

# Adolescent Health Plan 2003 - 2005



San Francisco Department of Public Health  
Office of Adolescent Health  
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## **The Purpose of This Report**

The purpose of this report is to provide a guide for the San Francisco Department of Public Health (DPH) toward its goal of improving the health of adolescents. The *Adolescent Health Plan 2003-2005* is a two-year strategic plan developed out of the newly created DPH Office of Adolescent Health. Although this plan is specific to DPH, it will be followed by a citywide plan to be issued in 2005. The contents of this report reflect the expertise and wisdom of many individuals throughout San Francisco and the nation and offers guidance regarding best practices for approaching adolescent health, addressing current gaps where they exist, and implementing strategies for building upon our strengths.

## **A Critical Issue for San Francisco**

The health and well-being of San Francisco's youth is critical for a healthy future for our city and county. The majority of adolescent mortality and morbidity is a result of preventable conditions. However, when decisions about where to invest significant health and other supportive resources are made, adolescents often receive less attention and fewer resources, despite the fact that after early infancy, adolescence is the period of greatest vulnerability until the diseases of old age. It is of utmost importance to ensure that teens have the opportunity and the skills to make healthy choices that will shape their lives as adults.

## **Approaches to Adolescent and Young Adult Health**

The vision for healthy youth fuses the youth development model to all programs for adolescents and young adults. Youth development is a model of viewing and working with youth that focuses on resilience and the positive outcomes of behavior; it is NOT seeing youth as problems or as having deficits to be controlled. The protective mechanisms for young people's well-being include peaceful environments, stable families and communities, opportunities for leadership, a well-supported school system, adult mentors, and youth participation. The more DPH focuses on what enhances young people's health, rather than their deficits, the more likely our youth will thrive and become healthy adults.

## **Guiding Principles for Adolescent Health**

The following five guiding principles incorporate the youth development model and represent the shift in how DPH approaches youth health.

1. Adolescence is an opportune time to shape healthy behavior, not simply a period of turbulence and stress.
2. Positive risk-taking and decision-making by adolescents influence their health and well-being.
3. Partnering with youth when making policy and developing, implementing, and evaluating programs build both leadership skills in youth and more effective programs.
4. Prevention and intervention strategies for youth are more effective when they are age-appropriate and reflect each stage of social, physical and psychological development.
5. Healthy environments for young people, including healthy air, water, soil, safe homes, communities, schools, streets and parks maximize adolescents' health and well-being.

## **Eight Recommendations for Improving Adolescent Health**

This plan grew from the California Adolescent Health Collaborative strategic plan, *Investing in Adolescent Health: A Social Imperative for California's Future*, and was made specific to the unique experiences of youth in San Francisco. The eight recommendations were developed through a collaborative effort between community members, DPH staff, Department of Children, Youth and Their Families staff, and other city agency/department staff to help DPH serve the needs of young people in San Francisco. The recommendations within each area do not pertain solely to DPH, but instead reflect community consensus planning for the entire city. The recommendations have their origins in current best practices for adolescent and young adult health and are broad goals for improving programs and services to youth. The full report provides a complete listing of specific recommendations for each of the eight strategies.

### Recommendation One:

**Integrate Youth Development Principles and Practices into Programs** - Positive youth development is a policy perspective that emphasizes providing services and opportunities to support all young people in developing a sense of competence, usefulness, belonging, and empowerment.

1. Create opportunities for youth to make decisions in key adolescent health programs within DPH and community contractors.
2. View youth as resources to be developed rather than problems to be managed.

### Recommendation Two:

**Support Families and Communities** - Supportive family relationships protect youth against many different kinds of health risks, including emotional distress; suicidal ideation and attempts; cigarette, alcohol and other drug use; violent behavior; and early sexual activity. Communities also play a key role in promoting and protecting adolescent health and well-being. Together, families and communities have great responsibility to support youth as they grow and develop into healthy adults.

1. Promote services that support family relationships.
2. Collaborate with other city agencies to provide family-oriented services in underserved neighborhoods.
3. Support healthy community environments.
4. Promote healthy youth development through positive job training and employment opportunities.

### Recommendation Three:

**Eliminate Racial/Ethnic Health Disparities** - A long-standing and well-documented pattern of racial/ethnic health disparities exists in the United States. This pattern is apparent in health outcomes and utilization and is supported by disproportionate incidence of disease, disability and death among specific racial and ethnic groups. In order to prevent and intervene in racial/ethnic health disparities, the major determinants of the disparities need to be addressed.

Some of the major determinants include racism, social gradient, unemployment, stress and food insecurity.

1. Support dialogue on racism and policies to decrease racial/ethnic health disparities and inequities.
2. Reduce the high detention rates for African American and Latino youth.
3. Reduce violence-related injury and death for communities disproportionately affected.
4. Increase access and utilization of health care services.

#### Recommendation Four:

**Ensure the Health of Vulnerable Youth Populations** - Among adolescents, there are specific vulnerable populations that experience disproportionate stressors to their health. Focus needs to be placed on the following populations during their childhood and adolescence.

1. Youth in Foster Care
2. Youth in the Criminal Justice System
3. Homeless Youth
4. Youth Who Are Newcomers
5. Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth
6. Youth With Special Needs

#### Recommendation Five:

**Integrate School-based Health and Public Health** - The crucial role that schools play in helping shape our children and youth's future makes them an essential partner in promoting a healthy lifestyle. This is achieved by creating a healthy school environment. When schools, families, and the broader community work together to support positive youth development, students thrive, risk behaviors are reduced and health and academic achievement are promoted.

1. Improve coordination between school health and public health.
2. Support connections between schools, families and their communities.

#### Recommendation Six:

**Ensure that Environments where Youth Live, Learn and Work are Healthy** - Young people's overall susceptibility to disease and disability is greater, and illness rates are higher, due to a broad range of environmental conditions. Primary determinants to a community's health include such environmental factors as poverty, educational opportunities, and social inequities.

1. Create community environments that promote safe, healthy choices.
2. Partner with other Departments, community based organizations, and community groups to improve environments.

#### Recommendation Seven:

**Coordinate Adolescent Health Programs and Services** - It is critical for the Department's adolescent health programs and services to be integrated and coordinated to ensure healthy outcomes for youth. There are many programs and services for adolescents and young

adults within the Department, however in order to be more effective and efficient in serving youth, collaborations need to be developed, or made stronger where they already exist.

1. Increase collaboration within adolescent health programs and services.
2. Respond to emerging health issues affecting youth.
3. Organize and implement trainings on Minor Consent and Youth Development Model.
4. Coordinate data and information for adolescent health.

### Recommendation Eight:

**Ensure Access to and Utilization of Comprehensive Health Care Services** - Access to and utilization of comprehensive health services by adolescents can make a critical difference between a healthy adolescence and one that is complicated by physical, mental and social problems.

1. Increase provider competence.
2. Implement minor consent policy.
3. Implement best practices for youth health care services.
4. Improve current services.

### **Program Strategies for Improving DPH Youth Health**

Although the core recommendations can have a profound impact on a wide range of health outcomes, there is still a need for the Department to strategically focus on specific outcomes for youth. The full report presents background information and program strategies as a guide to improve DPH's specific youth programs and services. In this section, the following areas of adolescent health are addressed:

**1. Behavioral Health**

- Alcohol, Tobacco and Other Drugs
- Mental Health

**2. Environmental Health**

**3. Injury and Violence**

**4. Nutrition and Physical Activity**

**5. Oral Health**

**6. Primary Care**

**7. Sexual Health**

- Pregnancy
- Sexually Transmitted Diseases/HIV

# Introduction

## **The Purpose of This Report**

The purpose of this report is to provide a guide for the San Francisco Department of Public Health (DPH) toward its goal of improving the health of adolescents. The *Adolescent Health Plan 2003-2005* is a two-year strategic plan developed out of the newly created DPH Office of Adolescent Health. Although this plan is specific to DPH, it will be followed by a citywide plan to be issued in 2005.

The *Adolescent Health Plan* was built off the work of DPH's Strategic Plan (2000), which identifies specific directions for the Department to better fulfill its mission to "protect and promote the health of all San Franciscans." Within the DPH Strategic Plan, children and youth are identified as being a focus population for services. Additionally, children's health was a specific concern described by African American, Asian/Pacific Islander, European American, Latino and Native American communities. Prevention is a key goal within the DPH Strategic Plan and the *Adolescent Health Plan* focuses on prevention as a priority with San Francisco's youth.

There are many progressive and effective services within DPH that focus on adolescents – from primary prevention to intervention and treatment. The contents of this report reflect the expertise and wisdom of many individuals throughout San Francisco and the nation and offers guidance regarding best practices for approaching adolescent health, addressing current gaps where they exist, and implementing strategies for building upon our strengths.

## **A Critical Issue for San Francisco**

The health and well-being of San Francisco's youth is critical for a healthy future for our city and county. The majority of adolescent mortality and morbidity is a result of preventable conditions. However, when decisions about where to invest significant health and other supportive resources are made, adolescents often receive less attention and fewer resources, despite the fact that after early infancy, adolescence is the period of greatest vulnerability until the diseases of old age. It is of utmost importance to ensure that teens have the opportunity and the skills to make healthy choices that will shape their lives as adults.

As a group, adolescents in San Francisco are generally physically healthy, i.e., few have chronic illnesses. However, some struggle with mental and emotional health issues. Many, because of the environments in which they live, experience mental health stressors like exposure to violence, unstable families, deteriorated communities, and poor learning environments. Poverty is the root cause in most environmental stressors. Threats to young people's health originate primarily from their environment and the behaviors in which their environments enable.

Adolescence is a time of growth, curiosity and risk-taking, as teens learn to manage new capabilities and greater independence. Risk-taking and experimentation are often a normal part of "growing up," and often lead to positive outcomes; however they can also lead to negative and potentially serious health consequences.

## **Approaches to Adolescent and Young Adult Health**

The vision for healthy youth fuses the youth development model to all programs for adolescents and young adults. Youth development is a model of viewing and working with youth that focuses on resilience and the positive outcomes of behavior; it is NOT seeing youth as problems or as having deficits to be controlled. The protective mechanisms for young people's well-being include peaceful environments, stable families and communities, opportunities for leadership, a well-supported school system, adult mentors, and youth participation. The more DPH focuses on what enhances young people's health, rather than their deficits, the more likely our youth will thrive and become healthy adults.

The health concerns that adolescents and young adults face are easily overlooked because they are not, for the most part, acute illnesses or chronic diseases. Primarily they are environmental and behavioral issues. Significant levels of preventable death, disability and illness occur to adolescents, including injuries due to violence, consequences of early and unprotected sex, and the negative impact of alcohol, tobacco and other drug abuse. In order for San Francisco to address the health issues of our youth, it is imperative that we focus on the spectrum of health needs including prevention, improved environments, promotion of positive physical and behavioral health, and access to health care. Adolescence and young adulthood are prime times for prevention and education.

## **Guiding Principles for Adolescent Health**

The following five guiding principles incorporate the youth development model and represent the shift in how DPH approaches youth health.

1. Adolescence is an opportune time to shape healthy behavior, not simply a period of turbulence and stress.
2. Positive risk-taking and decision-making by adolescents influence their health and well-being.
3. Partnering with youth when making policy and developing, implementing, and evaluating programs build both leadership skills and more effective programs.
4. Prevention and intervention strategies for youth are more effective when they are age-appropriate and reflect each stage of social, physical and psychological development.
5. Healthy environments for young people, including healthy air, water, soil, safe homes, communities, schools, streets and parks maximize adolescents' health and well-being.

## **Organization of this Report**

This report is organized into the following three sections.

### Section 1: Profile of San Francisco Adolescents and Young Adults

This section reviews the latest Youth Risk Behavior Survey data as well as general demographic data of adolescents and young adults in San Francisco.

## Section 2: Eight Recommendations for Improving Adolescent Health

This plan grew from the California Adolescent Health Collaborative strategic plan, *Investing in Adolescent Health: A Social Imperative for California's Future*, and was made specific to the unique experiences of youth in San Francisco. The eight recommendations were developed through a collaborative effort between community members, DPH staff, Department of Children, Youth and Their Families staff, and other city agency/department staff to help DPH serve the needs of young people in San Francisco. The recommendations within each area do not pertain solely to DPH, but instead reflect community consensus planning for the entire city. The recommendations have their origins in current best practices for adolescent and young adult health and are broad goals for improving programs and services to youth. The eight recommendations are:

1. Integrate Youth Development Principles and Practices into Programs
2. Support Families and Communities
3. Eliminate Racial/Ethnic Health Disparities
4. Ensure the Health of Vulnerable Youth Populations
5. Integrate School-based Health and Public Health
6. Ensure that Environments where Youth Live, Learn and Work are Healthy
7. Coordinate Adolescent Health Programs and Services
8. Ensure Access to and Utilization of Comprehensive Health Care Services

## Section 3: Program Strategies for Improving DPH Youth Health

Although the core recommendations can have a profound impact on a wide range of health outcomes, there is still a need for the Department to strategically focus on specific outcomes for youth. For example, while the core recommendations highlight the need for enhancing community capacity to create healthy and safe environments for youth, this section, Program Strategies for Improving DPH Youth Health, provides specific DPH programs and services with strategic focus for improving young people's environments, such as limiting availability of tobacco products, improving neighborhood safety, and enhancing nutrition and physical activity programs. This section is provided as a guide to improve the Department's specific youth programs and services, with many of the strategies already in progress.

The following areas of adolescent health are addressed:

1. Behavioral Health
  - Alcohol, Tobacco and Other Drugs
  - Mental Health
2. Environmental Health
3. Injury and Violence
4. Nutrition and Physical Activity
5. Oral Health
6. Primary Care
7. Sexual Health
  - Pregnancy
  - Sexually Transmitted Diseases/HIV

## **Acknowledgements**

In the *Adolescent Health Plan*, we want to acknowledge the programs that are currently modeling best practices in adolescent health. These programs will be acknowledged as a **Healthy Highlight** under each recommendation. These **Healthy Highlights** are only a *small sampling* of the many DPH programs dedicated to promoting and protecting the health of children and youth in San Francisco. The section **Youth Voice** is an opportunity for the Department to listen to what young people have to say about their health, their communities, and their hope for the future.

# **Section One**

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## **Profile of San Francisco Adolescents and Young Adults**

## San Francisco Youth Risk Behavior Survey Results

The Youth Risk Behavior Surveillance System was developed by the Division of Adolescent and School Health, National Centers for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention in collaboration with representatives from state and local departments of education and other federal agencies. The main purpose of the Youth Risk Behavior Survey (YRBS) is to monitor priority health-risk behaviors that contribute to the leading causes of morbidity, mortality, and social problems among youth and adults in the United States.

School-based surveys are conducted every two years among students in grades 9-12 in 42 states, 16 large cities, and 4 territories. The average sample size was 2,200. San Francisco is one of the local sites for the high school YRBS. The Middle School YRBS is a modified version of CDC's Youth Risk Behavior Survey, conducted biennially to a random sample of San Francisco students in grades 6-8. All survey results are self-reported. Below are results from the 2001 YRBS from San Francisco Unified School District.

### High School—

- Nearly half of the students (49%) have tried smoking cigarettes.
- Just over half of the students (58%) have tried alcohol; 29% of students reported current alcohol use (1 or more drinks on 1 or more days in the past month.)
- Most students (70%) have **NOT** had sexual intercourse.
- Among currently sexually active students, 63% used a condom the last time they had sex.
- In the past 12 months prior to the survey, 14% of students reported that they seriously thought about ending their life; 13% had made a plan and 7% attempted suicide 1 or more times.

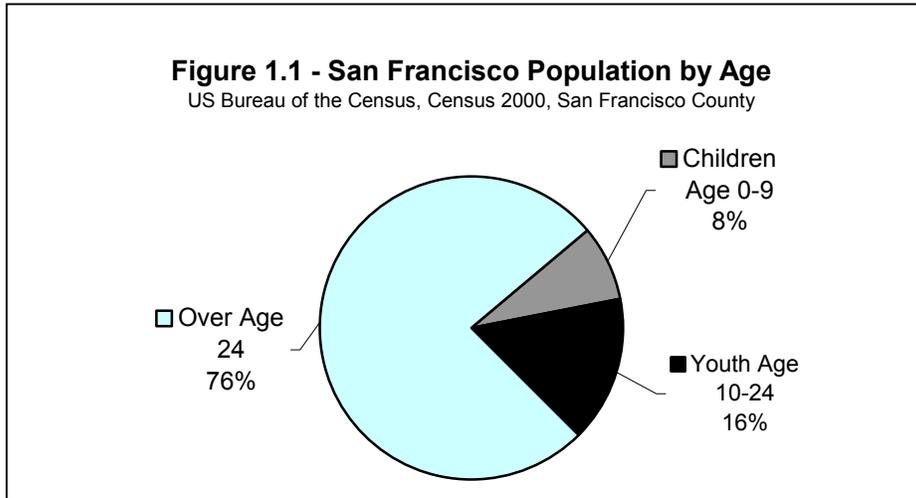
### Middle School—

- 15% of students had not attended school at some time because they felt they would be unsafe at school.
- One in five (20%) students said they had seriously thought about ending their life; 8% had attempted.
- In the 30 days prior to the survey, 67% of students reported feeling sad or depressed on one or more days.
- The majority of students (93%) have **NOT** had sexual intercourse.
- Many students (68%) reported having done aerobic activity (for at least 20 minutes) on three or more days in the week prior to the survey.

In looking at these responses, it is clear that our youth are dealing with many issues affecting their health and well-being. Services across the spectrum, from prevention to treatment, as well as real opportunities for young people need to be created and/or strengthened to better meet the needs of San Francisco's youth.

## Age

A total of 120,201 youth ages 10-24 reside in San Francisco, representing 16% of the total San Francisco population (see Figure 1.1).



## Sex

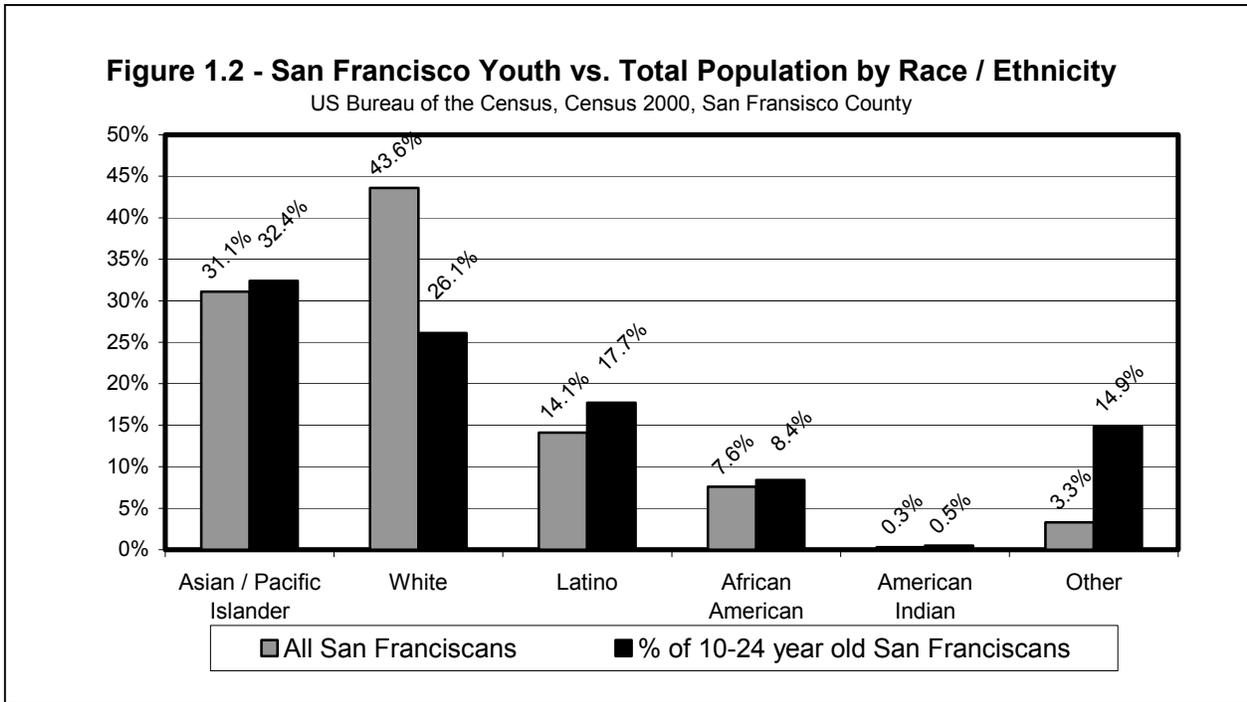
Of the 120,201 youth, 51% are males and 49% are females<sup>1</sup>.

## Race / Ethnicity

Youth age 10-24 years old are more racially and ethnically diverse than the total population in San Francisco (see Figure 1.2).

- One of the most dramatic differences between the youth and the total SF population is in the Other category (which combines the two census groups Two or More Races, or Other Race.) Youth comprise almost 15% of the Other category, as compared to only 3.3% of the total population.
- Asian/Pacific Islanders represent the largest racial/ethnic group of youth at just over 32%, and represent 31% of the total population.
- White youth represent 26% of all youth in San Francisco, whereas Whites comprise the largest racial/ethnic group for all San Franciscans at almost 44%.
- Latino youth represent almost 18% of all youth, with Latinos comprising 14% of all San Franciscans.
- African American youth represent 8.4% of youth, with African Americans comprising 7.6% of all San Franciscans.
- American Indian youth and the total American Indian population comprise 0.5% and 0.3% of San Francisco's population respectively.

<sup>1</sup> US Bureau of the Census, Census 2000, San Francisco County.



**Socioeconomic Status**

Poverty rates in the Bay Area are low compared to other similarly sized regions in the country. However, given the region’s higher cost of living, the actual poverty rate relative to other areas is arguably higher. Plus, the Bay Area poverty rate has been growing faster than the U.S. as a whole.

**Below Poverty Level, 1999**

(US Bureau of the Census, Census 2000, San Francisco County)

**Families - 7.8%**

- 11.8% with related children under 18 years
- 12.7% with related children under 5 years

**Families with female householder – 16.6%**

- 26% with related children under 18 years
- 32.4% with related children under 5 years

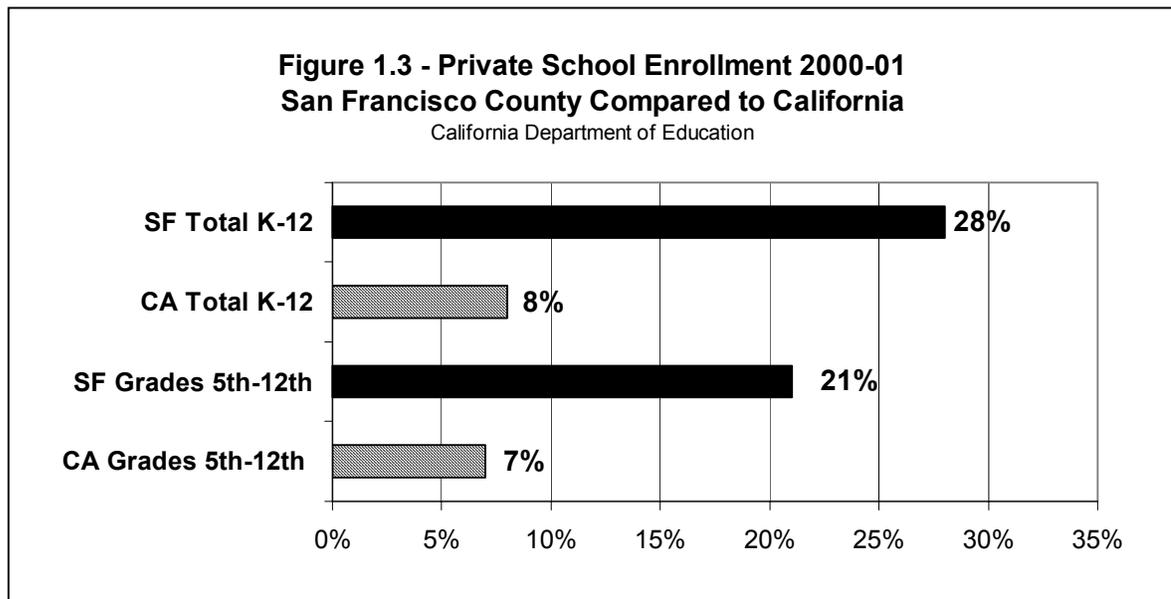
The poverty guideline in 1999 for a family of four is \$16,700.<sup>2</sup> The **poverty guidelines** are a version of the federal poverty measure, and they do not vary geographically. They are issued each year in the *Federal Register* by the Department of Health and Human Services. The guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain federal programs.

<sup>2</sup> Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; The 1999 HHS Poverty Guidelines; on December 17, 2002 at <http://aspe.hhs.gov/poverty/99poverty.htm>

- In San Francisco in 1999, 14.6% of 0-17 year olds live **below** the federal poverty level.<sup>3</sup>
- In 1999-2000, 53.7% of San Francisco Unified School District children (grades K-12) are low income, which is 185% of federal poverty level or below.<sup>4</sup>
- In 2001-2002, 41.1% of San Francisco Unified School District students are enrolled in the Free or Reduced Price Meal Program.<sup>5</sup>
- In 2001-2002, 5.7% of San Francisco Unified School District students are enrolled in CalWORKs.<sup>6</sup>

## Education

28% of students (K-12) in San Francisco attend private school. In 2000-2001, 21% of youth ages 10-19 attended private school in San Francisco, as compared to 7% for the entire state.<sup>7</sup>



In 2001-2002, 19.5% of 5<sup>th</sup>-12<sup>th</sup> graders in San Francisco Unified School District are English Language Learners<sup>8</sup>.

Asian/Pacific Islander, Latino and African American youth are over-represented within SFUSD. White youth are under-represented, as are youth who identified as Other. American Indian youth are equally represented (see Figure 1.4).

<sup>3</sup> US Bureau of the Census, 2000 Census, San Francisco County (SF 3 Data Set).

<sup>4</sup> Ibid.

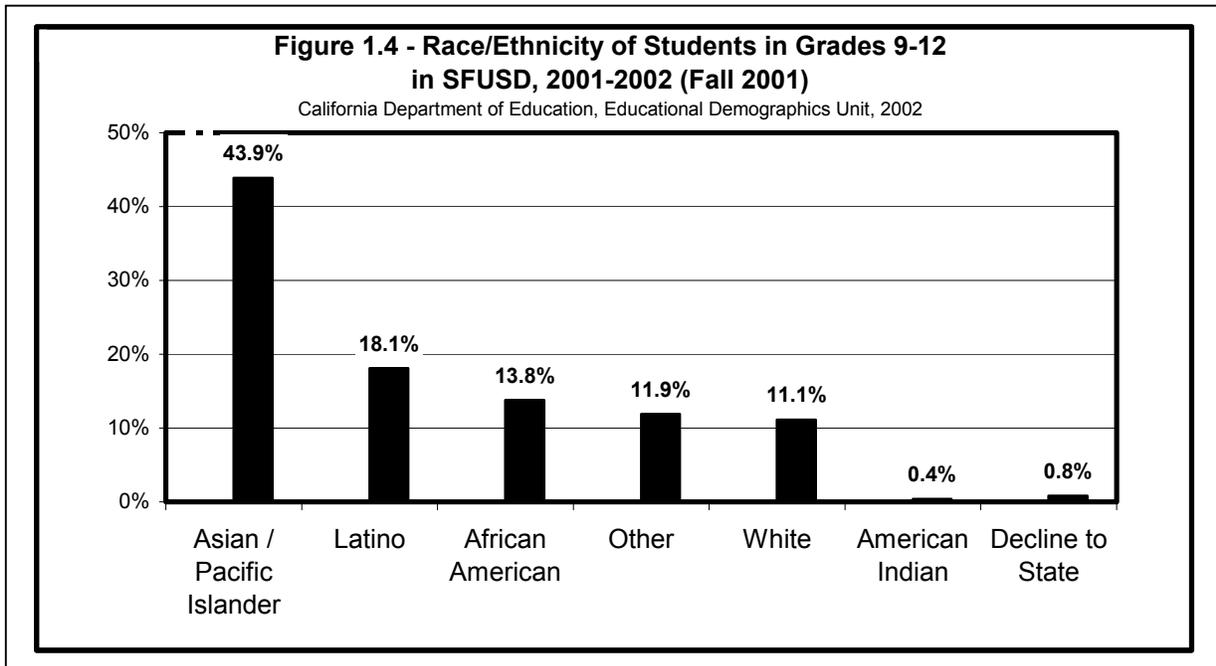
<sup>5</sup> California Department of Education, Educational Demographics Unit; San Francisco County, 2001-2002.

<sup>6</sup> Ibid.

<sup>7</sup> California Department of Education, Private School Enrollment 2001-02 for San Francisco County; <http://www.cde.ca.gov/privateschools/report2001.html>

<sup>8</sup> CA Department of Education; Educational Demographics Unit, 2001-02.

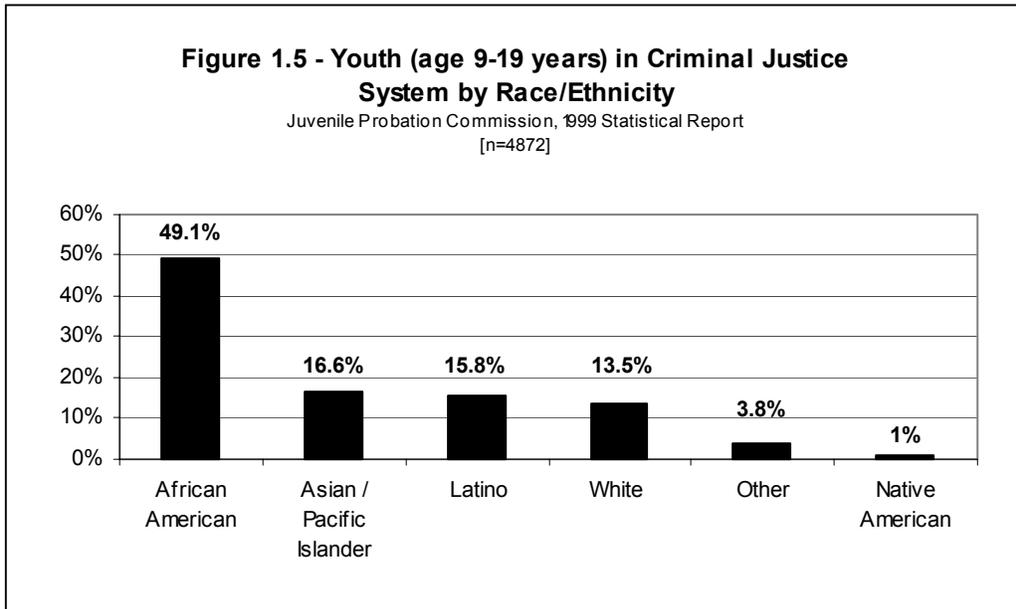
- Asian/Pacific Islander youth represent the largest racial/ethnic population within SFUSD at 43.9%.
- Latino youth represent the second largest racial/ethnic population at 18.1%.
- African American youth represent the third largest racial/ethnic population at 13.8%.
- White and Other youth represent 11% respectively.
- American Indian youth comprise less than one-half percent of youth within SFUSD.



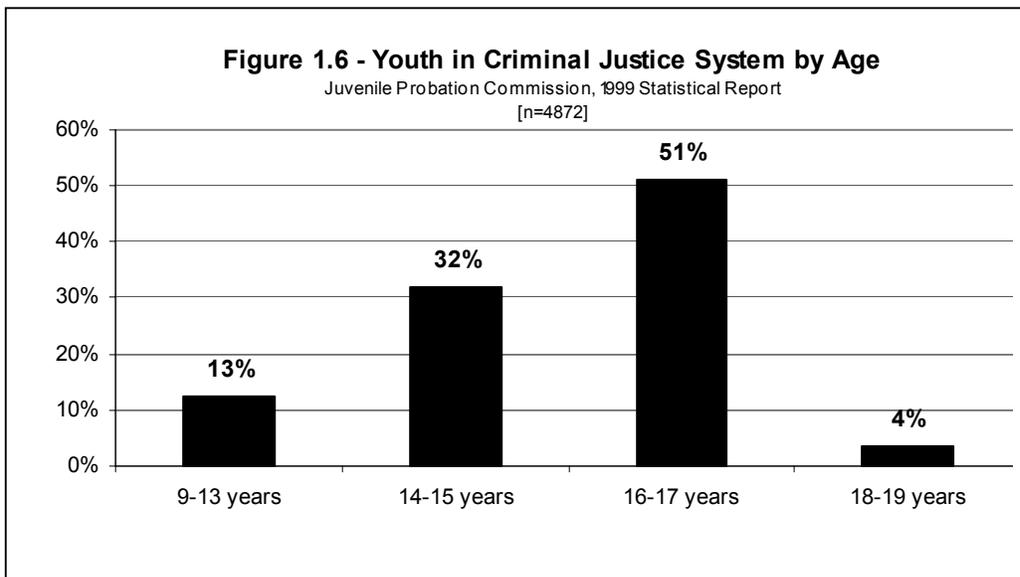
## Criminal Justice

In 1999, of the 4,872 youth in the criminal justice system, 71% are male (3,477) and 29% are female.

- African American youth comprise the majority of youth within the criminal justice system, representing 49.1% (see Figure 1.5).
- Asian/Pacific Islander youth represent 16.6%
- Latino youth represent 15.8%
- White youth represent 13.5%
- Other youth represent 3.8%
- American Indian youth represent 1%



In 1999, youth between the ages of 16-17 years represent the largest age group for youth within the criminal justice system (see Figure 1.6). Youth between the ages of 14-15 represent 32%; youth between the ages of 9-13 represent 13%. Youth aged 18-19 years represent the smallest percentage at 4%.



## **Section Two**

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# **Eight Recommendations for Achieving Adolescent Health**

## Recommendation One: Integrate Youth Development Principles and Practices into Programs

### Healthy Highlight -

#### Youth POWER Teen Survey:

Nearly 300 teens from the Mission and Bay View/Hunters Point neighborhoods were surveyed. A theme that came out of the survey was Youth Have Hope!

♥ Most expect to finish high school, college and get a job they really want

♥ Most feel independent, responsible for their lives and decisions

♥ Most report having a support network

YouthPOWER Report, 2002, was made possible through a grant from the Substance Abuse Mental Health Services Administration

### Background

Positive youth development is a policy perspective that emphasizes providing services and opportunities to support all young people in developing a sense of competence, usefulness, belonging, and empowerment.<sup>1</sup>

Key elements of positive youth development are<sup>2</sup>:

- Providing youth with safe and supportive environments.
- Fostering relationships between young people and caring adults who can mentor and guide them.
- Promoting healthy lifestyles and teaching positive patterns of social interaction.
- Supporting the development of youths' knowledge and skills in a variety of ways, including study, tutoring, sports, the arts, vocational education, and service-learning.
- Engaging youth as active partners and leaders who can help move communities forward.
- Providing opportunities for youth to show that they care about others and about their communities.

While individual programs are currently providing youth development activities and services, the youth development approach works best when the *entire community*, including young people, are involved in creating a continuum of services and opportunities that youth need to transition into healthy adults.

Some DPH Sections have successfully integrated youth development principles into their programs and services. However, with additional training and support the entire Department will be able to fully integrate youth development principles and practices into our mission.

Young people need opportunities to develop their assets and talents, form positive relationships with peers and adults, and serve as resources for their communities. DPH is set to be a leader for youth in San Francisco by implementing youth development principles throughout its programs and services for young people.

<sup>1</sup> The Administration for Children and Families; *Positive Youth Development*; obtained online on June 12, 2002 from <http://www.acf.dhhs.gov/programs/fysb/positive.htm>

<sup>2</sup> The Administration for Children and Families; *Toward a Blueprint for Youth: Making Positive Youth Development a National Priority*; obtained online on June 12, 2002 from <http://www.acf.dhhs.gov/programs/fysb/youthinfo/blueprint.htm>

## Strategies

### 1. Create opportunities for youth to make decisions in key adolescent health programs within DPH and community contractors.

- a. Encourage youth participation in all aspects of a project, from idea to outcome and all the challenges that lie between.
- b. Offer the flexibility to adapt to the needs and interests of the youth participants.
- c. Offer youth the opportunity to learn and practice new skills, such as public speaking, critical thinking or analytical skills, community organizing, and action planning.
- d. Explore the feasibility of having youth participate on the Population Health and Prevention JCC of the Health Commission.

### 2. View youth as resources to be developed rather than problems to be managed.

- a. Foster stable adult-youth relationships based on respect and trust.
- b. Offer gender-specific programming to fulfill the need for safe physical spaces where only females, males, or transgender youth congregate.
- c. Offer skill-building activities that are designed based upon what young people are interested.

#### YOUTH VOICE

Youth are usually stereotyped as being ruthless, annoying, uncontrollable, and lazy. But the truth is that we are respectable, always sharp, understanding, and leaders not followers. Adults need to open up to our book instead of judging us by our cover.

- Raul Villareal, 18 years old

**Recommendation Two:  
Support Families and Communities**

**Healthy Highlight -**

**Children’s Medical Services  
Family Centered Care**

Family centered care within Children’s Medical Services (including CCS, CHDP and CHDP Foster Care) recognizes the **importance of the family** and reflects this in the way services are planned and delivered.

Family centered care facilitates **parent/professional collaboration** at all levels of service provision, responds to family needs and the priorities that the family has set for itself, recognizes and builds on **individual and family strengths**, and honors the ethnic, cultural, and socioeconomic diversity of families. Family centered care also understands and incorporates the developmental needs of infants, children and **adolescents and their families** into service delivery systems.

**Background**

Supportive family relationships protect youth against many different kinds of health risks, including emotional distress; suicidal ideation and attempts; cigarette, alcohol and other drug use; violent behavior; and early sexual activity.<sup>3</sup>

Communities also play a key role in promoting and protecting adolescent health and well-being. As youth grow older, they spend more time in community settings outside of their immediate family. Together, families and communities have great responsibility to support youth as they grow and develop into healthy adults. The Department plays an important role in cultivating a supportive environment for families and communities.

An unhealthy material environment and unhealthy behavior have direct harmful effects, but the stress and insecurities of daily life and the lack of supportive environments also have an influence.<sup>4</sup> Social and economic factors at all levels in society affect individual decisions and health itself.

**Strategies**

**1. Promote services that support family relationships.**

- a. Support parents to raise healthy, safe children.\*
- b. Develop culturally and linguistically appropriate prevention-oriented programs for parents of adolescents.
- c. Provide support to parents of adolescents.
- d. Utilize data gleaned from the Department of Children, Youth and Their Families Community Needs Assessment Parent Survey and Focus Group to inform program development and quality improvement (DCYF Community Needs Assessment found online at [http://www.dcyf.org/307\\_publications.htm](http://www.dcyf.org/307_publications.htm)).
- e. Assist parents with finding after-school programs, recreation areas, and other community resources.

<sup>3</sup> Clayton SL, Brindis, CD, Hamor JA, Raiden-Wright H, Fong, C. (2000). *Investing in Adolescent Health: A Social Imperative for California’s Future*. San Francisco, CA: University of California, San Francisco. National Adolescent Health Information Center.

<sup>4</sup>Wilkinson, R., Marmot, M.; *Social Determinants of Health: The Solid Facts*; The World Health Organization; 2000

\* YouthPOWER Report & Recommendations, 2002; San Francisco Department of Public Health, Community Health Education Section; Funded by Substance Abuse Mental Health Services Administration.

### **2. Collaborate with other city agencies to provide family-oriented services in underserved neighborhoods.**

- a. Support parent initiated projects.
- b. Acknowledge the importance of immigration, reunification and intergenerational issues within families.
- c. Promote programs that address stress and pressure that parents/guardians and other family members are experiencing.

### **3. Support healthy community environments.**

- a. Create a broader support network for young people in their communities.\*
- b. Support young women in their homes, schools and communities.\*
- c. Support youth and family service providers to ensure the safe and healthy development of youth.\*
- d. Create necessary supports and opportunities for optimal academic learning in school settings.\*
- e. Provide free or low-cost, enriching, culturally and linguistically appropriate activities for youth.
- f. Ensure neighborhood safety - promote programs that decrease youth access to firearms, decrease gang activity, and decrease drug sales.
- g. Promote appealing physical environments; e.g., green spaces, less trash, billboards, liquor stores.
- h. Create positive and affordable after-school choices for youth; e.g., recreation, training, tutoring, athletics.
- i. Ensure safe spaces for youth to congregate.

### **4. Promote healthy youth development through positive job training and employment opportunities.**

- a. Pay youth a living wage for their labor, both DPH and contractors.
- b. Create internships/mentoring opportunities for youth within different sections of DPH.
- c. Involve youth in research and program development where appropriate.
- d. Collaborate with high schools, middle schools, colleges/universities to engage youth to the many different health careers; e.g., public health administrator, health educator, physician, nurse/nurse practitioner, therapist/LCSW, dentist.

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\* YouthPOWER Report & Recommendations, 2002; San Francisco Department of Public Health, Community Health Education Section; Funded by Substance Abuse Mental Health Services Administration.

**Recommendation Three:  
Eliminate Racial/Ethnic Health Disparities**

**Healthy Highlight -**

**Youth ENVISION:**

In March 2001 the DPH's **Environmental Health Section** began a partnership with two community based organizations in the **Bayview Hunters Point** neighborhood: the San Francisco League of Urban Gardeners (SLUG) and Literacy for Environmental Justice (LEJ). **A community action model** was used to train youth in the skills and resources needed to investigate food security in their neighborhood. **Youth were trained** in survey methods, data analysis, health impact assessment, public communications, and other areas.

SLUG youth interns and staff created a new **Bayview Community Farmers Market** as a community development project. Youth have assisted with outreach, vendor relations, and market operations. Neighborhood youth gained new skills and empowerment through job training and by working to educate and **serve their community**.

**Background**

A long-standing and well-documented pattern of racial/ethnic health disparities exists in the United States. This pattern is apparent in health outcomes and utilization and is supported by disproportionate incidence of disease, disability and death among specific racial and ethnic groups. Racial/Ethnic health disparities do not begin in adulthood, instead they begin at conception, and continue through infancy, childhood and adolescence. Racial/Ethnic health disparities in adult populations are most easily prevented in childhood or young adulthood, and any approach to eliminate health disparities should focus on prevention and intervention with young people.

In order to prevent and intervene in racial/ethnic health disparities, the major determinants of the disparities need to be addressed. Some of the major determinants include racism, social gradient, unemployment, stress and food insecurity.

The Intercultural Cancer Council, a national multicultural coalition, lists five reasons for disparities in health status for racial and ethnic minorities and medically underserved populations:

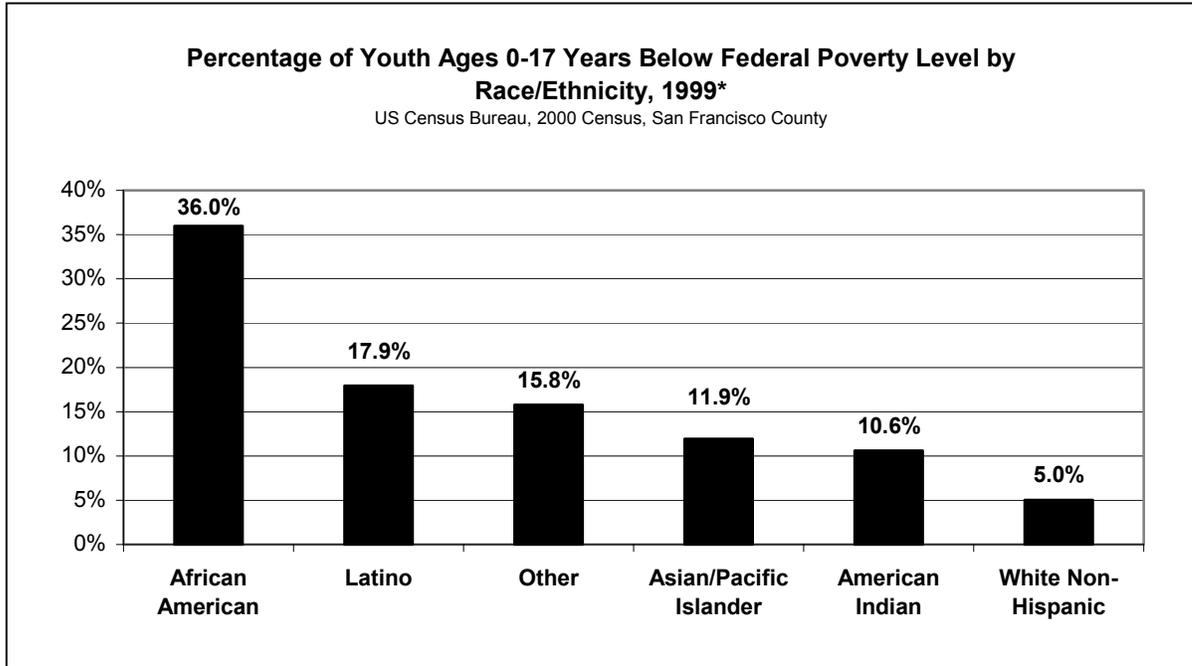
1. Unequal socioeconomic status, resulting in unequal availability, accessibility and use of health services.
2. Unequal diagnostic work-up and treatment after entering into the health care system.
3. Unequal scientific research, resulting in unequal data collection and unequal understanding of their medical needs.
4. Social, racial and environmental injustice.
5. Individual as well as institutional prejudices and discrimination.

People of color in San Francisco are disproportionately affected by poverty (see Figure 2.1). The following are the percentages of youth ages 0-17 years who are **below the**

**federal poverty level** in San Francisco in 1999 (\$16,700 for a family of four in 1999):

- 36% of African American youth
- 17.9% of Latino youth
- 15.8% of youth who identified as Other or Two or More Races
- 11.9% of Asian/Pacific Islander youth
- 10.6% of American Indian youth
- 5% of White Non-Hispanic youth

People with a higher income generally enjoy better health and longer lives than people with a lower income. Young people growing up in concentrated poverty are more likely to have poor health, drop out of school, be physically or sexually abused, become teen parents, and remain jobless than young people who live in socio-economically diverse neighborhoods.<sup>5</sup>



In 1999 among youth ages 10-24, there were 64 non-fatal assaults with firearms in San Francisco, with over half occurring to African American youth, and over a quarter to Latino youth (see Table 2.1). In 2001, there were 20 homicides to 10-24 year olds in San Francisco.<sup>6</sup> Of the 20 victims, half were African American, four were White, three were Latino and three were Asian. There were a total of 7 suicides among 10-24 year olds in 2002; four were White youth, two were Asian youth, and one was a Latino youth.

Race/Ethnicity	1999 Non-Fatal Assaults [Firearms Only]	2002 Homicides [All Causes]	2002 Suicides [All Causes]
Asian	6	3	2
African American	37	10	0
Latino	17	3	1
White	0	4	4
White Unknown Ethnicity	2	0	0
Unknown Race/Ethnicity	2	0	0
<b>Total</b>	<b>64</b>	<b>20</b>	<b>7</b>

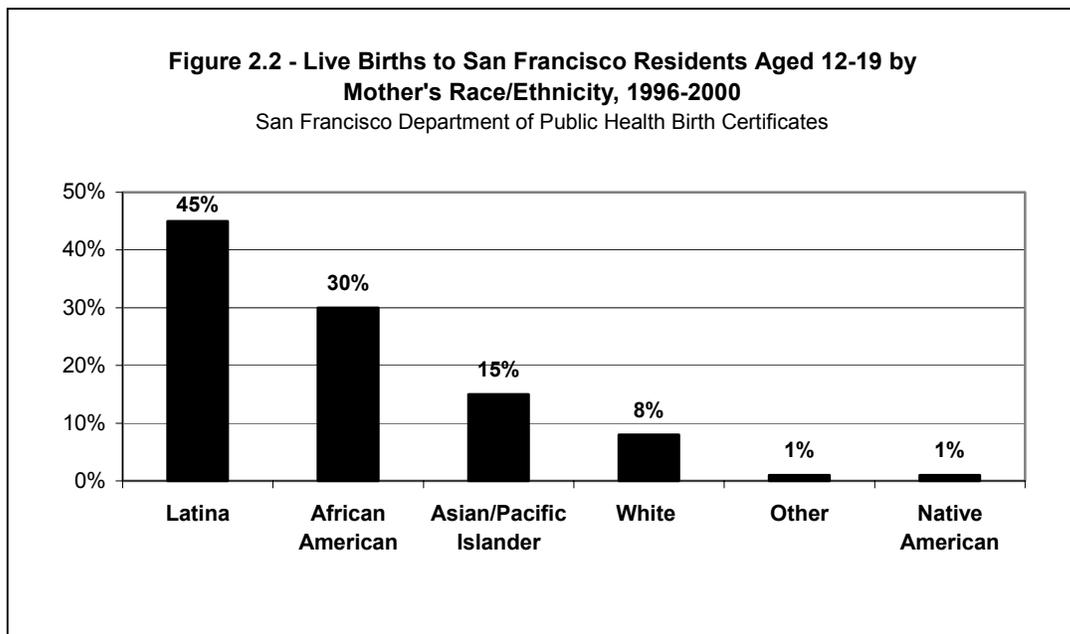
<sup>5</sup> *Impact of Poverty Report*; Rainbow Research Inc.; Minneapolis, Minnesota, 2001.

<sup>6</sup> San Francisco Violent Injury Reporting System (SFVIRS), 2001, SF DPH CHES.

\* Black, Asian/Pacific Islander, Other and American Indian data include those who also identified as Latino.

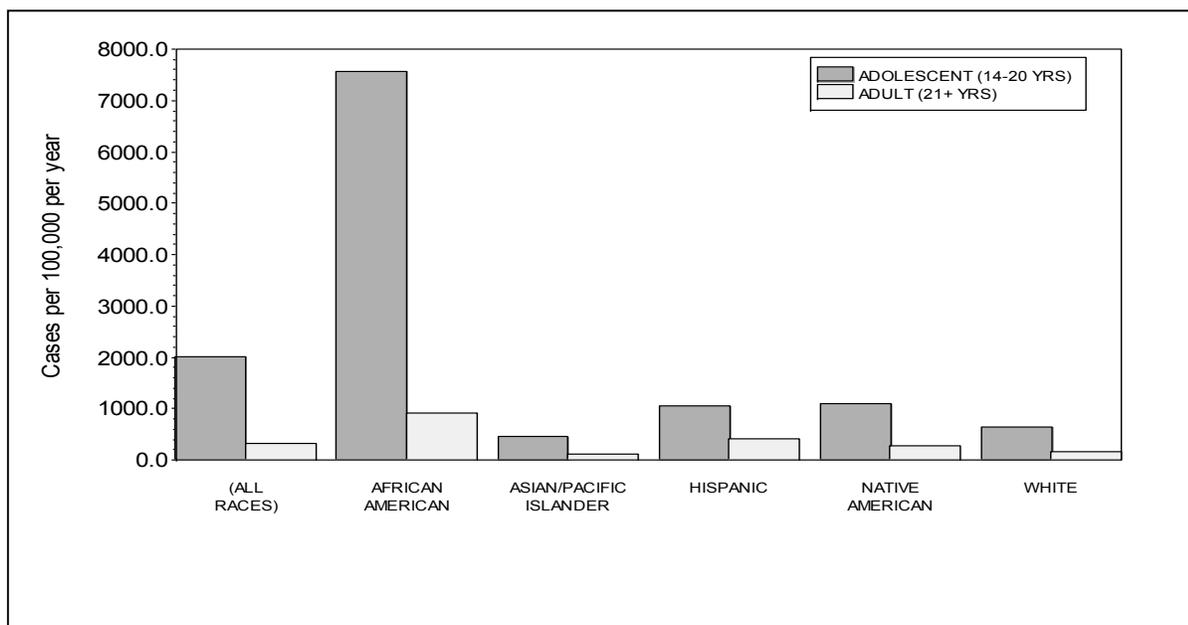
Infant mortality is considered a key marker of a population's health. The infant mortality rate for all San Franciscans in 2000 was 4.0 per 1,000 live births. However, the infant mortality rate for African Americans was 9.2 per 1,000 live births. Both of these rates are within the Healthy People 2000 Objective of 7.0 for all races and 11.0 for African Americans. However, infant mortality in San Francisco needs to decrease substantially to meet the Healthy People 2010 rate of 4.5 for both populations.

In 2000, 93% of teen births in San Francisco were to girls of color (see Figure 2.1). The highest teen birth rates were among Latina and African American females ages 15-19, 64.6 per 1,000 Latinas and 65.5 per 1,000 African Americans. These rates, however, are well within the Healthy People 2000 Objective rates of 105 for Latinas and 120 for African Americans.



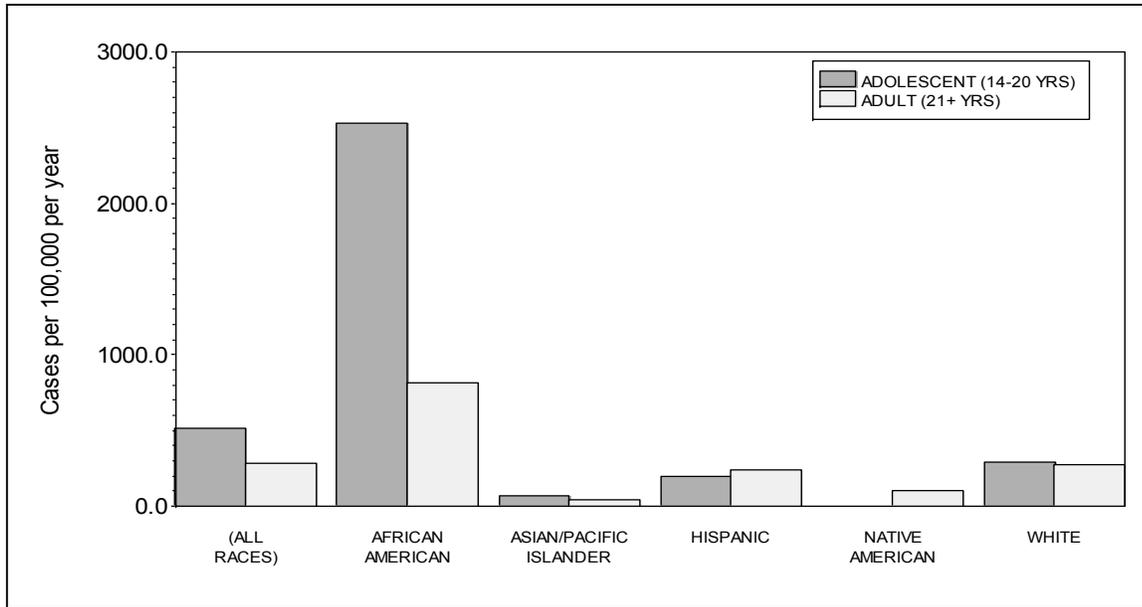
There is also disparity of sexually transmitted diseases within racial/ethnic adolescent populations.

**Figure 2.3 - Race-specific chlamydia rates for adolescents, San Francisco, 2001.**  
(Source: SF DPH, Sexually Transmitted Disease Prevention and Control Section)



Data indicate that African American residents have a greater risk for both chlamydia and gonorrhea than White residents.<sup>7</sup> Differences in race-specific rates are greatest for chlamydia, where rates for African Americans are about eight times the rates for Whites (see Figure 2.3). African Americans have the highest rates of gonorrhea, followed by Whites then Latinos (see Figure 2.4). Rates for Native Americans and Asians and Pacific Islanders are lowest.

**Figure 2.4 - Race-specific gonorrhea rates for adolescents, San Francisco, 2001.**  
 (Source: SF DPH, Sexually Transmitted Disease Prevention and Control Section)



According to San Francisco juvenile crime statistics, there is disproportionate minority confinement among African American youth in San Francisco. African Americans comprise only 8.4% of the 10-24 youth population, yet comprise 49% of the youth detained at Youth Guidance Center.

According to the San Francisco Girl’s Report (to be issued by the Department on the Status of Women in 2003), in January 2002 in San Francisco, 71.6% of all foster care youth were African American. This compares to the state of California average for African American youth in foster care at 33.8%.

According to “*Snapshot: San Francisco’s Children and Youth Today*,” a community needs assessment conducted by San Francisco’s Department of Children, Youth and Their Families, fewer white children attend public schools and higher income families enroll their children in private schools, causing the city’s public schools to become increasingly segregated by race and class.

The overall average high school reading test score in San Francisco is lower than the national average, and African American and Latino children are performing less successfully on math and

<sup>7</sup> San Francisco STD Annual Summary, 2001, San Francisco Department of Public Health website <http://www.dph.sf.ca.us/Reports/HlthAssess.htm>

reading standardized test (both high school and elementary) than children of other races/ethnicities.<sup>8</sup>

**Strategies**

**1. Support dialogue on racism and policies to decrease racial/ethnic health disparities and inequities.**

- a. Promote ally-building between racial/ethnic communities.
- b. Ensure that nutritional and physical activity programs exist within communities disproportionately affected by obesity and food insecurity.
- c. Develop and support programs to decrease disproportionate alcohol advertising and availability within low-income communities.

**2. Reduce the high detention rates for African American and Latino youth.**

- a. Collaborate with the Police Department, Juvenile Probation, SFUSD, and community partners to decrease the high detention rates for African American and Latino youth.
- b. Support gender-specific services for youth at risk for being involved in the juvenile probation system.

**3. Reduce violence-related injury and death for communities disproportionately affected.**

- a. Support programs and policies to decrease firearm accessibility.
- b. Ensure that youth who experience and/or witness violence receive mental health services to address potential post-traumatic stress and other physical and behavioral health outcomes associated with exposure to violence.

**4. Increase access and utilization of health care services.**

- a. Locate culturally and linguistically appropriate health care services in communities that are affected by racial/ethnic health disparities.
- b. Ensure that health care providers and staff are representative of the communities they serve.

**YOUTH VOICE**

My opportunity  
My time to excel  
My time to do nothing but prevail

My time to shine  
My time to put in work  
My time not to be a jerk

My time to show that with experience  
I will grow  
My time to stay on task  
This for a fact I know

My time not just to get paid  
But to learn from this new trade

My time to overcome  
All that has been done  
My time to start fresh  
Like the rising of the sun.

My time to show that something  
So small can be flipped into  
Something real tall

My time to accept and challenge my  
opportunity.

— Cloteal Norman, 18 years old

<sup>8</sup> Snapshot: San Francisco's Children and Youth Today, A Community Needs Assessment; San Francisco Department of Children, Youth and Their Families; 2002.

## Recommendation Four: Ensure the Health of Vulnerable Youth Populations

### Healthy Highlight -

#### Children System of Care Youth Task Force:

The Youth Task Force consists of **14 -18 year olds** who are currently in, or recently out of, two to four of the following systems: DHS (foster care, group homes), Special Education, Juvenile Justice, and Mental Health (therapy). These youth use their personal experiences to help create **positive change** in the systems they are in. This is done through facilitating workshops, conducting presentations, and speaking to the people of power in these four systems. The Youth Task Force is a program designed to **empower youth** to take action and voice their concerns. **These youth are the change they want to see.**

### Background

Among adolescents, there are specific vulnerable populations that experience disproportionate stressors to their health. Focus needs to be placed on the following populations during their childhood and adolescence. If attention is not paid, many costly health problems will ensue throughout adulthood. These economic, social, emotional and spiritual costs to young people can be mitigated by comprehensive prevention and early intervention strategies.

Many of the vulnerable populations highlighted within this section overlap, for example youth in foster care are at increased risk for becoming homeless as well as becoming involved in the juvenile justice system. The intersectionality of these vulnerable youth populations should be addressed by a comprehensive and coordinated system of care.

### Youth in Foster Care

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As of February 2002, there were 2,319 youth in foster care in San Francisco County. Over the past five years (1996-2001), there has been a 44% reduction in new foster care entries, while statewide, foster care caseloads increased by over 12%.<sup>9</sup> Much of this decline reflects a commitment by San Francisco Department of Human Services to preserving family unity, and placing children who have been removed for their safety from their parent's home, with kin whenever possible.

San Francisco County has a foster care rate per 1,000 children 0-17 years of 16.4 (average rate 2000-01.) This is the second highest rate in the state among the 15 largest counties, second only to Sacramento, which has a rate of 18.6 per 1,000. The statewide rate is 10.7 per 1,000.<sup>10</sup>

#### Barriers to Positive Health for Youth in Foster Care:

- Lack of stability in placements.
- Relatively high number of out-of-county placements making continuity of care difficult.
- Lack of social support, particularly in group-home settings
- Poor access to regular, comprehensive health care.

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<sup>9</sup> City and County of San Francisco Department of Human Services Annual Report, 2000-2001

<sup>10</sup> Choices for Youth: California Youth Violence Prevention Scorecard; November 2002 (Funding provided by the California Wellness Foundation).

- Few resources for youth transitioning out of foster care as an adult at age 18 or as an emancipated minor.

**Strategies - Youth in Foster Care**

1. Improve collaborations between DPH sections that work specifically with foster care youth (i.e. Foster Care Mental Health Program, CHDP Foster Care Unit, and Primary Care) to improve coordination of services, and ultimately the quality of services for this population.
2. Develop strategies to improve the health of youth living in group-home care.
3. Develop community support and social networks for youth in foster care.
4. Strengthen programs for youth transitioning out of foster care.
5. Create services for youth running away from group homes and other out-of-home placements to prevent homelessness and engagement in high-risk behavior (i.e. survival sex, substance abuse, criminal activity, etc.)

**YOUTH VOICE**

What about us?  
The children in the system who've been silent for many years?

What about us?  
The children in the system who have shed so many tears?

What about us?  
What about you?  
What about me?  
You throw us all in a house and make us all a family?  
In the back of my mind I'm sayin' I don't think so, but if you open your multi-colored  
Eyes, that's how my life really goes.  
In most group homes you get three "hots and a cot"  
Most of them are in a bad neighborhood where you most likely to get shot.  
Do you really think a lawyer cares when you have a suggestion?  
No, they are too busy telling me to be quiet, which brings me back to the main question.

What about us?  
The children in the system who've been silent for many years?  
What about us?  
What about me?

— Miracle Freeman, 16 years old

**Youth in the Juvenile Justice System**

In San Francisco in 2001 there were 3,963 law referrals to Juvenile Probation. More males than female are represented in juvenile probation, however girls are the *fastest growing* population being detained at Youth Guidance Center

(YGC). Of all girls detained by the juvenile justice system in San Francisco, 80% are African American, 15% are Latina, and 5% are another race/ethnicity. Although African American youth comprise 8.4% of the total youth population in San Francisco, African Americans comprise 49.1% of youth in Juvenile Justice System (see Figure 2.5). There is disproportionate minority confinement in the juvenile justice system in San Francisco.

As identified by the Juvenile Justice and Delinquency Prevention Act, *Disproportionate Minority Confinement* is a condition that exists when the proportion of youths detained or confined in secure detention facilities, correction facilities, jails and lockups who are members of minority groups exceed the groups' proportions to the general public.<sup>11</sup>

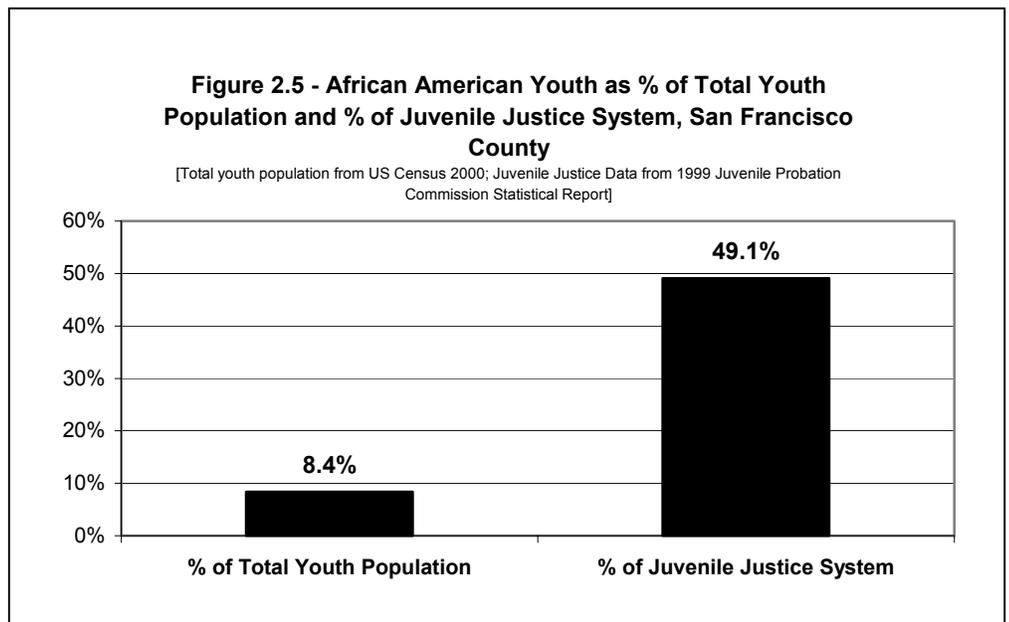
<sup>11</sup> Center on Juvenile and Criminal Justice web site on November 21, 2002; [http://www.cjcj.org/jjic/race\\_jj.php](http://www.cjcj.org/jjic/race_jj.php)

Barriers to positive health for Youth in Juvenile Justice System:

- Lack of comprehensive health care
- Long-term neglected health needs<sup>12</sup>
- History of sexual and physical abuse
- History of substance abuse, early sexual activity, post-traumatic stress disorder, violence and gang involvement
- Family fragmentation (history of family criminality and incarceration)
- Academic failure (suspension/expulsion, drop out, learning disability)
- High prevalence of physical and behavioral health problems including respiratory disease, nutritional deficiencies, dental problems, depression, suicidal ideation, and stress.<sup>13</sup>
- Lack of placement spaces (group homes, shelters, homes for parenting teens) for girls detained at YGC, thus increasing their time spent in juvenile hall.

**Strategies - Youth in the Criminal Justice System**

1. Improve collaborations between DPH and Juvenile Probation, Police Department, and other city agencies/ departments that work with youth who are detained or at risk of being detained.
2. Develop alternatives to incarceration for youth offenders.
3. Develop prevention strategies for youth at risk for being involved in the criminal justice system (build upon successful programs such as CARC – Community Assessment and Resource Center.)
4. Collaborate on gender-specific best practices such as the Girls Justice Initiative program of United Way of the Bay Area, to reduce the number of girls in the juvenile justice system.
5. Support services that address sexual abuse and assault of youth (70-90% of girls in the juvenile justice system have been sexually and/or physically abused.)
6. Promote economic opportunities for youth (job training, youth leadership development, etc.) by collaborating with community based organizations that offer these services for youth.
7. Encourage coordinated follow-up care once youth are released from detention to promote success and prevent recidivism.



<sup>12</sup> Council on Scientific Affairs; Health Status of Detained and Incarcerated Youth; *JAMA*; 263; 1990

<sup>13</sup> Health Care for Incarcerated Youth: Position Paper for the Society for Adolescent Medicine; *Journal of Adolescent Health*; 27; 2000.

8. Increase school-based programming such as Wellness Centers and Pupil Services to support at-risk youth in school.
9. Support programs for parents/guardians and other family members who have a youth in the juvenile justice system.

### Homeless Youth

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Homeless youth are individuals under the age of eighteen who lack parental, foster, or institutional care.<sup>14</sup> There are no clear data on how many homeless adolescents and young adults live in San Francisco, however Larkin Street Youth Services approximates that there are 3,000.

Homelessness among youth is a national problem. The homeless youth population in the United States is estimated to be approximately 300,000 young people each year.<sup>15</sup> According to the Research Triangle Institute, an estimated 2.8 million youth living in United States households reported a runaway experience during the prior year.<sup>16</sup> According to the U.S. Conference of Mayors, unaccompanied youth account for 3% of the urban homeless population.<sup>17</sup> For reasons largely unknown and speculative, San Francisco is seen as a magnet for homeless youth, not only throughout California but the entire country.

The root causes of youth homelessness include fleeing physical and/or sexual abuse by family members, strained relationships (e.g. conflicts with parents over youth's sexual orientation), substance abuse within the family, and neglect.) Youth may also become homeless when their families suffer from financial crisis involving lack of affordable housing, lack of employment, and separation from families due to shelter policies (often an adolescent boy will not be allowed to stay in the same shelter as his mother or younger siblings.) Youth who have been in foster care are more likely to become homeless at an earlier age and remain homeless for a longer period of time.<sup>18</sup>

Barriers to positive health for Homeless Youth:

- Lack of shelter beds for youth
- Few legal means by which youth can earn enough money to meet basic needs
- Engagement in survival sex for food, clothing, and shelter as their only chance of survival on the streets
- Increase risk for STDs, including HIV
- Increase risk for experiencing violence
- Severe anxiety and depression, post-traumatic stress syndrome, poor nutrition, lack of social support, and low self-esteem
- Challenges to obtaining an education and/or job training
- Inconsistent services which cause infrequent or unstable care for homeless youth

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<sup>14</sup> U.S. Department of Health and Human Services. Youth with Runaway, Throwaway, and Homeless Experiences-Prevalence Drug Use, and Other At-Risk Behaviors, Volume I; 1995.

<sup>15</sup> Institute for Health Policy Studies. Street Youth at Risk for AIDS. University of California, San Francisco. 1995.

<sup>16</sup> U.S. Department of Health and Human Services. Youth with Runaway, Throwaway, and Homeless Experiences-Prevalence Drug Use, and Other At-Risk Behaviors, Volume I; 1995.

<sup>17</sup> U.S. Conference of Mayors. *A Status Report on Hunger and Homelessness in America's Cities: 1998.*

<sup>18</sup> *The Health and Well-Being of Children and Youth in San Francisco*; San Francisco Department of Public Health, Coordinating Council for Children, Youth and Families; November 1998.

### Strategies - Homeless Youth

1. Expand Larkin Street Clinic model which supports a continuum of services for homeless youth, including housing, education completion and job training, medical care and mental health services, and substance abuse treatment.
2. Address need for residential substance abuse treatment beds for youth.
3. Increase connection between Dimensions Clinic and the Ark House, a homeless shelter for LGBTQ youth.
4. Promote mental health services for youth who are not diagnosed as Severely Emotionally Disturbed, to increase coping skills and resiliency of youth.
5. Provide comprehensive health education to homeless youth.
6. Create services for homeless youth to prevent their engagement in high-risk behavior (e.g. survival sex, substance abuse, criminal activity, etc.)
7. Support the creation of more shelter beds for adolescent girls who are to be released from juvenile detention yet have no home.

### Youth Who Are Newcomers

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Immigrant and refugee youth in San Francisco are extremely diverse and in general more likely than youth with U.S.-born parents to live in poverty, and less likely to have health insurance or receive regular medical care. Some may face an increased risk of specific medical problems, including drug-resistant tuberculosis. Others are given responsibility at a very young age for interpreting health issues for their family members and for assisting them in navigating the complex health care service system. Some youth and their parents or caretakers may be caught between what is considered acceptable socio-cultural norms and practices in the U.S. versus their country or culture of origin (for example child-rearing practices and female genital cutting).

Mental health is a significant concern for those who are refugees or children of refugees. This population may (have) experience(d) post-traumatic stress syndrome, separation between families, death of family members due to war and/or displacement, refugee camps, and other traumatic experiences associated with being a refugee.

Barriers to positive health for Youth Who Are Newcomers:

- Uninsured or underinsured
- Overcrowded and unhealthy housing in unsafe neighborhoods
- Legal status/Fear of being reported to INS if undocumented
- Limited language and cultural competency capabilities of providers
- Limited English proficiency of youth and their families
- Socio-cultural norms and practices
- Cultural norms of health and well-being
- Anti-immigrant sentiment in legislation

### Strategies - Youth Who Are Newcomers

1. Educate newcomers (including individuals and families) about services that are available.
2. Family oriented outreach and activities that promote health and well-being through an intergenerational approach.
3. Empower newcomer youth to be leaders in their communities by giving them meaningful opportunities.
4. Design youth-friendly services for newcomers.
5. Implement programs that specifically target the heterogeneous immigrant and refugee youth communities (e.g. public awareness campaign for availability of services.)
6. Ensure that language appropriate (including written material) and culturally competent services are available.
7. Train providers and other staff on the diversity of immigrant and refugee youth communities to improve the quality of services to this population.
8. Conduct specific outreach to newcomer communities to enroll eligible youth in health insurance programs (e.g. Healthy Kids.)
9. Promote job training and placements for immigrant youth to decrease participation in street economy and for gang prevention.

### Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth

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Many individuals first become aware of their sexual orientation during adolescence. For Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) youth, the time of adolescence may cause more anxiety than their straight counterparts due to the continued social stigma of being labeled LGBTQ. Active discrimination causes many LGBTQ youth to be isolated from their families, health care providers, schools and peers. The isolation for LGBTQ youth of color is particularly acute, as they are forced to confront racism and homophobia. LGBTQ youth often internalize society's negative messages regarding sexual orientation, contributing to low self esteem and depression.

Reported suicide attempts among LGBTQ youth range from 20-42%, compared with 8-13% among high school students in general.<sup>19</sup> Compared to other adolescents, self-reporting LGBTQ youth are two times more likely to use alcohol, three times more likely to use marijuana, and eight times more likely to use cocaine/crack.<sup>20</sup>

Many runaways leave home because of conflicts with parents over their sexual orientation. It is difficult to know the actual number of homeless LGBTQ adolescents however, youth service providers agree that rates are high, ranging from 20-40% in various studies.<sup>21</sup>

Barriers to positive health for LGBTQ Youth:

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<sup>19</sup> Hershberger, S.L. and D'Augelli, A.R.; "The Impact of Victimization on the Mental Health and Suicidality of Lesbian, Gay, and Bisexual Youth," *Developmental Psychology*, 31(65); 1995.

<sup>20</sup> Garofalo, R., et al.; "The Association Between Health Risk Behaviors and Sexual Orientation Among a School-based Sample of Adolescents;" *Pediatrics*; 101 (5); 1998.

<sup>21</sup> Ryan, C. and Futterman, D., *Lesbian and Gay Youth: Care and Counseling*, 1997.

- Health care providers may fail to fully address issues of sexual orientation and confidentiality with adolescents.
- Lack of culturally competent services for LGBTQ youth.

### Strategies - LGBTQ Youth

1. Increase provider education training on cultural competence with LGBTQ youth health.
2. Increase mental health promotion programming with a focus on LGBTQ youth.
3. In collaboration with SFUSD, community based organizations, and others develop suicide prevention programs and services with a focus on LGBTQ youth.
4. Conduct research on policies and practices to support and improve health services for transgender youth.
5. Expand Dimensions clinic hours.

### Youth With Special Needs

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Youth with special needs include those with physical disabilities, chronic physical health problems, emotional health problems, developmental disabilities, and learning disabilities.

The experience of youth with special needs at school is consistently less positive than it is for their peers without special needs. They miss more school, they change schools more often, they perceive themselves as not doing as well at school (as do their parents), they feel somewhat less positively about school, and they are slightly less likely to look forward to going to school.<sup>22</sup>

Barriers to positive health for Youth With Special Needs:

- Inadequate financial resources
- Lack of coordinated care and support systems for families
- Physical inaccessibility of facilities
- The lack of transportation
- Social isolation of the youth
- Lack of transition planning system (age 14-21)
- The failure to include parents and/or guardians early in planning for care
- Lack of trained adolescent medicine specialty providers
- Shortage of bilingual health professionals to work with parents who do not speak English in providing ongoing health care for young family members with special needs

### Strategies - Youth With Special Needs

- 1. Conduct strategic planning for youth with special needs to collect and analyze data, assess the gaps in services, and design a work plan to address the gaps.**
  - a. Promote the expansion and improvement of paratransit services.
  - b. Increase job training and other vocational opportunities for youth with special needs.
  - c. Ensure that housing options are available for youth with special needs.

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<sup>22</sup> Wellar, K.; Children and Youth with Special Needs; *Canadian Council for Social Development*; 2001.

### **2. Improve coordination of services for youth with special needs.**

- a. Improve collaboration between DPH sections, DHS, community resources, and Special Education programs at SFUSD to address:
  - appropriate after school care
  - appropriately trained teachers to modify curriculum for youth with special needs
  - support services for families
  - increasing school nurse involvement
- b. Support coordination between DPH, SFUSD, Golden Gate Regional Center, DHS, and state offices.
- c. Partner with community resources/agencies to assist the adolescent into young adulthood.

### **3. Improve transitional services for youth who 'age out' of services (i.e. foster care, mental health, etc.) and have special needs.**

- a. Improve link between pediatrician and adult provider for youth with special needs (consolidated medical care history, case management to ensure transition, etc.)
- b. Assist with early identification of health coverage that an adolescent may have access to once they reach age 21.
- c. Ensure that treatment programs are in place for youth transitioning into adult services.

**Recommendation Five:  
Integrate School-based Health and Public Health**

**Healthy Highlight -**

The Wellness Center initiative is a collaborative effort of **DPH, Department of Children, Youth and their Families (DCYF), and San Francisco Unified School District (SFUSD)** to support adolescent health and wellness. The wellness centers emerged from a youth-initiated process spearheaded by **Youth Making a Change** and are located in seven high schools.

**The goals of the wellness centers are to increase:**

- ♥ Youth’s awareness of and access to health services
- ♥ Health-related information at all grade levels
- ♥ Outreach and linkages to community partners
- ♥ Youth’s healthy behavior and capacity to develop personal and social skills
- ♥ Access to substance abuse prevention services
- ♥ Access to mental health services
- ♥ Youth’s attachment to school
- ♥ Youth’s academic performance

**Background**

Healthy schools - those that support comprehensive health and well-being as part of a total learning environment — produce healthy students. Healthy students are better able to develop and learn. Healthy students who achieve their educational potential form healthy communities. Healthy communities build a healthy San Francisco.

The crucial role that schools play in helping shape our children and youth’s future makes them an essential partner in promoting a healthy lifestyle. This is achieved by creating a healthy school environment. When schools, families, and the broader community work together to support positive youth development, students thrive, risk behaviors are reduced and health and academic achievement are promoted.

In San Francisco, 28% of school-aged youth attend private school.<sup>23</sup> For 5<sup>th</sup>-12<sup>th</sup> grade students, 21% attend private school, as compared to 7% for California.<sup>24</sup>

In order to better meet the needs of young people in school, it is essential for school-based health (including private schools) and public health to collaborate on programs and services.

**Strategies**

**1. Improve coordination between school health and public health.**

- a. Reconvene the citywide School Health Planning Committee.
- b. Support stronger integration and collaboration between DPH, DCYF and SFUSD for school-based health programs such as Wellness Centers.
- c. Engage private and parochial schools for data collection and collaboration on health programs and services.
- d. Link Special Education with Children’s Mental Health Services and Maternal and Child Health.

<sup>23</sup> 2000-2001 Private School Enrollment in California by County and by Grade; CA Department of Education; <http://www.cde.ca.gov/privateschools/report2001.html>

<sup>24</sup> Ibid.

- e. Improve collaboration with county/community schools to provide substance abuse treatment, mental health and job training services.
- f. Offer harm reduction principles and practices within appropriate school health curriculum.

**2. Support connections between schools, families and their communities.**

- a. Develop and implement a curriculum that links education, health and community service.
- b. Work collaboratively with community resources to provide continuing education opportunities to school staff on health related topics to increase their capacity to provide services to students.
- c. Ensure physically and emotionally safe environments for students.\*
- d. Support learning opportunities for students at risk of truancy or dropping out.\*
- e. Offer activities within schools to enhance growth and healthy development.\*
- f. Develop and implement “ally-building” curriculum in schools to improve relationships between different groups of youth.
- g. Conduct outreach within schools to ensure students are enrolled in health insurance programs in which they are eligible.

YOUTH VOICE

I started special education in the 4<sup>th</sup> grade. It was the most boring thing I have ever done in my life. I got put in special ed because I have ADD. I also had an anger management problem. In the 5<sup>th</sup> grade my doctor put me on some pill to help me control my anger. When I don't take my pills I can return to my old self like when I was younger. I feel like I am a slave to the pills. In the 6<sup>th</sup> grade I was given another type of pill. This one was to help me fall asleep at night. In the 7<sup>th</sup> grade I was sent to a school called Challenge to Learning. To me this school is another way for the government to say that I am stupid. In this school I don't really learn anything new. Right now I am trying to get into Mission High. Most of the time I wish I could live a normal life, but then I ask myself, “what is normal?” It helps a little to say that, but it makes me confused to try and figure it out. This is my life in special ed.

— Raphael Fritsch-Rudser, 14 years old

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\* YouthPOWER Report & Recommendations, 2002; San Francisco Department of Public Health, Community Health Education Section; Funded by Substance Abuse Mental Health Services Administration.

**Recommendation Six:  
Ensure that Environments where Youth Live, Learn, and Work are Healthy**

**Healthy Highlight -**

The San Francisco Tobacco Free Project works with a number of youth based organizations. These agencies use the Community Action Model (CAM) to advocate for policies that combat ways that Big Tobacco promotes tobacco use. **Youth advocates** are funded to implement the CAM, a five-step process that is **youth driven**. Youth choose the tobacco area to work on, design and conduct community based research, then draft and advocate for a policy, regulation and/or law that would lead to **sustainable change** in their community and abroad.

For example, youth advocates have achieved:

- ♥ A ban on smoking in playgrounds of the city's parks
- ♥ A school board ban on the purchase of tobacco subsidiary food products by schools
- ♥ Enforcement of the federally required warning label on bidis, Indian cigarettes popular among many youth
- ♥ Helped stop tobacco sales to teens over the Internet by documenting illegal sales.

**Background**

Young people's overall susceptibility to disease and disability is greater, and illness rates are higher, due to a broad range of environmental conditions. Primary determinants to a community's health include such environmental factors as poverty, educational opportunities, and social inequities. Far more than air and water, the environment is "anything external to individuals shared by members of the community."<sup>25</sup>

Focus groups conducted through the Department of Children, Youth and Their Families Community Needs Assessment found that cramped living conditions and stressful home environments (due to unemployment and cost of living challenges) were the primary factors leading to poor results in indicators, such as low reading achievement.<sup>26</sup>

Additionally, focus group members commented that a community's physical environment (cleanliness of streets, air quality, and quality of businesses and services) reflects how the city values its residents. The youth expressed that deteriorated environments affect their self-esteem and motivation to succeed in school.<sup>27</sup>

Barriers to healthy environments for youth:

- Targeted marketing and excessive outlets for unhealthy products including cigarettes and other tobacco products, alcohol, and fast food.
- Inadequate neighborhood access to health-encouraging environments including affordable, nutritious food; places to play and exercise, and effective transportation systems.
- Violence that limits the ability of youth to move safely within a neighborhood, increases psychological stress,

and decreases civic participation.

- Joblessness, poverty, discrimination, and institutional racism contribute to a depressing environment encouraging a sense of hopelessness among young people.<sup>28</sup>

<sup>25</sup> Mikkelsen L, et al., *Eliminating Health Disparities: The Role of Primary Prevention*; Oakland, CA: Prevention Institute; 2002.

<sup>26</sup> *Snapshot: San Francisco's Children and Youth Today, A Community Needs Assessment*; San Francisco Department of Children, Youth and Their Families; 2002.

<sup>27</sup> Ibid.

### Strategies

#### 1. Create community environments that promote safe, healthy choices.

- a. Promote and support programs that decrease youth access to firearms, decrease gang activity, and decrease drug sales.
- b. Promote seatbelt use, pedestrian safety, use of helmets while riding skateboards, bicycles, scooters, etc.
- c. Create positive and affordable after-school choices for youth (recreation, training, tutoring, athletics.)
- d. Encourage improvement of the physical condition of schools.

#### 2. Partner with other Departments, community based organizations, and community groups to improve environments.

- e. Partner with the Department of Parks & Recreation and SFUSD to develop programs to promote physical activity (for example, Walk a Child to School Day.)
- f. Partner with Department of Parks & Recreation and community based organizations (such as San Francisco League of Urban Gardeners) to make environments more appealing – increase green spaces, decrease trash, billboards, liquor stores, etc.
- g. Collaborate with SFUSD to promote healthy eating choices within schools.
- h. Promote and support Beacon Centers to increase community unity and safety.
- i. Encourage Housing Authority and tenant associations to include recreation rooms in new housing developments.

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<sup>28</sup> Mikkelsen L, et al., *Eliminating Health Disparities: The Role of Primary Prevention*; Oakland, CA: Prevention Institute; 2002.

**Recommendation Seven:  
Coordinate Adolescent Health Programs and Services**

**Healthy Highlight -**

**Larkin Street Youth Services – Pilot Project for Youth:**

The goal of this pilot project is to strengthen San Francisco’s treatment systems for youth (**age 15-23 years**) with co-occurring substance abuse and mental disorders, to include age-appropriate, effective intervention strategies fully integrated into Larkin Street’s existing comprehensive community-based services. This pilot program will ensure that **young people** have immediate access to coordinated mental health and substance abuse services, together with linkages to primary care, case management, education and employment services, and other supportive services. This program is **a collaboration** between Community Mental Health Services, Community Substance Abuse Services, and Larkin Street Youth Services.

**Background**

It is critical for the Department’s adolescent health programs and services to be integrated and coordinated to ensure healthy outcomes for youth. There are many programs and services for adolescents and young adults within the Department, however in order to be more effective and efficient in serving youth, collaborations need to be developed, or made stronger where they already exist.

The creation of the Office of Adolescent Health is a positive step for the coordination and integration of youth services, both within the Department as well as throughout the City. The Coordinator for the Office of Adolescent Health works collaboratively with Department section directors, DCYF and other city departments, San Francisco Unified School District, and community based organizations to create a coordinated system of health planning, prevention and treatment services for youth. The Coordinator also responds to emerging issues affecting youth health. This coordination and integration will improve services for youth.

**Strategies**

- 1. Increase collaboration within adolescent health programs and services.**
  - a. Collaborate between Department sections on prevention and intervention programs and services for youth.
  - b. Assist with the integration of Behavioral Health and Primary Care youth services.
  - c. Collaborate with other youth-serving city agencies/ departments and community based organizations to improve the health of San Francisco’s young people.
- 2. Respond to emerging health issues affecting youth.**
  - a. Collaborate with other city departments, agencies and community groups on city-wide youth issues (e.g. End Exploitation of Youth Task Force.)
- 3. Organize and implement trainings on adolescent health issues.**
  - a. Organize trainings for Department staff on Youth Development Model.
  - b. Develop implementation plan and organize provider and staff trainings for the Minor Consent Policy.

**4. Coordinate data and information for adolescent health.**

- a. Issue A *Snapshot of Adolescent Health in San Francisco* every three years to assess the current health status of youth.
- b. Implement youth development indicators into survey and other needs assessment and health status tools (e.g. "Number of youth who have supportive relationships and opportunities in the home".)
- c. Create and maintain an Adolescent Health web page on DPH intranet and internet site.
- d. Create a centralized database of youth services on DPH internet.

**YOUTH VOICE**

The (CSOC) Youth Task Force means a lot to me. I can finally let out some of the frustration that the system has been causing me for many years. I wanna make it easier for my little brothers and sisters growing up. I mean growing up is not easy. It takes a whole village to raise a child. Social workers, police officers, etc. all play big parts in adolescents becoming young adults. They can make or break you. ...I have friends who've been through the system and I just want to share my knowledge so we can try to make a change.

— Cyrone Byrd, 18 years old

**Recommendation Eight:  
Ensure Access to and Utilization of Comprehensive Health Care Services**

**Healthy Highlight -**

**Healthy Kids**

In January 2002, children and youth began enrolling in **Healthy Kids**, comprehensive medical, dental, and vision coverage through the **San Francisco Health Plan**.

The Health Commission approved the plan on January 31, 2001, and Mayor Brown and the Board of Supervisors included it in the FY 2001-02 budget. Uninsured San Francisco residents 18 years and younger in families 300% of the federal poverty level (approximately \$45,000 for a family of three) are eligible, regardless of immigration status.

As of December 1, 2002, **Healthy Kids** has enrolled 2,215 of an estimated 5,000 eligible residents, including 1,008 (46%) adolescents age 11 to 18.

**Background**

Compared to very young children and to the elderly, adolescents suffer from few life-threatening conditions. However, during the time of adolescence, formation of certain health habits with long-term negative consequences (such as smoking tobacco products, use of other addictive substances, or sexual activity without protection from STD and AIDS) does develop. The long-term consequences often do not produce morbidity or mortality in adolescence itself. Rather the effects, and the costs, develop over a lifetime.

Access to and utilization of comprehensive health services by adolescents can make a critical difference between a healthy adolescence and one that is complicated by physical, mental and social problems. However, adolescents and young adults have the lowest rates of health service utilization of any age group.<sup>29</sup>

Health insurance coverage is the key to accessing health services. Youth who are uninsured or underinsured are more likely to have an unmet health need and less likely to receive the preventive services necessary for healthy growth and development. Uninsured youth are 3.5 times more likely than insured youth to go without needed health care, and 6 times more likely to have no usual health care provider.<sup>30</sup>

It is important for health care services to be comprehensive for adolescents; including primary care, mental health services, substance abuse prevention and treatment, dental health services, reproductive health, health education, and vocational services.

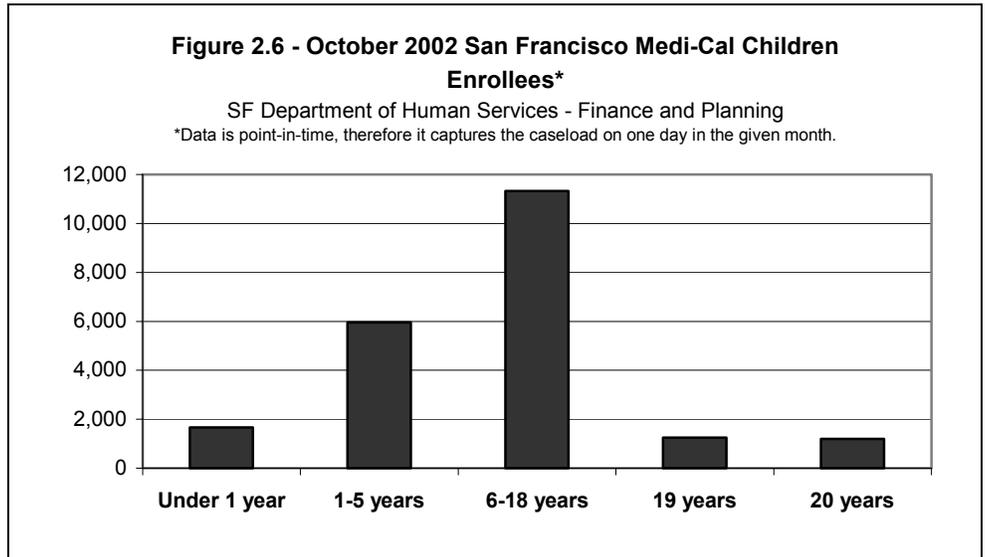
Medi-Cal provides free and low-cost health care coverage to many San Franciscans. Medi-Cal health coverage pays for doctor's visits, hospital care, prescription drugs, pregnancy-related treatment, dental and eye care, and other Medi-Cal services. Children (under 21), aged and disabled people, people in skilled nursing facilities, pregnant women, and many parents may qualify for free or low-cost coverage.

<sup>29</sup> Clayton SL, Brindis, CD, Hamor JA, Raiden-Wright H, Fong, C. (2000). *Investing in Adolescent Health: A Social Imperative for California's Future*. San Francisco, CA: University of California, San Francisco. National Adolescent Health Information Center.

<sup>30</sup> The Children's Partnership, Children Now, & Children's Defense Fund. (1998, September). *Reaching 100% of California's Children with Affordable Health Insurance: A strategic Audit of Activities and Opportunities*. Los Angeles, CA: 100% Campaign, Health Insurance for Every California Child.

As of October 2002, there were 21,377 children age 0-20 enrolled in Medi-Cal in San Francisco, comprising 46% of all enrollees (see Figure 2.6).

San Francisco has 10,150 children enrolled in **Healthy Families** as of October 2002. The **Healthy Families** program is a state- and federally-funded health coverage program for children with family incomes above the level eligible for no cost Medi-Cal and below 250% of the federal income guidelines (\$36,576 for a family of three.) The Healthy Families Program provides low cost health, dental and vision coverage. As of December 1, 2002 **Healthy Kids** has enrolled 2,215 of an estimated 5,000 eligible residents, including 1,008 (46%) adolescents age 11 to 18.



Barriers to access and utilization:

- Uninsured or underinsured (young adults become uninsured once they turn a certain age and are then terminated from parent’s/guardian’s insurance)
- Fear of breaches in confidentiality between provider and youth
- Lack of understanding of minor consent
- Stigma associated with accessing health care services (mental health, reproductive health, etc.)
- Belief that they do not need preventive health services
- Long waiting times, rude providers, not being listened to, and rushed appointments
- Not aware of services in which they are able to consent
- Lack of youth-specific services (such as residential substance abuse treatment)

**Strategies**

**1. Increase provider competence.**

- a. Designate as “youth friendly” those clinicians who want to serve teens and/or have demonstrated core competencies in adolescent health.
- b. Offer training programs to help providers become more comfortable and effective in serving young people.
- c. Encourage health care providers to refer youth to other services (e.g. housing, job training, tutoring, etc.)
- d. Conduct adolescent-specific outreach to encourage youth to utilize services that are available to them.

- e. Collaborate with Adolescent Health Working Group on provider curriculum for youth-friendly services.

### **2. Implement minor consent policy.**

- a. Continue implementation of Minor Consent Policy within DPH and appropriate contractors.
- b. Conduct trainings with DPH staff and community contractors on minor consent for physical and behavioral health services.
- c. Evaluate Minor Consent Policy to track number of youth seen through the implementation of this policy to assess an increase in adolescent utilization of health care services.

### **3. Implement best practices for youth health care services.**

- a. Co-location of services
- b. Time appropriate services
- c. Peer education model
- d. Improve standards of care for youth through tracking and assessing qualitative outcomes measures
- e. Support access to alternative and/or holistic medicine

### **4. Improve current services.**

- a. Assemble data on uninsured youth, Medi-Cal, Healthy Families and Healthy Kids in San Francisco.
- b. Expand residential substance abuse treatment services for uninsured youth under 18 years old.

## **Section Three**

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## **Strategies for Improving DPH Youth Services**

## Program Strategies for Improving Adolescent Health

Although the core recommendations can have a profound impact on a wide range of health outcomes, there is still a need for the Department of Public Health to strategically focus on specific outcomes for youth. For example, while the core recommendations highlight the need for enhancing community capacity to create healthy and safe environments for youth, this section, Program Strategies for Improving DPH Youth Health, provides specific DPH programs and services with strategic focus for improving young people's environments, such as limiting availability of tobacco products, improving neighborhood safety, and enhancing nutrition and physical activity programs. This section is provided as a guide to improve DPH's specific youth programs and services; the status of each specific strategy is indicated to show when it will be initiated, if it is in progress or if it is ongoing (see Appendix A – Implementation Plan for a complete list of DPH program strategies.)

The following areas of adolescent health are addressed:

1. Behavioral Health
  - Alcohol, Tobacco and Other Drugs
  - Mental Health
2. Environmental Health
3. Injury and Violence
4. Nutrition and Physical Activity
5. Oral Health
6. Primary Care
7. Sexual Health
  - Pregnancy
  - Sexually Transmitted Diseases/HIV

### Behavioral Health

Behavioral Health is an integrated, interdisciplinary system of care that approaches individuals, families and communities as a whole and addresses the interactions between psychological, biological, socio-cultural, and environmental factors. National trends show that between 60-70% of individuals presenting with mental health or substance abuse disorders have both.

#### Alcohol, Tobacco & Other Drugs

For the majority of adolescents, experimentation with tobacco, alcohol and other drugs represents a period of exploration that is characteristic of adolescence. For some youth, however, experimentation with alcohol and other substance use leads to negative consequences including direct physiological harm, impaired judgment leading to risk-taking and violence, disengagement from school, and the support of illegal drug trafficking that has a profound effect on community life. Experimentation can also lead to addiction for some adolescents. Also, adolescent substance use, particularly tobacco, can pave the way for later addictions in adulthood that can lead to serious illness and death, increased medical care utilization, and higher health care costs.

According to the 2001 High School Youth Risk Behavior Survey from San Francisco Unified School District:

- Nearly half of the students (49%) have tried smoking cigarettes.
- Just over half of the students (58%) have tried alcohol; 29% of students reported current alcohol use (1 or more drinks on 1 or more days in the past month.)
- In the month prior to the survey, 13% of students reported heavy drinking (consuming 5 or more drinks within 2 hours on 1 or more days in the past month.)
- Just over 34% reported using marijuana at some time in their life; 11% reported ecstasy use; 6% reported cocaine use, and 5% reported methamphetamine use.
- In the year prior to surveying, 37% of students reported being offered, sold or given an illegal drug on school property.

### Mental Health and Suicide

Young people experience many stressors to their mental health. Attention needs to be placed upon the spectrum of mental health needs for youth, including mental health promotion, counseling, and crises interventions. According to the 2001 High School Youth Risk Behavior Survey from San Francisco Unified School District:

- In the year prior to surveying, 29% of students reported feeling so sad or hopeless almost daily for two weeks or more in a row that they stopped doing some usual activities.
- In the 12 months prior to the survey, 14% of students reported that they seriously thought about ending their life; 13% had made a plan and 7% attempted suicide one or more times.
- In the 30 days prior to the survey, 7% of students had been victims of verbal slurs because of their physical appearance (24%), ethnicity (22%) or gender or sexual orientation (10%).

Clearly mental health and substance use are serious issues to young people. DPH has many programs that are focused on behavioral health needs for youth.

### Current Programs – Community Substance Abuse Services

- **Prevention Services:**  
Center for Human Development (Youth Striving for Excellence), Japanese Community Youth Council (Asian Youth Prevention Services), Larkin Street Youth Center (Homeless Youth Outreach Program), National Council on Alcoholism (Youth Aware Life Skills), Youth Leadership Institute (Friday Night Live/Club Live)
- **Outpatient and/or Day Treatment Services:**  
Bayview Hunter's Point Foundation (Bayview Youth Services), Horizons Unlimited, Morrisania West Inc. (Youth Outreach Recovery Education Services YORES), Ohlhoff Recovery Program (Adolescent/Young Adult Program), Potrero Hill Neighborhood House (ZAP Project), Walden House (Adolescent Residential Program), Westside Community Mental Health (Youth Awareness), YMCA Urban Services (OMI/Excelsior Youth Center)

### Current Programs – Community Health Promotion and Prevention

- **Tobacco Free Project** – This project works with a number of youth based organizations to design and conduct community based research, draft and advocate for policy,

regulation and/or law that would lead to sustainable change in their community and abroad.

Current Programs – Community Mental Health Services

- **24-Hour Services:**  
Comprehensive Child Crisis Service, McAuley Institute Adolescent Inpatient Services, and San Francisco Alternative Program
- **Residential Service Centers:**  
Larkin Street Youth Services, Lincoln Child Center, St. Vincent’s School for Boys, Walden House Adolescent Facility (for both boys and girls), and Willow Creek Treatment Center
- **Intensive Care Management Services:**  
Family Mosaic Project, Inpatient & Residential Case Management Unit, AB3632 Residential Case Management, and System of Care Intensive Care Management
- **Day Treatment Services:**  
Institute for the Arts of Living, McAuley Institute Adolescent Inpatient Services, and Westside School-Based Day Treatment
- **Outpatient Services:**  
AB3632 Unit, Bayview/Hunter’s Point Foundation, Chinatown Child Development Center, Chinatown/North Beach Clinical Services, Family Service Agency, Foster Care Mental Health Program, Homeless Children’s Network, Instituto Familiar De La Raza, Jewish Family & Children’s Services, Mission Family Center, New Leaf, OMI Family Center, Richmond Area Multi Services, SFGH/UCSF Department of Psychiatry Child and Adolescent Services, South of Market Outpatient Clinic, Southeast Child/Family Therapy Center, Sunset Mental Health, UC Center on Deafness, and Westside Community Mental Health Services future Living for Youth
- **Special Services:**  
Balboa Teen Health Center, Big Brothers/Big Sisters, Children System of Care, Children System of Care’s Youth Task Force, CYF/Transitional Services (16-22 year olds), Community Vocational Enterprises, Family Involvement Team, Healthy Families & Healthy Kids, Mentor Program - Instituto Familiar De La Raza, Primary Care Mental Health Project, Project Impact Assessment Outpatient Team, School/Mental Health Partnership Program, School Wellness Center Programs - Mental Health (RAMS), Therapeutic Behavioral Services/Shadow Services, West Bay Pilipino Multi Services Center, West Coast Children’s Center, and Youth Development Crime Prevention Project

Strategies for Alcohol, Tobacco and Other Drugs

1. Increase prevention services and programs for youth - ensure that the state mandate of 20% of substance abuse services includes a substantial commitment to youth services. [In progress: DPH Prevention Framework will address this]
2. Develop a reporting system designed to capture the prevention activities conducted by CSAS providers. [In progress: DPH Prevention Framework will address this]
3. Encourage CSAS providers to continue to incorporate innovative best practices in youth substance use/abuse prevention. [In progress: DPH Prevention Framework will address this]
4. Reconvene substance abuse prevention workgroup in collaboration with other sections and the community. [In progress: DPH Prevention Framework will address this]
5. Ensure culturally and linguistically appropriate programs and services for youth and their families. [Ongoing]

6. Emphasize young adults (18-24 year olds) as a focus population for the Tobacco Free Project. [In progress]

#### Strategies for Mental Health

1. Support stability in placement for foster care youth through interagency collaboration with DHS. [Ongoing: Foster Care Mental Health and CSOC]
2. Expand case management and placement options for transitional aged youth. [In progress: AB2034 and new grants]
3. Strengthen Existing Partnerships: Developing teen suicide prevention initiative; work with SFUSD, RAMS, AARS, Wellness Center Program, community-based organizations, and others. [In progress: Suicide Prevention Work Group]
4. Provide Children System of Care cross-training for multiple city departments. [Ongoing: SAMHSA CSOC grant]
5. Implement Youth Development Crime Prevention Project, a collaboration between CMHS, CSAS, Private Industry Council and Juvenile Probation Department, focusing on youth leaving Log Cabin. [In progress]
6. Expand the CSOC Youth Task Force to enable members to be involved in policy and program development within CMHS and CSAS. [Fiscal Year 2003]
7. Develop and implement a coordinated crisis response to violence, through collaborating with the LEAF Project, Critical Incidence Response Team (CIRT) and other services within DPH and the community. [In progress]
8. Improve collaborations between CMHS and Juvenile Probation Department (e.g. the MOU between CMHS and SPY- Project IMPACT, and participation in Juvenile Justice Coordinating Council and Juvenile Detention Alternative Initiative.) [Ongoing]

### **Environmental Health**

The environment plays an important role in the health of young people. A healthy environment offers clean air, water, soil, homes, schools, and parks, whereas unhealthy environments can contribute to asthma, neuro-developmental conditions, as well as anxiety and other social stressors. It is important to make clear that environmental concerns vary somewhat based on age and development. Children and young adolescents are physically smaller than adults and are growing rapidly, thus increasing their vulnerability to lower exposures of toxins and to workplace hazards.

#### Current program areas with overlap in adolescent environments

- **Chemical Hazards** – Work with SFUSD and Department of Recreation and Parks to inspect facilities and assist with the elimination of, or safety planning for, chemical hazards.
- **Property Clean-up** – The development of property for uses including parks, schools, and residences provides an opportunity to review the conditions in soil and groundwater and clean these sites where necessary.
- **Food Safety** – DPH conducts routine inspections of all places where food is produced for retail purchase. Violations of safety codes are strictly enforced. SF has a low number of known food borne illness outbreaks. School Food Services inspections are conducted

routinely. DPH worked with SFUSD food services recently to implement a model proactive program to identify and correct food preparation hazards.

- **Health Code Enforcement** – DPH enforces the sanitation and nuisance provision of the health code in housing, schools, and neighborhoods.
- **Indoor Air Quality** – DPH provides home visiting for asthma patients, and provides medical management teaching and environmental assessments. This caseload may include adolescent patients, although the majority of participants have been younger children. DPH staff has also participated in the SFUSD Indoor Air Quality Advisory Committee, which won recognition from the USEPA last year for working to implement a district-wide Indoor Air Quality Policy.
- **Tobacco Control** – A good deal of smoking related codes and statutes are designed to restrict access to tobacco products by adolescents. An example of this was legislation passed approximately 4 years ago that related to cigarette vending machines. Until recently, all of San Francisco's approximately 100 Bars had cigarette vending machines. A concerted effort was made by Environmental Health to enforce the removal of these vending machine units. To the best of our knowledge, all accessible machines have been removed.
- **Participatory Educational Approaches** – Unsafe or distressed conditions in schools and neighborhoods are frequently cited by youth as priority problems. Participatory or community based educational approaches build young people's capacity to research and organize around health issues of their own choosing. Environmental Health has been requested by community organizations that conduct action based learning in schools to provide planning and technical support for student-led investigation and action into environmental conditions.

### Strategies for Environmental Health

1. Implement Class Action curriculum to Upward Bound youth. *Class Action* builds upon young people's capacity to research and organize around health issues that reflect their realities and experiences; *Class Action* has a particular focus on structural or root causes of poor health. [In progress]
2. Continue collaborations with community organizations that conduct action based learning in schools to provide planning and technical support for student led investigation and action into environmental conditions. [Ongoing]
3. Provide support to SFUSD on their facility master plan. [Ongoing consultation]
4. Conduct asthma home visits to assess environmental conditions of clients with asthma (as part of clinical management plan.) [Ongoing]

## **Injury and Violence**

Injuries and violence are the primary causes of death for adolescents and young adults in San Francisco. Although the greatest impact of injury and violence is in human suffering and loss of life, the financial cost is staggering. Injury and violence results in reduced quality of life, lost productivity, high health costs, and a large burden on health resources.<sup>31</sup>

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<sup>31</sup> Centers for Disease Control and Prevention website on December 16, 2002;  
[http://www.cdc.gov/ncipc/anniversary/injuryoverview/01\\_injuryresearch.htm](http://www.cdc.gov/ncipc/anniversary/injuryoverview/01_injuryresearch.htm)

Nationally, motor vehicle crashes account for approximately half the deaths from unintentional injuries; other unintentional injuries rank second, and falls rank third, followed by poisonings, suffocations, and drownings<sup>32</sup>. Homicide is the second leading cause of death among 15 to 24-year-olds overall. Nationally, in this age group, homicide is the leading cause of death for African Americans, the second leading cause of death for Latino Americans, and the third leading cause of death for Native Americans (CDC 2001).

In many cases of fatal and nonfatal injuries, alcohol and other drug use is a significant contributing factor. Another contributing factor to injury is lack of safety equipment usage; use of safety equipment such as seat belts, bicycle helmets, mouth guards, and wrist guards can greatly reduce injury mortality and morbidity in adolescents.<sup>33</sup>

- For the year 2000, San Francisco ranked worst, among 12 similar sized California cities, for number of fatal and injury collisions involving drivers under 21 years of age who had been drinking, by number of vehicle miles; San Francisco ranked sixth, among those same 12 cities, by population.<sup>34</sup>
- For pedestrians less than 15 years of age killed and injured San Francisco ranked third worst by vehicle miles. For overall pedestrian injury and death, San Francisco ranked worst by all measures.<sup>35</sup>
- In 1998, young people, aged 15 to 24 years had the highest overall rate of motor vehicle related hospitalizations, just above that of people 75 to 84 years but representing nearly twice as many injury hospitalizations.<sup>36</sup>
- For 2002 assault, homicide and suicide data for 10-24 year olds please refer to page 18 of this report.

### Current Programs – Community Health Promotion and Prevention Section

- **YouthPOWER 2** – Funded by the US Department of Justice, Drug Free Communities program, this project will support two youth-led Community Action Teams to address availability and use of substances in Bayview Hunters Point neighborhood, utilizing the DPH Community Action Model. It is based on the work of the staff at YouthPOWER available at [www.dph.sf.ca.us/CHPP/YouthPOWER.htm](http://www.dph.sf.ca.us/CHPP/YouthPOWER.htm).
- **Children and Youth DV Free** – Funded by the California Department of Health Services, Maternal Child Branch, this project works with youth in Community Action Teams to address issues of domestic and dating violence as well as educating caregivers and providers about the effects to children of witnessing domestic violence.

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<sup>32</sup> HHS, CDC, National Center for Injury Prevention and Control. Ten Leading Causes of Injury Deaths; 2000.

<sup>33</sup> Sonoma County Adolescent Health Perspective: Data Profile and Recommendations for Action; Maternal Child Adolescent Health Advisory Board and County of Sonoma Department of Health Services; July 2001.

<sup>34</sup> California Office of Traffic Safety website on December 3, 2002; <http://www.chp.ca.gov/html/switrs2000.html>

<sup>35</sup> California Office of Traffic Safety, website on December 3, 2002; <http://www.chp.ca.gov/html/switrs2000.html>

<sup>36</sup> Profile of Injury in San Francisco; The San Francisco Injury Center and San Francisco Department of Public Health; July 2001.

- **Violence Prevention Network** – The Violence Prevention Network (VPN) is comprised of public and private agencies and those interested in preventing violence from a public health perspective. The VPN RoadMap for Preventing Violence is on the web at <http://www.safetynetwork.org>. The VPN is currently focusing its efforts on providing training and technical assistance for violence prevention practitioners in San Francisco.
- **Intimate Partner Violence Strategic Plan** – Department of Health Services, Epidemiology and Injury Control Section funded DPH to develop a five year strategic plan for primary prevention of intimate partner violence. This plan will be a blueprint for DPH policy and activities in preventing intimate partner violence.
- **Youth Violence Prevention** – In partnership with the Department of Children Youth and their Families and the Gang Free Communities Initiative, DPH is coordinating a planning and programming grant geared toward reducing violence and gang involvement of newcomer girls from Asian and Latin countries. The Substance Abuse Mental Health Services Administration funded a two-year project to understand and enhance services and programs for newcomer girls and their families.
- **Gang Free Communities** – Led by the Department of Children, Youth, and Their Families, Juvenile Probation Department, and Mayor’s Office of Criminal Justice in partnership with other City agencies, including DPH, and community based organizations to reduce and prevent gang violence throughout San Francisco, with a current focus in the Bayview Hunters Point and Mission neighborhoods.

#### Strategies for Injury and Violence

1. Maximize impact of youth services funding by enhancing collaboration and training.\* [Ongoing]
2. Increase mental health services for youth & families experiencing PTSD.\* [In progress]
3. Offer broader range of activities desired by youth.\* [In progress]
4. Promote protective factors (as identified in youth development framework) and address root causes (poverty, oppression, mental health) and risk factors (firearms, alcohol, community deterioration, media, witnessing violence, incarceration, etc.) to effectively reduce and prevent injury and create safe, healthy communities. [Ongoing]
5. Focus on primary prevention that addresses community-level sustainable change to prevent violence and injury. [Ongoing]
6. Develop support to improve school transportation alternatives. [Ongoing]
7. Develop support to make public transportation safer for adolescents and young adults. [Ongoing]
8. Involve more young people in traffic safety problem-solving by using a youth development model. [Ongoing]

### **Nutrition and Physical Activity**

Within the United States, poor diet and physical inactivity are second only to tobacco as preventable causes of death among adults.<sup>37</sup> There is a growing public health concern regarding

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\* YouthPOWER Report & Recommendations, 2002; San Francisco Department of Public Health, Community Health Education Section; Funded by Substance Abuse Mental Health Services Administration.

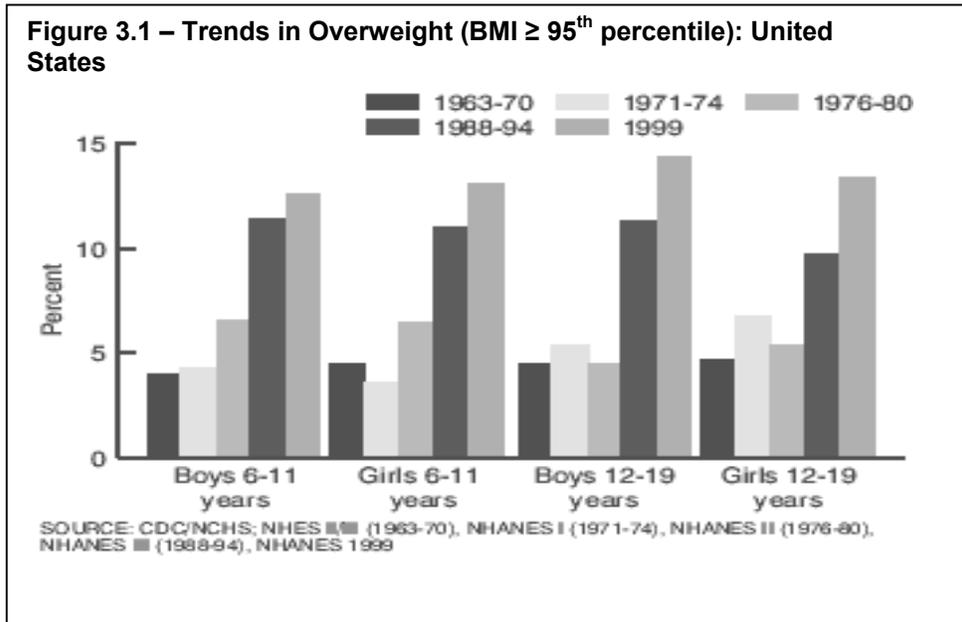
<sup>37</sup> McGinnis, M.M., & Foege, W.H.; Actual casuses of death in the United States; *Journal of American Medical Association*; 270 (18), 2207-2212; 1993.

the increasing prevalence of overweight and obesity among children and adolescents in the United States. The risk of adverse health outcomes, such as heart disease, diabetes, high blood pressure and stroke, increases with obesity in adulthood.

Overweight and obesity among children and adolescents is a multidimensional problem. It is a public health issue that requires a holistic response integrating lifestyle and behavioral approaches with structural environmental change.

Childhood and adolescence are critical times for the development of lifestyle habits that promote good nutrition and physical activity. Establishing healthy eating habits and incorporating appropriate physical activities

in an adolescent’s everyday life help to establish healthy lifestyles and behaviors that can prevent overweight and obesity in adulthood. In addition, the creation of environments that support healthy lifestyles during adolescence is important in promoting, sustaining and maintaining healthy lifestyles, therefore preventing overweight and obesity.



The National Health and Nutrition Examination Survey collected national data on overweight among children and adolescents (see Figure 3.1 and Table 3.1). Approximately one in five children in the United States is now overweight. In addition, overweight children are at risk for cardiovascular diseases, diabetes and other serious health problems that place fiscal burdens on the health care system. Over \$68 billion dollars are spent

**Table 3.1 – Percentage of overweight children and adolescents by sex and race/ethnic group, United States, 1988-94**

Sex and race-ethnic group	6-11 years	12-19 years
<b>Boys</b>		
Total	11.8	11.3
Non-Hispanic white	10.9	11.6
Non-Hispanic black	12.3	10.7
Mexican American	17.7	14.1
<b>Girls</b>		
Total	11.0	9.7
Non-Hispanic white	9.8	8.9
Non-Hispanic black	17.1	16.3
Mexican American	15.3	13.5

each year on direct health care to obesity; this represents 6% of the total U.S. health care expenditures.

Preliminary qualitative data collected through the food management strategies study conducted by DPH's Health Inequities Research Unit shows that San Francisco residents experiencing constrained resources have difficulties obtaining nutritious food or opportunities for physical activity. In addition, issues of transit, social exclusion, employment and housing impact food management strategies of families in San Francisco.

### Current Programs – Maternal Child Health Section

- **Feeling Good Project** – Funded by the US Department of Agriculture Food Stamp Program, provides programs and services to increase awareness and education about healthy eating and physical activity.
- **Project LEAN** – Funded by the US Department of Agriculture Food Stamp Program, aims to develop a community education program in the Mission District to promote fruit and vegetable intake and physical activity in order to apply this to diabetes prevention.
- **WIC Program** – Nutrition education, breastfeeding support and education, supplemental foods, and referral to health care and community services to those eligible (i.e. pregnant adolescents and their infants/children.)

### Current Programs – Environmental Health and OSH Section

- **The San Francisco Food Systems Council** – Created in January 2002 through a partnership between the Department's Environmental Health Section and the San Francisco Foundation Community Initiative Funds. The overall vision of this partnership has been to bring the residents of San Francisco closer to the food system through efforts to: 1.) eliminate persistent hunger, 2.) promote food security, and 3.) improve the sustainability of our food supply. In addition, the department continues to capacity build in the food system through collaborations with community-based organizations.

### Strategies for Nutrition and Physical Activity

1. Collaborate with other agencies to leverage funding for nutrition and physical activity programs for youth. [Ongoing]
2. Promote the integration of physical activity throughout elementary, junior and high school curriculum. [Ongoing]
3. Support policies that increase healthy eating (increase access to healthy foods and decrease access to unhealthy foods.) [In progress]
4. Partner with youth to develop nutrition and physical activity policies and programs. [In progress]
5. Increase the enrollment of students eligible for food assistance programs (free or reduced meal.) [Fiscal Year 2003]
6. Promote the integration of nutrition and physical activity into after-school program curriculum. [Fiscal Year 2003]
7. Create collaborative relationships with SFUSD to increase access to fresh produce and to support regional farmers. [In progress]
8. Promote nutrition and physical activity into Wellness Centers and other school-based health programs. [Fiscal Year 2003]

9. Explore feasibility in hiring exercise physiologist within Maternal, Child Health Section. [Fiscal Year 2003]
10. Promote Department-wide healthy food and beverage choices for staff and community functions. [In progress]
11. Create transit connections between neighborhoods with few food assets and farmers markets. [Ongoing]
12. Increase school and public gardening programs. [In progress: Farm to School Feasibility Study]

### Oral Health

For many San Francisco children and adolescents, oral health problems, such as tooth decay, gum disease, and oral injuries, cause significant pain, interference with eating, poor self-image, and valuable time lost from school and work. Oral diseases are almost entirely preventable, yet appropriate prevention measures are not easily accessible or utilized. Lack of adequate dental insurance is a major obstacle that can lead to chronic oral disease and dental decay.

#### Current Programs

Although most of the programs listed below do not directly affect the adolescent or young adult population, their effectiveness will reflect on the oral health of children as they age and reach adolescence.

- **"Smile for all Season" Dental Health Education Program** – California Children's Dental Disease Prevention Program state grant
- **"Seal San Francisco" School-based Sealant Program** – Materials funded by California Children's Dental Disease Prevention Program state grant.
- **"CCS Orthodontic Program** – Annual orthodontic screening
- **Preschool Children's Dental Health Program** – Education and screening
- **Kindergarten Screening Program** – S.F. Dental Assn collaboration
- **Provider training** – Educating pediatricians to conduct oral health screenings and educating dentists to see children aged 1 – 5 years

#### Strategies for Oral Health

1. Explore feasibility to provide middle and high school dental screenings and education. [Fiscal Year 2003]
2. Support the extension of sealant program to middle schools. [Fiscal Year 2003]
3. Support the increase of orthodontic screening to middle and high schools. [Fiscal Year 2003]
4. Explore the feasibility to expand school-based sealant program to include additional preventive procedures such as fluoride treatments. [Fiscal Year 2003]
5. Explore the feasibility to expand school-based sealant program to include all treatment services. [Fiscal Year 2003]

### Primary Care

Primary health care providers play an important role in adolescent health by assessing developmental progress, screening for health risks, coordinating care, and helping adolescents

and their families make healthy decisions. Primary care offers adolescents and young adults a full range of services including preventive care, care for chronic illnesses and disabilities, evaluation of problems related to growth and development, evaluation of school difficulties, care for depression and other emotional difficulties, evaluation and management of eating disorders and substance abuse, reproductive health information, evaluation of issues related to sexuality and sexually transmitted diseases, and contraception education.

Adolescents report that their doctor is an important and respected source of information about their health, however adolescents and young adults have the lowest rates of health service utilization of any age group. Outreach, education, and health insurance enrollment is key to drawing young people into primary care. Once they enter the primary care system, they need to be received by “teen-friendly” providers who are competent in youth culture, ensure confidentiality, and address teen-specific health concerns.

### Current Programs – Community Primary Care Services

- **Community Health Programs for Youth** – Includes Balboa Teen Health Center, Cole Street Youth Clinic, Larkin Street Medical Clinic; these clinics provide integrated comprehensive health care services to adolescents and young adults in collaboration with community partners
- **Special Programs for Youth** – Provides comprehensive health care to adolescents at Youth Guidance Center and Log Cabin Ranch
- **Prop D clinics** – Includes the Hip Hop clinic through Ocean Park Health Center, the Rap Clinic through Castro Mission, and the Hawkins Village Clinic through Silver Ave Health Center; provides part-time clinics that offer teen-specific services through a larger health center
- **Dimensions Clinic** – Provides health care services for queer youth in SF; offered through Castro Mission Health Center
- **Castro Mission and Maxine Hall Health Centers** – Offers teen-specific health care services on one or more days per week
- **SFGH Pediatrics Clinic** – Offers services seven days per week with a teen clinic on specified evenings; outpatient hospital based care

### Strategies for Primary Care

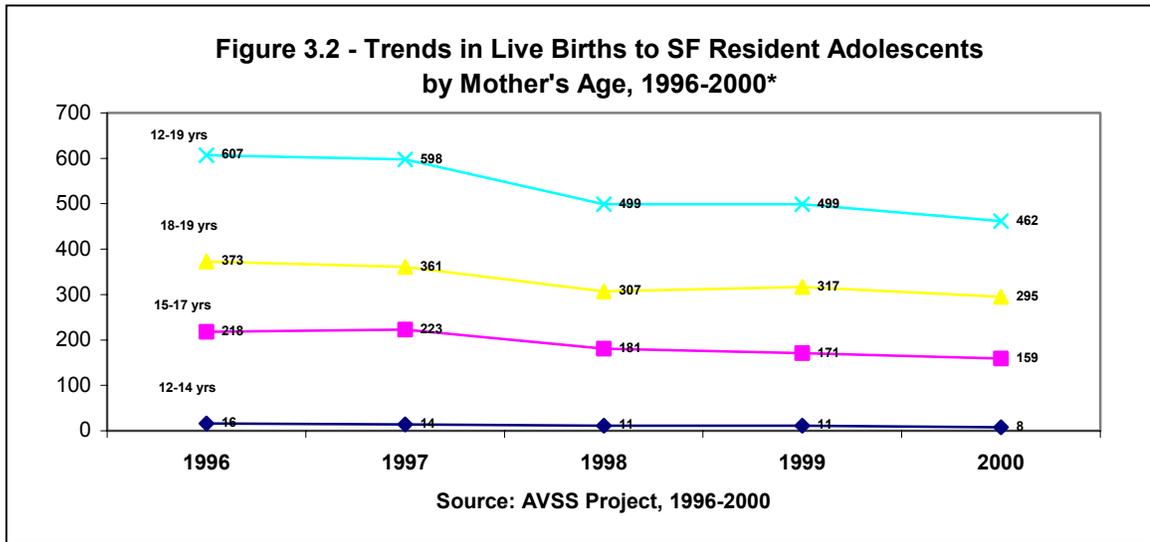
1. Continue implementation of Minor Consent Policy training to providers to increase youth access to primary care and behavioral health assessments and services. [In progress]
2. Create a stronger link between DPH clinics and Wellness Centers to improve referral process from SFUSD Nurses to clinic-based treatment, and to provide consultation and other support services to SFUSD Nurses. [June 2003]
3. Increase provider’s ability and comfort levels in discussing same sex and transgender issues through provider training on issues specific to queer youth. [Fiscal Year 2003]
4. Reconvene the citywide School Health Planning Committee. [To be reconvened in March 2003]

## Sexual Health

Becoming a sexually healthy adult is a key developmental task of adolescence. Sexual health encompasses sexual development and reproductive health, as well as such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one’s own body; interact with both genders in respectful and appropriate ways; and express affection, love and intimacy in ways consistent with one’s own values.

### Pregnancy

Young adolescents who become involved in sexual behaviors prematurely can face a number of negative consequences. The vast majority of adolescents who become pregnant indicate that their pregnancies were unplanned, unintended, or mistimed.<sup>38</sup> The National Center for Health Statistics reports that in almost 70% of births to teenage girls, the fathers were aged 20 years or older.<sup>39</sup> A California study found that the younger the mother, the greater the partner age gap. Among mothers aged 11 and 12, the fathers’ age averaged nearly 10 years older.<sup>40</sup>



Teen births are decreasing nationally as well as in San Francisco (see Figure 3.2). Factors related to reductions in teen birth rates include increased numbers of teens who are delaying sexual activity; increased use of traditional contraception; increased use of long lasting methods of contraception such as Norplant and Depo-Provera; and health education, social service supports and media campaigns.<sup>41 42</sup>

<sup>38</sup> Brown, S.S., & Eisenberg, L. (Eds.); *The Best Intentions: Unintended Pregnancy and the Well-being of Children and Families*; Washington, DC; National Academy Press; 1995.

<sup>39</sup> National Commission on Adolescent Sexual Health; “Facing Facts: Sexual Health for America’s Adolescents”; *Sexuality Information and Education Council of the United States*; 1995.

<sup>40</sup> California Vital Statistics Section, “California Resident Live Births, 1990, by Age of Father, by Age of Mother, “ Sacramento, California: California Vital Statistics Section Department of Health Services, 1992.

<sup>41</sup> Darroch, J.E. & Singh, S.; “*Why Is Teenage Pregnancy Declining? The Role of Abstinence, Sexual Activity and Contraceptive Use*,” New York, NY: The Allan Guttmacher Institute; 1999.

\* Data are based on live births to San Francisco resident adolescents.

Age of Mother	# of Births per population	Rate
15-17	159/9,119	17.4
18-19	295/7,191	41.0
13- 19	462/22,108	20.9

Levels of prenatal care initiated in the first trimester vary depending on the age of the adolescent. The younger the pregnant adolescent, the least likely they are to initiate prenatal care in the first trimester (see Table 3.3).

Age of Mother	Percent 1 <sup>st</sup> Trimester Prenatal Care
15-17	58.7%
18-19	71.0%
>19	88.2%

Current Programs – Maternal Child Health Section

- **Six FamilyPACT\*\* Clinics** – The following serve teens only or have teen clinic hours – Castro Mission Health Center, Maxine Hall Health Center, Cole Street Clinic, Larkin Street Youth Clinic, Hawkins Village, and Hip Hop to Health Clinic
- **MCH Family Planning TeenSMART Outreach Program** – Located at Maxine Hall Health Center, this state funded program’s mission is to reduce the risk of unintended pregnancy and STDs among adolescents 19 years and younger
- **MCH Family Planning Youth Health Initiative** – This program, funded by California Family Health Council, Inc., has an overall goal to increase access to family planning and STD screening services, as well as to improve the quality of services provided to youth ages 24 and under

Strategies for Pregnancy Prevention

1. Actively participate in the statewide teen pregnancy prevention campaign "Its Up to Me" sponsored by California Department of Health Services. [Ongoing]
2. Collaborate with the SFUSD to provide extensive Family Life Education classes in middle/high schools. [In Progress]
3. Provide clinic staff training in youth development model of care, i.e. "How to be teen friendly". [In Progress]
4. Hire and train peer educators to work in teen clinic settings, conduct outreach and education classes. [Ongoing]
5. Increase youth education and awareness on emergency contraception. [Ongoing]

<sup>42</sup> Centers for Disease Control and Prevention; “Trends in Sexual Risk Behaviors Among High School Students;” United State, 1991-97. Morbidity and Mortality Weekly Report; 47, pp. 749-52; 1998.

\* Data are based on live births to San Francisco resident adolescents.

\*\* FamilyPACT is a program for family planning and reproductive health services funded through the state of California.

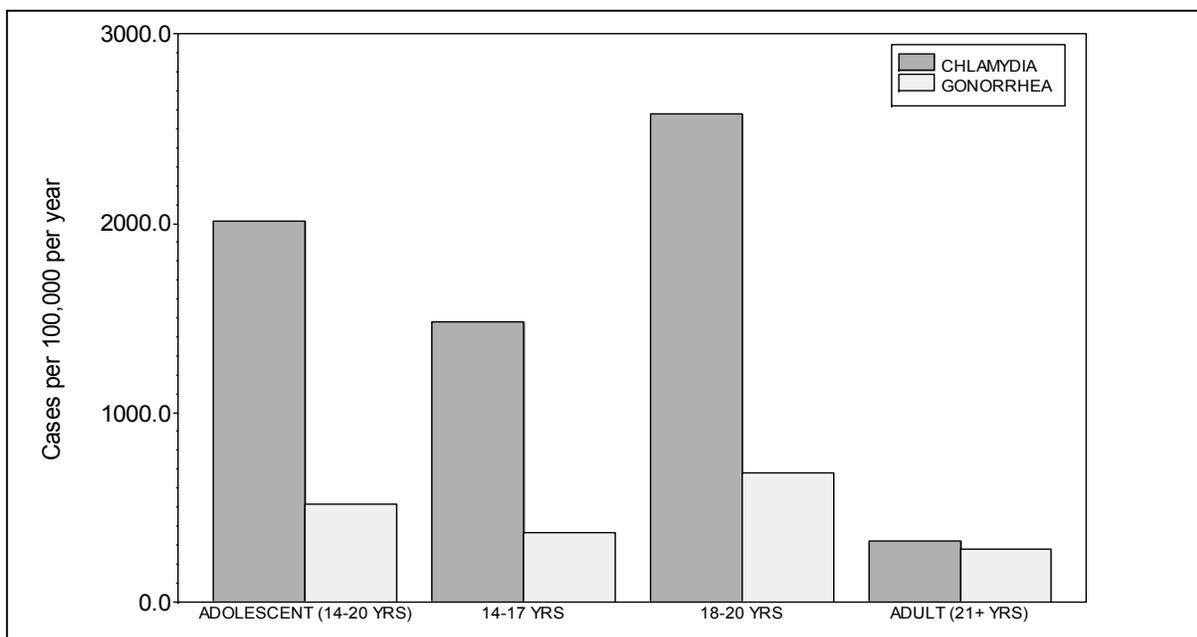
6. Encourage the hiring of health care providers trained in adolescent medicine. [Ongoing]

Sexually Transmitted Diseases / HIV

A risk of sexual activity is sexually transmitted diseases (STDs), including HIV. Due to biological, behavioral and environmental reasons, adolescents are at greater risk for STDs than older people.<sup>43</sup> Untreated STDs can cause pelvic inflammatory disease, ectopic pregnancies, infertility, genital cancers, and death from AIDS.

**Figure 3.3 - STD rates for adolescents compared, San Francisco, 2001.**

(Source: SF DPH, Sexually Transmitted Disease Prevention and Control Section)

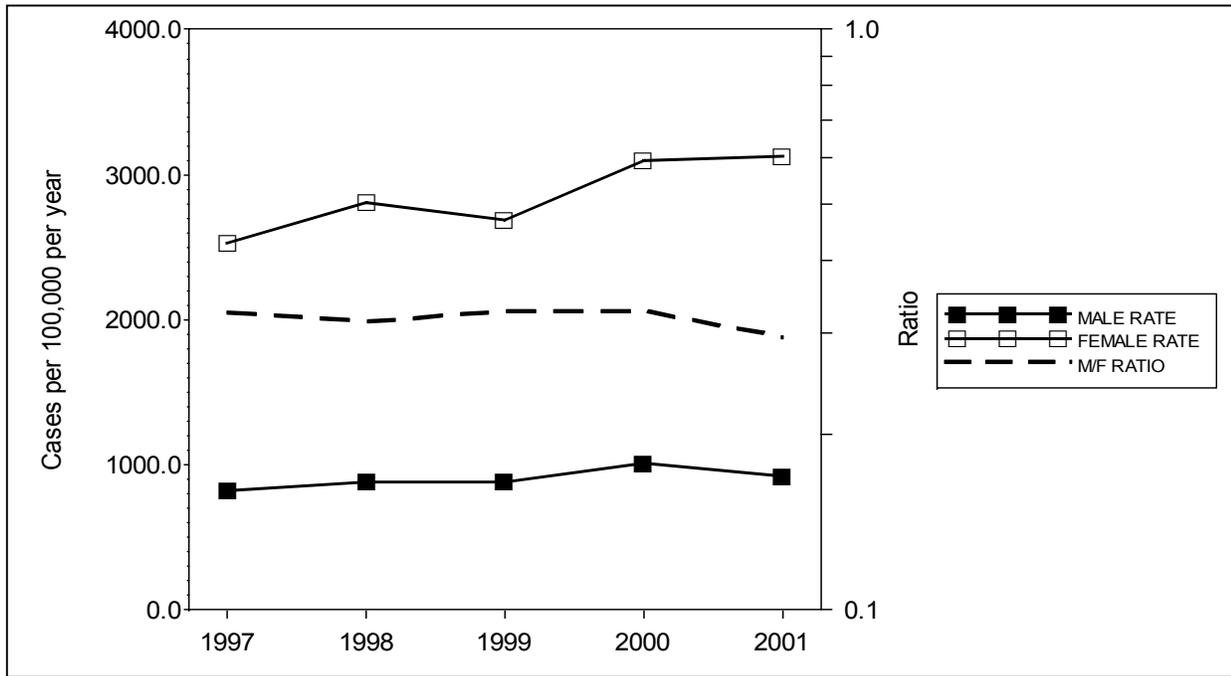


According to the *San Francisco STD Annual Summary, 2001*, STD rates are highly dependent on age and vary by gender. Overall rates of chlamydia are highest among residents 15 to 19 years old and decrease with age; gonorrhea rates peak among those 20 to 24 years old (see Figure 3.3).

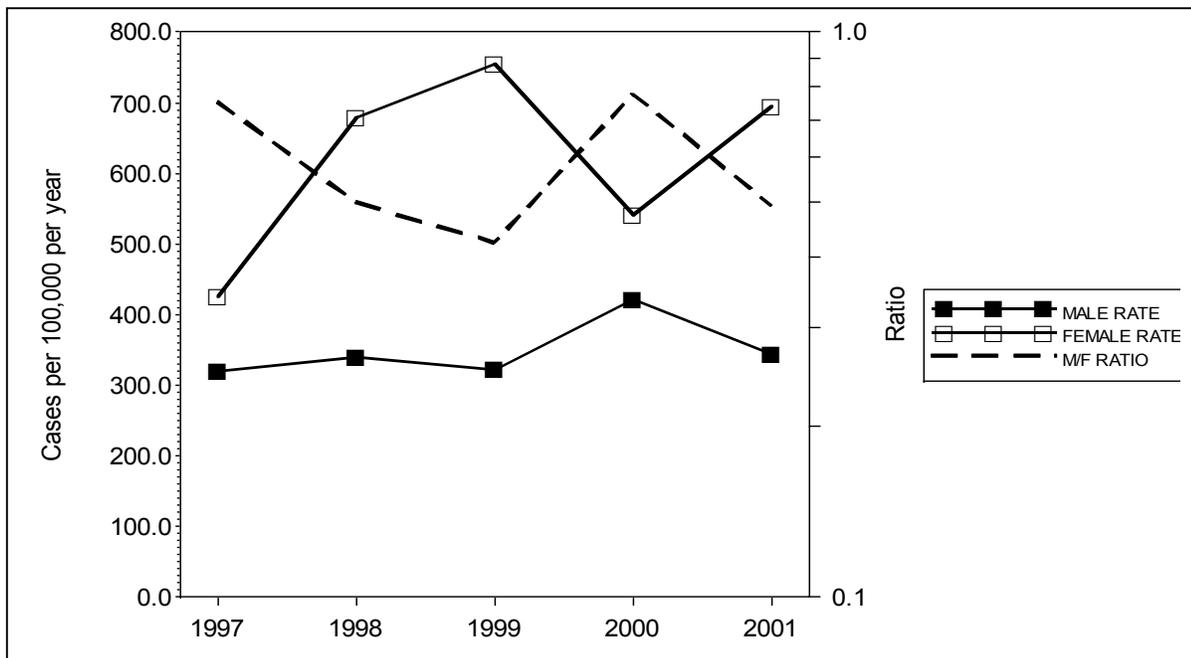
Age-specific chlamydia rates vary by gender (see Figure 3.5). Among females, the rate is highest for women 15 to 19 years old and falls sharply in older age groups. The rate for males is highest among residents 20 to 24 years old; this peak is much lower than the peak for females, but rates decrease less with age. Significant differences in age-specific rates are also seen between men and women for gonorrhea: the male gonorrhea rates peak in the 20- to 24-years old age group and then again in the 35- to 39-years old age group, while the female rate peaks among women 15 to 19 years old (see Figure 3.6).

<sup>43</sup> Irwin, C.E., Jr. & Schafer, M.A.; Adolescent sexuality: Negative outcomes of a normative behavior. In D.E. Rogers & E. Ginzberg (Eds.), *Adolescents at Risk: Medical and Social Perspectives*; (pp.35-79); Boulder, CO: Westview Press.

**Figure 3.5 - Gender-specific chlamydia rates for adolescents, San Francisco, 1997-2001**  
 (Source: SF DPH, Sexually Transmitted Disease Prevention and Control Section)



**Figure 3.4 - Gender-specific gonorrhea rates for adolescents, San Francisco, 1997-2001.**  
 (Source: SF DPH, Sexually Transmitted Disease Prevention and Control Section)



### Current Programs – STD Prevention and Control Section

- **Peer Health Education Programs** – Cole Street Youth Educators and Youth United Through Health Education
- **Juvenile Hall STD Screening** – Screen and treat youth who are detained at Youth Guidance Center
- **School condom availability program** – Four STD Prevention and Control staff conduct the condom availability program at four of SFUSD high schools
- **School Health Center based STD screening** – Provide all STD screening supplies, courier and lab work
- **Mission Neighborhood Health Center** – UCSF Teen Project
- **City-wide STD screening** – New Generations, Balboa, Larkin & Cole Street, and others.
- **Community partnerships for awareness and education** – KMEL radio station assists at our large venue-based events targeting youth and young adults; Providence Foundation and faith-based agencies request STD information and monthly stats and presentations; established partnerships with over 60 non-health related, youth serving agencies to assist in promoting chlamydia awareness with their target population
- **Medical partnerships** – UCSF, Kaiser and CHN to assure routine STD screening
- **Chlamydia Awareness Prevention Project (CAPP)** – A state funded collaborative project

### Current Programs – AIDS Office: HIV Health Services Unit and HIV Prevention Unit

- **Larkin Street** – Prevention services for street youth
- **Centerforce** – Service for young African American MSM who are pre and post release from incarceration into San Francisco County
- **Lavender Youth Recreation and Information Center** – Prevention services for LGBT youth and a second program for "queer identified" young African American MSM
- **Asian Pacific Islander (API) Wellness Center** – Prevention Services for API youth and Young Adults
- **BAY Positives** (Bay Area Young Positives) - Prevention Services for HIV positive youth, with linkages to care and treatment
- **Health Initiatives for Youth** – Training services for youth health providers
- **New Directions** - HIV prevention services for non-identified young African American MSM
- **Special Programs for Youth** – HIV prevention services at Youth Guidance Center, Cole Street Clinic and Dimensions Clinic for LGBT youth
- **Haight Ashbury Free Clinics Inc** – HIV prevention services and needle exchange for young adults on the Haight corridor
- **School-based Health Collaboration** – School staff from the AIDS Office serve as in-school health educators to meet the legal requirements of the San Francisco Unified School district for 'condom availability' and risk reduction education

### Strategies for STD/HIV Prevention

1. Increase partnerships with youth serving organizations. [Ongoing]
2. Review San Francisco Unified School District's family life STD curriculum. [In progress]
3. Strengthen condom availability programs. [In progress]

4. Conduct annual STD updates specifically for youth serving agencies. [Ongoing]
5. Re-establish community youth advisory committee (CYAC.) [Fiscal Year 2003]
6. Encourage a health promotion/youth development model for HIV prevention. [Ongoing]
7. Integrate HIV prevention programs, strategies and messages into other programs serving youth. [In progress]
8. Find innovative ways to utilize available federal and private funding (i.e. for abstinence-based services and faith-based initiatives) that are consistent with the needs and cultures of San Francisco youth. [Fiscal Year 2003]
9. Strengthen existing AIDS Office collaborations with the Adolescent Health Working Group, SFUSD, Wellness Center Program, Youth Task Force and others. [In progress]
10. Increase collaboration with the STD Prevention and Control Section and other agencies providing STD prevention and care services for youth, with an emphasis on those targeting young people at highest risk (e.g. young African American women at risk for chlamydia.) [Ongoing]
11. Promote visibility of and access to health services serving gay and bisexual youth and those non-identified youth who are sexually active and whose HIV knowledge base, perception of risk and risk reduction skills may be low, undeveloped or inconsistent. [Ongoing]

# **Appendix A**

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# **Implementation Plan**

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
I. Behavioral Health	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
<b>A. Alcohol, Tobacco, and Other Drugs</b>										
1. Increase prevention services and programs for youth (ensure that the state mandate of 20% of substance abuse services includes a substantial commitment to youth services.)	In progress: DPH Prevention Framework will address this	CBHS CHPP	√		√	√	√	√	√	
2. Develop a reporting system designed to capture the prevention activities conducted by CSAS providers.	In progress: DPH Prevention Framework will address this	CBHS							√	
3. Encourage CSAS providers to continue to incorporate innovative best practices in youth substance use/abuse prevention.	In progress: DPH Prevention Framework will address this	CBHS	√	√	√	√	√	√	√	√
4. Reconvene substance abuse prevention workgroup in collaboration with other sections and the community.	In progress: DPH Prevention Framework will address this	CBHS CHPP	√		√				√	
5. Ensure culturally and linguistically appropriate programs and services for youth and their families.	Ongoing	CBHS	√	√	√	√		√		
6. Emphasize young adults (18-24 year olds) as a focus population for the Tobacco Free Project.	In progress	CHPP	√					√		
<b>B. Mental Health</b>										
1. Support stability in placement for foster care youth through interagency collaboration with DHS.	Ongoing: Foster Care Mental Health and CSOC	CBHS DHS		√	√	√			√	√
2. Expand case management and placement options for transitional aged youth.	In progress: AB2034 and new grants	CBHS	√			√			√	√
3. Strengthen Existing Partnerships: Developing teen suicide prevention initiative; work with SFUSD, RAMS, AARS, Wellness Center Program, community-based organizations, and others.	In progress: Suicide Prevention Work Group	CBHS SFUSD DCYF		√	√	√	√		√	√
4. Provide Children System of Care cross-training for multiple city departments	Ongoing: SAMHSA CSOC grant	CBHS		√			√		√	
5. Implement Youth Development Crime Prevention Project, a collaboration between CMHS, CSAS, Private Industry Council and Juvenile Probation Department, focusing on youth leaving Log Cabin.	In progress	CBHS CBHS DJP	√	√	√	√			√	

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
I. Behavioral Health	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
6. Expand the CSOC Youth Task Force to enable members to be involved in policy and program development within CSAS.	Fiscal Year 2003	CBHS	√		√	√				
7. Develop and implement a coordinated crisis response to violence, through collaborating with the LEAF Project, Critical Incidence Response Team (CIRT) and other services within DPH and the community.	In progress	CBHS SFGH CHPP		√	√	√		√		
8. Improve collaborations between CMHS and Juvenile Probation Department, using such methods as the MOU between CMHS and SPY- Project IMPACT, and participation in Juvenile Justice Coordinating Council and Juvenile Detention Alternative Initiative.)	Ongoing	CBHS DJP PC			√	√			√	

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
II. Environmental Health	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
<b>A. Environmental Health</b>										
1. Implement the Class Action curriculum to Upward Bound youth. <i>Class Action</i> builds upon young people's capacity to research and organize around health issues that reflect their realities and experiences; <i>Class Action</i> has a particular focus on structural or root causes of poor health.	In progress	EH	✓		✓			✓		
2. Continue collaborations with community organizations to provide planning and technical support for student-led investigation and action into environmental conditions.	Ongoing	EH	✓		✓			✓		
3. Provide support to SFUSD on their facility master plan.	Ongoing consultation	EH SFUSD					✓	✓	✓	
4. Conduct asthma home visits to assess environmental conditions of clients with asthma (as part of clinical management plan.)	Ongoing	EH PC		✓		✓		✓	✓	

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
III. Injury and Violence	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
<b>A. Injury and Violence</b>										
1. Maximize impact of youth services funding by enhancing collaboration and training*	Ongoing	CHPP	✓	✓	✓	✓	✓		✓	
2. Increase mental health services for youth and families experiencing PTSD*	In progress	CBHS		✓	✓	✓				✓
3. Offer broader range of activities desired by youth*	In progress	DPH DCYF SFUSD	✓	✓		✓	✓	✓		✓
4. Promote protective factors (as identified in youth development framework) and address root causes (poverty, oppression, mental health) and risk factors (firearms, alcohol, community deterioration, media, witnessing violence, incarceration, etc.) to effectively reduce and prevent injury and create safe, healthy communities.	Ongoing	CHPP CBHS		✓	✓	✓	✓		✓	✓
5. Focus on primary prevention that addresses community-level sustainable change to prevent violence and injury.	Ongoing	CHPP	✓	✓	✓		✓	✓	✓	
6. Develop support to improve school transportation alternatives.	Ongoing	CHPP SFUSD		✓				✓		
7. Develop support to make public transportation safer for adolescents and young adults.	Ongoing	CHPP		✓				✓		
8. Involve more young people in traffic safety problem-solving, using youth development model.	Ongoing	CHPP	✓					✓		
* YouthPOWER recommendations <a href="http://www.dph.sf.ca.us/CHPP/YouthPOWER.htm">www.dph.sf.ca.us/CHPP/YouthPOWER.htm</a>										

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
IV. Nutrition and Physical Activity	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
<b>A. Nutrition and Physical Activity</b>										
1. Collaborate with other agencies to leverage funding for nutrition and physical activity programs for youth.	Ongoing	MCH EH CHPP DCYF SFUSD	√	√	√	√	√	√	√	
2. Promote the integration of physical activity throughout elementary, junior and high school curriculum.	Ongoing		√				√		√	
3. Support policies that increase healthy eating (increase access to healthy foods and decrease access to unhealthy foods.)	In progress	MCH EH		√			√	√		
4. Partner with youth to develop nutrition and physical activity policies and programs.	In progress	MCH EH CHPP	√							
5. Increase the enrollment of students eligible for food assistance programs (free or reduced meal).	Fiscal Year 2003			√	√	√	√			
6. Promote the integration of nutrition and physical activity into after-school program curriculum.	Fiscal Year 2003	MCH EH					√		√	
7. Create collaborative relationships with SFUSD to increase access to fresh produce and to support regional farmers.	In progress	MCH EH SFUSD					√		√	
8. Promote nutrition and physical activity into Wellness Centers and other school-based health programs.	Fiscal Year 2003	MCH EH DCYF SFUSD					√		√	√
9. Explore feasibility in hiring exercise physiologist within Maternal, Child Health Section.	Fiscal Year 2003	MCH						√		
10. Promote Department-wide healthy food and beverage choices for staff and community functions.	In progress	DPH		√				√		
11. Create transit connections between neighborhoods with few food assets and farmers markets.	Ongoing	EH		√	√			√		
12. Increase school and public gardening programs.	In progress: Farm to School Feasibility Study	EH SFUSD	√				√	√		

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
V. Oral Health	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
<b>A. Oral Health</b>										
1.	Explore feasibility to provide middle and high school dental screenings and education.	Fiscal Year 2003	MCH SFUSD	✓			✓		✓	✓
2.	Support the extension of sealant program to middle schools.	Fiscal Year 2003	MCH SFUSD	✓			✓		✓	✓
3.	Support the increase of orthodontic screening to middle and high schools.	Fiscal Year 2003	MCH SFUSD	✓			✓		✓	✓
4.	Explore the feasibility to expand school-based sealant program to include additional preventive procedures such as fluoride treatments.	Fiscal Year 2003	MCH SFUSD	✓			✓		✓	✓
5.	Explore the feasibility to expand school-based sealant program to include all treatment services.	Fiscal Year 2003	MCH SFUSD	✓			✓		✓	✓

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
VI. Primary Care	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
<b>A. Primary Care</b>										
1. Continue implementation of Minor Consent Policy training to increase youth access to primary care assessments and services.	In progress	OAH PC CBHS	√	√						√
2. Create a stronger link between DPH clinics and Wellness Centers to improve referral process from SFUSD Nurses to clinic-based treatment and to provide consultation and other support services to SFUSD Nurses.	June 2003	PC SFUSD DCYF					√		√	√
3. Increase provider's ability and comfort levels in discussing same sex and transgender issues through provider training on issues specific to queer youth.	Fiscal Year 2003	PC	√			√				√
4. Reconvene the citywide School Health Planning Committee.	To be reconvened in March 2003	MCH PC OAH DCYF SFUSD					√		√	

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
VII. Sexual Health	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
<b>A. Pregnancy</b>										
1. Actively participate in the statewide teen pregnancy prevention campaign "Its Up to Me" sponsored by California Department of Health Services.	Ongoing	MCH		✓	✓			✓	✓	
2. Collaborate with the SFUSD to provide extensive Family Life Education classes in middle/high schools.	In progress	MCH SFUSD		✓	✓		✓		✓	✓
3. Provide clinic staff training in customer service, e.g. "How to be teen friendly".	In progress	MCH OAH	✓	✓	✓				✓	✓
4. Hire and train peer educators to work in teen clinic settings, conduct outreach and education classes.	Ongoing	MCH PC	✓		✓	✓				✓
5. Increase youth education and awareness on emergency contraception.	Ongoing	MCH PC	✓							✓
6. Encourage the hiring of health care providers trained in adolescent medicine.	Ongoing	MCH	✓	✓		✓				✓
<b>B. Sexually Transmitted Diseases / HIV</b>										
1. Increase partnerships with youth serving organizations.	Ongoing	STDPC		✓		✓	✓		✓	✓
2. Review San Francisco Unified School District's family life STD curriculum.	In progress	STDPC SFUSD	✓		✓		✓		✓	
3. Strengthen condom availability programs.	In progress	STDPC PC	✓		✓	✓	✓		✓	✓
4. Conduct annual STD updates specifically for youth serving agencies.	Ongoing	STDPC							✓	
5. Re-establish Community Youth Advisory Committee.	Fiscal Year 2003	STDPC	✓						✓	

Program Strategies for Improving Youth Services		Rec:	1	2	3	4	5	6	7	8
VIII. Sexual Health	Status of Implementation	Section(s) / Depts. responsible	Youth Develop	Family & Community	Race/Ethn Disparities	Vulnerable Youth	School Health	Healthy Environments	Coordinate	Access & Utilization
<b>B. Sexually Transmitted Diseases / HIV</b>										
6. Encourage a health promotion/youth development model for HIV prevention.	Ongoing	AO/PU	√		√	√	√			
7. Integrate HIV prevention programs, strategies and messages into other programs serving youth.	In progress	AO/PU	√						√	
8. Find innovative ways to utilize available federal and private funding (i.e. for abstinence-based services and faith-based initiatives) that are consistent with the needs and cultures of San Francisco youth.	Fiscal Year 2003	AO/PU	√		√	√				
9. Strengthen existing AIDS Office collaborations with Adolescent Health Working Group, SFUSD, Wellness Center Program, YUTHE, Youth Task Force and others.	In progress	AO/PU OAH STDPC CBHS SFUSD	√	√			√		√	
10. Increase collaboration with the STD Prevention and Control Section and other agencies providing STD prevention and care services for youth, with an emphasis on those targeting young people at highest risk (e.g. young African American women at risk for chlamydia.)	Ongoing	AO/PU STDPC			√	√			√	
11. Promote visibility of and access to health services serving gay and bisexual youth and those non-identified youth who are sexually active and whose HIV knowledge base, perception of risk and risk reduction skills may be low, undeveloped or inconsistent.	Ongoing	AO/PU	√			√				

# **Appendix B**

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## **Glossary of Terms**

**Adolescence:** The time between 10-19 years which is marked by puberty, and a time of great physical, social and psychological development. Also referred to as *teenagers, teens, youth, and young people*.

**Behavioral Health:** An integrated, interdisciplinary system of care that approaches individuals, families, and communities as a whole and addresses the interactions between psychological, biological, socio-cultural, and environmental factors.

**Healthy People 2010:** A comprehensive, nationwide health promotion and disease prevention agenda that contains 467 objectives designed to serve as a road map for improving the health of all people in the United States during the first decade of the 21st century.

**LGBTQ youth:** Lesbian, Gay, Bisexual, Transgender, and Queer youth.

**Resiliency:** The ability of youth to overcome obstacles, to meet the new social demands of adolescence and to build the competencies necessary for success as adults. (From the California Adolescent Health Collaborative, 2000.)

**Young Adult:** Includes the age group between 20-24 years. Also referred to as *youth and young people*.

**Youth Development:** A process which prepares young people to meet the challenges of adolescence and adulthood through a coordinated, progressive series of activities and experiences which help them to become socially, morally, emotionally, physically, and cognitively competent. Positive youth development addresses the broader developmental needs of youth, in contrast to deficit-based models which focus solely on youth problems. (From the National Youth Development Information Center, 1998)

**Youth Risk Behavior Survey:** Developed by the Division of Adolescent and School Health, National Centers for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention in collaboration with representatives from state and local departments of education and other federal agencies, its purpose is to monitor priority health-risk behaviors that contribute to the leading causes of morbidity, mortality, and social problems among youth and adults in the United States.