Building Infrastructure for COORDINATED SCHOOL HEALTH

CALIFORNIA'S BLUEPRINT

Recommendations of the
COORDINATED SCHOOL
HEALTH GROUP
CALIFORNIA DEPARTMENT
OF EDUCATION
Sacramento, 2000

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Recommendations of the

School Health Work Group, convened jointly
by the California Department of Education
and the California Department of Health Services

Publishing Information

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Prepared for publication by CSEA members.

Contents

Foreword

> One of the most important, cross-cutting social policy perspectives to emerge in recent years is an awareness that no single institution can create all conditions that young people need to flourish, not only in schools but in their careers and as parents.
>
> —Melaville and Blank

We embrace the concept that a multitude of institutions, agencies, and organizations must assume responsibility for the health and academic success of California's children and youth. As such, more than 70 people from a broad spectrum of organizations worked together as members of the Coordinated School Health Work Group to determine how best to build an interagency system of supports for the state's children and their families. The result was the development of ***Building Infrastructure for Coordinated School Health: California's Blueprint*** to provide recommendations and action steps that can be initiated by the California Department of Education, the Department of Health Services, and other state departments; county offices of education; local health departments; school districts and schools; and community and business partners.

In the development of this document, the Work Group identified six goals focused on the following elements:

- **Youth development**
- **Policy development**
- **Collaboration and coordination**
- **Personnel capacity**
- **Research-based strategies**
- **Funding**

The aim of the Coordinated School Health Work Group is to enable California's children and adolescents to become healthy, successful students at school and contributing members in their communities. This Blueprint delineates the foundation upon which children and adolescents in California can develop their capabilities for leading rewarding and productive lives.

A coordinated school health approach effectively addresses students' health, thus improving their ability to learn. This approach features eight interrelated components: health education; physical education; school health services; school nutrition services; school counseling, psychological, and social services; a healthy school environment; and school-site promotion of health for staff.

The Coordinated School Health Work Group invites and encourages you and others to take action in your community by implementing the Blueprint recommendations that follow in this document.

Joan Davies, *Alameda County Office of Education*
Claudia Epperson, *Modesto City Schools, Robertson Road Healthy Start*
Alan Henderson, *American Cancer Society and California State University, Long Beach*
Carla Niño, *California State Parent–Teacher Association*
Maxine Sehring, *American Academy of Pediatrics*
Gregory Thomas, *California Conference of Local Health Department Officials/San Luis Obispo County Health Agency*

Preface

> The term *health* is used in the broadest sense. Health is much more than simply the absence of disease; health involves optimal physical, mental, social, and emotional functioning and well-being.
>
> —World Health Organization

RISING CONCERNS OVER THE STATE OF HEALTH OF OUR CHILDREN AND OUR YOUTH HAVE resulted in a national dialogue, proposed legislation, and myriad initiatives and proposals to deal with those concerns. Because schools touch most families, coordinated school health programs show considerable promise toward aiding those efforts.

The previous emphasis in the schools on prevention is slowly shifting away from merely "fixing the kid"—focusing on deficits—to creating an environment that provides proven support and opportunities for children and youth, especially among low-income and racial or ethnic populations. Youth are increasingly being given a meaningful role in the development of programs and efforts to address health issues. In the process they develop lifelong leadership skills that they may draw on in the future in their workplace and in their communities.

When asked to identify what is necessary for students to learn before high school graduation, Americans ranked health education above instruction in language arts, mathematics, and science in a recent Gallup Poll. Nine of 25 standards selected by the respondents—or 36 percent of the top 25 rated standards—were health standards (Marzano, Kendall, and Cicchinelli 1999).

Research has established links between a student's health and school performance (Symons et al. 1997; National Commission on the Role of the School and the Community in Improving Adolescent Health 1990; National Health/Education Consortium 1990). Further, numerous studies have established the effectiveness of school health programs in reducing specific risky behaviors (Symons et al. 1997; National Commission on the Role of the School and the Community in Improving Adolescent Health 1990; Dryfoos 1990). However, what has been lacking is a coordinated approach to school health and the necessary infrastructure to support it (Council of Chief State School Officers 1991; National Commission on the Role of the School and the Community in Improving Adolescent Health 1990). A coordinated approach will improve the health of children and youth and their capacity to learn through the support of their families, schools, and communities working together. At its very core, coordinated school health focuses on keeping students healthy over time, reinforcing positive healthy behaviors throughout the school day, and making clear that good health and productive learning go hand in hand.

Acknowledgments

> There is no question that our schools have a key role to play in helping our children begin a lifetime of good health.
>
> —Donna Shalala, U.S. Secretary of Health and Human Services

SPECIAL THANKS ARE OFFERED TO THE MEMBERS OF THE WORK GROUP AND THE STATE agency liaisons who participated in the meetings and developed the goals and action steps described in this document. Also appreciated are the contributions of the many persons who reviewed drafts and provided comments. In addition, thanks are extended to the thousands of Californians committed to building the infrastructure for coordinated school health so that children and youth will be mentally, socially, emotionally, physically, and spiritually healthy and will be lifelong learners.

The publication of this document and the important work that led to its development were made possible by funding from the Centers for Disease Control and Prevention, Division of Adolescent and School Health. That support is gratefully acknowledged. The assistance provided by the California Department of Education and the California Department of Health Services is also deeply appreciated.

Coordinated School Health Work Group

April Allen, Regional Manager, Dairy Council of California

Jackie Allen, Chair, California Alliance of Pupil Service Organizations

Lucinda Mejdell Awbrey, Coordinator, Student Support Services, Visalia Unified School District

Robin Gray Ballard, 1999–2000 President, California Association for Health, Physical Education, Recreation, and Dance

Lisa Bass, Youth Program Manager, American Cancer Society, California Division, Inc.

Robert Bates, Medical Consultant, California Department of Health Services

Bonnie Bernard, Senior Program Associate, WestEd, School and Community Health Research Group

Ruth Bowman, Consultant, California Department of Education

Beverly Bradley, Assistant Clinical Professor, University of California, San Diego, School of Medicine

Maria Campbell-Casey, Consultant, The Public Health Institute

Tricia Capri, Senior Program Manager, Corporate Contributions, Pacific Gas and Electric Company

Tricia Chicagus, Field Coordinator of Nursing Services, Los Angeles Unified School District

Norm Constantine, Director, WestEd, School and Community Health Research Group

Martha Cornejo, Secretary, Woodland Joint Unified School District, Community Service Learning Center

Peter Cortese, Chief (Emeritus), Program Development and Services Branch, Division of Adolescent and School Health, Centers for Disease Control and Prevention

Gus Dalis, Director, Los Angeles County Office of Education, Center for Health Education

*__Joan Davies,__ Director, Alameda County Office of Education, Bay Region IV School Support Center

Daphne Dennis, Social Services Administrator, City of West Hollywood

Pat Dumais, Registered School Nurse, Woodland Joint Unified School District

Francine Eisenrod, Director, Los Angeles Unified School District, Health, Drug, Alcohol, and Tobacco Education Programs

Margaret Elliot, Executive Director, California Physical Education and Health Project

*__Claudia Epperson,__ Healthy Start Project Coordinator, Modesto City Elementary School District

Dean Fenley, Project Officer, Centers for Disease Control and Prevention

Jared Fine, California Dental Association and Dental Health Administrator, Alameda County Public Health Department

Bruce Fisher, Teacher, Fortuna Union School District

Tara Gallagher, Student, Woodland Joint Unified School District

Beatriz Garcia-de la Rocha, CHAMP Coordinator, Los Angeles Unified School District

Wanda Grant, Child Nutrition Director, El Monte City School District, California School Food Service Association

Nina Grayson, Regional Adviser, California Department of Social Services, Welfare-to-Work Division

Cyndi Guerra-Walter, Writer

*__Alan Henderson,__ Past President, American Cancer Society, and Professor, California State University, Long Beach, Health and Science Department

Betty Hennessy, Physical Education Consultant, Los Angeles County Office of Education

Lisa Hershey, Coordinator, California Department of Health Services, Vehicle Occupant Safety Program

Taj James, Director of Youth Policy and Development, Coleman Advocates for Teens and Youth

Jim Kooler, Deputy Director, California Department of Alcohol and Drug Programs

Yvonne Larsen, Member 1992–2000, California State Board of Education

Kathy Lewis, Deputy Superintendent, California Department of Education

Willie Lopez, Communicable Disease Specialist II, Fresno County Human Services

Ric Loya, Coordinating Teacher Adviser, Los Angeles Unified School District, AIDS Prevention Unit, and Vice President, California Association of School Health Educators

*Member of the Steering Committee

†**Barbara Marquez,** Chief, California Department of Health Services, Office of Community Challenge Grants

Terry Maxson, Director, Children's Hospital (San Diego) School Health

Edward Melia, Special Assistant for Children and Youth, Health and Human Services Agency

Tameron Mitchell, Deputy Director, California Department of Health Services

*†**George Monteverdi,** Vice President, American Academy of Pediatrics, California Chapter

Dave Neilson, Chief, Children and Family Services, California Department of Mental Health, Mental Health Specialist Systems of Care—Children

Gary Nelson, Senior Program Officer, The California Wellness Foundation

Linda Neuhauser, Executive Director, University of California, Berkeley, Wellness Guide Project

*†**Carla Niño,** Vice President 1999, California State Parent–Teacher Association

Donna Petre, Judge, Yolo County Superior Court

Marisela Romero, Student, Woodland Joint Unified School District

†**Jennifer Rousseve,** Consultant, California Department of Education

Linda Ward Russell, Coordinator, Los Angeles Unified School District, Pregnant/Parenting Teen Programs

Sarah Samuels, President, Samuels and Associates

Michele Sartell, Manager, 100% Campaign: Health Insurance for Every California Child

Maxine Sehring, Pediatrician, American Academy of Pediatrics

Penny Stone, California School Nurses Organization

Linda Taylor, Codirector, University of California, Los Angeles, Center for Mental Health in School

*†**Gregory Thomas,** Representative, California Conference of Local Health Officers

Louis Vismara, Commissioner, California Children and Families State Commission

Stephen Wilkes, Facilitator, Stephen L. Wilkes and Associates

Deborah Wood, Director, California Healthy Kids Resource Center

*Member of the Steering Committee
†State staff liaison to the Steering Committee

State Staff Liaisons to the Coordinated School Health Work Group

*†**Jeanne Bartelt,** Physical Education Consultant, School Health Connections

*†**Barbara Baseggio,** Administrator, Elementary Networks Office

*†**Christine Berry,** HIV/AIDS Prevention Education Consultant, School Health Connections

*†**Donna Bezdecheck,** Assistant Consultant, School Health Connections

*†**Marilyn Briggs,** Director and Assistant Superintendent, Nutrition Services Division

*†**Wade Brynelson,** Assistant Superintendent, Learning Support and Partnerships Division

†**Anna Diaz,** School Outreach Coordinator for Health Care Access, School Health Connections

†**Larry Dickey,** Chief, Office of Clinical Preventative Medicine

†**Nancy Gelbard,** Chief, School Health Connections

*†**Gerald Kilbert,** Administrator, Healthy Kids Program Office

†**Donald Lyman,** Division Chief, Chronic Disease and Injury Control Division

*†**Paul Meyers,** Consultant, Student Support Services and Programs

*†**Patricia Michael,** Consultant, Special Education

*†**Emily Nahat,** Former Administrator, School Health Connections

†**Maggie Petersen,** Nurse Consultant, Children's Medical Services Branch

*†**Caroline Roberts,** Administrator, School Health Connections

†**Rugmini Shah,** Former Chief, Maternal and Child Health Branch

*†**Rhonda Simpson-Brown,** Pregnant Minor Program Consultant, Family and Community Partnerships Office

*†**Susan Thompson,** Administrator, Family and Community Partnerships Office

*†**Alice Trathen,** Child Development Consultant, Child Development Division

*California Department of Education
†California Department of Health Services

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Executive Summary

A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community, based on community needs, resources, standards, and requirements. It is coordinated by a multidisciplinary team and is accountable to the community for program quality and effectiveness.

—Institute of Medicine

THE MOST SERIOUS AND COSTLY HEALTH AND SOCIAL PROBLEMS THAT AFFLICT OUR nation are caused in large part by (1) behaviors that cause unintentional and intentional injuries; (2) abuse of drugs and alcohol; (3) behaviors leading to infection by sexually transmitted diseases, including HIV infection, and unintended pregnancies; (4) use of tobacco; (5) inadequate physical activity; and (6) dietary patterns that cause disease. Ultimately, all those behaviors are preventable. They are usually established during youth, persist into adulthood, are interrelated, and contribute simultaneously to poor health, inadequate education, and inappropriate social outcomes. By preventing health problems that afflict our youth and threaten their adulthood, coordinated school health programs can help reduce the spiraling costs of health care, help improve educational outcomes, and foster positive youth development.

To address the health concerns of children and youth in a coordinated, comprehensive manner, the California Department of Education and the California Department of Health Services have embarked on a process to build infrastructure support for coordinated school health through a grant provided by the Centers for Disease Control and Prevention. To that end the departments have established separate but coordinated school health program offices known as School Health Connections. The offices form a cross-departmental team and work with other state agencies and organizations and associations that support the well-being of children, youth, and families.

This planning document identifies goals and prioritized action steps that can be initiated by the Department of Education, the Department of Health Services, county offices of education, local health departments, school districts, and schools. The goals and action steps reflect input from a diverse group of respondents, including state-level policymakers; staff members in schools, school districts, and county offices; families; students; community leaders; and experts in the field of school health.

Infrastructure

1. An underlying base or foundation, esp. for an organization or a system.
2. The basic facilities, services, and installations needed for the functioning of a community or society, such as transportation and communications systems.

— The American Heritage College Dictionary

Needs Assessment

The California Department of Education contracted with the Evaluation and Training Institute (ETI) to conduct a statewide needs assessment and develop a preliminary plan for building infrastructure for coordinated school health in California. ETI undertook the work in conjunction with SRI International. The assessment identified assets and needs related to coordinated school health and comprehensive school health education at the state and local levels. The sources of the data used to develop the needs assessment were the following:

- Interviews with key informants from the California Department of Education, the California Department of Health Services, universities, local agencies, and nongovernmental organizations
- Focus groups comprising local school health professionals, students, parents, and community members in six rural and urban locations across the state
- A survey of school health professionals at county offices of education and local health departments

For an overview of the findings, see Appendix A, "Executive Summary of CSHP Needs Assessment." For a more detailed description of the needs assessment, see "Comprehensive School Health Program Needs Assessment Final Report" (California Department of Education 1998).

Coordinated School Health

The Centers for Disease Control and Prevention (CDC) describes coordinated school health as planned, integrated, school-affiliated programs designed to enhance the health of children and adolescents and comprising eight interrelated components:

- *Comprehensive school health education*
- *Physical education*
- *Parent/community involvement*
- *Healthful school environment*
- *Health services*
- *Counseling, psychological services and social services*
- *Nutrition services*
- *Health promotion for staff*

Each of the components is present to some extent in most schools and districts but usually functions independently. Rarely have staff members serving in individual components been directed to work with those in other components. Nor have they been informed of the activities taking place in those components.

To change this situation, CDC is funding efforts in several states, including California, through the California Department of Education and the California Department of Health Services, to implement coordinated school health programs. Its intent is to enable the California agencies to work together to provide guidance and leadership toward promoting the health of children and youth through the state's public school system.

—**Peter A. Cortese,** Chief (Emeritus), Program Development and Services Branch, Division of Adolescent and School Health, Centers for Disease Control and Prevention

Blueprint for California

In preparation for the development of a comprehensive plan for California, a draft blueprint was prepared and disseminated to the Coordinated School Health Work Group for review and comments (see Table 1, "Model for the Development of California's Blueprint for Coordinated School Health," on p. 5). The work group, composed of diverse stakeholders in school health, met twice between May and August 1999 to refine the draft. The group's work was based on the following assumptions (Lavin et al. 1992):

- Education and health are interrelated.
- Social morbidities are the biggest threats to health.

- A more comprehensive, integrated approach is needed.
- Efforts should be focused in and around schools.
- Prevention efforts are cost-effective (costs of inaction are high and escalating).

A draft reflecting input from members of the work group was also disseminated for field review to hundreds of persons working in coordinated school health. (See "Mission of the Coordinated School Health Work Group" on p. 6.) The final blueprint includes six goals for accomplishing the mission. California's youth, families, schools, communities, and government entities will work together to support the positive development of children and youth so that they will be mentally, socially, emotionally, physically, and spiritually healthy and will be lifelong learners. The blueprint also describes accompanying multilevel action steps that can be implemented by communities, organizations, and agencies at the local and state levels. The goals to be achieved are listed as follows:

Goal 1: Coordinated school health policies and programs will support and contribute to the positive development of children and youth.

Goal 2: Policies at all levels will fully support coordinated school health for California's diverse populations.

Goal 3: Funds and resources will be allocated to support coordinated school health for California's diverse populations.

Goal 4: Closer collaboration and better coordination will be established within and between the California Department of Education and the California Department of Health Services, other state and local agencies, and business and community partners.

Goal 5: Personnel capacity in school health at the state and local levels will increase and will reflect California's diverse populations.

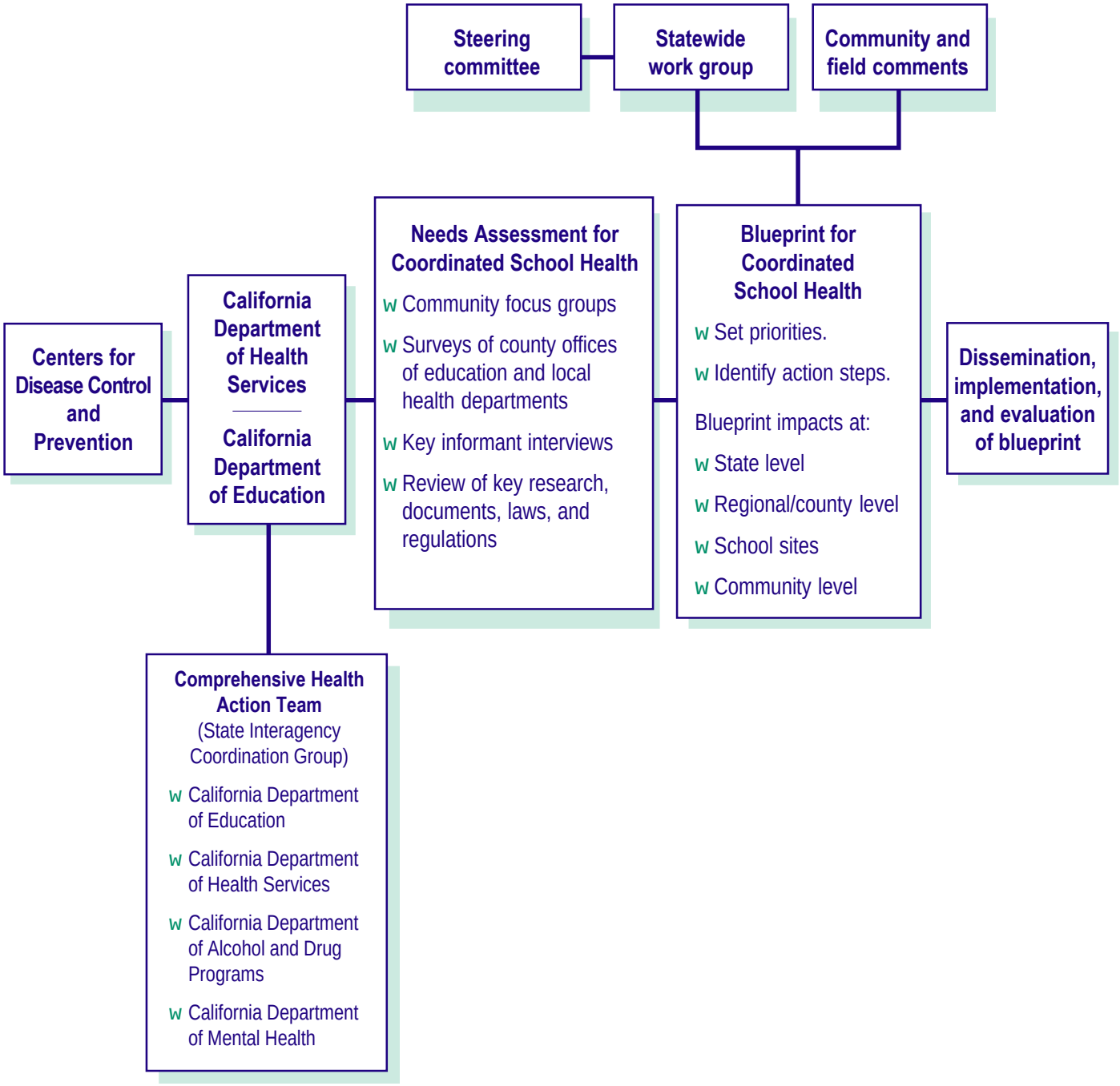
Goal 6: Use of state-of-the-art, research-based strategies to implement coordinated school health will increase.

Because California is one of the most diverse states in the nation, any effort of this magnitude must address the multicultural and multilinguistic needs of children and youth and their families. A number of other factors apply to the planning, implementation, and evaluation of many of the goals, such as youth development and social marketing.

Within each goal, action steps are identified for state agencies, local health departments, county offices of education, school districts, schools, and organizations. Although the blueprint was developed on behalf of the California Department of Education and the California Department of Health Services, implementation will be realized through broad-based partnerships involving families, schools, agencies, and communities to support further the well-being and success of California's children and youth.

Table 1

Model for the Development of California's Blueprint for Coordinated School Health



Source: California Department of Health Services/California Department of Education, School Health Connections, August 18, 1999

When we adults are well, we are able to focus, learn, work, and be successful in what we do. Would this not be more so for our children?

—Lucinda Mejdell-Awbrey, Coordinator
Student Support Services, Visalia Unified School District

Social Marketing

Social marketing approaches are being used by a variety of public health programs to achieve large-scale behavioral changes. A practical definition is that social marketing applies commercial marketing approaches to achieve social goals. Operationally, social marketing uses the traditional mix of advertising, publicity, promotion, and personal sales from commercial marketing and adds community development, consumer empowerment, institutional change, and partnership. It employs mass media and existing social systems, often called "channels," to reach large numbers of consumers.

—California Dietary Practices Survey, 1989–1997

Mission of the Coordinated School Health Work Group

What we do:

Through our contributions to this blueprint, this work group builds and maintains the infrastructure necessary for effective coordinated school health in California.

How we do it:

We work together through broad-based partnerships.

For whom we do it:

We do it for the agencies, organizations, groups, and communities that support the well-being and success of California's children and youth. Together, those groups will advocate the health of children and youth to enhance the social and economic development of the communities in which they live.

Purpose of the blueprint:

The blueprint proposes an infrastructure that will enable us to achieve our vision.

Why we do it:

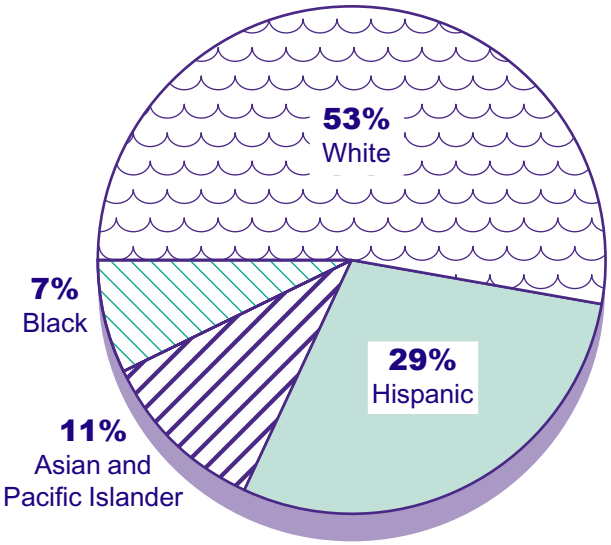
We do it to achieve our common vision for California's children, families, and communities.

California's Changing Demographics

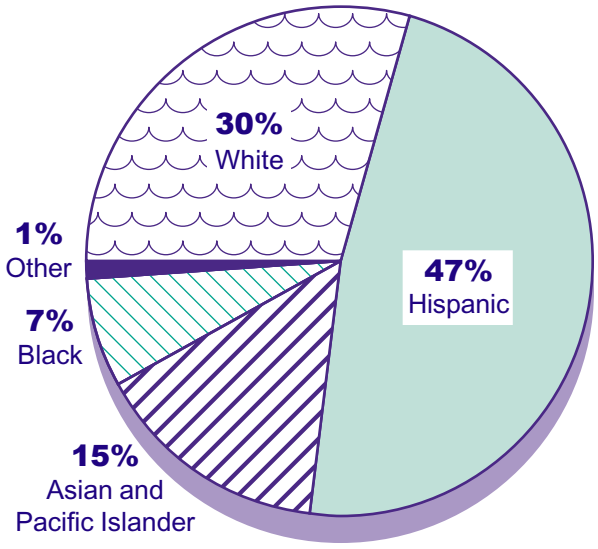
California is one of the fastest-growing and most diverse states in the nation. By 2040 California's majority population, now white, will become a minority as the Hispanic population increases. There will be no majority population. Consequently, it is imperative that all programs be designed and implemented in a culturally sensitive and linguistically appropriate manner. (See Fig. 1, below)

FIGURE 1

California Population Breakdown: 1996



California Population Projection: 2040



> Only when schools consider coordinated school health programs to be as essential as history, social studies, or language arts will they be able to maximize academic achievement and positive health outcomes among the children and youths they serve.
>
> —Harriet Tyson, "A Load off the Teachers' Backs: Coordinated School Health Programs"

Making a Case for Coordinated School Health

Tena Petix-Petersen, principal of Highland Elementary School, Riverside Unified School District, is passionate about coordinated school health because she witnessed its benefits and outcomes at her previous school, Longfellow Elementary, in the same district. "It was probably one of the most personally and professionally rewarding experiences of my life," Ms. Petix-Peterson said. "Because of the services and programs brought about through interagency coordination, teachers realized that they no longer needed to worry about feeding or clothing students. They could be concerned about teaching. The results were overwhelming." The students Longfellow served just recently graduated from high school and are going on to college. "And this was one of the most poverty-stricken schools in the area," Ms. Petix-Peterson said.

Ms. Petix-Peterson is taking the Longfellow experience into Highland Elementary School, where she hopes to bring mental health and public health agencies together to serve students and their families in a coordinated manner. "This approach allows us to offer families 'one-stop shopping.' Families interact with one person to access needed services (e.g., social, medical, employment, instead of having to contact 17 people)," Ms. Petix-Peterson said. "When families are taken care of, when they know how to access food and health care, then their children are ready to come to school to learn."

Ms. Petix-Peterson also said that administrators are challenged to venture outside the traditional school perspective of teaching reading and writing and to embrace the whole family instead of just the child. "I think we're shortsighted if we only look at the child," Ms. Petix-Peterson said. "When the family is well, the probability for academic success is going to rise. If we don't deal with issues like the mental and physical health of the entire family early on, we end up paying for it later. The people who get hurt by this are the kids."

Highest-Priority Risks Among Youth

Among persons five through twenty-four years of age, four causes account for nearly three-quarters of all deaths and a great amount of disease and social problems. Motor vehicle crashes cause 29 percent of the deaths, 40 percent of which are alcohol related; homicide, 20 percent; suicide, 12 percent; and other injuries (such as those from falls, fires, drownings), 11 percent. Further, although not contained in the mortality statistics, nearly one-quarter of all new HIV infections, one-quarter of all new cases of infections with other sexually transmitted diseases, and one million pregnancies occur among our nation's teenagers each year. Only three types of behavior contribute to the mortality and morbidity just described—behaviors that result in unintentional or intentional injuries, the use of alcohol and other drugs, and inappropriate sexual conduct.

In the general adult population, approximately two-thirds of all deaths and a great amount of morbidity, suffering, and rising health care costs result only from three causes. Heart disease causes 34 percent of all deaths; cancer, 25 percent; and stroke, 7 percent. Again, only three categories of behavior contribute enormously to those causes: use of tobacco, poor diets, and physical inactivity.

Thus, only six types of behavior cause the most serious problems that afflict most Americans. Those behaviors are usually established during youth, persist into adulthood, are interrelated, and are preventable. In addition to causing serious health problems, the behaviors simultaneously cause many of the educational and social problems that confront the nation, including failure to complete high school, unemployment, having children while lacking adequate means to support them, and crime.

Californians Value Role of Schools in Contributing to Children's Health

Recent surveys reveal compelling findings concerning the views of Californians on factors enhancing the health of communities, the health of children, and the influence of the school system on children's health and development. Over the past four years, the California Center for Health Improvement has surveyed the opinions of Californians on a variety of children's issues, attempting to understand the respondents' views on the help they need in raising their children and the services that are important to them in ensuring that their children are healthy and ready to learn when they enter school. Significant findings include the following:

- Fifty percent of surveyed Californians believed that high-performing schools enhance community health.[1]
- Fifty-seven percent believed that good schools contribute a good deal to health status.[2]
- Sixty-five percent believed that immunization and other preventive services should be provided.[3]
- Sixty-four percent believed that emergency care services should be available.[4]
- Fifty-four percent agreed that referrals and managing acute and chronic conditions should be accessible to students.[5]
- Sixty-three percent agreed that it is very important that children and youth receive health instruction concerning physical, mental, emotional, and social factors relating to health and that it be designed to improve student health, prevent disease, and reduce health-risk behaviors.[6]
- Seventy-nine percent believed that teachers in schools are very involved or somewhat involved in helping children grow up healthy and well.[7]
- When asked how effective they thought providing support for new parents might be to ensure that children get a safe and healthy start in the early years of life, nearly nine of ten adults surveyed (89 percent) said that they thought such services would be extremely or somewhat effective.[8]
- Schools should offer a variety of support services in addition to a comprehensive curriculum.
- Teachers should help children develop to their full potential.
- Parents need help and support services to prepare children for learning.

—Karen Bodenhorn, Executive Director, California Center for Health Improvement

Sources:
1. California Center for Health Improvement. *Getting Involved.* Sacramento: California Center for Health Improvement, 1996.
2. Ibid.
3. California Center for Health Improvement and the Field Institute. *Survey on School Health Education and Healthcare Services.* Sacramento: California Center for Health Improvement and the Field Institute, 1998.
4. Ibid.
5. Ibid.
6. Ibid.
7. California Center for Health Improvement and the Field Institute. *Children and Youth Survey.* Sacramento: California Center for Health Improvement and the Field Institute, 1997.
8. Ibid.

The California Blueprint:

Goals and Action Steps

> To help children meet these [educational, health, and developmental] challenges, education and health must be linked in partnership. . . . Health, education, and human service programs must be integrated, and schools must have the support of public and private health care providers, communities, and families. . . . School health programs support the educational process, integrate services for disadvantaged and disabled children, and improve children's health prospects.
>
> —*Health Is Academic*

The following goals and action steps have been recommended for California's blueprint for coordinated school health:

Goal 1: Coordinated school health policies and programs will support and contribute to the positive development of children and youth.

ACTION STEPS

Schools, school districts, county offices of education, and local health departments will:

A. Identify community assets, resources, and public support for coordinated school health and youth development. They will:

1. Work with youth, families, and community partners to map assets and conduct a poll to determine local support for coordinated school health and youth development.
2. Administer the California Healthy Kids Survey and the resilience assessment module.[1]

B. Advocate the inclusion of youth development in coordinated school health programs. They will:

1. Support youth development in implementing local coordinated school health programs and after-school programs.
2. Work with youth, families, and community partners to create developmental supports and opportunities for them.

The California Department of Education, the California Department of Health Services, and other state agencies will:

C. Advocate the inclusion of youth development in coordinated school health programs. They will:

1. Conduct a social marketing or media advocacy campaign, or both, to support coordinated school health through youth development.
2. Disseminate effective youth advocacy efforts that support coordinated school health.
3. Develop a schematic for broad dissemination that depicts the relationship between coordinated school health and asset building.
4. Disseminate the report of the coordinated school health work group to community and advocacy groups (e.g., the American Academy of Pediatrics, the California School Boards Association, the American Cancer Society).

D. Incorporate the youth development perspective in requests for applications in program design and implementation and in funding decisions. They will address the needs of the whole child/youth with these changes.

[1] The California Healthy Kids Survey is based on the CDC Youth Risk Behavior Survey and the California Student Survey.

> Weaving the strands of coordinated school health together creates a strong safety net for all children and youth.
>
> —Linda Taylor, Codirector, Center for Mental Health in School

A Word About Youth Development, Resilience, and Assets: A Shared Paradigm

The terms *youth development*, *resilience*, and *assets* are increasingly being spoken of and heard in prevention, education, and youth services. Youth development, which is what the terms refer to, connects youth to caring people and places that believe in them and provide them with opportunities for participation, competency development, and contribution. Regardless of the term used, the three concepts refer to a strength-based, developmental approach to serving children and youth. They represent a paradigm shift from individually focused, problem-oriented approaches to serving children and youth, often referred to as the *deficit* model, to environmentally focused and health-promoting interventions. This more positive approach assumes that *all* youth need critical developmental supports and opportunities in their families, schools, and communities—assets that economic forces have been eroding for all children and youth.

Youth development, resilience, and assets approaches to education and prevention are variations on the developmental theme illustrated in Table 1 (p. 5).

Youth Development Process: Resiliency in Action

Youth development is grounded in the assumption that children and youth, like all other human beings, have basic needs for safety (physical and psycho-logical), love and belonging, respect, mastery and challenge, power and autonomy, and meaning (purpose and calling), as illustrated in Table 2 (p. 15). When families, schools, and communities provide the developmental supports and opportunities that meet these needs, children and youth can achieve positive social, emotional, cognitive, and spiritual development. In turn they are protected against involvement in health-risk behaviors and are helped to achieve successful learning. Although each of the approaches uses somewhat different terms for the assets and the number of those assets, these approaches complement, support, and relate well to one another.

Variations on the Theme

The term *youth development*, although not new as a concept in community-based youth services, has achieved increasing attention at the *policy* level, largely through the work of Karen Pittman and the Center for Youth Development and Policy Research as well as the International Youth Foundation. The youth development movement has strongly emphasized the importance of creating "a coherent youth policy centered on providing young people with continuous developmental

A Word About Youth Development . . . (Continued)

support and learning opportunities across institutions throughout a young person's life" (Community Network for Youth Development). The language of youth development includes youth needs, developmental supports and opportunities, youth competencies, and developmental outcomes.

The *assets* approach is mainly identified with Peter Benson and the Search Institute, which has been studying the correlation between *community* supports and opportunities (assets) and health-risk behaviors among youth for over a decade. The Search Institute has developed a list of 20 internal assets (competencies and individual outcomes) and 20 external assets (supports and opportunities) that its research has found to mediate health-risk behaviors. It has focused primarily on mobilizing the various sectors of community life (families, neighborhoods, faith communities, employees, youth organizations, schools) to work together to increase the number of developmental assets in young people's lives.

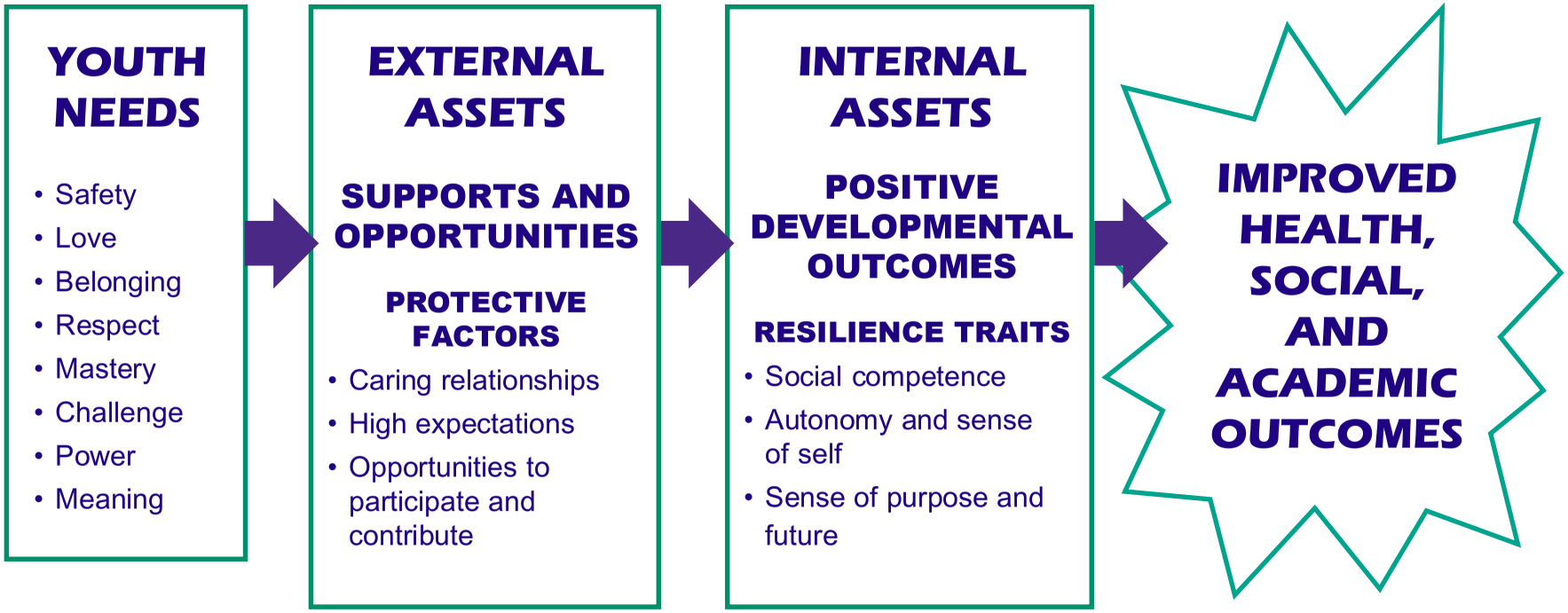
Traditionally, *resilience* refers to a growing body of research into how individuals have successfully transformed risk and adversity throughout their lifetime and have become, in the words of premier resilience researcher Emmy Werner, "competent, confident, and caring" adults. The research, also informed by studies in family social science, school effectiveness, brain science, community development, social work, medicine, and child and youth development, makes several contributions to the youth development approach. First, it clearly identifies the critical developmental supports and opportunities that can turn the life of a young person onto a positive path. These *protective factors* (external assets) are basically three: caring relationships, high expectation messages, and opportunities for participation and contribution. Second, resilience research names the individual strengths and traits (internal assets) that are the positive developmental outcomes of supportive environments: social competence, problem solving, and a sense of self, of one's purpose, and of the future.

Of most importance, resilience research provides powerful evidence that the youth development approach does indeed work as described previously. Research documents that resilience is a capacity that *all* individuals possess. It is a developmental wisdom that motivates persons to turn to the people, places, and experiences that meet their needs for safety, love, belonging, respect, power, accomplishment, challenge, and, especially, meaning. Whether a school favors youth development, assets, or resilience, the major challenge lies in changing the personal and institutional beliefs about the capacities of children and young people as learners and contributors to their school and community.

—Bonnie Benard, West Ed, School and Community Health Research Group, Oakland

Table 2

Resiliency in Action



Students Lobby Successfully for Healthier Snacks in School Vending Machines

A group of students at King City High School in Monterey County decided that it was time to make a change in the kinds of snacks provided in the vending machines at their school. They wanted healthier snack choices in those machines. Working with the vice principal and the snack-food vendor to identify low-fat foods that could be sold in the machines, they conducted campuswide taste tests so that all the students could vote for their favorite healthier snacks.

The group's hard work paid off. The vending machines now offer healthier snacks, such as pretzels and low-fat cereal bars that students like to eat, and various promotional events are conducted to market the snacks.

Both the snack-food vendor and vice principal are committed to continue offering the healthier snacks. Meanwhile, the original group is looking to tackle yet another issue. It hopes to find a way to offer more nontraditional physical activities on campus as a way to encourage lifelong physical activity for students who may not be interested in such traditional sports as football and basketball.

The group had been trained by the North Central Coast Region of California Project LEAN (Leaders Encouraging Activity and Nutrition), which implements one of 28 "Food on the Run" high school programs throughout the state. Food on the Run is conducted through various partnerships at the local level. In King City this partnership includes the Monterey County Health Department, King City High School, and California Project LEAN. Project LEAN is a program of the California Department of Health Services and the Public Health Institute. The project's Food on the Run campaign prepares teenage leaders to impact their school positively by advancing policies that increase student access to healthy eating and physical activity options.

—Peggy Agron, Director, California Project LEAN

> We know that children who come to school healthy, who have gotten their shots and participated in early childhood programs, are children who are engaged and ready to learn.
>
> —Richard Riley, U.S. Secretary of Education

Goal 2: Policies at all levels will fully support coordinated school health for California's diverse populations.

ACTION STEPS

Schools and school districts will:

A. Establish and maintain district policies supporting coordinated school health. They will:

1. Adopt or adapt a policy that promotes coordinated school health throughout the district and each school as described in the *Health Framework for California Public Schools* (California Department of Education 1994).
2. Require a course in health education as a high school graduation requirement.
3. Integrate policies that promote the health of students and staff for each of the eight components of coordinated school health.
4. Base policies on research-based and evaluation-based information related to student success.
5. Utilize research and model policies disseminated by such organizations as the California Center for Health Improvement and the California School Boards Association.

B. Inform, organize, and involve youth, families, and community partners in advocating for coordinated school health-related policies. They will engage partners in advocating the health and well-being of children and youth and policies that support and integrate coordinated school health at the local, county, and state levels.

C. Bring together an interdisciplinary team that can contribute to coordinated school health at school sites and at the district level. They will coordinate the planning, implementation, and evaluation of services with staff from different coordinated school health component areas and different grade levels.

Local health departments and county offices of education will:

D. Promote and support local policy adoption that embraces coordinated school health at the district and school site levels. They will advocate local policies and operating codes that support implementation and coordination of the eight components of coordinated school health.

The California Department of Education, the California Department of Health Services, and other state agencies will:

E. Provide technical assistance to school districts and municipalities in developing and implementing coordinated school health policies. They will:

1. Communicate national-level policy and research-based support for coordinated school health to stakeholders.
2. Develop and disseminate a compendium of model policies for schools, school districts, local health departments, and county offices of education that integrate the eight components of coordinated school health and include a process for engaging a broad range of participants in the development of local policies.
3. Present this approach as comprehensive and supported by the California *Education Code* and the *Health Framework for California Public Schools.*
4. Promote policies that support periodic assessment of students' health-related knowledge and behavior.
5. Provide school districts with validated tools to assess knowledge, attitudes, and behavior concerning health as part of the battery of state assessment instruments.
6. Utilize aggregated longitudinal data obtained from the assessment to influence program development and refine and allocate resources.

F. Promote coordinated school health interests within other policy initiatives. They will advocate the inclusion of coordinated school health issues within children's health programs, such as the Healthy Families program, Medi-Cal reimbursement, the Child Health and Disability Prevention Program, welfare reform, immigration, building code modifications, the Healthy Start Program, school reform, and after-school and child development programs.

G. Track coordinated school health-related legislation and share policy information. They will provide timely information on pending coordinated school health-related legislation to county offices of education, local health departments, school districts, institutions of higher education, and public and private entities.

> Achievement is better if [students] eat healthier foods.
>
> —Jack McLaughlin, Superintendent, Berkeley Unified School District

> These eight components [Health Education, Physical Education, Parent/Community Involvement, Health Services, Nutrition Services, Psychological and Counseling Services, Healthy School Environment, and Health Promotion for Staff] work together to develop and reinforce health-related knowledge, skills, attitudes, and behaviors and make health an important priority at the school. The components are linked in a mutually supportive, cooperative system focusing on children's health issues and the development of health literacy. Each of the eight components is a critical link in the overall support system for school health and is integrally related to the other components. Some of the components focus on education, others on services, and still others on the school environment. When they are planned and implemented in a supportive and consistent manner, the eight components achieve far more in promoting health literacy than is possible without a coherent, integrated system.
>
> —*Health Framework for California Public Schools*

Goal 3: Funds and resources will be allocated to support coordinated school health for California's diverse populations.

ACTION STEPS

Schools and school districts, local health departments, and county offices of education will:

A. Ensure that current and future school reform planning and funding opportunities include coordinated school health. They will:

1. Identify opportunities for expanding and combining categorical funds.
2. Explore the possibility of allowing grantees/contractors to maximize use of funds for coordinated school health while maintaining accountability for the results intended for each categorical program.

B. Make optimal use of dedicated and flexible funding to improve coordinated school health continuously. They will:

1. Focus on measurable outcomes when planning and implementing coordinated school health.
2. Be flexible in determining how the results are to be accomplished.
3. Use broad-based strategies that enable children and youth to develop skills that affect knowledge, attitudes, and behavior positively.
4. Identify and implement strategies that ensure equitable involvement of all stakeholders, including youth.

C. Advocate coordinated school health funding. They will:

1. Mobilize youth, families, and community partners to advocate adequate coordinated school health funds among local, state, and federal elected officials.
2. Include advocacy as part of a policy agenda for coordinated school health programs.

D. Identify local, state, federal, and private funding sources for coordinated school health programs. They will:

1. Explore financing options, including Medi-Cal reimbursement, funding through Title I and Title II, and support from managed care companies and foundations.
2. Establish consortia composed of county offices of education, local health departments, school districts, schools, and such institutions as universities, hospitals, businesses, and law enforcement agencies to identify funding opportunities and apply jointly for coordinated school health grants.

The California Department of Education, the California Department of Health Services, and other state agencies will:

E. Promote policy, legislation, and funding initiatives that support and provide additional federal and state nonrestrictive funding for coordinated school health programs.* (See Goal 2.) They will:

1. Incorporate coordinated school health into the fundamental structure of the educational system.
2. Support long-term mechanisms to fund the infrastructure of coordinated school health programs at the California Department of Education and the California Department of Health Services, including the use of categorical funds.
3. Pursue grant funds for coordinated school health.

F. Leverage funding for equitable services across all districts in the county. They will:

1. Identify existing funding sources that can support one or more components of coordinated school health programs.
2. Determine the feasibility of combining funding streams to permit greater flexibility at the local level while maintaining accountability for the results intended for each categorical program.
3. Link efforts with public and private entities that embrace the goals of coordinated school health programs for more effective use of limited resources.

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* Identified as a priority area.

4. Collaborate and develop school-based services with funds from sources that include but are not limited to such programs as Welfare to Work (CalWORKS), mental health, Family Preservation, Title IV Safe and Drug Free Schools and Communities, Cops in Schools, Healthy Start, tobacco control, and domestic violence and child abuse prevention.

G. Provide technical support to local agencies. They will develop or enhance (or both) coordinated school health by providing information and training in such topics as reimbursement options and funding sources.

H. Involve managed-care organizations and other insurers in supporting coordinated school health. They will:

1. Negotiate a system through which insurers, including Medi-Cal and Healthy Families, provide financial resources for school health services.
2. Ensure that students receiving school-based health services continue to be linked to their primary medical and dental care provider.

I. Seek better planning and accounting systems that will support coordinated school health. They will develop a master planning system for coordinating or combining work plans with a formula for dispersing expenses among different programs and projects so that, operationally, coordinated school health can be developed or enhanced and still satisfy reporting requirements and generally accepted accounting practices.

A coordinated effort allows us to go beyond teaching kids to say *no.* Instead, we are able to teach kids to *know!*

—Robin Gray Ballard, 1999–2000 President
California Association for Health, Physical Education, Recreation, and Dance

Healthy West Hollywood Families: Task Force Gets Results

West Hollywood, one of the founding participants in the California Healthy Cities Project, created a broad partnership to nurture, educate, and support families and their children. The city's Families and Communities Task Force took many steps to reach linguistically isolated Russian-speaking and Spanish-speaking immigrant families with children, including the following steps:

- Disseminating a quarterly newsletter for families that is published in three languages
- Developing a family guide to services, recreation, and cultural activities
- Holding a Kids' Fair for families and young children to provide needed immunizations, dental screenings, information about community services, and an enjoyable, low-cost festival for the community
- Offering conflict resolution and peer mediation programs for students, teachers, and parents at elementary schools
- Providing after-school tutoring and organized recreation at elementary schools and a job, internship, and volunteer placement program for teenagers
- Opening homework centers at two branch libraries equipped with computers and CD-ROM reference materials
- Earmarking funds that schools can access for cross-cultural programs on campus

The results of those efforts have been encouraging. Participants who responded to pretests and post-tests indicated increased knowledge and positive changes in behavior as a result of the information presented. Students involved in conflict resolution and after-school programs showed improved attendance, fewer disciplinary referrals, and improved academic performance.

The diverse partners involved in this effort included the Los Angeles Unified School District, private preschools and family child care providers, local businesses, the Los Angeles County Health Department, the Los Angeles County Fire Department, the Los Angeles Sheriff's Department, the Los Angeles city and county branch libraries, nonprofit social-service agencies helping families, and community members.

—Daphne Dennis, Social Services Manager, City of West Hollywood

> The school principal or chief administrator is a key player. In schools where family partnerships flourish, the principal has usually taken the first steps towards better communication and collaboration.
>
> —D. Davies, "The 10th School: Where School-Family-Community Partnerships Flourish"

Goal 4: Closer collaboration and better coordination will be established within and between the California Department of Education and the California Department of Health Services, other state and local agencies, and business and community partners.

ACTION STEPS

Schools and school districts will:

A. Address local barriers to community involvement. They will:

1. Create dialogues with families and community agencies specific to coordinated school health that identify and address local barriers adversely affecting community involvement.
2. Reach out to larger institutions, such as hospitals or universities, that have resources to contribute.
3. Establish district health councils with representatives from county offices of education, local health departments, health and human service providers, and hospitals to collaborate and coordinate services.

B. Adopt best practices for actively involving family and community members. They will:

1. Share effective strategies for working with families, business, and community partners to improve collaboration.
2. Include such best practices as involving various school and school district committees and councils and staff in actively engaging parents, making families feel welcome, providing families with meaningful roles, and resolving logistical difficulties related to parent, community, and student participation, such as off-campus after-hours opportunities and child care.

C. Create mechanisms to ensure continuity of services within and between schools and school districts. They will:

1. Create linkages to support student health programs more broadly by bringing together the interdisciplinary coordinated school health staff.
2. Collaborate with schools in the same geographic area to explore methods and implementation strategies for facilitating the transition process when students transfer into a new school or advance from one school level to the next.

Local health departments, county offices of education, and school districts will:

D. Develop, implement, and evaluate joint projects and programs. They will:

1. Conduct a grassroots outreach and information-gathering effort, such as community asset mapping and forums, to determine what health education and health services the families want in the schools.
2. Identify common goals and create a joint coordinated school health work plan.
3. Establish a county management-level policy group to work with key stakeholders to achieve common outcomes or integrate with an existing group.

E. Strengthen collaboration between schools and health and human service agencies and local public and private entities concerned about the health and well-being of youth. They will:

1. Promote the eight-component coordinated school health model as an integral part of school reform.
2. Expand the level of involvement that county offices of education and local health departments have with schools and school districts, community-based organizations, institutions of higher education, governmental agencies, parent–teacher associations, and nonprofit organizations in developing coordinated school health. Examples of such activities are as follows:
   - Local health departments can support schools and school districts in collecting, interpreting, and using health data for program development and evaluation more effectively.
   - County offices of education can increase involvement with community-based organizations to meet the needs of communities more effectively.
   - Local health departments and county offices of education can provide community-based organizations with technical assistance for accessing and working with schools and school districts.
   - Local health departments and county offices of education can establish a planning or advisory body that includes community-based organizations, such as medical and dental societies, health plans, and others, to participate in development and advocacy for coordinated school health programs at the local level.
   - County offices of education and districts can facilitate access to schools by local health departments.

F. Develop strategies for effectively sharing information with school district staff. They will:

1. Use information-sharing strategies, such as meetings, newsletters, web sites, e-mail, and broadcast faxes.
2. Have nurses from the local health department and school districts in the county meet periodically and communicate regularly to coordinate programs, provide mutual technical assistance, share resources, address challenges, and improve services to children, youth, and families.

The California Department of Education, the California Department of Health Services, and other state agencies will:

G. Develop common outcomes, utilizing and building on existing efforts and infrastructure and incorporating morbidity, mortality, and resiliency data.* They will:

1. Identify public and private sources of relevant and compelling data.
2. Employ evaluation tools that can be used by multiple agencies (e.g., California Healthy Kids Survey,[1] Healthy Start).
3. Convene an expert technical advisory body to collect, organize, and analyze existing data and develop prioritized goals and objectives (e.g., Maternal and Child Health, Title V needs assessment).
4. Establish common baseline and monitoring data. Improve the collection of and access to students' health-related information.
5. Establish a management-level policy group to work with key stakeholders.

H. Promote collaborative behavior in providing coordinated school health-related technical assistance. They will:

1. Conduct statewide and regional conferences and meetings jointly planned across departments and agencies and designed to promote interaction and collaboration among staff representing various programs and services.
2. Provide technical assistance on building, maintaining, and working in effective collaboratives.
3. Streamline the Request for Application (RFA) process, align reporting and evaluation requirements, and issue combined requests for applications from the California Department of Education and the California Department of Health Services.
4. Encourage communities to build on existing collaboratives rather than require the formation of new ones.

I. Recognize the specific needs of small counties and rural areas. They will deal with the unique needs of health and educational agencies in rural areas regarding training, technical assistance, and so forth.

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* Identified as a priority area.

[1] The California Healthy Kids Survey is based on the CDC Youth Risk Behavior Survey and the California Student Survey.

California's Healthy Start Initiative Connects School, Family, and Community

All eight components of coordinated school health involve partnerships between schools, families, and communities to benefit our children and youth. The Healthy Start initiative was established in 1991 (*Education Code* Section 8800 et seq.) to facilitate such coordinated efforts by local educational agencies and their collaborative partners. Healthy Start is a gateway to and the "glue" for comprehensive student and family-centered supports and services ranging from child/youth development through prevention and early intervention to more intense, multisystem interventions. Healthy Start also provides a process for moving communities beyond isolated, separate systems to interconnected teams centered on children and youth.

The initiative's philosophy is grounded in the belief that educational success, physical health, emotional support, and family and community strength are inseparable. Healthy Start provides additional resources that assist schools with integrating all the internal and external supports and services needed for student success, whose broad definition includes academic success as well as mastery of the skills needed for becoming good parents, good neighbors, good workers, and good citizens.

This initiative's many faces look as different as do the many types of communities found across California because it builds on the strengths, assets, and needs of each neighborhood. Each local initiative follows a process that includes collaborative decision making, community assessment, prioritization of goals, selection of effective strategies, integration and tracking of efforts, and evaluation of results. This process is cyclical and continuous; it involves ongoing reassessment, reevaluation, and reform.

Because each school and each community has its own combination of assets and needs, the "mix" of services and supports can vary. The local Healthy Start initiatives may include such services and supports as social service providers; educators across the lifespan; health, mental health, and dental service providers; law enforcement; employment development; recreation and arts; faith and service organizations; businesses; and peer support of the students and families themselves. Findings from the statewide 1997 Healthy Start evaluation data show that:

- Academic results for students most in need increased appreciably.
- Students' health issues, especially preventive care, are being addressed in areas that previously were not served.
- Improvements in the areas of housing, food and clothing, transportation, finances, and employment are allowing families to eliminate major impediments to supporting their children's academic achievements and overall development.
- Students receiving Healthy Start services are showing a decrease in drug use, improved self-esteem, and a heightened perception of support from parents, classmates, teachers, and friends.

(Continued on next page)

California's Healthy Start Initiative . . . (Continued)

- Family violence is decreasing. Parents possess a deeper awareness of the different stages of a child's development and a child's corresponding needs.

The Healthy Start story is being written in wide-ranging schools and communities across California. Funding for the Healthy Start initiative has grown from an initial level of $19 million in the 1991-92 fiscal year to its current annual level of $39 million. Nearly 500 operational sites at almost 1,500 elementary, middle, and high schools in nearly all of California's 58 counties now have the potential to reach more than one million young people and their families. Participants in Healthy Start throughout the state live in communities ranging from urban neighborhoods and barrios to rice and cotton fields to resort towns and suburbs to isolated logging towns. Every school community is different, and each Healthy Start site reflects the unique culture, politics, and economics of its locale. The common characteristic found at each Healthy Start site, as a member of the coordinated school health "family," is a commitment to making a better life for California's children, youth, families, and communities.

People support what they create.

—Claudia Epperson, Healthy Start Project Coordinator
Robertson Road Elementary School

Mendocino County Public Health Advisory Board Promotes the Health of Its Residents

The Mendocino County Public Health Advisory Board was formed in 1995 at the direction of the Mendocino County Board of Supervisors. Its purpose was to advise the supervisors on health issues and to help the Public Health Department create policies that improve the overall health of county residents .

This diverse advisory board, which includes representatives for mental health services, law enforcement, the local school district, and the local hospital and clinics, identified their top health concerns: lack of adequate treatment services for persons with drug and alcohol problems, lack of prevention education and activities regarding drug and alcohol abuse, poverty, domestic violence, and heart disease.

The health advisory board issues a *Community Health Status Report,* which provides an overview of the various health concerns in the county. The report provides the information needed for the community to write health-oriented grants and advocate for health-oriented legislation and health education.

—Carol Mordhorst, Director, Public Health Advisory Board, Mendocino County

A document is only a document. It takes people to bring about change.

—Gus Dalis, Senior Project Director
Center for Health Education
Los Angeles County Office of Education

Goal 5: Personnel capacity in school health at the state and local levels will increase and will reflect California's diverse populations.

ACTION STEPS

Schools and school districts will:

A. Employ well-qualified coordinated school health program staff members.* They will:

1. Designate qualified staff at the decision-making level to coordinate school health programs.
2. Employ appropriate credentialed staff members in all coordinated school health program areas, such as teachers well qualified to teach health education and physical education, credentialed school nurses to deliver or oversee health services, and child nutrition staff members trained in nutrition and food safety.

B. Ensure adequate professional development to promote the optimal physical, emotional, social, and educational development of students.* They will:

1. Elevate health as a priority by devoting more time to it in staff meetings and professional development.
2. Include all staff members in professional development.
3. Connect health with learning.
4. Provide school staff with the skills, knowledge, and resources needed to address student health issues more effectively.

C. Establish policies for bringing school-linked service providers into the schools. They will:

1. Develop guidelines for collaboration between school staff and contracted organizations working on campus, such as local health departments, community-based organizations, and health providers.
2. Create clear descriptions of roles of school-staffed and school-linked providers to maximize their effectiveness and avoid supplanting or displacing preexisting school staff.

* Identified as a priority area.

Local health departments, county offices of education, and other community health organizations will:

D. Employ appropriate credentialed school health program staff members to oversee the implementation of coordinated school health and provide appropriate professional development. They will:

1. Designate qualified staff to provide leadership for coordinated school health.
2. Oversee the use of community needs assessments to guide professional development that addresses local needs.
3. Urge local educational agencies and health agencies to conduct or attend trainings (or both) jointly to facilitate collaborative planning and implementation.

The California Department of Education, the California Department of Health Services, and other state agencies will:

E. Employ state staff members to represent all components of coordinated school health.* They will:

1. Provide leadership in each of the eight component areas, providing consultants to assist in such areas as school nursing and dental health services, physical education, health education, and counseling and guidance.
2. Generate models that demonstrate coordination of the components.

F. Support high-caliber teacher preparation programs.* They will:

1. Work with relevant organizations to establish comprehensive and rigorous standards in health for all candidates for a teacher credential.
2. Advocate a mandated course on health for all those candidates.
3. Work with schools of education to provide high-caliber coordinated instruction in school health and preparation of credential candidates.

G. Promote inclusion of school health issues within professional education and continuing education programs (e.g., nursing, medicine, public health, social work, dentistry, nutrition). They will:

1. Collect information about curricula in different fields and identify opportunities to address school health issues consistently among and between various disciplines.
2. Identify and share information about innovative health practices in the schools.
3. Provide opportunities for school health professionals and others to remain current on research and the best practices in their fields as related to coordinated school health programs.
4. Use data from such instruments as the School Health Education Profile to tailor the content and methods used in continuing education.
5. Include information on the relationship between coordinated school health programs and education reform.

H. Organize and promote a statewide summit on coordinated school health in collaboration with deans or department chairs (or both) of professional schools, including schools of medicine, nursing, and social work and dental, public health, and dietetics programs. They will develop a specific plan to integrate coordinated school health into professional education and training. The plan will address the recruitment and enrollment of professional program graduate students whose cultural and ethnic backgrounds are reflective of California's diverse population.

* Identified as a priority area.

A "Break-the-Mold" Model Developed at the Elizabeth Learning Center, Los Angeles

A venture supported by the New American Schools Development Corporation has resulted in a break-the-mold comprehensive school reform design first implemented in Los Angeles and now being replicated elsewhere.

The Elizabeth Learning Center in Los Angeles has produced a pioneering prekindergarten-through-grade-twelve model recognized by the U.S. Department of Education as an important evolving demonstration. The model expands school reform by moving from an approach that reforms curriculum and instruction and governance and management and deals with barriers to learning. A comprehensive and multifaceted continuum of learning supports is divided into six functional areas: (1) classroom-focused enabling; (2) support for transitions; (3) student and family assistance; (4) crisis response and prevention; (5) home involvement in schooling; and (6) community outreach, including an extensive focus on the use of volunteers.

Use of the model requires policy reform and operational restructuring, especially the following:

- Weaving together all learner support resources available at a school
- Expanding resources through integrating school, community, and home resources
- Enhancing access to and the impact of community resources by connecting as many as feasible to school programs

At the Elizabeth Learning Center, increases in achievement test performance were recently reported for all grade levels. Dropout rates declined to 1.22 percent (versus 5.28 percent in surrounding schools) and a districtwide rate of 7.84 percent. Over 1,000 parents attend adult education classes, and local volunteers provide more than 12,000 hours of service each year.

Development of an enabling or learning support component as a full partner in school reform is essential if all children are to benefit appropriately from instruction.

—Howard Adelman and Linda Taylor, Center for Mental Health in Schools, University of California, Los Angeles

> Training in interpersonal, decision-making, and coping skills can help students increase their self-control, help reduce stress and anxiety, and teach them ways to make friends if they are isolated and to assert themselves without resorting to violence.
>
> —Carnegie Council on Adolescent Development

Goal 6: Use of state-of-the-art, research-based strategies to implement coordinated school health will increase.

ACTION STEPS

Schools and school districts will:

A. Use research in making informed decisions about health curricula and programs.* They will:

1. Use the services of the California Healthy Kids Program Dissemination Center in previewing and selecting research-based programs.
2. Use existing data sources to inform and influence program design (e.g., the Youth Risk Behavior Survey, the California Student Information System, the California Special Education Management Information System, the California Healthy Kids Survey, the Healthy Start evaluation, the Maternal and Child Health Title V Needs Assessments, health-related fitness tests).

B. Conduct monitoring and evaluation of coordinated school health-related programs and curricula. They will:

1. Assess effectiveness through program implementation; feedback from students, families, and teachers; and Healthy People 2010 objectives.
2. Identify potential models successful with particular school communities.

C. Administer the California Healthy Kids Survey.[1] They will create a single source of health data that can be used as one of the multiple measures needed to test the effectiveness of programs that influence the health of youth.

Local health departments and county offices of education will:

D. Educate schools and school districts in research-based, coordinated school health curricula, programs, and other best practices and facilitate their adoption. They will:

1. Inform schools and school districts about data and models available to assist in planning, implementation, and evaluation.
2. Assist schools and school districts in developing mechanisms for implementing and assessing curricula and programs and educating their communities about the best practices in school health.

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* Identified as a priority area.

[1] The California Health Kids Survey is based on the CDC Youth Risk Behavior Survey and the California Student Survey.

The California Department of Education, the California Department of Health Services, and other state agencies will:

E. Include incentives for using research-based strategies. They will establish priorities for funding research-based strategies in requests for applications.

F. Disseminate information about the best practices in specific coordinated school health areas. They will identify schools that demonstrate effectively the implementation of coordinated school health.

G. Raise awareness of coordinated school health issues. They will:

1. Take a strong public stand in support of school health programs and research-based strategies.
2. Establish a blue ribbon task force as a joint effort of the California Department of Education, the California Department of Health Services, and the Governor's Office to support priorities identified in this document.

The Importance of Health Education

School health education is not new. It has been included to some extent, in one form or another, since the advent of public schools. It just hasn't been systematically implemented and maintained at the level needed to make a real difference for all students. Until recently education decision makers were reluctant to include health education as an integral part of the curriculum in all schools with adequate resources to make it truly meaningful. The last half of the 1990s presents a unique opportunity to make good on this lost opportunity. As demonstrated in [a] recent American Cancer Society public opinion poll, ample support exists among parents, school district administrators, and students to warrant broad-scale implementation of comprehensive school health education.

—David K. Lohrmann

Appendix A

Executive Sum
CSHP Needs As

IN RESPONSE TO GROWING CONCERNS ABO
of youth in today's society, a new mome
schools address health issues. Health and educational achievement are closely intertwined. As institutions central to their communities, schools are uniquely positioned to deal with the behavioral factors that underlie the major causes of morbidity and mortality. Those behaviors can result in unintentional and intentional injuries; abuse of alcohol and other drugs; sexual conduct that leads to the contraction of sexually transmitted diseases, including HIV infections, and unintended pregnancies; the use of tobacco; unhealthy dietary behaviors; and physical inactivity.

Note: This report reflects the findings of the Evaluation and Training Institute and SRI International from interviews and surveys that were conducted throughout California. It does not necessarily reflect the views of the California Department of Education or the Department of Health Services.

Data gathered by the California Youth Risk Behavior Survey show that California students practice high-risk behaviors in a number of areas. For example, alcohol use among youth far exceeds the Healthy People 2000 objectives for such use among youth. In addition, one-third of the respondents indicated that during the past month they had ridden in a car with someone who had been drinking alcohol. One-fifth of respondents reported having smoked at least one cigarette per day in the past month. Similarly high-risk factors were reported for sexual behavior, violence, suicide ideation, and nutrition. California students are closer to meeting the Healthy People 2000 objectives in physical activity than they are in other areas.

In response to those challenges, the California Department of Education (CDE) and the California Department of Health Services have joined to launch a new effort to strengthen school health programs across the state. The eight-component model of comprehensive school health programs was adopted to guide the work. The model identifies eight components that work together as a coordinated system to enhance the health of children and youth. One of those components, comprehensive school health education, is further elaborated into six priority risk areas: tobacco prevention; nutrition; physical activity; HIV/STD/unintended pregnancy prevention; intentional and unintentional injury prevention; and drug and alcohol prevention.

Components of Comprehensive School Health Programs

- Health Education
- Physical Education
- Health Services
- Counseling, Psychological, and Social Services
- Nutrition Services
- Healthful School Environment
- Parent/Community Involvement
- Health Promotion for Staff

In 1995-96 California received its first grant from the Centers for Disease Control and Prevention (CDC) to strengthen comprehensive school health programs across the state. The CDC identified four supports that provide a foundation for those comprehensive programs: authorization and funding; personnel and organizational placement; communication and linkages; and resources. On behalf of the California Department of Education and the California Department of Health Services, the Evaluation and Training Institute and SRI International conducted a needs assessment of the status of the four infrastructure supports at the state and local levels and of the implementation of comprehensive school health education at the local level. The needs assessment

will serve as the first step in developing a long-range strategic plan that will bring together public and private agencies (1) to strengthen infrastructure for the comprehensive school health programs; and (2) to expand and improve their implementation and comprehensive school health education in California.

Methodology

The needs assessment was based on four infrastructure supports to obtain information about existing assets and ongoing needs or challenges. The information was collected from individuals working in each of the eight component areas and from individuals with a broad perspective on overarching school health issues. Table A-1 describes each of the three primary methods used for data collection.

Table A-1

Primary Data Collection Methods Used in Needs Assessment

Method	Type of Data	Issues Addressed
Key informant interviews (N=88)	Qualitative	Status of four infrastructure supports at the state level; issues related to individual components of CSHP
Focus groups (six groups)	Qualitative	Local experience implementing school health programs, with emphasis on community involvement and health and physical education
County-level survey (N = 46 county offices of education and 51 local health departments)	Quantitative	Communication and linkages at the local level and between the local and state levels; comprehensive school health education implementation; local experiences of supports and barriers to CSHP/comprehensive school health education

Findings

The findings are divided into six categories. In addition to each of the four infrastructure supports, the needs assessment takes a more in-depth look at issues related to comprehensive school health education implementation and discusses perspectives on school health. It was found that several statewide funding and policy initiatives provide strong support for children's health, including Healthy Start, LEA Medi-Cal billing, Medi-Cal for Children, and Healthy Families.

Each of the eight components is supported to varying degrees by specific policy and funding:

- **Health Education** is supported by state requirements that schools teach health education to all students in grades one through six and teach AIDS-prevention education to all students (whose parents do not object) at least once in middle school and once in high school. The *Education Code* also outlines the topics to be included in health education, which schools may provide at the grade levels they deem appropriate. CDE must distribute guidelines for the preparation of comprehensive school health education plans and materials for the prevention of teenage pregnancy. Requirements exist as to what must be included in all sex education classes, yet schools may choose not to teach sex education at all.
- **Physical Education** is supported by requirements outlining the number of minutes of instruction for grades one through twelve and requiring standardized physical performance tests in grades five, seven, and nine. However, some respondents felt that policies should be strengthened to require daily physical education for all grades, K–12. In addition, despite the availability of a strong framework, there is no consistent curriculum in place for physical education. California's *Education Code* addresses this issue by authorizing a position in CDE for a physical education specialist, although the position is currently unfunded.
- **Health Services** are supported by state requirements that schools monitor immunizations and conduct health screenings. In addition, the *Education Code* contains strong requirements for the qualifications of school nurses. Weaknesses in current policy include the lack of a minimum nurse-to-student ratio, the use of nonlicensed "health clerks" to provide health services in schools, and the lack of a system or guidelines through which LEAs could work with managed-care organizations.
- **Counseling, Psychological, and Social Services** are supported by federal and state policies, including the federal Individuals with Disabilities Education Act (IDEA), the largest single source of funding for school psychologists. At the state level, this component is supported by Healthy Start, which has enabled schools to develop a range of supportive services for students and families. The primary weakness identified in current policy was the lack of a minimum ratio of school psychologists to students.
- **Nutrition Services** are supported by several laws authorizing programs and outlining requirements. The nutritional content of school cafeteria meals must meet minimum standards, although other food items sold on

campus may be of little or no nutritional value. Several programs are administered by the state to promote healthy eating habits. The Department of Health Services (DHS) is required to assess local food and nutrition data systems. However, federal government funding for Nutrition Education and Training programs has been reduced significantly.

- **A Healthful School Environment** is supported by legislation in several areas. Several policies and programs support school safety, including the requirement for each school to write a school safety plan, as well as programs to reduce school violence and student gang involvement. Policies also exist to support the biophysical environment of schools, including requirements for storing hazardous materials, screening school employees and volunteers for tuberculosis, and posting signs prohibiting smoking on campus.
- **Parent/Community Involvement** is well supported by a number of federal and state laws, including Title I of the Improving America's Schools Act; the California *Education Code* (Chapter 16, sections 11500–06), which directs school districts to adopt a policy on parent involvement; Assembly Bill 1334, Chapter 485, which requires CDE to promote family–school compacts; and the Family–School Partnership Act (AB 2590, Chapter 1290), which allows parents to take up to 40 hours off from work to participate in their children's school activities.
- **Health Promotion for Staff** has few policies supporting it. California's *Education Code* does not mandate that activities be conducted to promote the health and wellness of school staff. However, DHS is required to apprise school districts annually of current information on preventing employees' exposure to AIDS and hepatitis B.

In the area of authorization and funding, a number of significant challenges were identified as follows:

- Funding for many of the eight components is inadequate and is particularly inadequate for comprehensive health programs in which all of the components work together.
- Funding for school health comes through too many categorical programs, creating difficulties in the development of comprehensive, coordinated programs.
- At both the state and local levels, school health suffers from the lack of a strong constituency to move supportive policy initiatives forward.
- Policy changes at the state and national levels can adversely affect school health by shifting resources away from health-related activities (e.g., class size reduction), by creating fear and distrust (e.g., Proposition 187), and by reducing the supports available to families (e.g., welfare reform).
- Despite an expanding research base on effective strategies for CSHP and comprehensive school health education, best practices are often rejected for political reasons.

Recommendations:

- Conduct a social marketing campaign to raise support for school health and effective, research-based strategies.
- Address political opposition to school health and to specific health education programs by opening a dialogue with those who do not advocate CSHP and seeking to identify common ground.
- Develop an agenda that addresses policy and funding matters, specifically as they relate to CSHP, as well as broader policies within which school health interests should be represented.

Personnel and Organizational Placement

The California Department of Education (CDE) and the Department of Health Services (DHS) have many staff who possess expertise in the components of CSHP. CDE has a Child, Youth, and Family Services Branch, which administers a number of programs related to CSHP. Three of the ten major administrative divisions within DHS—Primary Care and Family Health, Prevention Services, and Medical Care Services—also administer wide-ranging programs in the eight CSHP component areas.

Respondents noted an absence of personnel designated at the state level to work in the following key areas:

- School health specialist or adolescent health specialist within DHS
- School nurse within CDE
- Dental health director
- Physical education specialist

At the county level, personnel infrastructure is weak. Although each county office of education has a staff person who handles school health, many of those individuals do not work full time and hold many other responsibilities. Within local health departments, staff who work on school health-related issues are frequently decentralized and lack a system for coordinating their efforts.

At the school and district levels, additional staff are needed for developing CSHP effectively. In particular, respondents see the need for health coordinators or health advocates (preferably school nurses) to coordinate the currently fragmented components of school health programs. In addition, qualified personnel are needed to teach health and physical education; and classroom teachers, administrators, and school board members need more training in health issues.

Recommendations:

- Fill critical personnel gaps at the state level. State-level leadership will provide an essential foundation for the development of local programs.

- Upgrade county-level infrastructure. Considering the size of California, counties will provide a critical link between the state and local levels.
- Provide funding for a health coordinator at every school.
- Address school staff training by restoring the requirement that teachers complete a health course as part of their credentialing program, promoting better coverage of school health in graduate programs for school administrators, and expanding professional development in health education for school staff.

Communication and Linkages

Important strides have been made in increasing communication and linkages at the state level. Examples include coordination and collaboration occurring between DHS and CDE through an infrastructure grant from the Centers for Disease Control and Prevention; collaborative efforts to promote comprehensive, integrated school-linked services leading to the Healthy Start Initiative and LEA Medi-Cal billing; the Comprehensive Health Action Team (CHAT); the CDE Health Issues Work Group; and the planning process for the annual Healthy Schools, Healthy People Conference. One challenge in this area is the lack of systemic, institutionalized mechanisms for collaboration that are supported by senior administrators and result in improved coordination of programs. Creating such mechanisms within agencies as large and geographically dispersed as CDE and DHS will be particularly challenging.

Regarding communication and linkages between the state and local levels, local-level staff report a fairly high level of dissatisfaction with the communication and support they receive from state agencies on school health-related issues. CDE and DHS staff reported having experimented with several methods for providing technical assistance, including the use of telephone hotlines, voice mail, training videos, and web pages. However, California's size alone represents a significant challenge in bridging this communication gap.

At the local level, collaboration between county offices of education and local health departments appears to be fairly high but is limited primarily to participating in coalitions, advisory groups, or committees and maintaining contact informally through personal networking. More substantive forms of collaboration must be developed.

Supportive attitudes regarding the development of linkages through collaboration and partnerships at the local level can be found in the current environment. A number of funding streams have been relaxed and more funding sources for community-driven programs now exist. The result of those changes has been an increase in collaboration among schools, community agencies, parents, and students as well as greater collaboration *within* school districts.

Although these developments at the local level generally are viewed as very positive, several challenges have emerged:

- The proliferation of collaboratives has become unmanageable. Systems are needed for coordinating, streamlining, and making more efficient use of time.
- Better mechanisms for sharing information are needed at the county and school-site levels.
- Community residents and community agencies need to learn how to access school sites.
- Schools need to learn how to reach out to and welcome parents and offer them meaningful, decision-making roles.
- Schools and districts need to develop strategies for overcoming liability and cost issues that prevent communities from using school facilities after school hours.
- Schools need assistance in developing procedures that will enable them to share information about students to increase continuity in services when students make transitions from one school to another.

Recommendations:

- *Involve senior-level CDE and DHS administrators in identifying opportunities for substantive collaboration that will result in better coordination of categorical programs related to CSHP.*
- *Develop systems at the county level for sharing information and coordinating the efforts of health-related collaboratives.*
- *Provide technical assistance to counties, schools, school districts, and communities on issues related to collaboration in school health.*

Technological Resources

Technological resources to support CSHP appear to be adequate at the state level. No major deficiencies were found in office or communication technologies, although a few offices were found to have e-mail that can be used only within the office/department. The state also possesses the number of important data resources that provide critical information about youth health and school health programs. The California Healthy Kids Survey represents an important step toward standardizing the collection of student health behavior data and creating greater consistency within this component of program evaluations.

Lack of resources at the local level presents a significant barrier to implementing CSHP. Human resources are in greatest demand. The factor most frequently identified by county office of education and local health department staff as a barrier to CSHP was that school staff are overextended and have no time for anything beyond the standard academic curriculum.

Recommendations:

- Promote implementation of the California Healthy Kids Survey and other standardized evaluation tools.
- Advocate policy changes that provide schools and local health departments with additional human resources to implement and coordinate health programs.

Comprehensive School Health Education

The *Health Framework* and *Physical Education Framework* were widely praised and viewed as important supports for comprehensive school health education in California. Regarding implementation of comprehensive school health education, county office of education staff reported that the areas most frequently covered by school districts are tobacco-use prevention, drug- and alcohol-abuse prevention, and physical education. In general, the quality of available health education curricula was thought to be fairly good and did not appear to be the most pressing need related to comprehensive school health education. Respondents did see a need for professional development opportunities for school and district staff. The two major obstacles to providing professional development have been (1) the lack of adequate funding/resources; and (2) the lack of staff preparation time or the demands of other competing professional development needs. With regard to methods for delivering professional development to school staff at the county level, respondents expressed the greatest enthusiasm for county workshops, mentoring or coaching, and school in-service training.

Challenges related to implementing comprehensive school health education include the following:

- Health education has always been considered an "add-on." Health education is not required at every grade level, is not included in standardized testing, and is not a high school graduation requirement.
- Funding for comprehensive school health education is divided into too many categories.
- A lack of emphasis on instruction in health education exists. Health education has not been viewed as a discipline and has no instructional "home"; rather, it is squeezed into the curriculum wherever a school chooses to place it.
- Many teachers are not prepared to teach health education because they do not have professional preparation for doing so or have not received adequate training in health education as part of their general teaching credential program.

Recommendations:

- Strengthen requirements for health education to include, at a minimum, health as a high school graduation requirement.
- Support districts in developing policies to implement health education in the K–12 curriculum.
- Expand professional development for school staff on health education in the six risk areas, particularly in the areas of injury prevention and comprehensive health.
- Restore the requirement that teachers complete a health course as part of their credentialing program.

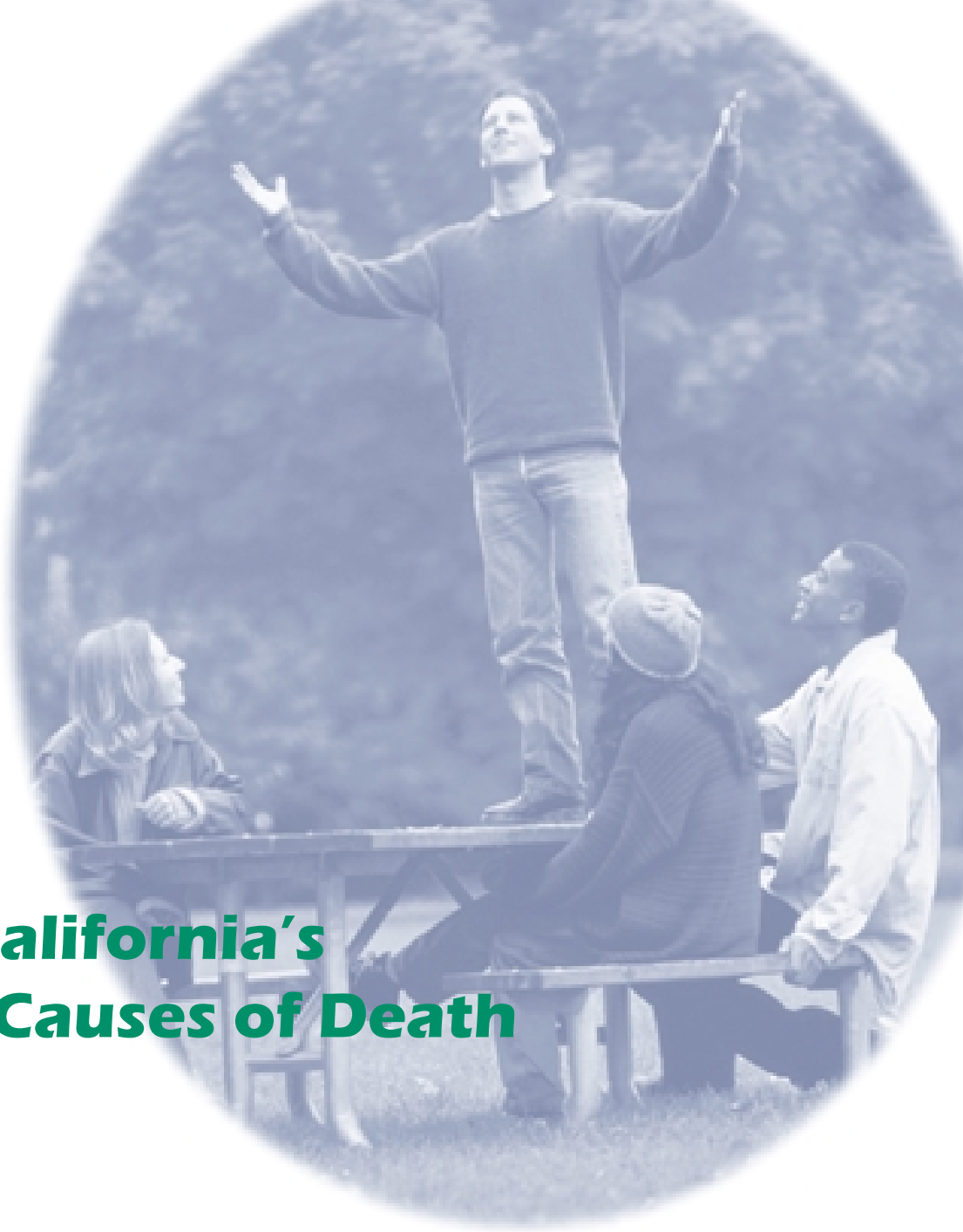
Perspectives on School Health

Two perspectives were found to be important in shaping respondents' thinking about school health. Youth development, often referred to as an assets-based approach, was strongly advocated by some respondents as an overarching framework for comprehensive school health. Youth development focuses on identifying the assets and strengths of youth—rather than focusing on deficits—and building on those assets and strengths to foster resiliency, which acts as a protective factor against a wide range of negative outcomes.

The second perspective emphasized by respondents was the importance of distinguishing between school-based and school-linked models for providing services related to comprehensive school health. Respondents favoring a school-based model emphasized the importance of developing health and social service capacity within the schools themselves. This model contrasts with the school-linked model, which focuses on creating linkages among schools and community-based service providers.

Recommendations:

- Promote youth development as a positive approach to CSHP at the state and local levels.
- Explore the appropriateness of school-based and school-linked models for providing comprehensive school health services.



Appendix B

Tables: California's Leading Causes of Death

TABLE B-1

LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
MALES BY RACE/ETHNICITY[2]
CALIFORNIA, 1997

(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Males			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
Under 1 Year																
All Causes of Death	001-999	1,663		595.4	120		401.9	243		1279.0	731		551.0	565		586.0
Certain Perinatal Conditions	760-779	733	1	262.4	54	1	180.8	133	1	700.0	307	1	231.4	238	1	246.9
Congenital Anomalies	740-759	407	2	145.7	34	2	113.9	30	3	157.9	210	2	158.3	131	2	135.9
Sudden Infant Death Syndrome	798.0	198	3	70.9	9	*	*	45	2	236.9	66	3	49.8	77	3	79.9
Unintentional Injuries	E800-949	45	4	16.1	2	*	*	3	*	*	21	4	15.8	19	4	19.7
Suffocation	E913	12		4.3	-		*	1		*	4		*	7		*
Diseases of the Heart	390-398,402, 404-429	37	5	13.2	2	*	*	2	*	*	20	5	15.1	13	5	13.5
Pneumonia & Influenza	480-487	30		10.7	2		*	1		*	20	5	15.1	7		*
Homicide	E960-969	19		6.8	2		*	2		*	10		7.5	5		*
All Other Causes		194			15			27			77			75		
1–4 Years																
All Causes of Death	001-999	362		31.5	33		26.3	41		50.1	154		29.2	133		32.3
Unintentional Injuries	E800-949	132	1	11.5	15	1	12.0	13	1	15.9	55	1	10.4	48	1	11.7
Motor vehicle	E810-825	49		4.3	4		*	6		*	28		5.3	11		2.7
Drownings	E910	43		3.7	5		*	2		*	14		2.7	22		5.3
Congenital Anomalies	740-759	44	2	3.8	4	*	*	5	*	*	16	2	3.0	19	2	4.6
Malignant Neoplasms	140-208	32	3	2.8	4	*	*	5	*	*	15	3	2.8	8	*	*
Homicide	E960-969	31	4	2.7	1	*	*	10	2	12.2	11	4	2.1	9	*	*
Child battering	E967	11		1.0	-		*	3		*	5		*	3		*
Pneumonia & Influenza	480-487	10	5	0.9	-	*	*	1	*	*	6	*	*	3	*	*
All Other Causes		113			9			7			51			46		
5–9 Years																
All Causes of Death	001-999	234		16.4	18		11.9	27		24.5	86		15.1	103		17.6
Unintentional Injuries	E800-949	90	1	6.3	10	1	6.6	14	1	12.7	33	1	5.8	33	1	5.6
Motor vehicle	E810-825	49		3.4	2		*	6		*	24		4.2	17		2.9
Drownings	E910	20		1.4	6		*	4		*	4		*	6		*
Malignant Neoplasms	140-208	48	2	3.4	2	*	*	1	*	*	18	2	3.2	27	2	4.6
Leukemia	204-208	15		1.1	-		*	-		*	8		*	7		*
Homicide	E960-969	20	3	1.4	3	*	*	3	*	*	6	*	*	8	*	0.6
Firearms/explosives	E965	12		0.8	1		*	2		*	3		*	6		*
Congenital Anomalies	740-759	17	4	1.2	-	*	*	2	*	*	6	*	*	9	*	*
All Other Causes		59			3			7			23			26		

- Represents zero events.
* Ranks and rates are not calculated for less than 10 deaths.
[1] Death Rates are per 100,000 population for each age, sex, and race group.
[2] Asian/Pacific Islander, Black, and White exclude Hispanic ethnicity. Hispanic includes any race category. White includes Other Races, Not Stated, and Unknown.
[3] Total Female Deaths include American Indian.
Source: State of California, Department of Health Services, Death Records; State of California, Department of Finance, 1997 Population Projections by Age, Sex and Race/Ethnic Groups, December 1998.

TABLE B-1 (Continued)

LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
MALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Males			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
10–14 Years																
All Causes of Death	001-999	287		23.9	30		21.9	38		41.4	84		19.7	135		25.1
Unintentional Injuries	E800-949	100	1	8.3	11	1	8.0	11	1	12.0	35	1	8.2	43	1	8.0
Motor vehicle	E810-825	49		4.1	4		*	6		*	20		4.7	19		3.5
Drownings	E910	22		1.8	4		*	3		*	7		*	8		*
Malignant Neoplasms	140-208	46	2	3.8	5	*	*	1	*	*	15	2	3.5	25	2	4.7
Leukemia	204-208	22		1.8	3		*	1		*	9		*	9		*
Homicide	E960-969	32	3	2.7	4	*	*	9	*	*	8	*	*	11	4	2.0
Firearms/explosives	E965	23		1.9	4		*	5		*	6		*	8		*
Suicide	E950-959	16	4	1.3	1	*	*	3	*	*	-	*	*	12	3	2.2
Congenital Anomalies	740-759	14	5	1.2	2	*	*	2	*	*	2	*	*	8	*	*
All Other Causes		79			7			12			24			36		
15–19 Years																
All Causes of Death	001-999	1,156		103.0	103		78.5	140		155.5	518		134.7	387		76.1
Unintentional Injuries	E800-949	408	1	36.4	33	2	25.2	29	2	32.2	158	2	41.1	181	1	35.6
Motor vehicle	E810-825	285		25.4	20		15.2	21		23.3	111		28.9	128		25.2
Poisonings	E850-869	25		2.2	1		*	-		*	10		2.6	14		2.8
Drownings	E910	31		2.8	5		*	3		*	10		2.6	13		2.6
Firearms/explosives	E922	20		1.8	-		*	1		*	11		2.9	7		*
Homicide	E960-969	400	2	35.7	40	1	30.5	85	1	94.4	230	1	59.8	45	3	8.8
Firearms/explosives	E965	363		32.4	36		27.4	80		88.9	216		56.2	31		6.1
Suicide	E950-959	120	3	10.7	8	*	*	6	*	6.7	42	3	10.9	63	2	12.4
Firearms/explosives	E955	83		7.4	5		*	5		5.6	27		7.0	45		8.8
Malignant Neoplasms	140-208	64	4	5.7	9	*	*	4	*	*	27	4	7.0	24	4	4.7
Leukemia	204-208	14		1.2	3		*	-		*	5		*	6		*
Diseases of the Heart	390-398,402, 404-429	23	5	2.1	2	*	*	2	*	*	11	5	2.9	8	*	*
All Other Causes		141			11			14			50			66		
20–24 Years																
All Causes of Death	001-999	1,435		129.4	94		69.6	235		251.5	635		166.4	459		93.5
Homicide	E960-969	498	1	44.9	17	3	12.6	153	1	163.7	264	1	69.2	57	3	11.6
Firearms/explosives	E965	415		37.4	13		9.6	142		152.0	221		57.9	34		6.9
Unintentional Injuries	E800-949	439	2	39.6	24	2	17.8	29	2	31.0	192	2	50.3	189	1	38.5
Motor vehicle	E810-825	283		25.5	17		12.6	14		15.0	130		34.1	117		23.8
Poisonings	E850-869	40		3.6	-		*	7		*	11		2.9	22		4.5
Drownings	E910	19		1.7	4		*	2		*	6		*	7		*
Firearms/explosives	E922	14		1.3	-		*	1		*	8		*	5		*
Suicide	E950-959	218	3	19.7	30	1	22.2	18	3	19.3	71	3	18.6	99	2	20.2
Firearms/explosives	E955	121		10.9	19		14.1	12		12.8	40		10.5	50		10.2
Malignant Neoplasms	140-208	54	4	4.9	4	*	*	3	*	*	26	4	6.8	21	4	4.3
Leukemia	204-208	14		1.3	1		*	2		*	8		*	3		*
Diseases of the Heart	390-398,402, 404-429	35	5	3.2	3	*	*	5	*	*	11	5	2.9	16	5	3.3
Acquired Immune Deficiency Syndrome	042-044	16		1.4	-		*	1		*	10		2.6	5		*
All Other Causes		191			16			27			71			77		

TABLE B-1 (Continued)
LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
MALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Males			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
25–34 Years																
All Causes of Death	001-999	3,676		131.2	208		71.1	522		260.3	1,310		127.5	1,601		126.6
Unintentional Injuries	E800-949	963	1	34.4	61	1	20.8	71	3	35.4	363	1	35.3	461	1	36.5
Motor vehicle	E810-825	446		15.9	41		14.0	39		19.5	182		17.7	181		14.3
Poisonings	E850-869	260		9.3	3		*	16		8.0	101		9.8	137		10.8
Homicide	E960-969	631	2	22.5	22	4	7.5	195	1	97.3	293	2	28.5	114	5	9.0
Firearms/explosives	E965	494		17.6	15		5.1	171		85.3	224		21.8	79		6.2
Suicide	E950-959	485	3	17.3	38	2	13.0	30	5	15.0	108	4	10.5	306	2	24.2
Firearms/explosives	E955	222		7.9	15		5.1	17		8.5	51		5.0	138		10.9
Acquired Immune Deficiency Syndrome	042-044	369	4	13.2	7		*	73	2	36.4	132	3	12.8	156	3	12.3
Malignant Neoplasms	140-208	280	5	10.0	27	3	9.2	21		10.5	95	5	9.2	136	4	10.8
Diseases of the Heart	390-398,402, 404-429	216		7.7	15	5	5.1	34	4	17.0	58		5.6	106		8.4
All Other Causes		732			38			98			261			322		
35–44 Years																
All Causes of Death	001-999	6,415		228.7	333		112.2	823		447.1	1,528		201.0	3,683		238.0
Unintentional Injuries	E800-949	1,283	1	45.7	39	3	13.1	116	3	63.0	342	1	45.0	772	1	49.9
Motor vehicle	E810-825	402		14.3	19		6.4	30		16.3	132		17.4	218		14.1
Poisonings	E850-869	581		20.7	5		*	66		35.9	138		18.2	364		23.5
Diseases of the Heart	390-398,402, 404-429	837	2	29.8	51	2	17.2	134	2	72.8	148	4	19.5	498	2	32.2
Ischemic heart	410-414	396		14.1	22		7.4	44		23.9	66		8.7	261		16.9
Other heart diseases	420-429	347		12.4	22		7.4	64		34.8	68		8.9	191		12.3
Malignant Neoplasms	140-208	783	3	27.9	76	1	25.6	85	4	46.2	159	2	20.9	460	3	29.7
Acquired Immune Deficiency Syndrome	042-044	700	4	25.0	16		5.4	158	1	85.8	148	4	19.5	375	5	24.2
Suicide	E950-959	569	5	20.3	35	4	11.8	28		15.2	73		9.6	429	4	27.7
Firearms/explosives	E955	246		8.8	11		3.7	11		6.0	29		3.8	193		12.5
Chronic Liver/Cirrhosis	571	398		14.2	9		*	22		12.0	158	3	20.8	203		13.1
Homicide	E960-969	345		12.3	21	5	7.1	80	5	43.5	132		17.4	111		7.2
Firearms/explosives	E965	233		8.3	20		6.7	65		35.3	87		11.4	61		3.9
All Other Causes		1,500			86			200			368			835		

TABLE B-1 (Continued)

LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
MALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Males			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
45–54 Years																
All Causes of Death	001-999	9,465		480.8	576		276.8	1,161		971.8	1,675		414.7	6,002		490.3
Diseases of the Heart	390-398,402, 404-429	2,417	1	122.8	144	2	69.2	344	1	287.9	354	1	87.6	1,565	1	127.8
Ischemic heart	410-414	1,344		68.3	91		43.7	156		130.6	178		44.1	915		74.7
Acute myocardial infarction	410	616		31.3	51		24.5	74		61.9	80		19.8	409		33.4
Coronary atherosclerosis	414.0	424		21.5	22		10.6	47		39.3	62		15.3	291		23.8
Other heart diseases	420-429	837		42.5	43		20.7	133		111.3	141		34.9	515		42.1
Cardiomyopathy	425	255		13.0	9		*	45		37.7	46		11.4	154		12.6
Malignant Neoplasms	140-208	2,258	2	114.7	197	1	94.7	218	2	182.5	334	2	82.7	1,502	2	122.7
Lung cancer	162	551		28.0	38		18.3	71		59.4	55		13.6	385		31.4
Unintentional Injuries	E800-949	867	3	44.0	29	4	13.9	97	3	81.2	195	3	48.3	536	3	43.8
Motor vehicle	E810-825	294		14.9	18		8.7	17		14.2	75		18.6	181		14.8
Chronic Liver/Cirrhosis	571	593	4	30.1	16		7.7	48	5	40.2	182	4	45.1	337	5	27.5
Suicide	E950-959	429	5	21.8	24	5	11.5	11		9.2	34		8.4	360	4	29.4
Firearms/explosives	E955	226		11.5	9		*	9		*	16		4.0	192		15.7
Acquired Immune Deficiency Syndrome	042-044	391		19.9	4		*	77	4	64.4	68		16.8	241		19.7
Cerebrovascular Disease	430-438	355		18.0	54	3	26.0	44		36.8	75	5	18.6	180		14.7
All Other Causes		2,155			108			322			433			1,281		
55–64 Years																
All Causes of Death	001-999	12,949		1096.2	978		817.2	1,510		2057.8	1,774		844.7	8,610		1117.7
Malignant Neoplasms	140-208	4,366	1	369.6	372	1	310.8	485	2	661.0	460	2	219.0	3,024	1	392.6
Colon cancer	153	332		28.1	29		24.2	35		47.7	24		11.4	244		31.7
Lung cancer	162	1,414		119.7	101		84.4	181		246.7	92		43.8	1,028		133.4
Prostate cancer	185	227		19.2	4		*	50		68.1	23		11.0	149		19.3
Diseases of the Heart	390-398,402, 404-429	3,974	2	336.4	260	2	217.2	500	1	681.4	491	1	233.8	2,700	2	350.5
Ischemic heart	410-414	2,431		205.8	171		142.9	227		309.4	313		149.0	1,703		221.1
Acute myocardial infarction	410	1,086		91.9	94		78.5	89		121.3	149		70.9	746		96.8
Coronary atherosclerosis	414.0	653		55.3	37		30.9	72		98.1	81		38.6	459		59.6
Other heart diseases	420-429	1,280		108.4	77		64.3	204		278.0	160		76.2	833		108.1
Cardiomyopathy	425	273		23.1	14		11.7	46		62.7	29		13.8	181		23.5
Cerebrovascular Disease	430-438	579	3	49.0	72	3	60.2	96	3	130.8	115	5	54.8	295	5	38.3
Chronic Liver/Cirrhosis	571	532	4	45.0	17		14.2	40		54.5	167	3	79.5	304	4	39.5
Chronic Obstructive Pulmonary Disease	490-496	515	5	43.6	23		19.2	48	5	65.4	30		14.3	413	3	53.6
Unintentional Injuries	E800-949	460		38.9	40	4	33.4	48	5	65.4	78		37.1	289		37.5
Diabetes	250	420		35.6	33	5	27.6	55	4	75.0	136	4	64.8	190		24.7
All Other Causes		2,103			161			238			297			1,395		

TABLE B-1 (Continued)
LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
MALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Males			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
65–74 Years																
All Causess of Death	001-999	23,763		2698.3	1,596		1984.2	1,898		4275.0	2,704		2039.9	17,482		2825.6
Malignant Neoplasms	140-208	7,715	1	876.1	500	1	621.6	609	2	1371.7	737	2	556.0	5,841	1	944.1
Colon cancer	153	567		64.4	32		39.8	46		103.6	58		43.8	427		69.0
Pancreatic cancer	157	409		46.4	26		32.3	32		72.1	49		37.0	301		48.7
Lung cancer	162	2,699		306.5	169		210.1	238		536.1	189		142.6	2,095		338.6
Prostate cancer	185	733		83.2	26		32.3	97		218.5	76		57.3	530		85.7
Urinary cancer	188-189	412		46.8	24		29.8	22		49.6	33		24.9	332		53.7
Diseases of the Heart	390-398,402, 404-429	7,543	2	856.5	476	2	591.8	619	1	1394.2	848	1	639.7	5,579	2	901.7
Hypertensive heart	402,404	330		37.5	25		31.1	58		130.6	33		24.9	213		34.4
Ischemic heart	410-414	5,192		589.6	325		404.0	331		745.5	576		434.5	3,949		638.3
Acute myocardial infarction	410	2,227		252.9	141		175.3	138		310.8	235		177.3	1,711		276.6
Coronary atherosclerosis	414.0	1,223		138.9	85		105.7	80		180.2	141		106.4	912		147.4
Other heart disease	420-429	1,912		217.1	117		145.5	223		502.3	227		171.2	1,336		215.9
Cardiomyopathy	425	385		43.7	23		28.6	35		78.8	41		30.9	281		45.4
Chronic Obstructive Pulmonary Disease	490-496	1,560	3	177.1	84	4	104.4	91	4	205.0	93		70.2	1,290	3	208.5
Emphysema	492	309		35.1	18		22.4	13		29.3	16		12.1	262		42.3
Cerebrovascular Disease	430-438	1,312	4	149.0	161	3	200.2	126	3	283.8	193	3	145.6	829	4	134.0
Pneumonia & Influenza	480-487	839	5	95.3	65	5	80.8	72		162.2	117	5	88.3	582	5	94.1
Diabetes	250	740		84.0	48		59.7	85	5	191.5	184	4	138.8	414		66.9
All Other Causes		4,054			262			296			532			2,947		
75–84 Years																
All Causes of Death	001-999	31,796		6542.8	1,882		4559.4	1,728		8196.2	2,328		4341.9	25,785		7009.1
Diseases of the Heart	390-398,402, 404-429	10,878	1	2238.4	571	1	1383.3	607	1	2879.1	749	1	1396.9	8,923	1	2425.5
Hypertensive heart	402,404	417		85.8	39		94.5	59		279.8	31		57.8	288		78.3
Ischemic heart	410-414	7,905		1626.6	398		964.2	382		1811.9	536		999.7	6,537		1776.9
Acute myocardial infarction	410	2,899		596.5	159		385.2	157		744.7	208		387.9	2,365		642.9
Coronary atherosclerosis	414.0	2,300		473.3	111		268.9	113		536.0	158		294.7	1,912		519.7
Other heart disease	420-429	2,414		496.7	126		305.3	160		758.9	176		328.3	1,946		529.0
Cardiomyopathy	425	410		84.4	24		58.1	25		118.6	32		59.7	325		88.3
Malignant Neoplasms	140-208	7,941	2	1634.0	439	2	1063.5	469	2	2224.5	576	2	1074.3	6,443	2	1751.4
Colon cancer	153	683		140.5	45		109.0	43		204.0	50		93.3	543		147.6
Pancreatic cancer	157	386		79.4	21		50.9	22		104.3	25		46.6	317		86.2
Lung cancer	162	2,258		464.6	122		295.6	138		654.6	133		248.1	1,861		505.9
Prostate cancer	185	1,324		272.4	44		106.6	120		569.2	103		192.1	1,055		286.8
Urinary cancer	188-189	464		95.5	21		50.9	13		61.7	25		46.6	403		109.5
Cerebrovascular Disease	430-438	2,374	3	488.5	202	3	489.4	114	3	540.7	173	3	322.7	1,877	3	510.2
Chronic Obstructive Pulmonary Disease	490-496	2,164	4	445.3	135	5	327.1	87	5	412.7	111		207.0	1,827	4	496.6
Emphysema	492	379		78.0	18		43.6	16		75.9	14		26.1	330		89.7
Pneumonia & Influenza	480-487	2,095	5	431.1	158	4	382.8	107	4	507.5	160	4	298.4	1,667	5	453.1
Diabetes	250	829		170.6	83		201.1	71		336.8	122	5	227.5	546		148.4
All Other Causes		5,515			294			273			437			4,502		

TABLE B-1 (Continued)

LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
MALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Males			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
85 Years and Over																
All Causes of Death	001-999	19,759		16465.0	1,279		10403.4	842		16245.4	1,517		8652.3	16,086		19091.4
Diseases of the Heart	390-398,402, 404-429	7,763	1	6468.8	484	1	3936.9	309	1	5961.8	579	1	3302.3	6,376	1	7567.2
Ischemic heart	410-414	5,499		4582.3	342		2781.8	193		3723.7	406		2315.6	4,548		5397.7
Acute myocardial infarction	410	1,716		1429.9	112		911.0	64		1234.8	137		781.4	1,401		1662.8
Coronary atherosclerosis	414.0	2,052		1709.9	128		1041.2	74		1427.7	152		866.9	1,695		2011.7
Other heart disease	420-429	1,917		1597.4	104		845.9	80		1543.5	145		827.0	1,583		1878.8
Heart failure	428	428		356.6	25		203.4	10		192.9	26		148.3	366		434.4
Malignant Neoplasms	140-208	2,980	2	2483.2	178	2	1447.9	155	2	2990.5	215	2	1226.3	2,429	2	2882.8
Colon cancer	153	285		237.5	13		105.7	8		*	14		79.8	250		296.7
Lung cancer	162	567		472.5	35		284.7	27		520.9	45		256.7	459		544.8
Prostate cancer	185	801		667.5	36		292.8	66		1273.4	53		302.3	644		764.3
Pneumonia & Influenza	480-487	2,027	3	1689.1	132	4	1073.7	67	4	1292.7	169	3	963.9	1,654	3	1963.0
Cerebrovascular Disease	430-438	1,834	4	1528.3	147	3	1195.7	87	3	1678.6	131	4	747.2	1,464	4	1737.5
Chronic Obstructive Pulmonary Disease	490-496	1,137	5	947.5	83	5	675.1	41	5	791.0	110	5	627.4	902	5	1070.5
All Other Causes		4,018			255			183			313			3,261		

TABLE B-2

LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
FEMALES BY RACE/ETHNICITY[2]
CALIFORNIA, 1997

(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Females			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
UNDER 1 Year																
All Causes of Death	001-999	1,428		535.2	107		375.5	232		1280.4	665		524.3	418		454.0
Certain Perinatal Conditions	760-779	608	1	227.9	33	2	115.8	127	1	700.9	270	1	212.9	175	1	190.1
Congenital Anomalies	740-759	424	2	158.9	38	1	133.3	38	2	209.7	229	2	180.6	119	2	129.2
Sudden Infant Death Syndrome	798.0	130	3	48.7	11	3	38.6	24	3	132.5	45	3	35.5	49	3	53.2
Unintentional Injuries	E800-949	24	4	9.0	1	*	*	3	*	*	13	4	10.3	7	*	*
Motor vehicle	E810-825	7		*	-		*	1		*	4		*	2		*
Suffocation	E913	6		*	-		*	-		*	5		*	1		*
Heart Disease	390-398,402, 404-429	23	5	8.6	1	*	*	5	*	*	11		8.7	5	*	*
Pneumonia/Influenza	480-487	17		6.4	-		*	3		*	12	5	9.5	2		*
All Other Causes		202			23			32			85			61		
1–4 Years																
All Causes of Death	001-999	285		25.9	26		22.0	34		42.8	116		22.9	105		27.0
Unintentional Injuries	E800-949	97	1	8.8	8	*	*	10	1	12.6	46	1	9.1	31	1	8.0
Motor vehicle	E810-825	37		3.4	4		*	1		*	22		4.3	9		*
Drownings	E910	27		2.5	3		*	2		*	10		2.0	12		3.1
Congenital Anomalies	740-759	42	2	3.8	6	*	*	3	*	*	14	2	2.8	19	2	4.9
Homicide	E960-969	27	3	2.5	3	*	*	5	*	*	8	*	*	11	4	2.8
Malignant Neoplasms	140-208	25	4	2.3	2	*	*	2	*	*	8	*	*	12	3	3.1
Pneumonia/Influenza	480-487	16	5	1.5	2	*	*	2	*	*	8	*	*	4	*	*
All Other Causes		78			5			12			32			28		
5–9 Years																
All Causes of Death	001-999	174		12.8	26		18.1	26		24.2	56		10.3	64		11.6
Unintentional Injuries	E800-949	56	1	4.1	6	*	*	10	1	9.3	22	1	4.0	16	1	2.9
Motor vehicle	E810-825	35		2.6	4		*	4		*	14		2.6	13		2.3
Malignant Neoplasms	140-208	34	2	2.5	4	*	*	4	*	*	11	2	2.0	15	2	2.7
Congenital Anomalies	740-759	17	3	1.3	2	*	*	3	*	*	8	*	*	4	*	*
Homicide	E960-969	12	4	0.9	2	*	*	2	*	*	2	*	*	6	*	*
Heart Disease	390-398,402, 404-429	9		*	3		*	3		*	1		*	2		*
All Other Causes		46			9			4			12			21		

- Represents zero events.

* Ranks and rates are not calculated for less than 10 deaths.

[1] Death Rates are per 100,000 population for each age, sex, and race group.

[2] Asian/Pacific Islander, Black, and White exclude Hispanic ethnicity. Hispanic includes any race category. White includes Other Races, Not Stated, and Unknown.

[3] Total Female Deaths include American Indian.

Source: State of California, Department of Health Services, Death Records; State of California, Department of Finance, 1997 Population Projections by Age, Sex and Race/Ethnic Groups, December 1998.

TABLE B-2 (Continued)
LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
FEMALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Females			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
10–14 Years																
All Causes of Death	001-999	150		13.1	24		18.3	10		11.2	47		11.5	69		13.6
Unintentional Injuries	E800-949	45	1	3.9	10	1	7.6	2	*	*	17	1	4.1	16	2	3.1
Motor vehicle	E810-825	29		2.5	6		*	1		*	9		*	13		2.6
Malignant Neoplasms	140-208	35	2	3.1	4	*	*	1	*	*	9	*	*	21	1	4.1
Leukemia	204-208	16		1.4	2		*	-		*	7		*	7		*
Suicide	E950-959	9		*	-		*	1		*	-		*	8		*
Congenital Anomalies	740-759	8		*	1		*	1		*	4		*	2		*
All Other Causes		53			9			5			17			22		
15–19 Years																
All Causes of Death	001-999	355		33.7	40		31.9	37		43.8	120		32.9	157		33.2
Unintentional Injuries	E800-949	135	1	12.8	15	1	12.0	7		*	37	1	10.1	75	1	15.9
Motor vehicle	E810-825	115		10.9	15		12.0	4		*	32		8.8	63		13.3
Homicide	E960-969	44	2	4.2	2	*	*	10	1	11.9	22	2	6.0	10	4	2.1
Firearms/explosives	E965	33		3.1	2		*	9		*	19		5.2	3		*
Suicide	E950-959	35	3	3.3	7	*	*	3	*	*	9	*	*	16	2	3.4
Malignant Neoplasms	140-208	31	4	2.9	5	*	*	6	*	*	8	*	*	12	3	2.5
Leukemia	204-208	8		*	-		*	3		*	4		*	1		*
Heart Disease	390-398,402, 404-429	14	5	1.3	2	*	*	2	*	*	1	*	*	9	*	*
All Other Causes		96			9			9			43			35		
20–24 Years																
All Causes of Death	001-999	418		41.8	51		40.2	55		69.5	150		43.6	158		35.6
Unintentional Injuries	E800-949	138	1	13.8	16	1	12.6	7	*	*	52	1	15.1	63	1	14.2
Motor vehicle	E810-825	106		10.6	12		9.5	3		*	44		12.8	47		10.6
Poisonings	E850-869	14		1.4	2		*	3		*	1		*	8		*
Malignant Neoplasms	140-208	48	2	4.8	7	*	*	4	*	*	20	2	5.8	17	2	3.8
Leukemia	204-208	9		*	2		*	-		*	4		*	3		*
Homicide	E960-969	45	3	4.5	3	*	*	18	1	22.7	15	3	4.4	9	*	*
Firearms/explosives	E965	31		3.1	2		*	13		16.4	12		3.5	4		*
Suicide	E950-959	25	4	2.5	5	*	*	1	*	*	8	*	*	10	3	2.3
Diseases of the Heart	390-398,402, 404-429	21	5	2.1	1	*	*	6	*	*	5	*	*	9	*	*
All Other Causes		141			19			19			50			50		

TABLE B-2 (Continued)
LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
FEMALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Females			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
25–34 Years																
All Causes of Death	001-999	1,358		54.4	105		36.5	217		116.5	367		45.7	655		54.5
Unintentional Injuries	E800-949	297	1	11.9	24	1	8.3	29	2	15.6	75	2	9.3	165	1	13.7
Motor vehicle	E810-825	167		6.7	16		5.6	12		6.4	53		6.6	83		6.9
Poisonings	E850-869	70		2.8	1		*	10		5.4	12		1.5	47		3.9
Malignant Neoplasms	140-208	257	2	10.3	24	1	8.3	32	1	17.2	78	1	9.7	123	2	10.2
Breast cancer	174	52		2.1	4		*	6		*	19		2.4	23		1.9
Suicide	E950-959	118	3	4.7	15	3	5.2	7		*	20	4	2.5	74	3	6.2
Firearms/explosives	E955	47		1.9	4		*	5		*	6		*	31		*
Homicide	E960-969	97	4	3.9	6	*	*	23	4	12.3	33	3	4.1	33	5	2.7
Firearms/explosives	E965	58		2.3	3	*	*	16		8.6	23		2.9	16		1.3
Diseases of the Heart	390-398,402, 404-429	91	5	3.6	5		*	28	3	15.0	18		2.2	39	4	3.2
Acquired Immune Deficiency Syndrome	042-044	55		2.2	-		*	19	5	10.2	20	4	2.5	16		1.3
All Other Causes		443			31			79			123			205		
35–44 Years																
All Causes of Death	001-999	3,241		119.5	247		77.3	561		287.5	596		87.6	1,812		120.9
Malignant Neoplasms	140-208	1,047	1	38.6	116	1	36.3	149	1	76.4	209	1	30.7	568	1	37.9
Breast cancer	174	342		12.6	29		9.1	57		29.2	79		11.6	176		11.7
Unintentional Injuries	E800-949	397	2	14.6	26	2	8.1	44	3	22.5	71	2	10.4	249	2	16.6
Motor vehicle	E810-825	153		5.6	18		5.6	9		*	37		5.4	87		5.8
Poisonings	E850-869	179		6.6	4		-	28		14.3	19		2.8	123		8.2
Diseases of the Heart	390-398,402, 404-429	322	3	11.9	23	3	7.2	73	2	37.4	40	4	5.9	184	3	12.3
Ischemic heart	410-414	108		4.0	15		4.7	23		11.8	9		*	60		4.0
Other heart disease	420-429	125		4.6	3		*	32		16.4	18		2.6	71		4.7
Suicide	E950-959	174	4	6.4	10	5	3.1	9		*	14		2.1	141	4	9.4
Chronic Liver/Cirrhosis	571	168	5	6.2	4		*	20		10.2	41	3	6.0	99	5	6.6
Cerebrovascular Disease	430-438	136		5.0	20	4	6.3	40	4	20.5	27	5	4.0	49		3.3
Homicide	E960-969	106		3.9	10	5	3.1	33		16.9	25		3.7	37		2.5
Acquired Immune Deficiency Syndrome	042-044	86		3.2	-		*	34	5	17.4	17		2.5	35		2.3
All Other Causes		805			38			159			152			450		

TABLE B-2 (Continued)

LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
FEMALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Females			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
45–54 Years																
All Causes of Death	001-999	5,691		284.7	443		192.0	780		580.6	863		217.9	3,562		291.2
Malignant Neoplasms	140-208	2,389	1	119.5	222	1	96.2	233	1	173.4	346	1	87.4	1,579	1	129.1
Lung cancer	162	419		21.0	24		10.4	50		37.2	25		6.3	318		26.0
Breast cancer	174	694		34.7	71		30.8	71		52.9	89		22.5	461		37.7
Cancer of female genitals	183-184	195		9.8	17		7.4	18		13.4	25		6.3	135		11.0
Diseases of the Heart	390-398,402, 404-429	851	2	42.6	46	2	19.9	177	2	131.8	114	2	28.8	508	2	41.5
Ischemic heart	410-414	431		21.6	24		10.4	70		52.1	53		13.4	281		23.0
Acute myocardial infarction	410	213		10.7	17		7.4	29		21.6	27		6.8	140		11.4
Coronary atherosclerosis	414.0	115		5.8	4		*	27		20.1	16		4.0	67		5.5
Other heart disease	420-429	261		13.1	11		4.8	65		48.4	39		9.8	143		11.7
Unintentional Injuries	E800-949	305	3	15.3	24	4	10.4	38	4	28.3	49	5	12.4	192	3	15.7
Motor vehicle	810-825	137		6.9	15		6.5	8		*	26		6.6	87		7.1
Cerebrovascular Disease	430-438	272	4	13.6	37	3	16.0	51	3	38.0	49	5	12.4	133		10.9
Chronic Liver/Cirrhosis	571	238	5	11.9	5		*	25		18.6	50	4	12.6	154	4	12.6
Diabetes	250	186		9.3	10		4.3	38	4	28.3	51	3	12.9	85		6.9
Suicide	E950-959	166		8.3	12	5	5.2	3		*	6		*	143	5	11.7
Chronic Obstructive Pulmonary Disease	490-496	147		7.4	7		*	31		23.1	7		1.8	100		8.2
All Other Causes		1,137			80			184			191			668		
55–64 Years																
All Causes of Death	001-999	9,024		723.1	601		447.9	1,101		1321.5	1,265		562.3	6,005		753.5
Malignant Neoplasms	140-208	3,883	1	311.1	261	1	194.5	364	1	436.9	437	1	194.3	2,799	1	351.2
Colon cancer	153	255		20.4	18		13.4	30		36.0	30		13.3	174		21.8
Lung cancer	162	1,034		82.9	52		38.8	94		112.8	59		26.2	826		103.6
Breast cancer	174	768		61.5	49		36.5	70		84.0	83		36.9	563		70.6
Cancer of female genitals	183-184	239		19.2	10		7.5	13		15.6	31		13.8	184		23.1
Diseases of the Heart	390-398,402, 404-429	1,799	2	144.2	101	2	75.3	315	2	378.1	283	2	125.8	1,095	2	137.4
Ischemic heart	410-414	1,067		85.5	56		41.7	156		187.2	179		79.6	674		84.6
Acute myocardial infarction	410	527		42.2	29		21.6	75		90.0	86		38.2	335		42.0
Coronary atherosclerosis	414.0	268		21.5	8		*	41		49.2	50		22.2	169		21.2
Other heart disease	420-429	530		42.5	29		21.6	113		135.6	85		37.8	303		38.0
Chronic Obstructive Pulmonary Disease	490-496	493	3	39.5	17		12.7	45	5	54.0	17		7.6	410	3	51.4
Cerebrovascular Disease	430-438	448	4	35.9	60	3	44.7	74	4	88.8	81	4	36.0	232	4	29.1
Diabetes	250	415	5	33.3	36	4	26.8	81	3	97.2	120	3	53.3	174	5	21.8
Chronic Liver/Cirrhosis	571	230		18.4	5		*	10		12.0	52	5	23.1	161		20.2
Pneumonia & Influenza	480-487	223		17.9	15		11.2	22		26.4	33		14.7	150		18.8
Unintentional Injuries	E800-949	218		17.5	19	5	14.2	24		28.8	29		12.9	145		18.2
All Other Causes		1,315			87			166			213			839		

TABLE B-2 (Continued)
LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
FEMALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Females			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
65–74 Years																
All Causes of Death	001-999	19,124		1794.2	1,297		1232.3	1,603		2725.6	2,260		1415.3	13,901		1887.1
Malignant Neoplasms	140-208	6,770	1	635.2	445	1	422.8	494	2	840.0	633	1	396.4	5,180	1	703.2
Colon cancer	153	484		45.4	42		39.9	54		91.8	45		28.2	341		46.3
Pancreatic cancer	157	376		35.3	42		39.9	39		66.3	44		27.6	251		34.1
Lung cancer	162	2,072		194.4	82		77.9	147		249.9	98		61.4	1,742		236.5
Breast cancer	174	954		89.5	39		37.1	77		130.9	86		53.9	746		101.3
Cancer of female genitals	183-184	428		40.2	20		19.0	25		42.5	38		23.8	342		46.4
Diseases of the Heart	390-398,402, 404-429	4,839	2	454.0	308	2	292.6	514	1	874.0	619	2	387.6	3,378	2	458.6
Hypertensive heart	402,404	293		27.5	29		27.6	67		113.9	27		16.9	170		23.1
Ischemic heart	410-414	3,178		298.2	211		200.5	299		508.4	436		273.0	2,218		301.1
Acute myocardial infarction	410	1,394		130.8	93		88.4	146		248.2	181		113.3	964		130.9
Coronary atherosclerosis	414.0	833		78.2	58		55.1	70		119.0	122		76.4	580		78.7
Other heart disease	420-429	1,198		112.4	56		53.2	142		241.4	143		89.6	851		115.5
Chronic Obstructive Pulmonary Disease	490-496	1,510	3	141.7	42	5	39.9	70	5	119.0	55		34.4	1,341	3	182.0
Emphysema	492	302		28.3	7		*	12		20.4	4		*	279		37.9
Cerebrovascular Disease	430-438	1,302	4	122.2	137	3	130.2	130	3	221.0	196	4	122.7	838	4	113.8
Diabetes	250	774	5	72.6	78	4	74.1	91	4	154.7	223	3	139.6	378		51.3
Pneumonia & Influenza	480-487	632		59.3	41		39.0	62		105.4	90	5	56.4	437	5	59.3
Chronic Liver/Cirrhosis	571	293		27.5	15		14.3	11		18.7	63		39.5	199		27.0
All Other Causes		3,004			231			231			381			2,150		
75–84 Years																
All Causes of Death	001-999	32,320		4508.1	1,671		3051.1	1,952		5492.6	2,490		3120.3	26,109		4801.8
Diseases of the Heart	390-398,402, 404-429	10,630	1	1482.7	497	1	907.5	746	1	2099.1	856	1	1072.7	8,492	1	1561.8
Hypertensive heart	402,404	588		82.0	34		62.1	88		247.6	53		66.4	409		75.2
Ischemic heart	410-414	7,247		1010.8	347		633.6	483		1359.1	580		726.8	5,811		1068.7
Acute myocardial infarction	410	2,809		391.8	143		261.1	201		565.6	225		282.0	2,229		409.9
Coronary atherosclerosis	414.0	2,380		332.0	101		184.4	161		453.0	192		240.6	1,919		352.9
Other heart disease	420-429	2,513		350.5	101		184.4	162		455.8	204		255.6	2,039		375.0
Heart failure	428	444		61.9	16		29.2	22		61.9	41		51.4	364		66.9
Malignant Neoplasms	140-208	7,191	2	1003.0	349	2	637.2	386	2	1086.1	507	2	635.3	5,932	2	1091.0
Colon cancer	153	680		94.8	33		60.3	42		118.2	46		57.6	557		102.4
Pancreatic cancer	157	483		67.4	23		42.0	36		101.3	34		42.6	390		71.7
Lung cancer	162	1,946		271.4	78		142.4	84		236.4	93		116.5	1,682		309.3
Breast cancer	174	858		119.7	15		27.4	47		132.2	51		63.9	743		136.6
Cancer of female genitals	183-184	378		52.7	15		27.4	18		50.6	25		31.3	319		58.7
Cerebrovascular Disease	430-438	3,276	3	456.9	229	3	418.1	219	3	616.2	265	3	332.1	2,552	3	469.4
Chronic Obstructive Pulmonary Disease	490-496	2,399	4	334.6	83	5	151.5	71		199.8	83		104.0	2,159	4	397.1
Emphysema	492	374		52.2	8		*	9		*	8		*	348		64.0
Pneumonia & Influenza	480-487	2,008	5	280.1	101	4	184.4	92	5	258.9	160	4	200.5	1,652	5	303.8
Diabetes	250	899		125.4	83	5	151.5	103	4	289.8	148	5	185.5	555		102.1
Alzheimer's Disease	330-337	471		65.7	15		27.4	29		81.6	23		28.8	404		74.3
All Other Causes		5,446			314			306			448			4,363		

TABLE B-2 (Continued)

LEADING CAUSES OF DEATH AND AGE-SPECIFIC DEATH RATES[1]
FEMALES BY RACE/ETHNICITY[2] — CALIFORNIA, 1997
(By Place of Residence)

Age in Years and Cause of Death	ICD Codes	Total Females			Asian/Pacific Islander			Black			Hispanic			White		
	(Rev. 9)	Deaths [3]	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates	Deaths	Rank	Rates
85 Years and Over																
All Causes of Death	001-999	36,825		13590.0	1,255		7828.1	1,657		13547.5	2,414		7436.8	31,438		15052.3
Diseases of the Heart	390-398,402, 404-429	15,906	1	5870.0	488	1	3043.9	741	1	6058.4	1,056	1	3253.2	13,592	1	6507.7
Hypertensive heart	402,404	939		346.5	37		230.8	69		564.1	70		215.7	762		364.8
Ischemic heart	410-414	10,805		3987.5	339		2114.5	485		3965.3	748		2304.4	9,210		4409.7
Acute myocardial infarction	410	3,131		1155.5	98		611.3	178		1455.3	233		717.8	2,617		1253.0
Coronary atherosclerosis	414.0	4,774		1761.8	134		835.8	205		1676.1	320		985.8	4,103		1964.5
Other heart disease	420-429	3,990		1472.5	108		673.7	180		1471.7	228		702.4	3,469		1660.9
Heart failure	428	888		327.7	26		162.2	30		245.3	53		163.3	778		372.5
Cerebrovascular Disease	430-438	4,444	2	1640.0	169	3	1054.1	204	2	1667.9	226	4	696.2	3,837	2	1837.1
Pneumonia & Influenza	480-487	3,658	3	1350.0	124	4	773.5	149	4	1218.2	237	3	730.1	3,141	3	1503.9
Malignant Neoplasms	140-208	3,530	4	1302.7	170	2	1060.4	172	3	1406.3	240	2	739.4	2,947	4	1411.0
Colon cancer	153	561		207.0	28		174.7	31		253.5	32		98.6	470		225.0
Lung cancer	162	576		212.6	32		199.6	22		179.9	40		123.2	482		230.8
Breast cancer	174	420		155.0	13		81.1	21		171.7	20		61.6	365		174.8
Chronic Obstructive Pulmonary Disease	490-496	1,445	5	533.3	51	5	318.1	52	5	425.1	82	5	252.6	1,260	5	603.3
Alzheimer's Disease	331.0	790		291.5	13		*	18		147.2	38		117.1	719		344.3
Atherosclerosis	440	736		271.6	15		93.6	26		212.6	49		151.0	644		308.3
Diabetes	250	553		204.1	35		218.3	43		351.6	81		249.5	391		187.2
All Other Causes		5,763			190			252			405			4,907		

Schools offer the most systematic and efficient means available to improve the health of youth and enable young people to avoid health risks. . . .

—U.S. Public Health Service

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