aid organization. The mission of the partnership is to provide free legal services or referrals for children and youth who are patients at SCVMC or one of its clinics^{xxvii} in order to improve health, and to encourage collaborative work between doctors and lawyers to improve health. The MLP Clinic has two main components: providing legal assistance to patients in need, and providing education to medical staff, residents, and students about legal issues that affect patients.

Doctors are in a unique position to learn about families' living conditions and other social determinants of health. For example, people who live in housing with mold or rodents, in clear violation of sanitary codes, are in a physical environment that leads to illness or exacerbates existing health conditions. Furthermore, issues like unaddressed bullying or lack of access to special education services affect school success among children and youth. Children who do not complete high school are more likely to have poor health and engage in criminal activity than those with higher educational levels.⁵ These social determinants of health constitute health-harming legal needs, and they can be treated effectively with some level of legal care. That is why collaboration between doctors and lawyers is so important; many health problems can be remedied by legal advocacy that will significantly improve the health of children and families.

There are currently 294 medical-legal partnerships in health care institutions in 41 states across the country. The Silicon Valley Medical-Legal Partnership Clinic at Santa Clara Valley Medical Center Pediatrics is one of the early innovators in the South Bay Area.

All legal services are free for children and youth and are completely confidential. Families can ask to be referred to the Medical-Legal Partnership (MLP) clinic by their doctor, nurse, or medical social worker, or any member of the healthcare team. Families can also call the intake coordinator themselves, or go to 3 SCVMC clinic locations during walk-in clinic hours. MLP clinic can help with questions about:

- Guardianship
- Paternity, custody, and visitation for teen parents
- Public benefits for children and youth such as Supplemental Security Income (SSI), disability or food stamps

^{xxvii} Three SCVMC clinics: Valley Health Center (VHC) Bascom, VHC Downtown, and VHC Gilroy

- Educational programs including special education or individualized educational programs (IEP)
- Housing rights
- Domestic violence involving teens
- Immigration questions like Special Immigrant Juvenile Status and The DREAM Act

SANTA CLARA FAMILY HEALTH PLAN

HEDIS Measures for the Medi-Cal Managed Care Child and Adolescent Population and the Healthy Kids Program

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of health plans in the United States to measure performance on key dimensions of care and service. The HEDIS system enables comparison of the performance of health plans, and in turn, health plans use HEDIS results to help focus improvement initiatives. HEDIS includes a number of quality care measures related to preventive care for child and adolescent health, such as childhood and adolescent immunization status and Body Mass Index (BMI) assessment.⁶ This section reports on HEDIS measures for the 2014 service year (reported in 2015) for Santa Clara Family Health Plan (SCFHP), the local, public, not-for-profit health plan dedicated to improving the health and well-being of the residents of Santa Clara County. SCFHP offers comprehensive healthcare coverage through several programs, including Medi-Cal and Healthy Kids.⁷ In 2014, SCFHP served more than 50,000 children and adolescents through its Medi-Cal Managed Care (MMC) program for children and adolescents, and approximately 4,700 children through the Healthy Kids program, a locally funded health insurance program for children who did not qualify for Medi-Cal. Healthy Kids program covers children up to age 19 years in families with incomes up to 300% of the federal poverty level.

Compared to Medicaid percentiles, HEDIS measures for 2015 for the SCFHP MMC population are higher for well-child visits for children; immunizations for adolescents; medication management for people with asthma; and weight assessment and counseling for BMI (documentation of assessment), nutrition, and physical activity. For example, 78.35% of the SCFHP MMC population had a well-child visit in the third, fourth, fifth, and sixth years of life, which is above the Medicaid 75th percentile (77.26%). The percentages of SCFHP MMC patients meeting HEDIS standards are also high for access to primary care and childhood immunization, though statistically lower than Medicaid rates due to the tight distribution of results. For example, nearly all (94.65%) SCFHP MMC patients had access to a primary care provider for ages 12 to 24 months. While this is between the 10th and 25th percentiles for Medicaid (93.58% and 95.92%), the access to primary care measure has very tight percentile distribution, with less than 5% separating the 10th percentile from the 90th percentile. While the comparison to Medicaid percentiles is accurate, use of percentile comparisons does not assist in drawing meaningful conclusions.

Statistics for Healthy Kids members show some differences from data for Medi-Cal members, with Healthy Kids members more likely to have received specific immunizations by their 2nd and 13th birthdays, but less likely to have access to a primary care provider than the SCFHP MMC population

for most age groups or to have completed well-child visits. The Healthy Kids program should not be compared to Medicaid percentiles, as the Healthy Kids program is a local insurance program with no comparable national patient population.

Annual dental visits were reported for Healthy Kids only, as the dental benefit for Medi-Cal members is provided through Denti-Cal. The percentage of Healthy Kids members with at least one dental visit during the measurement year was highest among those ages 11 to 14 (66.45%) and lowest among ages 2 to 3 (9.68%).

HEDIS MEASURES FOR SANTA CLARA FAMILY HEALTH PLAN (SCFHP) MEDI-CAL MANAGED CARE AND HEALTHY KIDS PATIENTS, 2015 (FOR 2014 SERVICE YEAR)

Measure	SCFHP Medi-Cal Managed Care 2015	SCFHP Healthy Kids 2015	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
	%	%	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Children and Adolescent Access to Primary Care Practitioners, Ages 12-24 Months	94.65	1	93.58	95.92	96.96	97.86	98.53
Children and Adolescent Access to Primary Care Practitioners, Ages 25 Months-6 Years	87.69	71.76	82.16	86.07	89.08	91.73	93.58
Children and Adolescent Access to Primary Care Practitioners, Ages 7-11	90.15	60.98	83.57	87.78	91.15	91.15	95.19
Children and Adolescent Access to Primary Care Practitioners, Ages 12-19	86.77	53.74	81.57	85.83	89.98	89.98	94.42
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.35	70.59	60.18	65.97	71.76	77.26	82.69
Adolescent Well-Care Visit	Not reported	48.91	NA	NA	NA	NA	NA
Childhood Immunization Status [^]	71.53	87.18*	58.70	66.67	72.33	77.78	80.86
Immunizations for Adolescents [#]	81.27	93.29	53.94	61.70	71.29	80.90	86.46

Medication Management for People with Asthma, Medication Compliance 50%*							
Ages 5-18	59.94	40.74*	43.59	47.88	54.07	58.94	66.96
Ages 5-11	58.51	36.36*					
Ages 12-18	52.40	43.75*					
Medication Management for People with Asthma, Medication Compliance 75%*							
Ages 5-18	37.01	Not reported	20.07	24.55	30.19	35.37	43.08
Ages 5-11	33.70	Not reported					
Ages 12-18	32.27	Not reported					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/Adolescents	76.64	Not reported	32.18	41.85	57.40	73.72	82.46
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Counseling for Nutrition	74.94	Not reported	40.74	50.00	60.58	69.21	77.47
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Counseling for Physical Activity	61.80	Not reported	33.77	41.67	51.16	60.82	69.76
Annual Dental Visit: Ages 2-3	Not reported	9.68	NA	NA	NA	NA	NA

Annual Dental Visit: Ages 4-6	Not reported	51.70	NA	NA	NA	NA	NA
Annual Dental Visit: Ages 7-10	Not reported	62.74	NA	NA	NA	NA	NA
Annual Dental Visit: Ages 11-14	Not reported	66.45	NA	NA	NA	NA	NA
Annual Dental Visit: Ages 15-18	Not reported	61.92	NA	NA	NA	NA	NA
Annual Dental Visit: Age 19	Not reported	61.76	NA	NA	NA	NA	NA

Note: The Medicaid percentile corresponding to the SCFHP Medi-Cal Managed Care HEDIS outcome is highlighted in green.

^ Reported for the following combination: Four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV) by second birthday.

Reported for the following combination: one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by 13th birthday.

* Identifies the percentage of children ages 5 to 20 with persistent asthma who were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: The percentage who remained on an asthma controller medication for at least 50 percent of their treatment period and the percentage who remained on an asthma controller medication for at least 75 percent of their treatment period.

Source: Santa Clara Family Health Plan, 2015.

PARTNER AGENCIES AND COMMUNITY ORGANIZATIONS

This section highlights select partner agencies and community organizations which provide services in Santa Clara County with a focus to improve the health of children, youth and their families. The section includes eclectic narratives compiled by individual agencies and organizations with minimal editing by the assessment team.^{xxviii} The team acknowledges the significant contributions of these agencies and organizations in improving the health of children and youth in the county.

Bill Wilson Center

For hundreds of homeless, disconnected Lesbian, Gay, Bisexual and Transgender (LGBT) youth in Santa Clara County, daily life is fraught with perils that no child should have to face. Severe harassment, physical and sexual harm, rejection from family, and the prospect of not knowing where they will sleep at night significantly harms the health and well-being of these youth.⁸ Bill Wilson Center (BWC) aims to address the challenges and barriers LGBT youth face when they are rejected by their family due to their sexual orientation or gender identity and end up on the streets. LGBT youth face a particular set of challenges, more so if they are also homeless or trying to avoid homelessness.

Nationwide, we are seeing a new epidemic of homeless LGBT youth largely because youth are coming out earlier. In fiscal year 2014-2015, 30% of the youth accessing services at BWC self-identified as LGBT. Of the 900 unduplicated transition-age youth served by BWC during this time period, 264 self-identified as LGBT. Of these youth, 68% were currently, or had been, in the foster care or juvenile justice system at some point in their lives. Youth of color were over-represented, with 52% of youth served being Latino, 18% African American and 3% Asian. The majority of youth (88%) self-reported that they were ejected from their homes due to their sexual orientation/gender identity. All youth (100%) acknowledged that they have been participating in "risky" behaviors such as drug usage, sex trafficking, pan-handling, unprotected sexual behaviors and criminal activities.

LGBT youth, especially transition age youth (TAY), have long been identified by BWC as an underserved and very vulnerable population, with very specific mental health and support needs. Because of these identified needs, comprehensive services at the Drop-In Center (DIC) have been targeting LGBT youth (e.g. inclusive workshops, education, health care) for years. The DIC has historically been a place where all youth are welcomed and the atmosphere is one of acceptance and compassion for youth from every type of background.

In 2014-2015, BWC provided outreach and engagement services to 464 LGBT youth, and connected 242 LGBT youth to comprehensive services through our Drop-In Center. This included housing access/support, mental health support, physical health services, life skills and employment development, educational services, peer counseling, case management, and for some, family reconnection services. Research shows that families, parents, foster parents/caregivers and guardians can have a very dramatic impact on their LGBT children. Family rejection has a serious impact on a gay or transgender young person's risk for health and mental health problems.⁹ Sixty LGBT youth

^{xxviii} The list of agencies and organizations is arranged alphabetically.

were "reconnected" to a significant family member through a careful, trauma-informed care approach based on the *Family Acceptance Project*. BWC found that family acceptance promotes well-being and helps protect LGBT young against various risk factors. Although the goal was not necessarily "reunification," having reconnected with family proved to be a significant motivating factor for the youth to work on his/her issues.

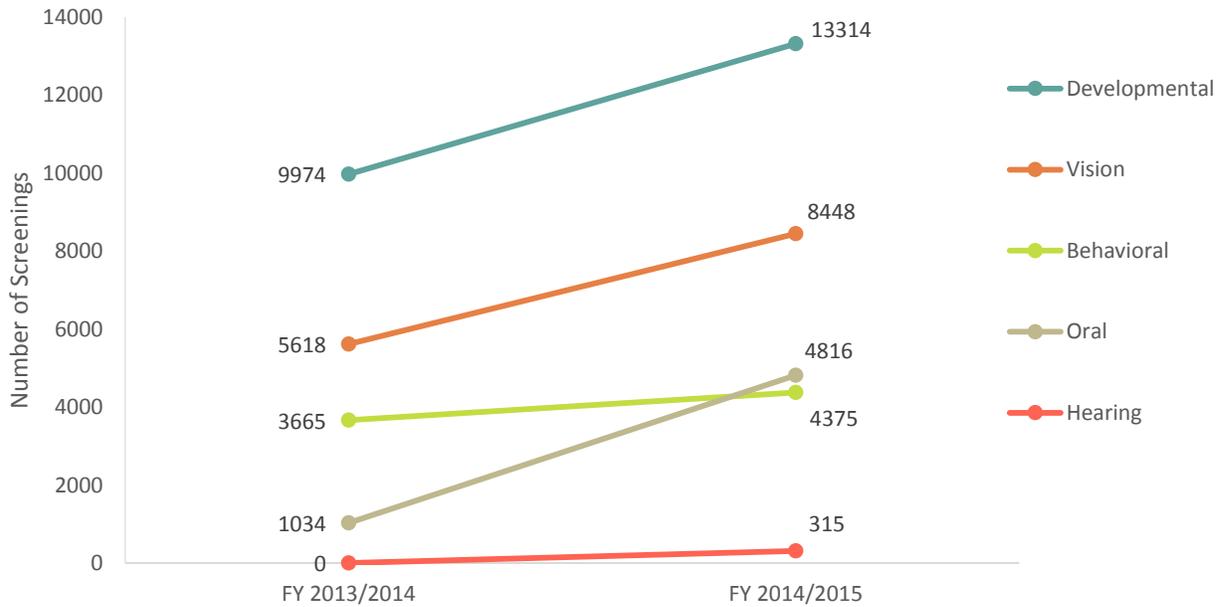
First 5 Santa Clara County

FIRST 5 Santa Clara County's (FIRST 5) Children's Health and Wellness Initiative provides a systemic approach to ensure children ages 0 to 5 years receive routine health screenings (vision, hearing, oral, developmental and social-emotional) and connections to early interventions services, in partnership with Santa Clara Valley Health and Hospital System, Behavioral Health Services Department, Healthier Kids Foundation, The Health Trust, Children's Dental Group, and Gardner Family Health Network.

For the youngest children, routine health care can make the difference between a strong beginning and a fragile start.¹⁰ Health prevention efforts through physical and developmental health screenings help with early identification of potential problems with hearing, vision, and oral health, and developmental and/or behavioral delays. Using advanced, state-of-the-art equipment, such as the *Digital Optic Scan Camera* for vision screening, the *Optoacoustic Emission (OAE) equipment* for hearing screening, and the standardized *Ages and Stages Questionnaires-3rd Edition (ASQ-3)* and *ASQ: Social-Emotional*/screening tool for developmental and behavioral health screening, children with potential concerns are identified and connected to early intervention services. Early intervention services provided by service providers trained in evidence-based practices support children's healthy development and readiness for school and beyond by supporting them to meet developmental and behavioral milestones, have corrected vision, better hearing and healthier teeth and gums.¹¹

In fiscal year 2014-2015, FIRST 5 partners conducted more developmental, vision, behavioral, oral and hearing screenings than the previous year. Of particular note, there was a 50% increase in the number of vision screenings and a 33% increase in the number of developmental screenings from fiscal year 2013-2014 to fiscal year 2014-2015.

INCREASE IN THE NUMBER OF HEALTH SCREENINGS CONDUCTED (BY TYPE) FROM FY 2013/2014 TO FY 2014/2015



Note: Hearing screenings began in FY 2014-2015
 Source: FIRST 5

In Fiscal Year 2014-2015, FIRST 5 partners conducted 31,268 health screenings (54% increase from last fiscal year): 13,314 developmental screenings, 8,448 vision screenings, 4,816 oral health screenings, 4,375 behavioral health screenings, and 315 hearing screenings. Of the 31,268 health screenings conducted, 33% indicated a potential developmental, behavioral, or physical health concern; and 73% of children who flagged on a health screening were connected to early intervention services, such as optometrists, audiologists, dentists, behavioral and/or therapeutic services.

More children were screened and connected to early intervention services

31,268

HEALTH SCREENINGS (VISION, HEARING, ORAL, DEVELOPMENTAL, BEHAVIORAL) WERE CONDUCTED



THIS IS A
54% ↑
 INCREASE FROM
 LAST FISCAL YEAR

Evaluation findings indicate that identified children connected to early intervention services show improved vision, oral, hearing, developmental and behavioral health outcomes (e.g., corrected vision with eye glasses, healthier teeth with comprehensive dental care, improved hearing with hearing aids, and enhanced child and family functioning with strengthened parent-child relationships and ability to cope with trauma).

Healthier Kids Foundation

Healthier Kids Foundation Santa Clara County believes that even one child without access to healthcare or health coverage is one child too many and that health greatly impacts a child's educational attainment. Possessing a "*Healthier Earlier*" philosophy at its core, Healthier Kids Foundation is the only nonprofit organization in Santa Clara County that solely focuses on improving children's health, with an emphasis on prevention and wellness.

... when she first picked up her glasses she looked around the room and she shouted "I see so clearly." It was like she was seeing the world more clearly. This moment brought tears to my eyes. After receiving glasses, my daughter made the Honor Roll for the first time ...

Healthier Kids Foundation (HKF) connects with community partners in over 584 sites to strengthen the quality of its services and support for families, such as Head Start preschools, State preschools, Transitional Kindergartens (TK California), elementary, middle, and high schools, county/community clinics, local hospitals, community-based organizations, county Public Health Department and many others. HKF administers six programs that address the needs of children ages 0 to 18. Since inception of each program, HKF has:

- Visited 5,156 mothers beside in three hospitals and assisted with the process to enroll 4,287 newborns into Medi-Cal through the Baby Gateway Program
- Identified 4,404 uninsured children and assisted them with enrolling into healthcare coverage;
- Screened 38,798 children for vision issues (over 1,956 children have received glasses), 19,091 children for oral health issues (over 2,263 children have received dental care), and 5,203 children for hearing issues; all children getting a referral receive case management assistance; and
- Delivered "*10 Steps to a Healthier You*" healthy lifestyle parenting workshops to 3,737 parents/caregivers

Three of the most critical, yet often overlooked, fundamentals of pediatric health are proper vision, dental, and hearing screening – the first line of defense for early detection and treatment of a number of problems. Common conditions, such as strabismus (misaligned vision) and hearing loss, can develop in infants or young children, often

without any obvious symptoms. If these problems are caught early, then they can be treated with a high rate of success, often using non-invasive techniques. Unfortunately, the negative effects of not receiving treatment early are long-lasting. The need for proper screening is clear:

... my son benefited from this program because we were able to get the services he needed early on and I know that is going to make a difference in his life in the long run ... there are people that also care for my child and want the best for him. ...

- Approximately 80% of children's learning is visual
- An estimated 80% of children with a learning disability have an undiagnosed vision problem.
- An estimated two out of every 100 children under 18 has undetected hearing loss. Hearing loss is the top cause of delayed speech/language development.
- Approximately 25% of children dental screened have urgent/emergency needs.

According to the 2014 Obesity, Physical Activity, and Nutrition in Santa Clara County Report, 18-28% of children ages 5 to 11 using Santa Clara County Children Healthy and Disability Prevention (CHDP) program have Body Mass Index (BMI) more than 85%, with higher rates among Latino children (up to 32%) for that age group.

HKF's delivery model is innovative. Partnering with schools to offer onsite health screenings is a cost-effective approach to identifying children who need care. The model is incredibly efficient as

... I really liked that I got a call from you guys ... you were very patient and explained the results and the possible reasons ... I just felt someone cared for my child's health. ... I am very happy that my child finally received services that he needed ... feel at peace when sleeping because I notice that his breathing is normal. ...

screenings are provided in a location where children already spend a great deal of time. And it's equally beneficial for schools that are required to offer screenings, yet do not have the staff or resources to provide proper testing. HKF uses the latest technology to increase efficiency and case managers call parents of children that receive a referral up to eight times to assist parents in accessing the correct services needed. "10 Steps" classes are taught to parents at sites convenient to parents and include child care for small children.

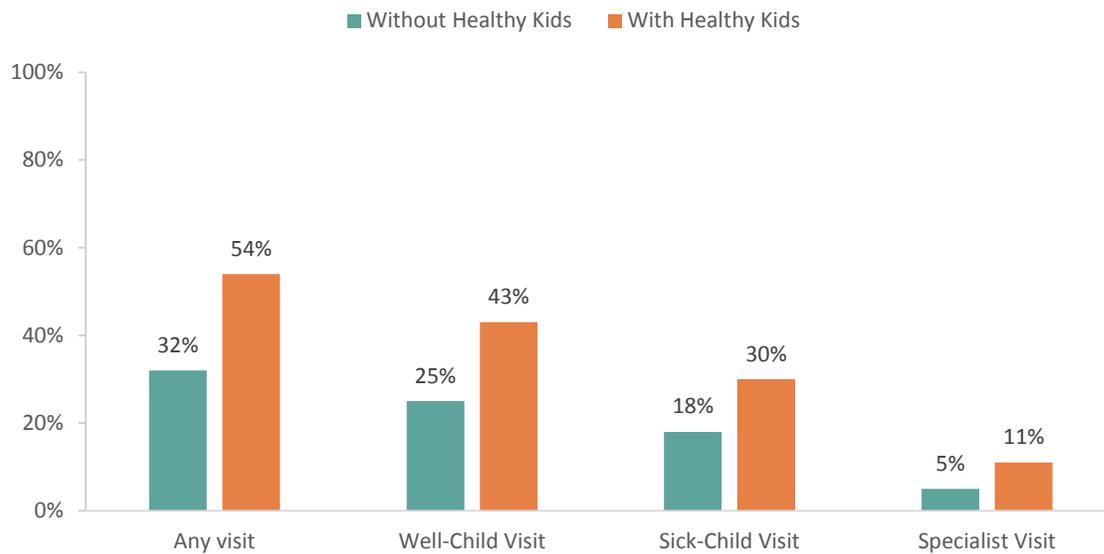
Healthy Kids Program

The Healthy Kids program is a component of the Santa Clara County Children's Health Initiative (CHI) that expands health insurance coverage among children in the county. The Healthy Kids program provides coverage to over 13,000

children in the county with household incomes up to 300 percent of the federal poverty level who are ineligible for the two major California state insurance programs, Medi-Cal and Healthy Families, for reasons such as immigration status. Evaluations of the program demonstrated short-term and intermediate impact of the program on children’s health status and access to medical and dental care.

Overall, the percentage of children who accessed medical and dental care was higher among children who were enrolled in the program for at least one year compared to children who were recently enrolled in the program.

IMPACT OF HEALTHY KIDS PROGRAM ON USE OF MEDICAL CARE IN THE PAST SIX MONTHS AMONG CHILDREN



Source: Evaluation of the Santa Clara County Children’s Health Initiative, In brief number 4, March 2007

In Santa Clara County, the percentage of children with fair or poor health decreased to 4%.

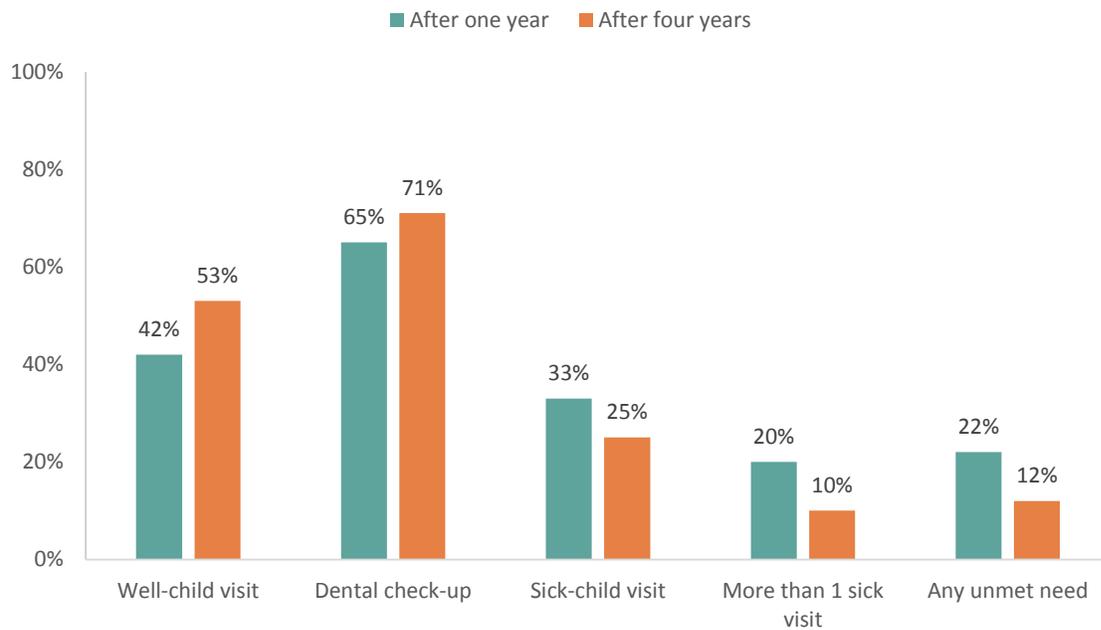
- 2016 Child Health Intercept Survey

Among children who enrolled for a nonmedical reason, significant differences were observed between program participants after one year of enrollment and those who were recently enrolled. The percentage of children with fair or poor health was lower among children who had Healthy Kids coverage for at least one year (12%) compared to children recently enrolled in the program (18%). Furthermore, after one year in the program, a lower percentage of children missed 3 or more school days in the past month due to health problems (5%) than those who recently enrolled in the program (11%).

After four years of Healthy Kids coverage, children continued to experience additional benefits from having a stable healthcare coverage. A comparison of children's

experiences after four years of Healthy Kids coverage with their experiences after one year showed that children received more preventive, specialty and oral health care. The percentage of well-child visits increased from 42% after year one to 53% after four years. Children with four years of coverage experienced declines in the use of sick care. The percentage of children with multiple sick visits in the past 6 months declined from 20% after year one to 10% after four years in the program. Children also experienced improvements in dental care. The percentage of children with a usual source of dental care increased significantly from 83% after year one to 90% after year four.

HEALTHCARE UTILIZATION IN THE PAST 6 MONTHS AMONG CHILDREN ENROLLED IN THE HEALTHY KIDS PROGRAM



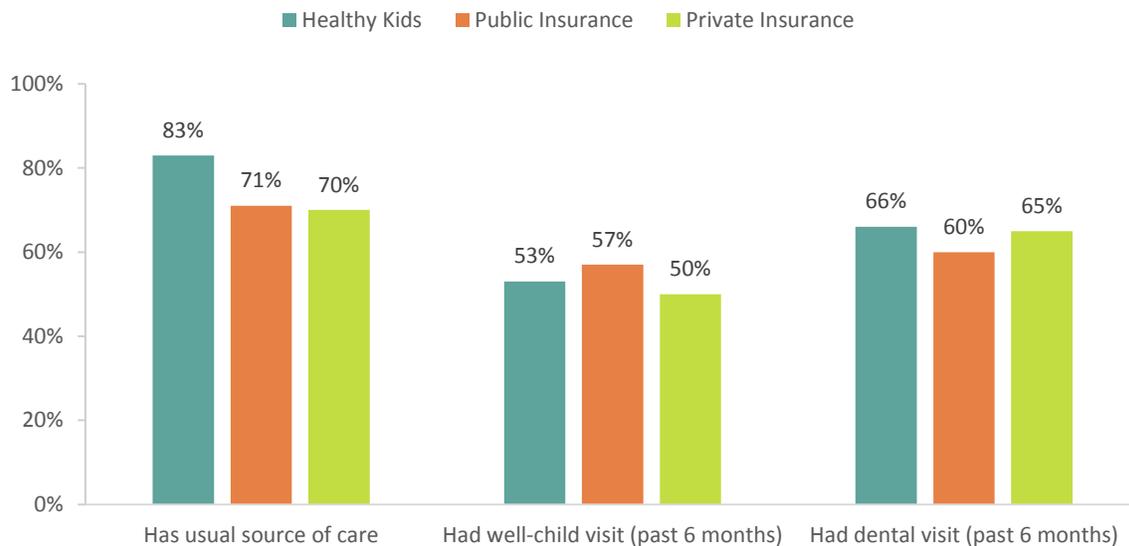
Source: Evaluation of the Santa Clara County Children’s Health Initiative, In brief number 5, June 2007

In Santa Clara County, the percentage of children with a usual source of care (Medical Home) was 92% in 2016.
 - 2016 Child Health Intercept Survey

Unmet healthcare needs among children declined. The percentage of parents reporting that their child had an unmet healthcare need (medical or dental) declined from 22% after one year to 12% after four years in the program. Additionally, a lower percentage of parents reported being very or somewhat worried about meeting their children’s healthcare needs after four years in the program (61% after year one to 38% after four years).

After four years of Healthy Kids coverage, children ages 12 to 17 had similar healthcare utilization (usual source of care, preventive medical visit, and preventive dental visit) compared to children with other healthcare coverage who had similar socio-demographic characteristics.

CHILDREN'S HEALTHCARE ACCESS AND USE BY INSURANCE COVERAGE TYPE AMONG CHILDREN AGES 12 TO 17



Source: Evaluation of the Santa Clara County Children's Health Initiative, In brief number 5, June 2007

Kidsdata.org

Kidsdata.org, a program of Lucile Packard Foundation for Children's Health, promotes the health and well-being of children in California by providing an easy to use resource that offers high-quality, wide-ranging, local data to those who work on behalf of children.

Through Kidsdata.org, the foundation aims to raise the visibility of key issues affecting California's children and make it easy for leaders and policymakers to use data in their work, whether that's assessing community needs, setting priorities, tracking progress, making program or policy decisions, preparing grant proposals and reports, or other work.

According to 2015 data that can be customized, visualized and downloaded from Kidsdata.org:

- In 2015, nearly 5 percent of the state's child population resided in Santa Clara County.
- In 2015, more than 1 in 3 children (36%) in Santa Clara County were of Hispanic/Latino descent, followed by 32% Asian American and 24% White.
- In 2015, nearly 1 in 4 students (24%) in Santa Clara County were English Learners.
- In 2015, 1 in 10 students (10%) in Santa Clara County were enrolled in special education.
- In 2015, more than 1 in 10 students (11%) in Santa Clara County did not complete high school education.
- In 2014, there were more than 2,000 substantiated cases of child abuse and neglect in Santa Clara County.
- In 2014, there were 1,254 juvenile felony arrests in Santa Clara County.

- In 2014, there were nearly 1,400 children in foster care in Santa Clara County.
- In 2013, 11 children ages 0 to 19 committed suicide in Santa Clara County.
- In 2012, 1 in 5 children (20%) in Santa Clara County lived in a food insecure household.
- In 2014, nearly 4 in 10 children (39%) in Santa Clara County were eligible to receive free or reduced price school meals.
- In 2014, 4,549 public school students in Santa Clara County were homeless.
- In 2015, more than 3 in 10 students in grade 5 (35%), grade 7 (32%) and grade 9 (31%) in Santa Clara County were overweight or obese.

Kidsdata.org allows users to easily find, customize, and use data on more than 500 measures of child health and well-being. Data are available for every county, city, school district, and legislative district in California.

The Foundation also invests in promoting systems that offer high-quality, family-centered, culturally competent, and coordinated care within a medical home for children with special health care needs.

Santa Clara County Dental Society

Each February, to observe National Children’s Dental Health Month, Santa Clara County Dental Society teams with local schools, and Boys and Girls Clubs to screen children for dental problems with a program called *“Give Kids a Smile.”* This helps the school nurses meet their requirement for screening, and helps families get their children into dental care if it is needed. In 2016, 68 dentist volunteers visited 43 schools and 3 Boys and Girls Club locations to screen 5,149 students. Each child is categorized into the following recommendations: no obvious problem found; early dental care recommended, urgent care needed; evidence of dental care per child report; early orthodontics needed; and visible decay present. Results are compiled by school and given to the school nurse, who then works with parents of children who need care. Nurses work with the Dental Society to get children into dentist offices if the family does not have other access and cannot afford dental care.

Santa Clara County Dental Society represents more than 1,600 local dentists and is a component organization of the California Dental Association and the American Dental Association. *“Give Kids A Smile”* is one of several projects local dentists support to improve the oral health status of children in the community.

Second Harvest Food Bank of Santa Clara and San Mateo Counties

Despite the booming economy, local hunger remains pervasive. Second Harvest Food Bank is not seeing a decline in the number of people who need food assistance. In fact, the number is rising. Second Harvest provides food to 250,000 people every month – that’s 1 in 10 people in Santa Clara and San Mateo counties.¹² The high cost of housing is making it difficult for lower-income families to make ends meet. Since 2010, the average rent in San Jose has increased by 65%.¹³

Every year, Second Harvest partners with Santa Clara University’s Leavey School of Business to release the *Hunger Index*, a measure of the gap between how many meals are needed for low-income residents in Santa Clara and San Mateo counties to eat three meals a day and how many they are

able to purchase on their own or acquire through food-assistance programs. The most recent *Hunger Index* shows a meal gap of 125 million meals in Santa Clara County.¹⁴

The fact that so many local families are struggling to put food on the table doesn't bode well for kids who need nutritious food to grow up healthy. Hunger is particularly concerning among kids because it can have a devastating impact on their futures. Hunger and food insecurity can hurt kids' ability to perform well at school, depriving them of a decent education.

Studies show that kids who are food insecure have more frequent stomach aches, headaches, colds, hospitalizations, anemia, chronic health conditions, anxiety, depression, and difficulties at school.¹⁵ They also have more difficulty with interpersonal skills, self-control, attentiveness, flexibility, and persistence.¹⁶ Infants who are food insecure are more likely to have insecure attachments and perform more poorly on cognitive tests.¹⁷

Second Harvest is working to ensure kids and families have access to the nutritious food they need to thrive, but the Food Bank can't solve local childhood hunger alone. School meals play an important role in keeping kids nourished. In Santa Clara County, 38% of kids qualify for free or reduced-price school meals.¹⁸ Of those who qualify, 68% participate in the school lunch program while only 35% participate in the school breakfast program. Additional federal meal reimbursements that could be received per school year with increased breakfast participation was \$9,239,000 in 2014-15. During the summer months, the percentage of school lunch participants reached through the federal summer meal program is a strikingly low 19%.¹⁹

A recent report by the Food Research and Action Center shows that providing breakfast after school starts instead of before increases access to a nutritious breakfast and contributes to an enhanced learning environment. According to the report, 82% of principals surveyed reported increased school breakfast participation by serving breakfast after the bell, 66% reported fewer occurrences of student hunger, 46% reported improved student attentiveness, 33% reported fewer tardy students, 22% reported fewer visits to the school nurse, 21% reported fewer school absences, and 18% reported fewer disciplinary referrals.²⁰

More than 85,000 kids in Santa Clara and San Mateo counties rely on Second Harvest for food every month. Second Harvest ensures that kids have access to healthy, nutritious food in a number of ways. The Food Bank provides groceries and fresh produce to families through its *Family Harvest*, *Produce Mobile*, and *School Pantry* programs. Second Harvest also distributes food to families through a network of nearly 330 nonprofit partners at more than 700 sites up and down the peninsula, including pantries, shelters, after-school programs, and soup kitchens. In addition, Second Harvest has a team of nutritionists who work out in the community helping local families prepare more nutritious meals and eat healthier. The Food Bank also collaborates with schools, libraries, and community organizations to provide summer feeding sites for kids during the summer, a particularly tough time for families because kids lose access to the free and reduced-price meals they receive at school.

We know how critical good nutrition is for proper development, so we have to pull every lever available to us to connect kids and their families to healthy food. That means working together to

leverage federally funded nutrition programs such as *CalFresh*, *National School Lunch and Breakfast Program*, *Summer Food Service Program*, and *WIC* to achieve full participation by eligible children. It is also imperative that we work with elected officials and public agencies to make policy and institutional changes that will strengthen the nutritional safety-net. There is also an opportunity to link eligible children to funded nutrition programs within the medical community and educational systems.

REFERENCES

- ¹ Houtrow AJ, Okumura MJ, Hilton JF, andRehm, RS. Profiling Health and Health Related Services for Children with Special Health Care Needs with and without Disabilities. *Academic Pediatrics*. 2011;11(6), 508–516.
<http://doi.org/10.1016/j.acap.2011.08.004>.
- ² California Department of Health Care Services. California Children's Services. (n.d.). California Department of Health Care Services. <http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx>. Updated 9/27/2016. Accessed September 4, 2015.
- ³ Kidsdata.org Data and Resources about the Health of Children. Kidsdata.org. <http://www.kidsdata.org/>. Accessed September 4, 2015.
- ⁴ Centers for Disease Control and Prevention. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. Centers for Disease Control and Prevention. <https://www.cdc.gov/sids/data.htm>. Updated 2/8/2016. Accessed 2016. August 9, 2013.
- ⁵ Kidsdata.org. Summary: High School Graduation Kidsdata.org. <http://www.kidsdata.org/topic/21/high-school-graduation/summary#jump=why-important>. Accessed 2016.
- ⁶ The National Committee for Quality Assurance (n.d.). HEDIS® and Quality Compass. The National Committee for Quality Assurance (n.d.). <http://www.ncqa.org/hedis-quality-measurement/what-is-hedis>. Accessed June 7, 2016.
- ⁷ The Santa Clara Family Health Plan (n.d.). Healthcare plans. <https://www.scfhp.com/>. The Santa Clara Family Health Plan (n.d.). Accessed June 7, 2016.
- ⁸ Ray N. Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness. New York: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless; 2006.
- ⁹ Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. *Journal of the American Academy of Pediatrics*, 2009; 123:346-352.
- ¹⁰ Shonkoff J, & Phillips D. From neurons to neighborhoods: The science of early child development. Washington, D.C.: National Academy Press;2000.
- ¹¹ Heckman JJ. Investing in disadvantaged children is an economically efficient policy. Paper presented at the Committee for Economic Development/Pew Charitable Trusts/PNC Financial Services Group Forum on "Building the Economic Case for Investments in Preschool." January 2006.
- ¹² Second Harvest Food Bank of Santa Clara and San Mateo Counties
- ¹³ Rent Jungle. Rent trend data in San Jose, California. Rent Jungle. <https://www.rentjungle.com/average-rent-in-san-jose-rent-trends/>. Accessed 2016.
- ¹⁴ Hunger Index, Santa Clara University Leavey School of Business
- ¹⁵ Nord M, Coleman-Jensen A, Andrews M, and Carlson S. Household Food Security in the United States, 2009. ERR- 108, U.S. Dept. of Agriculture, Econ. Res. Serv. November 2010.
- ¹⁶ Howard LL, Does food insecurity at home affect non-cognitive performance at school? A longitudinal analysis of elementary school classroom behavior. 2010 *Economics of Education Review* 20, 157-176
- ¹⁷ Zaslow M, Bronte-Tinkew J, Capps R, Horowitz A, Moore KA, Weinstein D.. Food security during infancy; Implications for attachment and mental proficiency in toddlerhood. 2009 *Maternal and Child Health Journal* 13(1) 66-80.
- ¹⁸ As cited on kidsdata.org, California Dept. of Education, Student Poverty FRPM Data (Mar. 2016); U.S. Dept. of Education, NCES Digest of Education Statistics (Mar. 2016).
- ¹⁹ California Food Policy Advocates. Nutrition and Food Insecurity Profile. California Food Policy Advocates. <http://cfpa.net/county-profiles>. Updated 7/7/2016. Accessed 2016
- ²⁰ Food Research and Action Center, National Association of Secondary School Principals. School Breakfast After the Bell: Equipping Students for Academic Success. Food Research and Action Center, National Association of Secondary School Principals. <http://frac.org/pdf/secondary-principals-bic-report.pdf>. November 2015.

COMMUNITY ENGAGEMENT AND PARTICIPATION

The commitment, passion, and participation of community members, key leaders and advocates, working to improve the health and well-being of children and youth in Santa Clara County, played an important role in guiding and completing this health assessment. Their collective expertise, and input provided an invaluable and important perspective to every facet of the health assessment. The two year health assessment process was informed by Children’s Health Assessment Advisory Committee, an advisory group comprised of key community leaders representing various organizations and agencies working with children and youth and their families throughout the county. Community members and stakeholders at large participated in the health assessment via a series of focus groups, key informant interviews and key venues, including a community prioritization meeting and Call to Action community forum. Collectively, the community engagement efforts generated thoughtful and critical contributions that were instrumental in capturing diverse community perspectives.

The partnership and collaboration between the Santa Clara County Public Health Department, the Children’s Health Assessment Advisory Committee, and community members served to:

- Prioritize the key areas of concern for the health and well-being of children and youth,
- Highlight the disparities and inequities in health status of children and available resources to families,
- Identify the gaps in accessing the healthcare system, and
- Lay out the pathway to move from data to action on the key health priority areas.

CHILDREN’S HEALTH ASSESSMENT ADVISORY COMMITTEE

Children’s Health Assessment Advisory Committee is an advisory panel to the Healthcare Reform Implementation Stakeholder’s Working Group. Throughout the assessment, the Children’s Health Assessment Advisory Committee served in both an advisory and decision maker capacity, and was chaired by René G. Santiago, Deputy County Executive and Director of Santa Clara Valley Health & Hospital and Dr. Padmaja Padalkar, Assistant Chief of Pediatrics, Kaiser Permanente San Jose Medical Center. The Children’s Health Assessment Advisory Committee (referred to as advisory group in the report) helped guide the assessment from start to finish, providing input on health assessment framework, data collection methods and tools (available in appendix a and b), focus areas for the assessment, and the identification and selection of population groups and sites, and key informants for data collection. The advisory group met on a monthly basis to stay abreast and provide feedback on the assessment phases, including the identification of vulnerable and hard to reach populations, review preliminary findings and plan next steps.

COMMUNITY LEADERS AND STAKEHOLDERS

Key community stakeholders provided their support and expertise through their participation in the prioritization meeting and the Call to Action community form. A total of 31 community leaders participated in the key informant interviews highlighting specific health and social concerns, and inequities and disparities relevant to the children, youth and their families in Santa Clara County. Community leaders were selected because of their expertise and experience in the following areas:

- Children’s health issues
- Maternal and child health
- Health policies
- Early childhood development
- Behavioral and mental health
- Child neglect and abuse
- Pediatric vision health care
- Pediatric oral /dental health
- Newborn hearing screenings
- Childhood obesity
- Food access
- Homelessness and housing resources for low-income families
- Children of different ages and their families
- Multiple county government agencies
- Foundations and funding entities
- Healthcare patients and social services clients
- Criminal justice system-involved youth and parents
- Immigrant and linguistically isolated communities
- American Indian community
- LGBTQ youth
- Filipino community
- African/African ancestry communities
- Spanish-speaking communities
- Mandarin-speaking communities.

COMMUNITY PARTICIPATION

As part of this health assessment, nearly 150 community members (n=148) participated in 19 focus groups throughout the county. The community conversations captured the voices and lived experience of diverse families, and served as an opportunity to develop a comprehensive understanding of the health needs and concerns of children, youth, and parents. The focus groups participants were either parents of children ages 0 to 17 or youth ages 12 to 17 residing in the county. In some instances, transitional age youth ages 18 to 20 were also included.

Participants lived in 10 different cities within Santa Clara County, including Cupertino, Gilroy, Los Altos, Los Altos Hills, Morgan Hill, Mountain View, Palo Alto, San Jose, Santa Clara, and Sunnyvale. Three quarters of the participants have lived in Santa Clara County for at least 10 years. Three in four participants were adult parents (75%) and 25% were youth and transient age youth. While the majority of parent participants were foreign born (53% of adult parent participants), nearly 8 in 10 youth participants were born in the U.S. More than half of the participants were Latino (57%). Nearly 1 in 5 youth (19%) and 3% of adult parents identified as LGBTQ. Among the parent participants, the majority had an annual household income of less than \$75,000 (56%).

FROM DATA TO ACTION: SELECTION OF PRIORITY AREAS

The Children's Health Assessment Advisory Committee and the community members played a vital role in prioritizing the areas of concern for the children and youth in the county, along with the recommendations to address these concerns. This groundwork will inform the transition from assessing the health status of children and youth to identifying action-oriented strategies to address the health needs and inequities.

On August 31, 2016, the Santa Clara County Public Health Department organized a prioritization meeting for the Children's Health Assessment Advisory Committee and community stakeholders to discuss preliminary findings and rank the top priority areas from the assessment. After reviewing and discussing the data, the meeting attendees voted for each area against the following guiding principles:

- Seriousness of the issue (severity/number of people affected)
- Actionable
- Alignment with existing resources/efforts
- Degree of inequity
- Identified leader or champion.

The top 4 priority areas selected are:

- Barriers to accessing services
- Economic inequality and housing
- Early learning and the educational system
- Structural racism and discrimination.

On September 14, 2016, the Santa Clara County Public Health Department presented the top 4 priority areas at a Call to Action community forum. Over 100 people (n=109) attended the forum representing diverse groups, including community members, community stakeholders, community based organizations, various government agency and departments. The attendees discussed recommendations and strategies for addressing the 4 priority areas to improve the health and well-being of children and youth in the county.

CALL TO ACTION

Over 21 strategies to address children's health were identified from data collected at a call-to-action forum held on September 14, 2016; from parent and youth focus groups, key informant interviews, and a data prioritization community meeting held on August 31, 2016. These strategies were further refined by grouping 'like' strategies and highlighting those that were supported by evidence-based practices. Members of the Children's Health Advisory Committee prioritized the strategies using the following criteria:

- Assigned lead/agency
- Builds on existing efforts/momentum
- Closes existing gap
- Funding availability
- Measurable
- Political will
- Sustainable

Strategies selected by the Children's Health Assessment Advisory Committee members are related to the following areas: Access to healthcare services, delivery of services, early learning and the educational system, economic stability, racism and discrimination, and safe and cohesive communities. A total of seven key strategies were identified and are organized into two domains: Services and Policy and Systems.

Services

Adopt Universal Developmental Milestone Screenings for All Children in the County

Children's access to healthcare is crucial to their overall health and development. However, access to healthcare means much more than having health insurance coverage. Healthcare access also involves adopting universal developmental milestone screenings for all children in the county, which can help ensure that all children have quality healthcare. Additionally, there is an urgency to remove the systemic barriers experienced by families which include expanding and improving the accessibility of high quality medical and dental services for all children with a key focus on children with special needs. (Please see Barriers to Healthcare and Health Development Chapters for data on this topic)

Expand and Improve Accessibility of High Quality Medical and Dental Services for All Children with a Focus on Children with Special Needs.

Poor access to healthcare results in both personal and societal cost. Children with health and dental coverage are more likely to utilize medical and dental healthcare services and are less likely to be hospitalized for conditions that could have been prevented. Parents expressed their frustrations over the unaffordability of both medical and dental care.

Additionally, this strategy is especially important for children with special needs because of the lack of oral health and medical specialists needed to serve this specific population. Community members mentioned that not all medical and dental providers are fully equipped to service special needs children. For example, children with developmental disabilities or those in a wheelchair may be unable to find providers who provide hospital dentistry. Thus, access and affordability are major factors for families utilizing healthcare services.

Expand Food/Nutrition Programs at School Sites and Outside of School Time (Summer, Afterschool, Home).

Eating a healthy diet promotes optimal growth and development among children and reduces their risk of illness. Having access to healthy food and proper nutrition, including the recommended daily amounts of fruits and vegetables, is an important aspect of healthy eating. Regular consumption of fast food or sugar sweetened beverages put children and youth at a higher risk of unhealthy weight gain, which can lead to diabetes and obesity. Schools can include practices to existing wellness policies such as improving availability of fresh fruits and vegetables in school meals and restricting sugar sweetened beverages on school campuses. Improving feeding practices at home will also reduce some of the barriers to healthy eating. Family meal times are important, but it is not routinely implemented as a key solution to healthy eating. A good step in this direction is linking family meals, feeding practices to healthy eating

The lack of nutrition and summer enrichment programs can result in negative health and developmental outcomes for children including weight gain and a "summer slide" in learning. . Expanding these services will contribute to the efforts of accessing healthy food and providing nutritious meals ensuring that our children particularly the most vulnerable, have what they need to thrive and learn. (Please see Health Eating and Active Living for data on this topic)

Policies and Systems

Address Structural and Institutional Racism, Discrimination, Harassment, and Biases Across Systems (Health, Education, Criminal Justice, and Other Service Sectors) that Contribute to Inequitable Outcomes for Children and Their Families

The historical legacy and current reality of the multi-level forms of racism^{xxix} in this country has contributed to the limited opportunities and resources that people of color, and other vulnerable groups can access.¹ This has led to cumulative, and multi-generational impacts, adversely shaping employment, housing, education, healthcare, and other parts of families' lives.

^{xxix} Structural racism refers to the historical systems and institutions that work together to create the negative cumulative effects that systematically disadvantage people of color. Institutional racism refers to the policies and practices that exist in schools, businesses, and government agencies that result in inequities for people of color. Individual racism refers to the internal beliefs that people hold about race that are influenced by our culture, and are expressed between individuals. Discrimination, exclusion, and harassment are listed below the visual to illustrate that they relate to systems of oppression that operate in parallel to racism. People of color is often a preferred collective, inclusive and unifying term, across different racial groups that are not White, to address racial inequities. (Race Forward)

Structural racism refers to the interplay of the structures and systems that perpetuate inequalities throughout the lifespan, contributing to an epidemic of racial disproportionality, as observed in poor health outcomes for the most vulnerable. Adverse exposure and experiences with racial discrimination are associated with illness irrespective of a life stage – childhood or adulthood.² Structural racism and discrimination, as social determinants of health, are examples of the factors and structures of inequality, beyond our genetic make-up that influence health outcomes, and exacerbate health inequities.

Health inequities are differences in health that are avoidable, unfair, and unjust. In order to combat health inequities and promote equity for all in Santa Clara County, the connection and drivers between structural racism and discrimination at multiple systemic must be acknowledge, named, and disrupted.

A racial and health equity lens and vision is needed to in order to be intentional and make necessary system-wide improvements to provide all children living in Santa Clara County with the fair opportunity to achieve their full potential. Government systems, school districts, advocates, and communities can come together to develop activities that address structural and institutional racism.

Increase High Quality, Affordable Housing for Families.

Economic inequality and housing instability are two concerns that have emerged throughout this assessment. Although there has been positive economic growth in the Silicon Valley, the income gap has also widened between high and low income families. Poverty and income inequality are major contributors to lower life expectancies and are associated with many chronic diseases. Housing is a fundamental determinant for health over one's life span.

Support Quality Universal Preschool and Expand Quality Affordable Childcare.

One of the critical concerns that emerged throughout this assessment is the importance of quality preschool among children in Santa Clara County. The path to academic success and a professional career begins at a very early age. Children who receive high quality early learning particularly from birth to age 5 have improved kindergarten readiness, which is associated with higher educational attainment. Early education begins with a child's experiences at home, other preschool settings, and quality child care. Quality child care allows parents to go to work or go to school, while also providing their child with early childhood education experiences. However, there are many barriers to participating in child care programs among low-income families. Even a small increase in earnings can result in the loss of important subsidized programs. To address this issue, child care subsidies can make quality child care programs more affordable and accessible for low-income families. Universal preschool for children, including summer programming for low-income children and programs for children with development disabilities, is another strategy to reduce educational inequities opening pathways to future academic success. (Please see Economic Inequality and Housing Instability for data on this topic)

Support School and Community Based Efforts to Prevent Bullying and Violence Among Children.

Bullying occurs when children at school are facing unwanted, aggressive behavior that involves a real or perceived stereotype and power imbalance. Many instances of bullying are based on race and ethnicity with both implicit and explicit bias from people in positions of authority. Bullying comes in many forms (physical, relational, verbal, and cyber) and it can threaten a child and youth's well-being, both in school and in their neighborhood. Although bullying has declined in the last ten years among middle and high school students, it is a serious concern and problem for parents, and a threat to learning within schools. To combat bullying, parents and youth alike identified the development of proactive strategies in all school settings, such as the establishment and/or enforcement of a "no bullying" policy, that involves working closely with students, teachers, and parents to both understand and identify bullying behavior and develop strategies for adequately addressing the behavior. Children's safety is also an important priority because it nurtures a learning and positive environment where children can develop and achieve their full potential. Unsafe neighborhoods are associated with high rates of infant mortality, juvenile delinquency, high school dropout, child abuse and neglect, and poor motor and social development among preschool children. (Please Community Safety and Violence chapter for data on this topic)

NEXT STEPS

The completion of the Children's Health Assessment report presents an opportunity for the Santa Clara County community to come together with the goal of creating equitable, action-oriented programs, policies, and practices to improve the lives of all children, youth, and their families. In 2017, the Children's Health Assessment Advisory Committee will reconvene to develop specific work plans to advance and fulfill the promise behind each of the high priority strategies identified.

REFERENCES

¹ Advancing Racial Equity and Transforming Government; A Resource Guide to Put Ideas into Action. Local and Regional Government Alliance on Race and Equity. Accessed on October 20, 2016 at: http://www.racialequityalliance.org/wp-content/uploads/2015/02/GARE-Resource_Guide.pdf.

² Gee GC, Walsemann KM, Brondolo E. A Life Course Perspective on How Racism May Be Related to Health Inequities. *American Journal of Public Health*. 2012;102(5):967-974. doi:10.2105/ajph.2012.300666.

METHODS

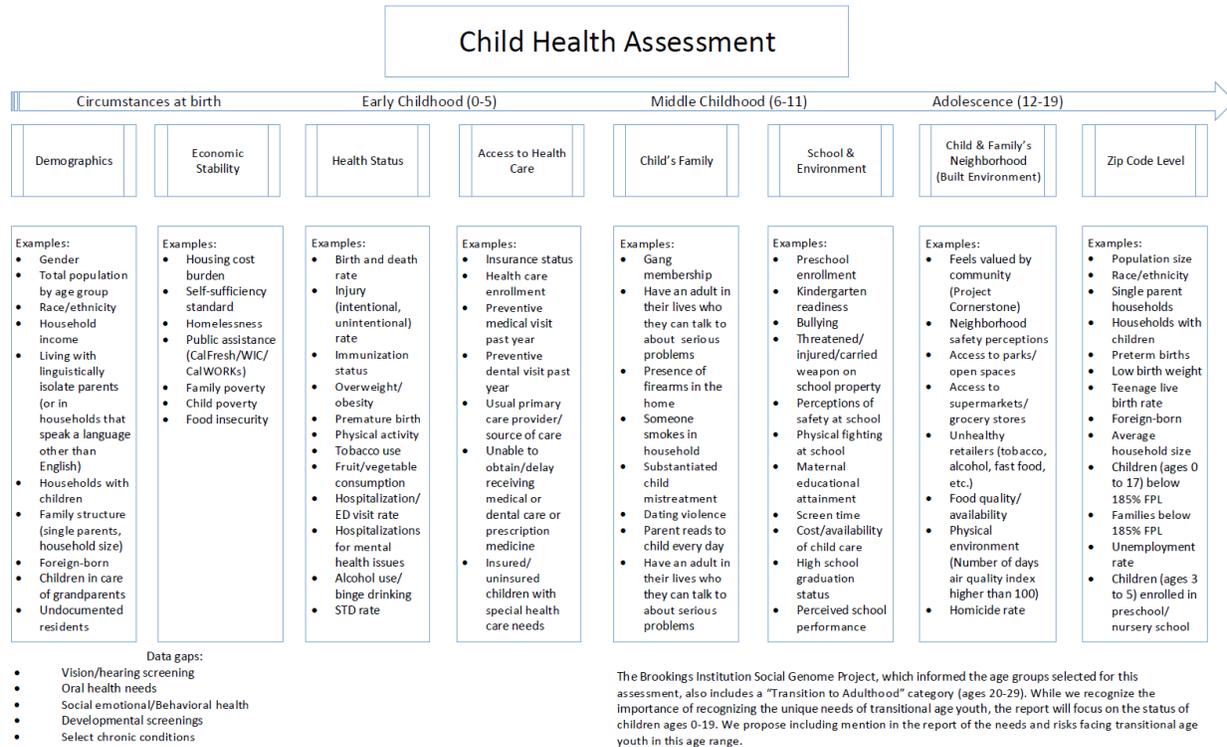
The findings presented in this report are drawn from qualitative and quantitative data sources. Qualitative data sources include focus group discussions with parents and youth residing in Santa Clara County, key informant interviews with community leaders, experts, and service providers, and an online survey. Quantitative data sources include a children's health telephone survey and a children's health intercept in-person survey of parents of children ages 0 to 17 and a variety of other existing data sources. Additionally, many programs and organizations shared their child and youth client service data. Qualitative and quantitative data collection and analysis methods are presented in greater detail in this section.

Assessment Framework

In 2015, Santa Clara County Public Health Department proposed a draft framework to the advisory group to help guide the assessment. The framework was developed to refine the scope of the assessment. The framework incorporated the Social Determinants of Health concept with a life-course approach. Seven main domains were created which encompassed key health indicators relevant for children and youth. The framework supported the discussion to identify existing data gaps and focus the assessment efforts to address the data gaps and highlight the health disparities and barriers to accessing services for children, youth and families in the county. The following seven domains were approved by the advisory group members:

1. Health Status
2. Access to Healthcare
3. School & Environment
4. Child's Family
5. Child & Family's Neighborhood
6. Demographics
7. Economic Stability

The framework helped finalize the data collection methods and guided the development of questionnaires and tools for data collection.



COMMUNITY OUTREACH

A multifaceted outreach plan was developed to enhance the awareness about the assessment and its data collection efforts and to recruit participants. Santa Clara County Public Health Department developed a webpage entirely dedicated to the assessment (www.ChildHealthSCC.org). Posters and fliers were designed to provide information about the various activities happening as part of the assessment such as telephone survey, intercept survey, focus groups, prioritization meeting, Call to Action community forum, report release. The posters/fliers were developed in multiple languages, including English, Spanish, Vietnamese and Mandarin. Special emphasis was placed on the look and feel of the communication materials so that it is culturally sensitive and relevant to diverse communities, e.g., the pictures and colors used in the posters/fliers were community specific. The posters and fliers were distributed to various community partners and advisory group members for posting in their organizations and agencies in areas where clients were served. Certain partner agencies requested to brand fliers with their logos. The outreach plan also included dissemination of information via shared newsletters, emails, and at meeting presentations throughout the county. Throughout the assessment, announcements on significant milestones and activities were posted periodically on the Public Health Departments' Social media platforms (*Twitter, Facebook and Pinterest*) and website. Additionally, informational postcards were mailed to the households selected for the telephone survey to authenticate the survey and enhance the participation. Messages were also posted on the *Nextdoor* app to increase awareness about the various surveys and data collection efforts related to the assessment; reaching over 100,000 residents.

Furthermore, Office of President of the Board of Supervisors, Dave Cortese, helped with the grassroots style outreach campaign, including published columns on multiple newspapers about the assessment (Milpitas Post, Tri-City Voice, El Observador, La Oferta, Evergreen Times, many Asian papers) and the distribution of assessment posters and fliers at all county libraries. Information was also shared with Supervisor Cortese's constituents at various events and was included in the District 3 Newsletter. Most city council members also posted announcements about the assessment in their newsletters.

QUALITATIVE DATA COLLECTION AND ANALYSIS

As discussed earlier, the assessment framework and volume 1 report guided the qualitative data collection. A total of 19 focus groups were conducted with 148 parents and youth from hard-to-reach populations from across Santa Clara County. Thirteen focus groups were conducted with parents and primary caregivers of children ages 0 to 17, and 6 focus groups were conducted with youth. Focus groups were conducted in English (n=12), Spanish (n=5), Vietnamese (n=1), and Mandarin (n=1). Additionally, a total of 30 key informant interviews were also conducted with 32 community leaders and stakeholders who represented a range of service sectors and communities throughout the county. The assessment team for qualitative data comprised of the Santa Clara County Public Health Department and Raimi and Associates, a research firm in Berkeley, CA.

Tool Development

A collaborative approach was used to develop the protocols for the focus groups and key informant interviews. The following guiding questions were presented to the advisory group in order to help develop the protocols/tools:

- What is working to support children to thrive in Santa Clara County? What is not working?
- What are community strengths in supporting children's health? Innovations?
- What are community needs related to children's health? And gaps?
- What factors contribute to the disparities in children's health that exist across the county?
- What can we do to address the disparities?

Based on the discussions with the advisory group, a draft question set was presented to and vetted by the advisory group. The review process focused on alignment with the main domains of the assessment and cultural relevancy of the language used in the questions. Final question sets are presented in 'appendix a' of the report.

Sampling Plan

A sampling plan was developed to help reach the identified population subgroups for focus groups. The plan also included the non-English speaking groups and countywide locations for conducting focus groups. Advisory group selected the following priority population subgroups and perspectives for conducting focus groups and key informant interviews:

PRIORITY POPULATION SUBGROUPS AND PERSPECTIVES

Priority groups	Focus groups	Key informant interviews
African / African ancestry	X	X
American Indian	X	X
Families of youth with mental illness	X	X
Foreign-born families	X	X
Incarcerated / criminal justice system-involved youth	X	X
Homeless families/marginally housed	X	X
LGBTQ youth	X	X
Low-income families	X	X
New parents	X	X
Teen parents	X ^{xxx}	
Undocumented families		X
Youth with disabilities	X	X
Youth in foster care / child welfare system	X	X

Data Collection

Focus groups and key informant interviews were conducted during the spring and summer of 2016. Community organizations and partner agencies helped the assessment team coordinate and conduct focus groups, including donating space for hosting focus groups. Parent focus groups participants were identified from the following key populations: African/African Ancestry, American Indian, of children with developmental and/or physical disabilities, of children with severe mental illness, in East San Jose, fathers, foster and adoptive parents, homeless or marginally housed*, Mandarin speakers, in South County*, Spanish speakers*, and Vietnamese speakers. Youth focus group participants were identified from the following key populations: in East San Jose, in foster care/child welfare system, in Juvenile Hall*, LGBTQ, in South County and Spanish speakers*. (* marks priority populations which were included in multiple focus groups).

^{xxx} Although teen parents were not a target population for any focus group, they were represented in multiple focus groups.

FOCUS GROUP SUMMARY

Count	Target population subgroups	City	Language in which focus group was conducted
1	African/African ancestry	San Jose	English
2	American Indian	San Jose	English
3	Children with mental health issues	Los Altos	English
4	Children with special needs	San Jose	English
5	East San Jose / Alum Rock residents	San Jose	Spanish
6	Fathers	Gilroy	Spanish
7	Foster and adoptive parents	San Jose	English
8	Homeless families	San Jose	English
9	Mandarin speakers	Cupertino	Mandarin
10	South County residents	Gilroy	Spanish
11	South County residents	Gilroy	English
12	Vietnamese speakers	San Jose	Vietnamese
13	Young and low-income parents	Santa Clara	English
14	Foster youth	San Jose	English
15	LGBTQ youth	San Jose	English
16	South County youth	Gilroy	English
17	Spanish speaking youth	San Jose	Spanish and English
18	Young men in juvenile justice system	San Jose	English
19	Young men in juvenile justice system	San Jose	Spanish

The Public Health Department, in close collaboration with the advisory group, developed a comprehensive list of community leaders and stakeholders who either serve the child/youth population in the Santa Clara County or have knowledge of health concerns of child/youth population were included in the interviews. Key informant interviews were conducted by phone with select leaders and stakeholders, based on their availability and consent. Key leaders with the following expertise and experience were included in the list:

- Children's health issues
- Maternal and child health
- Health policies
- Early childhood development
- Behavioral and mental health
- Child neglect and abuse
- Pediatric vision healthcare
- Pediatric oral /dental health
- Newborn hearing screenings
- Childhood obesity
- Food access
- Homelessness and housing resources for low-income families
- Children of different ages and their families
- Multiple county government agencies
- Foundations and funding entities
- Healthcare patients and social services clients
- Criminal justice system-involved youth and parents
- Immigrant and linguistically isolated communities
- American Indian community
- LGBTQ youth
- Filipino community
- African/African ancestry communities
- Spanish-speaking communities
- Mandarin-speaking communities
- Vietnamese-speaking communities

Data Analysis

The qualitative findings in this report emerged from the focus groups and key informant interviews. All qualitative data were coded and analyzed using ATLAS.ti software. A codebook, which closely aligned with the qualitative protocols, was developed to code the transcripts for emerging themes. To begin with, only one coded interview transcript and one coded focus group transcript was analyzed by the assessment team to ensure inter-coder reliability and the codebook was revised and finalized accordingly. All the coded transcripts were analyzed to identify common themes across interviewees and focus group participants, as well as specific themes that emerged for any population subgroups.

Children's Health Online Survey

The online survey was administered during spring and summer 2016. The survey was available online on the Santa Clara County Public Health Department's Child Health Assessment webpage. The survey was limited to adult residents of Santa Clara County who have at least a child under the age of 18 years. The survey included 6 questions, including the top concerns parents had for their children, reasons for the concerns and potential solutions to improving children's health in the county, along with other demographic questions. The survey was available online in English, Spanish and Vietnamese. Nearly 700 parents or primary caregivers participated in the online survey.

QUANTITATIVE DATA COLLECTION AND ANALYSIS

Quantitative data sources include a children's health telephone survey and a children's health intercept in-person survey of parents or primary caregivers of children ages 0 to 17, as well as a variety of secondary data sources. The aim was to collect county-level data on health status of children ages 0 to 17, and health practices and risk behaviors prevalent among children ages 0 to 17.

Tool Development

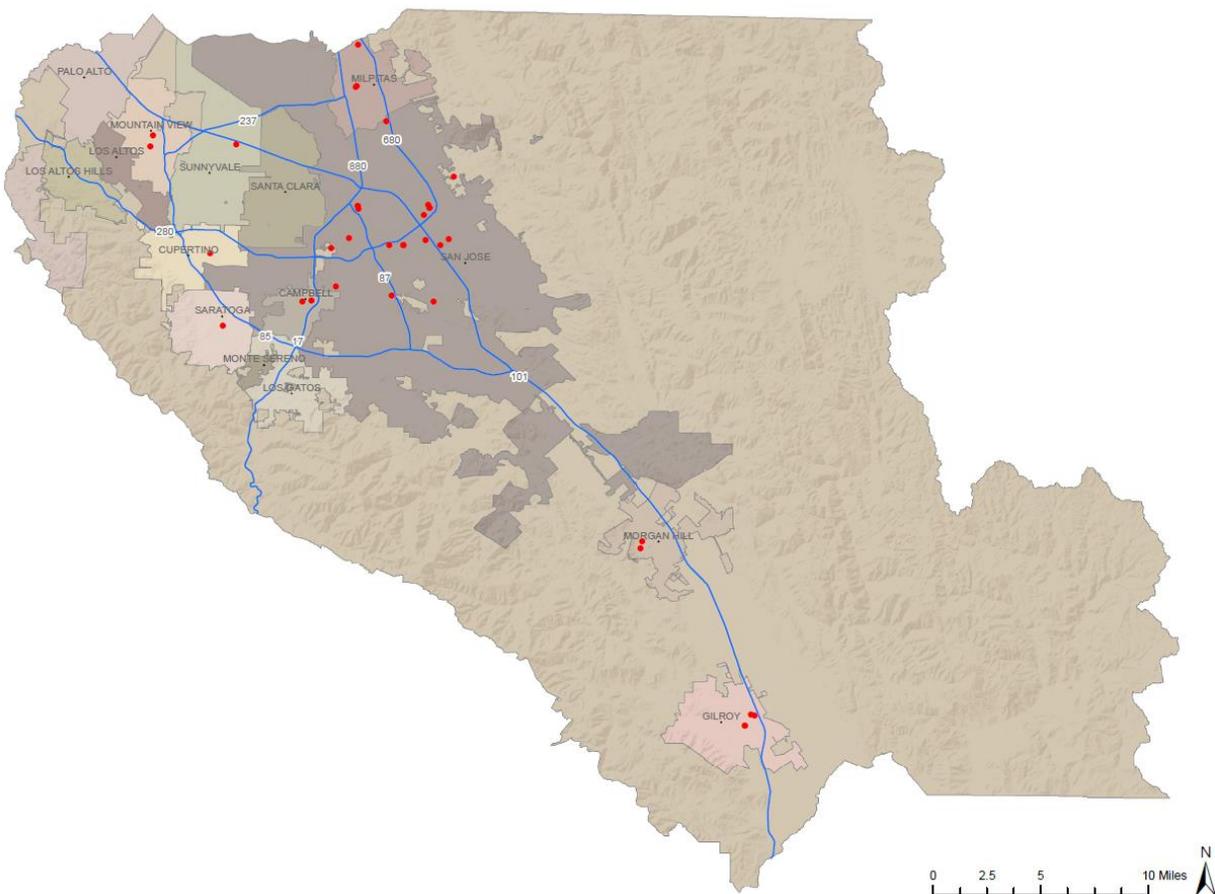
The telephone survey questionnaire was adapted from the National Survey of Children's Health (NSCH) 2011-2012 Survey. The questionnaire was designed to maximize comparability with previous children's surveys administered in the county, as well as national and state-level NSCH data, and to address a number of contemporary health topics. The advisory group members provided feedback on the survey domains to be included in the questionnaires and the Public Health Department finalized the structure and order of the questions. The final questionnaire included approximately 75 questions, inquiring about the health status of child, childhood conditions, healthcare access and utilization, oral health, mental health, and vision and hearing screenings. The survey also included a number of questions on demographics. In addition to English, the survey was translated to Spanish, Mandarin and Vietnamese languages. Computer Assisted Telephone Interview (CATI) scripts were then programmed and pilot tested for each of the four languages. The intercept survey questionnaire was designed as a shorter subset of the telephone survey questionnaire for the face-to-face parent surveys.

Sampling Plan

Santa Clara County Public Health Department contracted with Impaq International, Inc. to administer the telephone survey using CATI software. The survey sample was drawn with the aim to obtain a representative sample of the total child population and racial/ethnic-specific subgroups in the county. A simple random sample of landline and cell phone numbers was used. This simple random sample was then screened for usability/eligibility and stratified by presence of children in the household. This cleaned and stratified sample was used for calling and assured to constitute at least 30% of expected completes as cellphone numbers.

For the intercept survey, the sampling plan for selecting locations of survey administration was based on countywide representation of child population with special focus on racial/ethnic subgroups. Factors included in the sampling plan were location was within Santa Clara County, estimated numbers of parents or primary caregivers in attendance, primary languages spoken, and diverse socioeconomic status of families.

LOCATIONS FOR INTERCEPT PARENT SURVEY ADMINISTRATION



Source: Santa Clara County Public Health Department, created 11/10/2016

Quantitative Data Collection

Children's health telephone survey was administered from February 9, 2016 to May 31, 2016. The survey was administered through landline and cell phone random digit dialing (RDD), supplemented with an address-based sampling (ABS) design. ABS was utilized to enhance the sample size of minority populations, such as Vietnamese and African American. A total of 4000 pre-notification post cards were mailed to targeted households in the sample to notify about the legitimacy of the survey, encourage their participation as well as provide an informational point-of-contact should respondents have questions about the study. Only adult residents of Santa Clara County who have at least a child ages 0 to 17 years were eligible to participate in the survey. Survey participants were offered a \$15 incentive for completing the survey; sent as a gift card code via email or by mail. After survey administration, a dataset was created for analysis. In total, 120 parents or primary caregivers participated in the telephone survey.

The intercept survey was administered during summer 2016. Parents or primary caregivers of children ages 0 to 17 filled the paper survey offered in English, Spanish or Vietnamese languages. While most of the surveys were administered in-person; some surveys were distributed at certain locations for clients to fill in (drop off sites). A \$5 incentive was offered to the survey participant after completing the survey; handed as gift cards or sent as gift codes via email for surveys filled at drop off sites. The survey was limited to adult residents of Santa Clara County who have at least a child ages 0 to 17 years. All survey data were entered into the online survey tool, SurveyMonkey, and analyzed by the Santa Clara County Public Health Department. More than 1,100 surveys were collected.

Quantitative Data Analysis

The survey data were coded and analyzed using SPSS and SAS software. A data dictionary was created. The data were tabulated to present data at county-level and by various categories, including age group, sex, race/ethnicity and Asian subgroup of the child, and annual household income of the family. In order to provide statistically reliable estimates, survey results were not reported for indicators which had fewer than 50 responses in a given group. Relative standard error (RSE) was also calculated for the phone survey data to ensure reliable estimates.

SECONDARY DATA SOURCES

Where possible, the report included results from existing/secondary data sources, including, but not limited to, the U.S. Census Bureau, American Community Survey; Behavioral Risk Factor Survey; California Department of Education, Santa Clara County Homeless Census & Survey, California Healthy Kids Survey. Secondary data sources are cited where appropriate in the text and in figures.

PROGRAM HIGHLIGHTS

The report also shines light on the significant work being done by various organizations and agencies, located in Santa Clara County, for improving the health and well-being of children and youth. This section documents methods used by some organizations and agencies for analyzing their client service data:

Foster Care Data

All primary data were extracted from the administrative California statewide child welfare data system CWS/CMS.^{xxxi} To investigate trends in Santa Clara County child welfare populations, entry and exit cohorts were analyzed based on Calendar Years (CY). The data represent unique counts of children and youth per CY. In the instances where a youth was indicated more than once within a CY, the more severe dependency category was chosen for the case opening cohort and the first instance was chosen for the entry and exit cohorts.

^{xxxi} Supplemental data included in this report are from UCB CWS/CMS website. Ethnicity categories were collapsed using the methodology established by UCB.

Case openings by voluntary and dependency status were based on the case start date. A child was categorized as a voluntary or dependency case based on the most severe case status in a specific CY. Dependency status, the more severe category, was established on the presence of initial court detention hearing information.

Entries into foster care were identified by the date children/youth were removed from family and placed into foster care. The foster care exits were based on the date that a child/youth exited from foster care placement. Non-Minor Dependent cases were selected based on the first date that the case transitioned to the service component 'Supportive Transition.'

LIMITATIONS

Public health surveillance data (births, deaths, infectious disease, emergency room visits, and hospitalizations) utilized in the health assessment were subject to both misclassification and reporting bias; however, this bias is expected to be minimal.

Data on adolescents from the California Healthy Kids Survey (CHKS) were subject to selection bias as well. Only public schools participate in the CHKS and participation is subject to both school district and parent consent.

Other data sources utilized in the health assessment were also subject to limitations. The telephone survey surveyed primarily individuals with landline telephones; with only 30% of the estimated completes to be cell phones. Households without landline phones are more likely to include low-income and younger individuals as well as males.^{xxxii} The number of people who live in cell phone-only households has increased dramatically over the past several years. Homeless individuals without landlines and residents who were too ill to speak on the phone or take the survey could not be interviewed, leading to a potential bias toward healthier individuals. All information on health and social indicators on surveys utilized in the health assessment was self-reported and so is subject to reporting bias. Although wherever possible the health assessment used validated survey questions from established sources, there is a possibility of measurement error for some indicators. The survey was administered in English, Spanish, Mandarin, and Vietnamese. Santa Clara County residents who did not speak any of these languages were not interviewed. This may lead to some under-representation of immigrant residents.

^{xxxii} Blumberg, SJ & Luke, JV. Wireless substitution: early release of estimates from the National Health Interview Survey, July-December 2009. 2010: Centers for Disease Control and Prevention, Division of Health Interview Statistics, Centers for Disease Control and Prevention, Atlanta.

ACKNOWLEDGEMENTS

Santa Clara County Board of Supervisors

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Community Members

We are deeply grateful to all the community members who contributed their time in participating in the focus groups, key informant interviews, intercept survey, and phone survey.

Santa Clara County Public Health Department Assessment Team

Pamela Amparo, Mandeep Baath, Lilia Chavez, Alexis Fields, Analilia Garcia, Ethan Giang, Kate Kelsey, Amy Lara, Wen Lin, Rocio Luna, Vanessa Merlano, Maritza Rodriguez, Roshni Shah, Pamela Stoddard, Anandi Sujeer, Andrea Truong, Brianna Van Erp, Gina Vittori.

Interns, Facilitators and Transcribes

Thank you to all the interns and Public Health Department staff that assisted with collecting data, by administering intercept surveys, and facilitators and transcribes who helped coordinate the Data Prioritization Meeting and Call to Action Community Forum.

Program Contributions

Thank you to all the departments, agencies and organizations which shared their data on select populations and programs to be included in the assessment: **Behavioral Health Services** (Family and Children’s Services Division, School Linked Services, Substance Use Treatment Program); **Office of Medical Examiner-Coroner** (Santa Clara County Child Death Review Team); **Probation Department** (Juvenile probation); **Santa Clara County Public Health Department** (Adolescent Pregnancy Prevention Network, Black Infant Health Program, California Children’s Services Program, Child Health and Disability Prevention Program, Child Passenger Safety Program, Childhood Feeding Collaborative, Childhood Lead Poisoning Prevention Program, Comprehensive Perinatal Services Program, Maternal, Child, and Adolescent Health Program, Nutrition Education and Obesity Prevention Program, Public Health Nursing – Health Care Program for Children in Foster Care, Public Health Nursing Home Visitation Program, Public Health Nursing Regional Services Program, Safe Routes to School Program, Tobacco-Free Communities Program, Universal Prenatal Screening Pilot project); **Santa Clara County Public Schools and School Districts** (School Wellness Policy); **Santa Clara Family Health Plan** (HEDIS Measures for the Medi-Cal Managed Care Child and Adolescent Population and the Healthy Kids Program); **Santa Clara Valley Medical Center** (Pediatric Primary Care, Silicon Valley Medical-Legal Partnership Clinic at Santa Clara Valley Medical Center Pediatrics); **Social Services Agency**, Santa Clara County Department of Family and Children Services (Child Welfare System (Foster Care)); and **Organizations** (Bill Wilson Center, FIRST 5 Santa Clara County, Healthier Kids Foundation, Kidsdata.org, Santa Clara County Dental Society, Second Harvest Food Bank of Santa Clara and San Mateo Counties).

Community Organizations and Partner Agencies

Thank you to following Community organizations and partner agencies for helping coordinate and hosting the focus groups: Bill Wilson Center, Community Health Awareness Council (CHAC), FIRST 5 Santa Clara County, Greene Scholars Program, The Hub Resource Center, ICAN, Indian Health Center of Santa Clara Valley, LGBTQ Youth Space/Children and Family Services of Silicon Valley, Parent Chat, Parents Helping Parents, Rebekah Children’s Services, Saint Joseph’s Family Center, Santa Clara County Kinship, Adoptive, and Foster Parent Association, Santa Clara County Probation Department, Juvenile Hall, Superintendent’s Parent Advisory Resource Council (SPARC), Alum Rock Union School District, and Washington United Youth Center, Catholic Charities of Santa Clara County.

Advisory Group

Thank you to René Santiago and Dr. Padmaja Padalkar who served as co-chairs for this health assessment and to representatives from the following organizations who provided guidance on the assessment: African American Community Service Agency, Anthem, Bill Wilson Center, Black Leadership Kitchen Cabinet, Community Health Partnership, FIRST 5, The Health Trust, Healthier Kids Foundation, International Children Assistance Network, Kaiser Permanente, Kids in Common, LGBTQ Youth Space, Lucile Packard Children’s Hospital Stanford, Roots Community Health Center, Santa Clara County Behavioral Health Services, Santa Clara County Office of Education, Santa Clara County

Probation Department, Santa Clara County Public Health Department, Santa Clara County Social Services Agency, Santa Clara Valley Health & Hospital System, School Health Clinics of Santa Clara County, Second Harvest Food Bank, Silicon Valley Council of Nonprofits, Working Partnerships USA.

Report Design, Outreach and Website

Santa Clara County Public Health Department Communications team.

Contractors

Impaq International, Inc., Raimi and Associates.

APPENDIX A: QUALITATIVE DATA COLLECTION PROTOCOLS

This section lists the question sets used during the key informant interviews, adult parent focus groups, and youth focus groups:

Key Informant Interview Question Set

Introduction

1. Could you give me a brief description of your organization, and your role there?
 - a. Within Santa Clara County, what geographic area do you primarily serve? (specific or county-wide) We have selected you because of your expertise in/knowledge about [(Latinos, youth, LGBTQ, etc.)—is that correct?
2. In your opinion, what do you think are the most important issues that have the greatest impact on children’s health in Santa Clara County? [Probe: poverty, violence, obesity, stress, mental health issues such as depression]
3. Who- in Santa Clara County- is most affected by the health issues you just mentioned? [Probe: (e.g., Latino children, Vietnamese young people, high schoolers, etc.)]
4. What do you think the main causes (or drivers) are of the issues you just listed above? [Probe: poverty, etc.]
5. What can be done to address the issues and inequities you just mentioned? [Probe: What programs, collaborations, systems changes can be created? Also at what level could these inequities or issues be addressed?: different government levels, organizations, community-wide, or at the individual level].

Health Behaviors

1. In your opinion, what are the biggest challenges for children to make healthy choices? [Probe: local and affordable fresh fruits and vegetables? Healthy food choices for school lunches? Food at home?]
2. What do you think helps support young people in leading mentally and physically healthy lives? [Probe: What makes it difficult to exercise and eat healthy? What sources of stress impact young people’s lives?]
3. Who- in Santa Clara County- is most affected by the health issues we just talked about? [Probe: e.g., Latino children, Vietnamese young people, high schoolers, etc.]

4. What do you think the main causes (or drivers) are of the issues we just talked about?
5. What can be done to address the issues and inequities we just talked about?

Economic Stability and Housing

1. What are the social and economic issues that have the largest influence on child health in Santa Clara County? [Probes: poverty? Lack of jobs? Perceived or real fear of violence? Is there is a strong sense of community? No good jobs available for parents or teens, residents don't have needed skills, jobs not near where residents live?]
2. Who- in Santa Clara County- is most affected by the health issues we just talked about? [Probe: e.g., Latino children, Vietnamese young people, high schoolers, etc.]
3. What do you think the main causes (or drivers) are of the issues we just talked about?
4. What can be done to address the issues and inequities we just talked about? [Probe: What programs, collaborations, systems changes can be created? Also at what level these inequities or issues could be addressed? Different government levels, organizations, community-wide, or at the individual level].

Physical and Social Environment

1. What are the physical and environmental issues that have the largest influence on child health in Santa Clara County? [Probes: poor air quality, unsafe to walk, no nearby parks, violence].
2. Who- in Santa Clara County- is most affected by the health issues we just talked about? [Probe: e.g., Latino children, Vietnamese young people, high schoolers, etc.]
3. What do you think the main causes (or drivers) are of the issues we just talked about?
4. What can be done to address the issues and inequities we just talked about? [Probe: What programs, collaborations, systems changes can be created? Also at what level these inequities or issues could be addressed? Different government levels, organizations, community-wide, or at the individual level].

Systems Change and Collaborations

1. Do you have suggestions for systems-level collaborations that could help to address the inequities we just talked about?
 - a. Are there any innovations that will help address the health issues of children in Santa Clara County? [NOTE: Innovations are any new ideas, processes, methods, practices, or programs that can work to solve difficult problems or address challenges.]
2. Looking across all sectors, who are some potential community partners that could help to improve children's health in Santa Clara County?

Conclusion

1. Is there anything else you would like to share about children's health that hasn't already been addressed?

Adult Parent Focus Group Question Set

Introduction

1. Let's start by going around the room and briefly saying your name, and the ages of your children, [and a favorite activity to do with your children in your neighborhood. Note: if it's a small group then ask about favorite activity].
2. From your perspective, what are the top concerns that you have for your children? [Probes, for example: family finances, housing, access to healthcare, hunger, safety]
3. What do you think are some reasons why these issues occur in your community? [Probes: Access to housing, access to care, access to education, economic security.]

Physical and Social Environment

1. What changes in your community or neighborhood would help your children eat more fruits and vegetables instead of fast food? [Probe: how easily can you purchase fresh fruits and vegetables? Are they affordable?]
2. What would make you and your children feel safer in your community? Why? [Probe: community policing, social services, cleaner streets, good lighting, more sidewalks?]

Education and School Environment

1. What types of support would help your child do well in school? [Probe: Help young children in preschool and elementary school? Help youth finish high school?]
2. How, if at all, have you been involved in your child's school? [Probe: help with homework, parent/teacher conferences, school meetings, etc.]
3. What are some reasons why young people/your children are sad, stressed, or depressed? [Probe: Have you heard any young people in your community talk about being depressed, feeling hopeless, getting bullied, academic stress, peer pressure?]
4. What would help your children/young people feel less sad/stressed/depressed?
5. Have you heard your child or other young people in your community talk about experiencing discrimination or racism at school? [Probe: can you tell me briefly about that experience?]
6. What would help to ensure that children feel safe at school? [Probe: what would help reduce the bullying?][Note: bullying is defined as unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance. Both kids who are bullied and who bully others may have serious, lasting problems].

Economic Stability and Housing

1. The cost of housing is particularly high in the Bay Area. More than 2 in 5 households in Santa Clara County are spending a third or more of their income on housing alone. How has the housing crisis affected your family?
2. What, if anything, has helped support parents/caregivers to find and maintain jobs to provide for the family?

3. What are some challenges that parents/caregivers have experienced to find and maintain jobs to provide for the family?

Access to Healthcare and Social Services

1. Can I have everyone raise their hand if their children have health insurance? If not, why not?
 - a. If so, what has your experience been getting healthcare for your child/children?
[Probe: What has the quality of the services been?]
2. Can I have everyone raise their hand if their children go to a dentist regularly?
 - a. What has your experience been getting dental care for your child/children?
3. What are the most common reasons why children don't get needed healthcare, dental, or social services? [Probe: don't have health insurance? Services aren't close enough? Stigma? Immigration status/issues, language barriers, unsafe neighborhoods, working multiple jobs/lack of time, lack of awareness of available resources, etc.]
4. Have you experienced any discrimination or racism in any of the services you have received?

Social and Family Support

1. What supports exist in your community to help your children thrive?
 - a. Do you have people that you go to when you need help with your children?
2. What additional activities, services, or community improvements do your children need to thrive?
 - a. How connected do you feel to your neighbors? [Probe: Do you have a strong sense of community?]

Conclusion

1. Based on our conversation today, what are the top three things that you think would improve children's health in Santa Clara County?
2. Is there anything else you would like to share about your child's health [that hasn't already been addressed]?

Non-Custodial Youth Focus Group Question Set

Introduction

1. Let's start by going around the room and briefly saying your name and how old you are.
2. From your perspective, what are the top concerns that you and your friends have? [Probes, for example: family finances, housing, hunger, safety, access to healthcare,
3. What do you think are some reasons why these issues occur in your community? [Probes: lack of jobs, affordable housing, good education, lack of safety.]

Physical and Social Environment

1. What changes in your home, neighborhood, or school do you think would help support you and your friends in eating healthier food? [Probe: how easily can you purchase fresh fruits and vegetables? Are they affordable?] Home, Neighborhood, School.
2. In your opinion, what makes you and your friends feel safer in your neighborhood? Why? [Probe: community policing, social services, cleaner streets, good lighting, more sidewalks?]
 - a. What are some reasons why you and your friends might not feel safe in your neighborhood?

Education and School Environment

1. What are the top concerns you and your friends have about your education? [Probe: What are your concerns about the quality of your education?]
2. What, if any, types of support help you or your friends do well in school? [Probe: Help youth finish high school? Bilingual support? After school programs? Mentors? Free or reduced price meals?]
3. What, if any, are some reasons why young people are sad, stressed, or depressed? [Probe: Have you heard other youth in your community talk about being depressed, feeling hopeless, getting bullied, academic stress, peer pressure?]
 - a. What would help the young people you know feel less sad/stressed/depressed?
4. Have you experienced discrimination or racism at school? Have you heard other young people in your community talk about experiencing discrimination or racism at school? [Probe: Can you tell me briefly about that experience?]
5. What would help to ensure that you and your friends feel safe at school? [Probe: What would help reduce bullying? Reduce violence?] [Note: bullying is defined as unwanted, aggressive behavior that involves a real or perceived power imbalance.]

Economic Stability and Housing

1. How, if at all, has the cost of housing affected you and your friends?
2. What, if anything, has helped support youth to find and maintain work? [Probe: livable wages, flexible work hours, transportation, and education?]
3. What are some challenges that youth have experienced in finding and maintaining work? [Probe: Wages and hours, transportation, education?]

Access to Healthcare, Dental Care, and Other Support Services

1. Could you briefly describe what your experience has been, if any, going to the doctor?
[Probe: What has the quality of the services been?]
2. What are some reasons why young people do not regularly go to a dentist? [Probe: don't have health insurance? Services aren't close enough? Stigma? Immigration status/issues, language barriers, unsafe neighborhoods, working multiple jobs/lack of time, lack of awareness of available resources, mental health, drugs and alcohol? etc.]
3. What has your experience been, if any, getting dental care, if you have gone?
4. Have you or any family member experienced discrimination or racism in any of the services you received? [Probe: Can you tell me briefly about that experience?]

Social and Family Support

1. What community resources help you and your friends be successful, healthy, and happy?
[Probe: support services, schools, faith-based organizations, etc.]
2. Who, if anyone, do you or your friends go to when you need help?
3. Who, in your opinion, do you consider as your community?
4. How connected do you feel to your community?

Conclusion

1. Based on our conversation today, what are the top three things that you think would improve the health of youth in Santa Clara County?
2. Is there anything else you would like to share about improving the health of youth in the county that we haven't talked about?

Custodial Youth Focus Group Question Set

Introduction

1. From your perspective, what are the top concerns that you and your friends have about your lives? [Probes, for example: about your lives, family finances, housing, hunger, safety, access to healthcare,
2. What do you think are some reasons why these issues occur in your community? [Probes: lack of jobs, affordable housing, good education, lack of safety.]

Physical and Social Environment

1. What changes in your home, neighborhood/community do you think would help support you to lead a healthy life/to be healthy? [Probe: how easily can you purchase fresh fruits and vegetables? Are they affordable?] Home, Neighborhood/community.
2. What are the challenges in your home, neighborhood/community or school that are a barrier to leading a healthy life?
3. What do you think makes you and your friends feel safer in your neighborhood/community? Why? [Probe: community policing, social services, cleaner streets, good lighting, more sidewalks?]
 - a. What are some reasons why you and your friends might not feel safe in your neighborhood/community?

Education, School, Community Environment

1. What are the top concerns you and your friends have about your education? [Probe: What are your concerns about the quality of your education?]
2. What, if any, are some reasons why youth are sad, stressed, depressed, or angry? [Probe: Have you heard other youth in your community talk about being depressed, feeling hopeless, getting bullied, academic stress, peer pressure?]
 - a. What would help the youth you know feel less sad, stressed/depressed/angry?
3. Have you or other youth experienced discrimination or racism in your community/neighborhood? Have you heard other youth in your community talk about experiencing discrimination or racism in your community/neighborhood? [Probe: Can you tell me briefly about that experience?]
4. What would help to ensure that you and your friends feel safe in your community/neighborhood? [Probe: What would help reduce bullying? Reduce violence?] [Note: bullying is defined as unwanted, aggressive behavior that involves a real or perceived power imbalance.]

Economic Stability and Housing

1. What, if anything, has helped support youth to find and maintain work? [Probe: livable wages, flexible work hours, transportation, and education?]

2. What are some challenges that youth have experienced in finding and maintaining work?
[Probe: Wages and hours, transportation, education?]

Social and Family Support

1. What community programs or resources are needed to help you and your friends to successfully transition back into the community? [Probe: support services, schools, faith-based organizations, etc.]
2. Who, if anyone, do you or your friends go to when you need help?
3. Who, in your opinion, do you consider as your community?
4. How connected do you feel to your community?

Conclusion

1. Based on our time here today, what are the top three things that you think would improve the lives of youth in Santa Clara County?
2. Is there anything else you would like to share about improving the lives of youth in the county that we haven't talked about?

APPENDIX B: INTERCEPT PARENT SURVEY QUESTION SET

This section has the question set used for the intercept survey:

1. Are you an adult who is at least 18 years old?
 - Yes
 - No
2. What city do you live in?
 - Campbell
 - Cupertino
 - Gilroy
 - Los Altos
 - Los Altos Hills
 - Los Gatos
 - Milpitas
 - Monte Sereno
 - Morgan Hill
 - Mountain View
 - Palo Alto
 - San Jose
 - Santa Clara
 - Saratoga
 - Sunnyvale
 - Unincorporated area of Santa Clara County (Alum Rock, Burbank, Cambrian Park, East Foothills, Fruitdale, Lexington Hills, Loyola, San Martin, Stanford)
 - I do not live in Santa Clara County
3. How many children under 18 years old are living or staying in your household?
 - Number of children-----
 - Don't know/Not sure
 - Prefer not to answer
4. The questions on this survey are about one of the children living in your household. In order to select a child, please tell us the age of the child with the most recent birthday.

- Months-----
- Years-----

-
5. Is your child male or female?
 - Male
 - Female
 - Don't know/Not sure
 - Prefer not to answer
 6. What is your relationship to your child?
 - Biological parent
 - Step parent
 - Foster parent
 - Adoptive parent
 - Grandparent
 - Guardian
 - Some other relationship
 - Prefer not to answer
 7. In general, how would you describe your child's health?
 - Excellent
 - Very good
 - Good
 - Fair
 - Poor
 - Don't know/Not sure
 - Prefer not to answer
 8. Does your child currently have any physical, behavioral, or mental conditions that limit or prevent him/her from doing childhood activities usual for his/her age? [Mark all that apply]
 - YES, physical condition
 - YES, behavioral condition
 - YES, mental condition
 - No
 - Don't know/Not sure
 - Prefer not to answer
 9. Does your child have any kind of healthcare coverage, including health insurance, prepaid plans such as HMOs, or government plans such as MediCal?
 - Yes
 - No
 - Don't know/Not sure
 - Prefer not to answer
 10. Does your child's health insurance offer benefits or cover services that meet his/her needs?
 - Never
 - Sometimes
-

-
- Usually
 - Always
 - Don't know/Not sure
 - Prefer not to answer
11. In the past 12 months did your family have problems paying or were unable to pay any of your child's medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, or home care.
- Yes
 - No
 - No expenses
 - Don't know/Not sure
 - Prefer not to answer
12. Is there a place that your child USUALLY goes when he/she is sick or you need advice about his/her health?
- Yes
 - No
 - There is more than one place
 - Don't know/Not sure
 - Prefer not to answer
13. During the past 12 months, did your child see a doctor, nurse, or other healthcare professional for any kind of medical care, including sick-child care, well-child check-ups, physical exams, and hospitalizations?
- Yes
 - No
 - Don't know/Not sure
 - Prefer not to answer
14. During the past 12 months, how many times did your child see a doctor, nurse, or other healthcare provider for preventive medical care such as a physical exam or well-child checkup?
- -----Times
 - Don't know/Not sure
 - Prefer not to answer
15. During the past 12 months, did your child have a toothache, decayed teeth, or unfilled cavities?
- Yes
 - No
 - Don't know/Not sure
 - Prefer not to answer
 - Not applicable; my child is less than 12-months-old and/or his or her first tooth has not erupted
-

-
16. About how long has it been since your child last visited a dentist or dental clinic? Include dental hygienists and all types of dental specialists.
- Has never visited
 - 6 months or less
 - More than 6 months up to 1 year ago
 - More than 1 year up to 2 years ago
 - More than 2 years up to 5 years ago
 - More than 5 years ago
 - Not applicable; my child is less than 12-months-old and/or his or her first tooth has not erupted
 - Don't know/Not sure
 - Prefer not to answer
17. Has your child ever had any difficulties with his or her emotions, concentration, or behavior or experienced some other mental health condition?
- Yes
 - No
 - Don't know/Not sure
 - Prefer not to answer
18. Has your child ever received any treatment or counseling from a mental health professional? Mental health professionals include psychiatrists, psychologists, and clinical social workers.
- Yes
 - No
 - Don't know/Not sure
 - Prefer not to answer
19. During the past 12 months did your child's doctors or other healthcare providers ask if you have concerns about his/her learning, development, or behavior?
- Yes
 - No
 - Don't know/Not sure
 - Prefer not to answer
20. Has your child ever had his or her vision tested with pictures, shapes, or letters?
- Yes
 - Not
 - Not applicable; my child is less than 3 years old
 - Don't know/Not sure
 - Prefer not to answer

21. Besides a hearing screening at birth, has your child ever had his or her hearing screened or tested using headphones, audio probe/electrodes, or a sound booth?

- Yes
- No
- Don't know/Not sure
- Prefer not to answer

22. Is your child of Hispanic, Latino or Spanish origin?

- Yes
- No
- Don't know/Not sure
- Prefer not to answer

Please choose one or more of the following categories to describe your child's race.

23. Is your child White, Black or African American, American Indian, Alaska Native, Asian, or Native Hawaiian or other Pacific Islander? [Mark all that apply]

- White/Caucasian
- Black/African American
- American Indian/Native American
- Alaska Native
- Asian
- Native Hawaiian
- Pacific Islander
- Other (please specify) -----
- Don't know/not sure
- Prefer not to answer

24. If you marked that your child is Asian, is he/she ... ? [Mark all that apply]

- Chinese
- Filipino
- Asian Indian
- Japanese
- Korean
- Pakistani
- Taiwanese
- Vietnamese
- Other (please specify) -----
- Not applicable, my child is not Asian
- Don't know/not sure
- Prefer not to answer

25. Please think about your total combined family income during 2015 for all members of the family. What was that amount before taxes?

- Less than \$5,000
- \$5,000 to under \$10,000
- \$10,000 to under \$15,000
- \$15,000 to under \$20,000
- \$20,000 to under \$25,000
- \$25,000 to under \$30,000
- \$30,000 to under \$45,000
- \$45,000 to under \$60,000
- \$60,000 to under \$75,000
- \$75,000 to under \$90,000
- \$90,000 to under \$105,000
- More than \$105,000?
- Don't know/not sure
- Prefer not to answer

APPENDIX C: QUALITATIVE DATA CODING SCHEME

The table below lists the coding scheme used for analyzing the qualitative data (key informant interviews and focus groups):

QUALITATIVE DATA CODING SCHEME

Family	Code	Definition
Populations	Age_0-5_preschool	Comments related to 0 to 5 age group. NOTE: Comments related to preschool or early education should be coded under Ed_early_preschool.
Populations	Age_elementaryschool	Comments related to elementary school
Populations	Age_preteen_middleschool	Comments related to preteen or middle school
Populations	Age_teen_HS	Comments related to teens or high school
Barriers_challenges	Barriers_cost	Comments related to cost as a barrier
Barriers_challenges	Barriers_cultural_conflicts_differences	Comments related to cultural conflicts and differences
Barriers_challenges	Barriers_discrim	General code that should be double-coded (when possible) in relation where it happens (e.g., school, neighborhood). Experiences and comments related to experiences of racism and discrimination.
Barriers_challenges	Barriers_Issue_challenge_problem	These are the issues that participants identify as being challenges or barriers - recommendations may address common issues.
Barriers_challenges	Barriers_language	Comments related to language as a barrier
Barriers_challenges	Barriers_location_distance	Comments related to distance or location as a barrier (e.g., resources are far away or spread out and difficult to access)
Barriers_challenges	Barriers_stigma	Comments related to stigma as a barrier
Barriers_challenges	Barriers_time	For example: long wait time long travel time limited hours office/clinic/etc. are open not enough time in the day to get everything done so some things don't happen
Populations AND Systems	criminal_justice	Comments related to criminal justice system and individuals involved in the criminal justice system
<i>none assigned</i>	Disparities_inequities	Participants refer to a range of disparities or inequities, for example in education.

Individuals AND Physical and social environment / neighborhood AND Social and family support	Drugs_SubstanceUse_Alcohol	Comments regarding substance abuse generally and drug use of any kind
Economic security and housing	Econ_Cost_of_living	Cost of living and the costs of supporting a family in Bay Area
Economic security and housing	Econ_economic_Security	Comments related to economic wellbeing, food insecurity, and drivers of poverty including educational attainment of adults (e.g., graduation rates, poverty, housing costs, cost of living, job availability, income inequality, workforce)
Economic security and housing	Econ_employment_living_wage	Employment that pays living wage/ sufficiency to be able to support living expenses
Economic security and housing	Econ_Housing	Comments regarding housing (e.g., cost of housing, overcrowding, etc.)
Economic security and housing	Econ_Job_opps	Employment opportunities (both parents and teens)
Education / school environment	Ed_absences_truancy	Comments related to parents keeping their kids out of school due to barriers (e.g., transportation) or illness, youth/children missing class or school, AND comments related to parents being unable to keep sick children home due to work.
Education / school environment	Ed_Access_high_qual_ed	Access to high quality education (or lack thereof)
Education / school environment	Ed_caregiver_involvement	Comments related to the importance of parenteral/ caregiver involvement in youth education. NOTE: Discussion of caregiver or parenteral involvement outside of education should be coded under Support_supportive_adults_RoleModels.
Education / school environment	Ed_earlyed_preschool	Comments related to early education or preschool. NOTE: Comments regarding general 0-5 age group should be coded under Age_0-5_preschool.
Education / school environment	Ed_edu_environment	Experiences and comments related to education and school environment
Education / school environment	Ed_safety_at_school_bullying	Safety issues in the school environment include general safety, bullying, harassment
Education / school environment	Ed_soc_emot_develop	Comments related to Social Emotional Development/ Learning. NOTE: If social emotional development is coming up outside of the education realm (either preschool or K-12), make a note of that -- if that happens multiple times we may need to move this out of the Education family.
Physical and social environment / neighborhood	Enviro_access_healthy_food	Access to affordable, healthy foods (or lack thereof)

Physical and social environment / neighborhood	Enviro_access_phys_activity	Access to safe spaces for physical activity (or lack thereof)
Physical and social environment / neighborhood	Enviro_infrastructure_built	Comments related to physical infrastructure and built environment and or lack thereof (e.g., sidewalks, street lighting, speed bumps, crosswalks, potholes) NOTE: General comments about physical and social environment should be coded under Enviro_phys_social_enviro.
Physical and social environment / neighborhood	Enviro_Phys_social_enviro_general	Physical and social environment (neighborhood conditions)
Physical and social environment / neighborhood	Enviro_racism_racial_profiling	Comments about any type of racism (explicit and implicit, individual-level and systemic) and ways that racism plays out (such as through racial profiling)
Physical and social environment / neighborhood	Enviro_transportation	Transportation that is affordable, local, frequent/reliable, reduces time in transit (or lack thereof)
Populations	Geographic_area	Geographic areas in the county
Individuals	Individ_experiences	Comments related to experiences (e.g., experiences access services, resources, healthcare, etc.)
Individuals	Individ_health_behav	Experiences and comments related to health behaviors
Individuals	Individ_parent_education	Parent education
Individuals	Individ_provider_education	Comments related provider education or increased workforce capacity
Systems	Policies_laws_ballotmeasures	Specific policies, ordinances, laws, and ballot measures that are referenced
Populations	Pop_AfAm_Black	Comments related to African American/African/African ancestry/Black communities/populations/individuals
Populations	Pop_American_Indian	Comments related to American Indian/Native American/indigenous communities/populations/individuals Also all comments made in American Indian language focus groups
Populations	Pop_foster_youth	Comments related to youth who were or are in the foster care/child welfare system
Populations	Pop_homeless	Comments related to homeless people/population/individuals Also all comments made in focus group with homeless and rapid re-housing programs (but NOT the focus group at Peacock Commons, which included participants who had not been homeless)
Populations	Pop_immigrants	Comments related to immigrants (regardless of status; both undocumented and those with legal status)

Populations	Pop_Latinx	Comments related to Latino/a community/populations/individuals Also all comments made in Spanish language focus groups
Populations	Pop_LGBTQ	Comments related to LGBTQ community/populations/individuals
Populations	Pop_Mandarin_speakers	All comments made in the Mandarin language focus group
Populations	Pop_other_vulnerable	Comments related to other vulnerable populations that do not have a specific code (e.g., Filipino community, teen parents) Comments about low-income and poor communities/people should be coded using Poverty Comments related to people currently or formerly involved in the criminal justice system should be coded using Criminal_justice Comments in focus groups should be coded to the target population for the focus group
Populations	Pop_people_with_disabilities	Comments related to community/populations/individuals with physical, developmental, psychological, and/or learning disabilities
Populations	Pop_SouthCounty_residents	Comments made by South County residents (in focus groups held in Gilroy)
Populations	Pop_Vietnamese	Comments related to Vietnamese community/population/individuals Also all comments made in the Vietnamese language focus group
Populations	Poverty	Comments related to poverty and its effects on children or youth. Include in this code comments about communities living in poverty.
<i>none assigned</i>	Quotable	Quote that is compelling
<i>none assigned</i>	Reasons_Causes	These are the reasons or causes participants give for the top concern or issues they mention prior. These could also be considered "drivers" or root causes of the issues.
Solutions / recommendations	Rec_recommendations	Comments about potential recommendations or suggestions to address identified issues. Include innovative things and things that have worked in this code.
Solutions / recommendations	Rec_Top_3_changes	Top 3 changes that would improve child health in SCC
Social and family support	Support_other	Comments regarding general social and family support
Social and family support	Support_Resilience	Comments that relate to or demonstrate resilience and positive coping
Social and family support	Support_Stress	Comments regarding stress

Social and family support	Support_supportive_adults_RoleModels	Comments related to supportive adults and role models (e.g., parents, caregivers, or other adults)
Access to healthcare and services	Svcs_childcare	Comment related to childcare services
Access to healthcare and services	Svcs_eligibility	Comments related to eligibility of services or insurance, including comments regarding benefit cliffs
Access to healthcare and services	Svcs_gap_insufficient	Comments related to service gaps and lack of services/providers (in general or within accessible geographic area) If appropriate, double code with relevant systems-level codes (i.e., EBT cards not widely accepted = services_gap_insufficient AND systems_general)
Access to healthcare and services	Svcs_healthcare	Comments related to healthcare access or healthcare services
Access to healthcare and services	Svcs_insurance	Comments related to health insurance
Access to healthcare and services	Svcs_mental_health	Access to mental healthcare or general comments about mental health services
Access to healthcare and services	Svcs_navigation	Comments related to navigating services (e.g., families having difficulty navigating services, knowing what exists or is available to them, or coordination of services)
Access to healthcare and services	Svcs_oral_health	Comments about access to oral healthcare, utilization of oral health preventative services and dentists, and oral health disease prevalence (e.g., decay, gum disease, or infection)
Access to healthcare and services	Svcs_quality_of_svcs	Comments related to quality of services
Access to healthcare and services	Svcs_resources	Comments about social services in general and about specific services/resources
Access to healthcare and services	Svcs_vision_care	Access to vision care or general comments about vision care
Systems	Systems_general	Comments that relate to systems that are not focused on planning/strategy or siloes
Systems	Systems_planning_strategy	Comments that relate to systems/structural level planning and strategizing -- for example, needing to change countywide priorities and how resources are allocated or needing to thinking about children or families more holistically
Systems	Systems_siloes	Comments that relate to systems/structural level siloes -- for example, the lack of cross-sector collaboration, the need for data sharing between agencies to better serve clients/residents, and when programs within the same agency don't communicate or collaborate
<i>none assigned</i>	TopConcerns	Top concerns/ top issues that participant has in life/ greatest impact on children's health

<i>none assigned</i>	Trauma	Comments related to trauma
<i>none assigned</i>	Violence	Comments related to violence, fear or threat of violence, perception of safety, injury from violent crime, domestic abuse, child abuse (e.g., rape, assault, gang activity, police violence, homicide, crime)

APPENDIX D: CALL TO ACTION COMMUNITY FORUM PARTICIPANTS

The table below lists the groups, organizations and agencies represented by the participants of the Call to Action community forum:

GROUPS, ORGANIZATIONS AND AGENCIES PRESENT AT THE COMMUNITY FORUM

African American Community Service Agency	Minority Business Consortium
Alum Rock Counseling Center	National Coalition of 100 Black Women
American Diabetes Association	Office of Education
American Heart Association	Office of the County Executive
Asian American Recovery Services/ HealthRight 360	Palo Alto Healthcare System
Asian Americans for Community Involvement	Portuguese Organization for Social Services and Opportunities
Bay Area Women's Sports Initiative	Project Cornerstone – Young Men's Christian Association (YMCA)
Bill Wilson Center	PRx Digital Inc
Board of Supervisors	Raimi + Associates
Boldly Me	Sacred Heart Community Service
Breathe California of the Bay Area	San Andreas Regional Center
Catholic Charities of Santa Clara County	San José State University
Children's Dental Center	San José State University Chamber
City of Palo Alto	Santa Clara County Behavioral Health Services Department
Community Child Care Council of Santa Clara County, Inc.	Santa Clara County Commission of Senior Care
Community Child Care Council of Santa Clara County, Inc. - 4Cs Early Head Start	Santa Clara County Department of Family & Children's Services
Community members	Santa Clara County Health and Hospital System
Family & Children Services of Silicon Valley	Santa Clara County Public Health Department
FIRST 5 Santa Clara County	Santa Clara University
Foothill Community Center	School Health Clinics
Foothill Community Health Center	School Health Clinics

Franklin-McKinley School District, San Jose	Second Harvest Food Bank
Fremont Union High School District	Service Employees International Union Local 521
Gardner Family Health Network	Services, Immigrant Rights, and Education Network
Gilroy Unified School District	Silicon Valley Council of Nonprofits
Go Kids	Silicon Valley Leadership Group
Housing Choice Coalition	Social Services Agency
International Children Assistance Network	Sourcewise
Iranian Federated Women's Club	Stanford Children's Health
JACUE	Sunday Friends Community
Justice 4 Josiah	Superior Court of California
Kaiser Permanente	Union Elementary School District
Kidango	Union School District
Kids In Common	Unity Care Group
Law Foundation of Silicon Valley	Uplift Family Services
Legal Advocates for Children & Youth	Year Up
Licencias.US	Young Men's Christian Association (YMCA) of Silicon Valley
Mental Health	Young Women's Christian Association (YWCA) of Watsonville

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