

**Middle Childhood:
The Stage Between
Tot and Teen**

**The Status of Georgia's Children
Ages Five Through Nine**



May 2006



**Georgia Department of Human Resources
Division of Public Health
Family Health Branch**

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EXECUTIVE SUMMARY

Results of an extensive literature review conducted by the Georgia Department of Human Resources (DHR), Division of Public Health (DPH), Family Health Branch indicates that Georgia's children are less healthy than their counterparts in most other states, rank below average in mathematics and reading scores in fourth grade tests, are last in SAT scores, rank 40th in school dropout rates, and often lack access to health care or health insurance. For these reasons, public and community programs are challenged to use scarce resources in the most effective ways possible to help our children develop into healthy, productive adults. This report highlights a significant stage in child development, as children begin school and develop habits and attitudes that carry over into later stages of life.

Most research and programs addressing children's health focus on early childhood (birth through five years of age) or the teen years. This report presents information about the health conditions and concerns of Georgia children ages five through nine, the stage of middle childhood. It also provides key demographics for Georgia's 622,129 children in this age group, and discusses this group's access to health care.

This report also highlights gaps in current knowledge and research about middle childhood, points out significant problem areas and describes best practices. Most important, the report outlines areas for assessment and further evaluation to assure that Georgia's children ages 5 to 9 are healthy and able to achieve in school, and reach their maximum potential later in life. These areas for assessment have implications for public and private health services, prevention programs, and environmental improvement.

The report discusses several key concerns. Asthma ranks first because it is the number one cause for hospitalizations and missed days of school for children in this age group in the United States and in Georgia. Oral health and dental problems are significant causes of school absence. The near epidemic prevalence of overweight and obesity are issues of major concern among children in middle childhood. Without serious intervention, Type 2 diabetes, cardiovascular disease, and other problems will soon loom large as health care issues for Georgia's children and taxpayers. Other societal issues (commercialization, consumerism, early sexualization, and negative mass communications) also threaten the physical and mental health of children in middle childhood.

This report outlines areas of concern and provides an overview of best practices to strengthen health delivery systems for youth. Areas for consideration include:

- Applying the "assets approach" to wellness and youth development;
- Conducting outcome research on current health initiatives for newborn to five-year-olds;
- Conducting outcome research on programs delivered in middle childhood to measure their impact on adolescence and adulthood;
- Increasing the reach of coordinated school health programs to every school;
- Assuring safe, accessible after-school programs that provide physical activity, good nutrition, and youth development opportunities;
- Expanding youth development programs;
- Expanding the use of the family team approach to child protection;
- Expanding the use of anticipatory guidance, as presented in *Bright Futures*;
- Developing media literacy and safety programming; and
- Providing outreach to link families to medical homes and financial resources.

I. INTRODUCTION

This report examines the lack of focus children receive as they begin traditional settings, such as school and structured activities outside of the home environment. Rosalyn K. Bacon, M.P.H., Director of DHR's Family Health Branch commissioned this report because she recognized that a child's well being during middle childhood (ages 5 to 9) sets the child on the path to success. During middle childhood, a child begins school, grows in size, and develops his/her outlook on life.

A healthy child is more likely to attend school regularly, navigate through teenage years successfully, and become a self-sufficient, productive adult. Yet, middle childhood is just becoming its own recognized stage of human development. For example, some data sets and programs define middle childhood anywhere from ages 5 to 12. Within this report, we hope to establish a specific definition of this stage of childhood, determine the most significant obstacles to well being during this period, and to present material that will lead to the development of a strategic plan to improve health and developmental outcomes for Georgia's middle childhood population.

According to the most comprehensive monograph on middle *childhood*, *Building a Strong Foundation: Creating a Health Agenda for the Middle Childhood Years*, relative to other children, children between the ages of 6 to 11 have received little attention from health researchers and policymakers. There are substantial health issues in middle childhood that need close attention. It is necessary to create further research, improve monitoring, pilot effective prevention programs, provide better health services, and create policies that improve the health and well being of the middle childhood population. Middle childhood is an important link in the continuum between early childhood and adolescence. What occurs during infancy, and early and middle childhood, influences the behaviors and the health, educational, and social outcomes of adolescents and, ultimately, adults.¹

Georgia's report on middle childhood has drawn extensively from *Building a Strong Foundation: Creating a Health Agenda for the Middle Childhood Years*, and a companion monograph, *The Health of America's Middle Childhood Population*,² by the same authors. We acknowledge these monographs as seminal literature in the field. Also, Florida conducted a review of health in middle childhood: *The Health of Florida's Children and Youth: Atlas of Key Status Indicators, Goals and Objectives for Strategic Planning*, which produced key indicators for this age group.³ Readers are encouraged to read these monographs as well as the section on elementary aged children in *The Health of Florida's Children and Youth*, as companions to the Georgia report.

It is important to acknowledge the many strong programs, activities, and efforts in Georgia's public, private, and non-profit sectors already in place that are advancing the health of children in middle childhood. This report will assist in determining which bridges from early childhood to adolescence can be strengthened for the well being of Georgia's children.

¹ Brindis, C. D., Biehl, M. C., Park, M. J., Pantell, R. H., Irwin, C. E., Jr. *Building a strong foundation: Creating a health agenda for the middle childhood years*. San Francisco: University of California, San Francisco, Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health, 2002. <http://youth.ucsf.edu/policy>

² Biehl, M. C., Park, M. J., Brindis, C. D., Pantell, R. H., Irwin, C. E., Jr. *The health of America's middle childhood population*. San Francisco: University of California, San Francisco, Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health, 2002. <http://youth.ucsf.edu/policycenter/publications.html>

³ Zervigon-Hakes A.,. *The health of Florida's children & youth: Atlas of key status indicators, goals and objectives for strategic planning*. Tampa, FL: University of South Florida. The Lawton and Rhea Childes Center for Healthy Mothers and Babies, 2002. <http://www.doh.state.fl.us/family/childhealth/childreport/goals/goal1/youths.html>

II. DEMOGRAPHICS AND HEALTH ISSUES

Middle childhood is a significant period in which children may embrace positive behaviors and competencies. The values and beliefs established during this time have implications for subsequent adolescent and adult behavior and health. This report examines four broad areas to provide a comprehensive picture of Georgia's children ages 5 to 9:

- Demographic characteristics
- Mortality
- Morbidity
- Factors influencing health and well being

The age group 5 to 9 was chosen to represent middle childhood. Because of variation in data sources and availability of data, the age group data provided may vary, as may the time frame available to analyze the data. To the extent possible, Georgia-specific data are provided. Where state sources are not available, national data are provided.

A. DEMOGRAPHIC CHARACTERISTICS

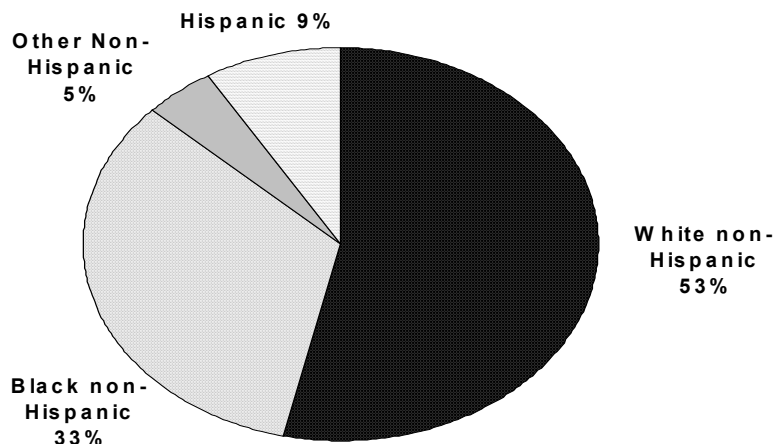
Population Stratified by Race and Ethnicity

In calendar year 2004, children ages 5 to 9 comprised seven percent of Georgia's population. Based on U.S. Census population estimates, the number of children ages 5 to 9 children in Georgia increased from 528,530 in 1994 to 622,129 in 2004 representing an 18 percent increase.

The following pie chart displays the population of children ages 5 to 9 in Georgia by race and ethnicity. In this age group, the Hispanic population grew the fastest from 15,133 in 1994 to 53,303 in 2004, representing a nearly 250 percent increase.⁴

Table #1

**Percent Race and Ethnicity in Georgia
Ages 5 through 9, 2004**



⁴ Georgia DHR, Division of Public Health, Office of Health Information and Policy, 2004.
<http://oasis.state.ga.us/webquery/population.html>

B. MORTALITY

In Georgia, there were a total of 385 deaths among children ages 5 to 9, representing a mortality rate of 15.6 per 100,000 from 2001 to 2004. Although the mortality rate is lower in this age group than in any other, any death generally represents a tragedy because of the significant number of years of potential life lost and because the causes are often preventable.⁵

Racial and Ethnic Disparity

From 2001 to 2004 among children ages 5 to 9, 183 deaths were among Non-Hispanic white children, 158 among Non-Hispanic black children, 20 among Hispanic children, and 6 among children of other racial/ethnic groups.* While Non-Hispanic white children experienced the largest number of deaths, the highest rate of deaths was among Non-Hispanic black children with a rate of 19.0 per 100,000 compared to rate of 13.6 for Non-Hispanic white children and 10.7 for Hispanic children.⁶

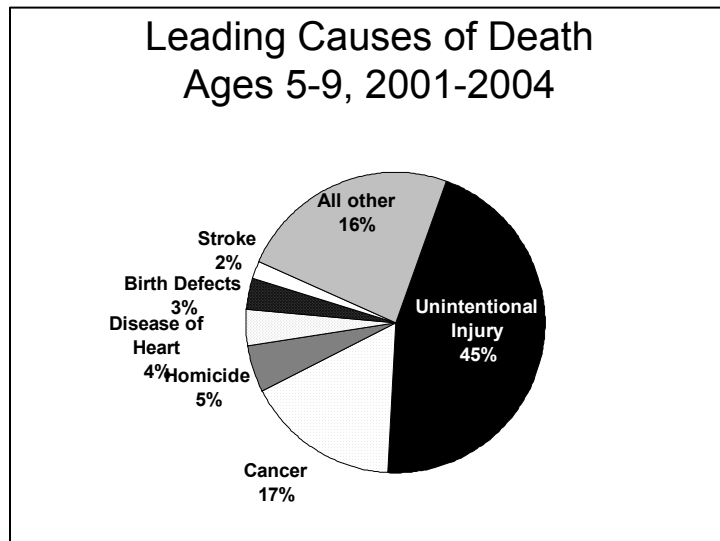
* Note: The total number of deaths by racial and ethnic groups does not add to 385 due to incomplete ethnicity data on death certificates.

Leading Causes of Death

- The five leading causes of death for children ages five through nine from 2001-2004 were **unintentional injuries, cancer, homicide, heart disease, and birth defects** (see chart above). There were a total 174 unintentional injury deaths. About 56% (98) were due to motor vehicle crashes; fire and smoke exposure accounted for 13% (22) of the deaths, and drowning accounted for an additional 13% (23) of deaths.
- Among children ages five through nine years involved in motor vehicle crashes who were treated, seriously injured, or killed:
 - 5.5 percent were using a booster seat
 - 64.1 percent were using a seat belt alone
 - 20.9 percent had no restraint
- According to the Centers for Disease Control and Prevention (CDC), one in four crash-related child deaths among child passengers under 14 years old involves alcohol use. The majority of children in alcohol-related crashes were unrestrained.⁷
- Unintentional injury and homicide (20 deaths) together accounted for half of the deaths, resulting in a total 194 deaths.⁸

Death from fire and smoke exposure is the second leading cause of injury death for Georgia's children five through nine. Smoke detectors are the best prevention against these deaths. Drowning is the third leading cause of injury death for Georgia's children five through nine. Although pool safety is the most important precaution for younger children, those in middle

Table #2



⁵ Georgia DHR; Division of Public Health; Chronic Disease, Injury and Environmental Epidemiology Section. Georgia Vital Statistics.

⁶ Georgia DHR, Division of Public Health, Office of Health Information and Policy. OASIS Web Query. <http://oasis.state.ga.us/>.

⁷ Morbidity and Mortality Weekly Report Atlanta: Centers for Disease Control. 2-6-04.

⁸ Georgia DHR; Division of Public Health; Chronic Disease, Injury and Environmental Epidemiology Section. Georgia Vital Statistics.

childhood are more at risk of drowning in open water, where adult supervision is particularly necessary.

C. MORBIDITY

From 1999 to 2002, asthma, pneumonia, injuries, dehydration, and appendicitis were the five leading causes of hospitalizations among five through nine-year-olds.

Asthma

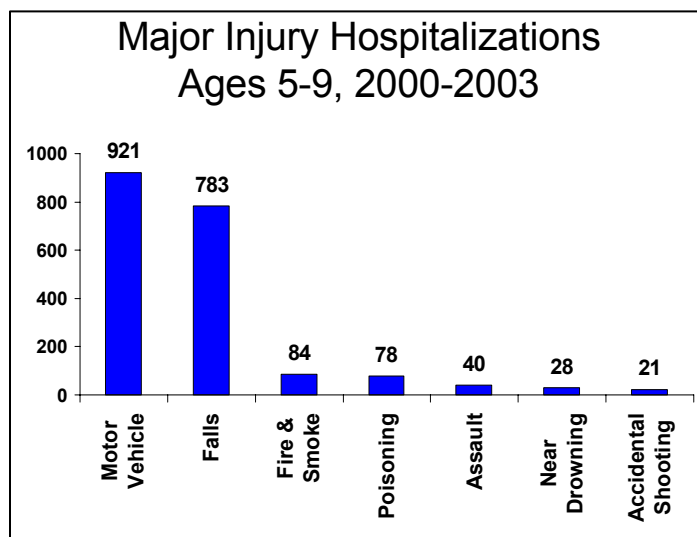
Asthma is a major public health problem in Georgia, especially for children. Based on data from the 2002-2003 Georgia Childhood Asthma Survey, children ages 5 to 9 had the highest prevalence of asthma among all the age groups, with an estimated prevalence of 12% (about 72,000 children). In this age group, 46% of children (32,000) missed 173,000 school days in 2002-2003 due to asthma.⁹ In addition, asthma remained the leading cause of hospitalization for children ages 5 to 9 over the four-year period 2000 to 2003, accounting for 3,747 hospital discharges among 3,199 children of this age group.

Injuries

Injury was the second leading cause of hospitalization for children ages 5 to 9 in Georgia. From 2000–2003, there were 2,763 children, ages five through nine hospitalized for external causes, primarily due to injury, resulting in 2988 hospitalizations.

- Motor vehicle crashes accounted for 31% of hospitalizations, and were the leading cause of hospitalization from injury.
- While falls accounted for only one death from 2000 to 2003, it represented 26 percent of hospitalizations.
- Fire and smoke related injuries resulted in 84 hospitalizations.¹⁰

Table #3



Oral Health

Oral health is an essential and integral component of health throughout life. Poor oral health has been related to decreased school performance, poor social relationships, and less success later in life.¹¹ Data on the oral health status of third grade children in Georgia were collected in the 2005 Oral Health Screening. Among third grade children:

- 1 in 2 (56%) have experienced dental caries
- 1 in 4 (27%) have untreated dental decay.
- 4 in 10 (40%) have dental sealants.
- 1 in 4 (26%) need either early or urgent dental care.

⁹ Blackwell AD, Wu M, Mertz KJ, Powell KE, Williams CP, Chowdury P. *The Burden of Asthma in Georgia 2003*. Georgia Department of Human Resources; Division of Public Health; Chronic Disease, Injury and Environmental Epidemiology Section, December 2003. Publication number DPH03/127HW.

¹⁰ Georgia DHR; Division of Public Health; Chronic Disease, Injury and Environmental Epidemiology Section. Georgia Hospital In-Patient Discharge Data.

¹¹ U.S. Department of Health and Human Services (HHS). *Oral Health in America: A Report to the Surgeon General*. Rockville, MD: HHS, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000.

The percent of third grade children in Georgia with caries experience, untreated dental decay, and dental sealants does not meet Healthy People 2010 objectives. Significant differences in oral health were found between high and low socioeconomic households. In addition, access to insurance and utilization of dental care were important factors in promoting good oral health.¹²

Overweight and Obesity

Childhood obesity is a severe public health problem. Obese children are at increased risk for hypertension, asthma, sleep apnea, diabetes, and decreased well being (poor self-esteem). In addition, obese children are more likely to become obese adults and contribute to rising health care costs associated with obesity.¹³

Data are limited on the prevalence of obesity in middle childhood in Georgia but various studies nationally and in Georgia from other age groups or specific populations provide a picture of the issue. National data indicates that 15 percent of children 6 to 11 were overweight* and 16 percent were obese† (measured) during 1999 – 2000.¹⁴ Prevalence estimates from Georgia's surveillance systems and surveys are listed below:

- The Pediatric Nutrition Surveillance Survey (PedNSS) reported 16 percent of four year-olds in Georgia's Women, Infants and Children (WIC) population were overweight* and 15 percent were obese† (measured) in 2004.¹⁵ Results from the 2005 Oral Health Screening found 19 percent of third grade students in Georgia were overweight* and 24 percent were obese† (measured).¹⁶ The Georgia Student Health Survey (GSHS) found 21 percent of sixth grade students were overweight* and 19 percent were obese† (self-reported) in 2003.¹⁷

* Definition of overweight: BMI-for-age 85th ≥ 95th percentile

† Definition of obesity: BMI-for-age 95th percentile or above

Disability After Birth

Most disabilities exist at birth. According to the CDC, **bacterial meningitis** is the leading cause of disability after birth. It is essential that children be immunized early in life for meningitis, as the disease may result in brain damage, hearing loss, or learning disability. In 2003, Atlanta only had 2 bacterial meningitis cases in children ages five through nine, attesting to the effectiveness of meningitis immunization.¹⁸

D. FACTORS INFLUENCING HEALTH AND WELL BEING

School Success

School success is a continuous concern for Georgia's children because it affects health and well being throughout life. Compared to the national percentages, Georgia's fourth graders were below the national standards in Basic Reading (41 percent vs. 38 percent) and Math Assessment (28 percent vs. 24 percent). The following table compares the performance of Georgia's fourth graders with national data.

¹² Falb M, Kanny D, Duval T, Koskela L. *Oral Health of Georgia's Children: Results from the 2005 Oral Health Survey*. Georgia Department of Human Resources, Division of Public Health, March 2006, Publication Number: DPH06XX.XXXHW.

¹³ Institute of Medicine of the National Academies (2004). *Preventing Childhood Obesity: Health in the Balance*. Washington D.C.: National Academies Press.

¹⁴ Ogden, CL, Flegal, KM, Carroll, MD, & Johnson, CL. *Prevalence and trends in overweight among US children and adolescents, 1999, 2000*. JAMA 288: 1728-32, 2002.

¹⁵ Pediatric Nutrition Surveillance 2004. Atlanta, GA.: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

¹⁶ Falb M and Kanny D. Obesity in Georgia's 3rd Graders: Results from the 2005 Oral Health Survey. Georgia Department of Human Resources, Division of Public Health, January 2006. Publication Number: DPH06.004HW.

¹⁷ Kanny, D. & Powell KE. 2003 Georgia Student Health Survey. Georgia Department of Human Resources, Division of Public Health, November 2003. Publication Number: DPH03/144.

¹⁸ *Developmental Disabilities Br, Div of Birth Defects and Developmental Disabilities*. Atlanta, GA: Centers for Disease Control, National Center for Environmental Health, 2004.

Table #4

Two-Year Comparison of Georgia and National Achievement Levels on the National Assessment of Educational Progress (NAEP) for 4th Grade, 2002-2003

Reading	Below Basic	Basic	Proficient	Advanced
Georgia	41%	32%	20%	6%
National	38%	32%	23%	7%
Math	Below Basic	Basic	Proficient	Advanced
Georgia	28%	45%	23%	3%
National	24%	45%	28%	4%

Visual Impairments

More children and adults have visual impairments than any other disability. Visual impairment, even with correction, adversely affects a child's educational performance. The term visual impairment includes those children who are partially sighted or blind and require special services in school.¹⁹ According to *The Need for Comprehensive Vision Examination of Preschool Children*, adopted by the American Optometric Association and four other leading groups in 2003, "It is estimated that nearly 25 percent of school-age children have vision problems, and vision disorders are the fourth most common disability in the United States and the leading cause of handicapping conditions in childhood."²⁰

Parents' Education / Parental Involvement

According to the *Child Trends Data Bank*, 2001 "higher levels of parent educational attainment are strongly associated with positive outcomes for children in many areas including school readiness and educational achievement, health and health-related behaviors including smoking and binge drinking, and pro-social activities such as volunteering. Children of more educated parents are also likely to have access to greater material, human, and social resources."²¹

Parental involvement can make a significant difference in student performance. Research shows that students whose parents are actively involved in their education have better grades, test scores and long-term academic achievement.

Poverty

Being raised in poverty increases the risk of several health, social, and behavioral problems. Poverty data specifically for children in the middle childhood age group are not available. Data for children for a broader range of ages provides an estimate of the problem. According to the U.S. Census Bureau's Current Population Survey, nearly 17 percent of Georgia's children ages 5 through 17 live below the federal poverty level, a percent comparable to the national average, and 46 percent of all children enrolled in school receive free or reduced price meals.²²

Children's Health Insurance Status

Data from the Georgia Healthcare Coverage Project Survey, 2002, indicates that

- 33 percent of children ages six through ten were covered by public health insurance
- 66 percent were covered by private insurance
- 8 percent did not have any kind of insurance at the time of the study

¹⁹ Oregon Department of Education, <http://www.ode.state.or.us/sped/spedareas/visimpdef.htm>

²⁰ *The Need for Comprehensive Vision Examination of Preschool Children*. The American Optometric Association, 2003.

²¹ *Child Trends Data Bank*, 2001. <http://www.childtrendsdatbank.org/basic.cfm>

²² U.S. Census Bureau. Current Population Survey, 2003. http://ferret.bls.census.gov/macro/032004/pov/new46_100125_02.htm

- Rural children were less likely than urban children to be covered by private or employment-based coverage, and more likely to be covered by public health insurance or to be uninsured.

Child Abuse and Neglect

Child abuse and neglect is a serious issue affecting too many of Georgia's children. The state's child abuse and neglect rate increased from 14.2 per 1,000 in 2000 to 19.1 in 2003. In 2003, there were more than 85,000 reports of child abuse or neglect and 43,923 confirmed victims of abuse or neglect. Our youngest children are most at risk for maltreatment. In 2003, 21.7 out of 1,000 4 to 7 year old children were victims of maltreatment and the rate for 8 to 11 years olds was 18.3 per 1,000.²³ Four out of five incidents of child maltreatment involve child neglect, most frequently a result of inadequate supervision.²⁴

Bullying

Bullying is “one of the most underrated and enduring problems in schools today. Bullying actually begins earlier than the middle years and for some children intensifies by the middle years. Children who are bullied miss more school than children who are not bullied, have greater problems with self-esteem, and if repeatedly victimized, sometimes see suicide as their only escape. Overweight and disabled children are common targets of bullies, adding to their difficulties at school. Bullying also represents a risk factor for both substance abuse and suicide. Children labeled by their peers as bullies, require more support as adults from government agencies, have more court convictions, more alcoholism, and more antisocial personality disorders, and use more mental health services. By age 24, sixty percent of identified bullies have criminal convictions.”²⁵

Juvenile Crime Precursors

Several precursors to juvenile crime have been identified. They include acting out at school, bullying, intentional juvenile fire setting (resulting in burns, school absence, conviction of a crime), substance abuse, early sexual activity, and endangering small animals.

Truancy

Truancy has been clearly identified as one of the early warning signs that youth are headed for potential delinquent activities, social isolation, and/or educational failure. Several studies have established lack of commitment to school as a risk factor for substance abuse, delinquency, teen pregnancy, and dropping out of school.²⁶ Decades of research have also identified a link between truancy and later problems such as violence, marital problems, job problems, physical and emotional abuse or neglect, adult criminality, and incarceration.²⁷

E. POSITIVE INDICATORS OF WELL BEING

The following are suggested positive indicators of well being for children ages five through nine:

- Have **stable medical homes**. The American Academy of Pediatrics defines a medical home as the provision of care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. The medical

²³ U.S. Department of Health & Human Services, Administration for Children, Youth and Families, Children's Bureau. *Child Maltreatment*, 2003.

²⁴ GA Department of Human Resources, Division of Family & Children Services. *Protective Services Data System Annual Report, 2004*.

²⁵ *Bully B'ware*. Bully B'ware Productions Coquitlam, British Columbia, Canada: 2004. www.bullybeware.com/moreinfo.html#eight

²⁶ Bell, A.J., Rosen, L.A., Dynlacht, D. *Truancy intervention*. The Journal of Research and Development in Education, 1994, 57(3): 203–211.; Dryfoos, J.G. *Adolescents at risk: Prevalence and prevention*. New York, NY: Oxford University Press, 1990.

Huizinga, D., Loeber, R., Thornberry, T. *Urban delinquency and substance abuse: Initial findings*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 1995.

http://www.ncjrs.org/html/ojjdp/jjbul2001_9_1/page1.html

²⁷ Robins, L.N., Ratcliff, K.S. *Long-range outcomes associated with school truancy*. Washington, DC: U. S. Public Health Service, 1978. http://www.ncjrs.org/html/ojjdp/jjbul2001_9_1/page1.html

home implies joint accountability between the physician and the family. Providing a medical home means addressing the medical and non-medical needs of the child and family. For the primary care physician, this role may involve identifying and making referrals to community, state, and federally funded resources that will benefit the child and family.²⁸

- Have **health insurance coverage** that emphasizes decreasing barriers;
 - including decreasing racial and cultural barriers,
 - locating children not covered by insurance or without medical homes,
 - conducting outreach to faith communities,
 - using linguistically and culturally appropriate outreach approaches, and
 - assisting in enrollment in Medicaid or PeachCare.
- Attend a school that has a **coordinated school health program**.
- Have **access to a medical home** with accessible hours that are convenient for working parents.
- Have **accessible dental homes** that provide treatment for oral and dental problems, dental screenings, and on-schedule fluoridation and teeth cleaning.
- Have at least two **well child health checks** during ages five through nine, with close attention given to body mass index, nutrition, and physical activity practices.
- Receive needed **age-appropriate mental health/behavioral health services**.
- Receive **integrated health and social services and case management** through an expanded Children 1st model.
- Are in schools that provide **healthy food options**, daily recess and **physical education**.
- Are in schools that follow and enforce **USDA nutritional guidelines**.
- Attend school and after-school program sites that are monitored to assure **buildings meet recommended standards** for humidity, mold, ventilation, indoor air quality, allergens such as cockroaches, dust mites and classroom animals, and dust control, to reduce asthma incidence.
- Use size/age appropriate **motor vehicle child restraints** (booster seats/seatbelts).
- No exposure to **second hand tobacco smoke**.
- Have appropriate education and parent-set limits on **media exposure**.
- Are safe per the recommendations of the **Georgia Child Fatality Review Panel**.

²⁸ American Academy of Pediatrics, <http://www.aap.org/advocacy/mmchlhom.htm>

III. KEY MIDDLE CHILDHOOD EFFORTS ADDRESSED BY OTHER ORGANIZATIONS AND OTHER STATES

Most published health planning documents do not list key efforts needed for middle childhood well being. However, a few plans do, including those developed by the Los Angeles County Health Department, Brown University, and the State of Florida. These plans include information confirming the findings of this review, and Georgia's health initiatives for children.

Several of the health concern areas presented previously are confirmed in the Los Angeles County Health Department's (LACHD) plan as keys to health in middle childhood. LACHD's plan focuses on obesity prevention; physical fitness; asthma prevention, management, and treatment; access to health insurance and medical care; and tobacco use prevention.

Brown University produced a paper addressing health and safety for middle childhood identifying the need for further research. Entitled *Key Indicators of Health and Safety: Infancy, Pre-School and Middle Childhood*, it reports: "In middle childhood as children near adolescence, risk-taking behaviors (sexuality and use of tobacco, alcohol, and other illicit drugs) and community risks (domestic violence, adult unemployment, under-resourced schools, and minority status discrimination) are key determinants of adolescent adaptation and transition to adult roles (higher education, employment, family formation)."²⁹

*The Health of Florida's Children and Youth*³⁰ report outlines major public health efforts for elementary school children, which are similar to Georgia's initiatives. They include:

- After-school facility health care provision
- Asthma management
- Child abuse and neglect prevention
- Child health insurance and services for children with special health care needs and their families
- Oral/dental health care and education
- Health care for elementary age children with special needs
- Motor vehicle and booster seat safety
- Nutrition and physical activity
- Playground and pedestrian safety
- Coordinated school health services

²⁹ Key Indicators of Health and Safety: Infancy, Pre-School and Middle Childhood, Brown University, 2003. http://www.pstc.brown.edu/disability/docs/key_indicators_paper.pdf

³⁰ Zervigon-Hakes, A. *The health of Florida's children & youth: Atlas of key status indicators, goals and objectives for strategic planning*. Tampa, FL.: University of South Florida, The Lawton and Rhea Childes Center for Healthy Mothers and Babies, 2002. <http://www.doh.state.fl.us/family/childhealth/childreport/goals/goal1/youths.html>

IV. PREVENTION ACTIVITIES THAT SUPPORT A HEALTHY MIDDLE CHILDHOOD

A review of the literature and programs found several prevention activities particularly important for children who are ages 5 to 9:

- Support “assets-based” attitudes and actions toward children by teachers, parents, and program leaders. (Through research, the “assets approach” identifies concrete, common sense, positive experiences, and qualities essential to raising successful young people. These assets have the power during critical middle childhood years to influence choices young people make and help them become caring, responsible adults.) Also, research by The Search Institute,³¹ and national youth development expert Michael Carerra, M.D.,³² and others finds this assets-based approach plus supportive adults are associated with delaying sexual activity and other risk-taking when children reach adolescence. An assets-based approach in middle childhood has been shown to delay sexual risk-taking and subsequent parenting in adolescence, according to the Robin Hood Foundation.³³
- Efforts to help each child connect with school emotionally, to be physically healthy and able to learn, and to succeed educationally are keys to preventing school drop out.³⁴ Since high absenteeism and grade failure are among the strongest predictors of dropout, these efforts are essential to children’s current and future well being.
- *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*³⁵ is the accepted standard in health supervision and well child health recommendations, as developed by the U.S. Department of Health and Human Services. It recommends the provision of well child developmental screenings at ages six, eight, and ten.
- *Bright Futures* recommends that each child have a secure medical home in which mutual responsibility and trust develops between the service provider, the child, and caregivers. Medical homes, as defined by the American Academy of Pediatrics, provide care that is accessible, continuous, family-centered, comprehensive, coordinated, and compassionate. This model should also be followed for defining the best practice for establishment of dental homes.
- Safe, well-supervised after-school and out-of-school-time activities offer a child a sense of connection and provides a safe place for children with working parents. After-school and out-of-school-time activities are important to child well being and healthy social, emotional, and physical development.
- The Division of Adolescent and School Health at CDC provides a model approach to Coordinated School Health Programs. The implementation of school health programs nationwide could be one of the most efficient strategies that a nation might use to prevent major health and social problems.³⁶
- An evidence-based and comprehensive approach to injury prevention is needed. Unintentional and intentional injuries such as child abuse, neglect, and suicide should be included.

³¹ *Developmental assets in middle childhood*. Minneapolis, MN: The Search Institute, 2004. <http://www.search-institute.org/assets/>

³² Carerra, M. Dr. *Michael Carerra has a dream*. Milledgeville, GA: www.stopteenpregnancy.com/news/news_unionrecord.html

³³ Ibid.

³⁴ Newman, L. *The relationship between social activities and school performance for secondary students with learning disabilities. Findings from the national longitudinal transition study of special education students*. Paper presented at the Annual Meeting of the American Educational Research Association, 1991.

³⁵ Green, M., Palfrey, J.S., eds. *Bright futures: Guidelines for health supervision of infants, children, and adolescents (2nd ed., rev.)*. Arlington, VA: National Center for Education in Maternal and Child Health, 2002.

³⁶ Kolbe LJ, Collins J, Cortese P. Building the capacity of schools to improve the health of the nation: A call for assistance from psychologists. *American Psychologist*. 1997;52(3):1-10.

- Overweight, obesity, and diabetes prevention programs that promote increased physical activity and appropriate nutrition.
- Universal first, third, and fifth grade screening and follow-up treatment assure early identification of vision and hearing conditions that can affect a child's ability to succeed in school.
- Oral health screening and associated follow-up treatment or referral during the middle childhood years, in addition to the screening required upon school entry, identifies oral health problems that affect school absenteeism and a child's readiness and ability to learn.
- Immunization catch-ups for children new to Georgia, or otherwise late on immunizations, are needed to prevent vaccine-preventable diseases.
- Community supports to prevent child abuse and neglect have been found to be effective in keeping many children safe in their homes and reduce foster care placements. Additionally, studies have documented that community supports result in a reduction in the amount of time spent in foster care and better outcomes for children when they are returned to their homes.³⁷
- In 2004, the Georgia Legislature passed a booster seat law that requires booster seats for five-year-olds. Georgia joins 22 other states that have passed booster seat laws in an effort to keep children safe while traveling in motor vehicles.

³⁷ *In-Depth: Program for children*. New York, NY: Edna McConnell Clark Foundation, 2001-2004.
<http://www.emcf.org/programs/children/indepth/>

V. AREAS FOR ASSESSMENT

The most significant contribution of this report is its suggested areas for assessment to improve health in middle childhood. These should be reviewed for recommendations for future actions by experts in the field of middle childhood, lay people, parents, academicians, staff of public health and child welfare agencies, other service providers, business leaders, community organizations, and planning groups.

The areas for assessment presented below address two broad areas and a specialty area:

- A. Health concerns
- B. Systems issues
- C. Children with special needs

Some of the areas for assessment may lead to recommendations that are relatively inexpensive to implement; others will be costly. Current Georgia fiscal conditions and the benefits of prevention must be considered in determining future priorities.

A. HEALTH CONCERNS

The major health concerns of middle childhood identified in this report are:

1. Asthma
2. Overweight and Obesity
3. Oral and Dental Health
4. Mental Health

The following provides details on each of the major health concerns:

1. Asthma

The following information is provided by the CDC as an assessment of asthma prevention in Georgia:

Asthma Case Management. During CDC's annual site visit to the DHR asthma program, the CDC Project Officer recommended increased emphasis on asthma case management. In particular, the Project Officer suggested that Georgia should expand the number of children with an Asthma Case Manager. Further, the Project Officer wrote, "Caregivers, parents, and patients should be educated about recognizing triggers, signs, and symptoms, and exacerbations of asthma. Parents should be educated on reducing triggers in the home. Schools should focus on becoming a vital part of the asthma management team."³⁸ The Division of Public Health responded by developing case management education that teaches, "Through case management, families interface frequently with the case manager, develop goals, ensure a medical home, review the asthma treatment plan, demonstrate the use of asthma treatment tools, and receive answers to questions about the disease. The trust that is built between the case manager and patient/family leads to the possibility of more compliance with asthma therapy, reduced fear, and knowing what constitutes an emergency for the asthmatic."³⁹

Asthma and School Health Services. Schools, after-school programs, and other sites should consider their ability to adopt asthma action plans for students with asthma, and consider how they can educate staff, parents, and students.

³⁸ Ibid.

³⁹ Kuestler, Sarah, CDC Annual site visit, 2004.

Asthma and the Environment. The report *The Burden of Asthma in Georgia, 2003* indicated that significant reductions in asthma symptoms and related school absenteeism could be realized by implementing the following recommendations:

- Georgia school buildings and other public and private sites where children gather should have heating, ventilation, and air conditioning (HVAC) units sized, maintained, and retrofitted to meet standards for relative humidity (not to exceed 50 percent) and adequate ventilation for healthier indoor air exchange.⁴⁰ Each school and after-school program site should be monitored to meet standards for humidity, ventilation, indoor air quality, mold, allergens such as cockroaches, dust mites, and classroom animals, and dust control.
- Each classroom and other rooms where children gather (i.e., cafeterias, auditoriums) could benefit from a hygrometer that teachers and students can use to monitor the relative humidity and note fluctuations during the day. When relative humidity exceeds 50 percent, the school should take immediate action to lower the level.
- Buildings should be designed, renovated, and repaired to avoid fumes, mold, mildew, inadequate dust control, use of mercury-based thermometers, other irritants, and inadequate maintenance. Smoking and perfume bans on school property should be enforced.⁴¹

Indoor Air Quality. Schools should evaluate their capacity to:

- Conduct tests for radon gas (a naturally occurring carcinogen that is the second leading cause of lung cancer).
- Incorporate integrated pest management to reduce pesticide exposure.
- Modify practices that allow diesel fumes from buses and other equipment to enter buildings.
- Implement EPA's Indoor Air Quality (IAQ) Action Plan⁴² discussed at <http://www.epa.gov/iaq/> to monitor indoor air problems and take actions that ameliorate them.

2. Overweight and Obesity

The *Georgia's Nutrition and Physical Activity Plan to Prevent Obesity and Other Chronic Diseases, 2005-2015* sets out the following recommendations for statewide efforts for families, communities, schools, local governments, and health care. Overweight and obesity prevention requires a comprehensive approach from a variety of sectors using education, policy, and environmental strategies, including the following:

Families.

- Work with families to provide them with information and parenting skills to improve healthy eating and increase physical activity in the home.
- Provide support services so families will feel empowered to make positive changes in their diets and physical activities.
- Encourage families to be active and enjoy family meals together more often.

⁴⁰ Atiles, J.H., *Indoor Air Quality Guide for School Nurses*. Athens, GA: University of Georgia Cooperative Extension Service, 2004.

⁴¹ Ibid.

⁴² *IAQ Action Plan*. Washington, D.C.: Environmental Protection Agency, 2004. <http://www.epa.gov/iaq/>

Communities.

- Provide opportunities for healthy eating and physical activity in existing and new community-based programs involving public and private partners, including youth based organizations.
- Improve family access to healthy food choices such as fruits and vegetables through supermarkets, community gardens and farmers markets.
- Develop community-wide campaigns to promote healthy eating and physical activity as the norm in the community.
- Implement walk/bike to school initiatives year-round in collaboration with school districts and other community partners.

Local Governments.

- Expand and promote opportunities for physical activity in the community through changes in ordinances, capital improvement programs, and other planning practices.
- Ensure that children and youth have safe routes to walk and bike to school.

Schools.

- Educate lawmakers about the importance and the return on investment for physical activity, comprehensive nutrition, and physical education in schools, grades K-12.
- Conduct BMI screening as scheduled for children in grades K-12.
- Conduct an assessment of the school nutrition and physical policies and environment using the School Healthy Index.
- Improve the nutritional quality of competitive foods and beverages served and sold in schools and as part of school-related activities.
- Increase opportunities for frequent, more intensive and engaging physical activity during and after school.
- Implement school-based interventions to reduce the amount of time children spend doing sedentary activities such as viewing television, playing videos, and using a computer.
- Develop, implement and evaluate innovative programs for both staffing and teaching about wellness, healthy eating and physical activity.
- Develop and implement a local wellness policy based on the Child Nutrition Reauthorization Act.

Health care.

- Routinely track Body Mass Index (BMI) and offer appropriate counseling and guidance to children and their families.⁴³

3. Oral and Dental Health

Tooth decay is the single most common chronic childhood disease and is five times more common than asthma.⁴⁴ Since oral health problems are frequent causes of school absenteeism in Georgia, it is essential that DPH, the Department of Education (DOE), private dentists and dental professionals, and others work together to provide preventive care and treatment for all of Georgia's children.

⁴³ Georgia Department of Human Resources, Division of Public Health. Georgia's Nutrition and Physical Activity Plan to Prevent and Control Obesity and Chronic Diseases in Georgia, July 2005. Publication Number: DPH05/048HW
<http://health.state.ga.us/programs/nutrition/publications.asp>

⁴⁴ U.S. Department of Health and Human Services. *Oral health in America*. A report of the Surgeon General, Rockville, MD: National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000.

The dental and medical public/private providers should assess the unavailability of dental homes for children age five through nine. These providers should also assess how they can collaborate to assure a medical and dental home for all middle childhood children.

4. Mental Health

Mental health is a critical component of learning and general health. Many children have mental health problems that interfere with normal development and functioning.

Services. Consider the need to increase availability of age-appropriate mental health/behavioral health services in all areas of the state.

Screenings. Promote mental health screening services for children and parents. Education. Access availability of school health education classes, health education activities and material, and media campaigns to explain mental health conditions to reduce stigma. Access availability of education for children in middle childhood, their families, and teachers about mental health and wellness in order to improve early identification, screening and facilitate help-seeking behaviors as these children enter their teenage years.

B. SYSTEMS CONCERNS

There is a wide range of systems concerns that impact children in middle childhood. It is recommended that each be assessed for enhancement. They are:

- School-based health services
- Assets development
- Out-of-School-Time
- Anticipatory guidance
- Medical and Dental Homes
- Media safety and literacy
- Injury prevention
- Immigrant services

The following provides detail on each of these systems concerns:

School-Based Health Services. Coordinated school-based health services managed by licensed professional school nurses have been found to be effective in meeting the needs of students with asthma and other conditions for safe, continuous, and coordinated care in a protected environment.

Assets Development. Continue to assess the need for and ability to continue training youth development professionals, teachers, and other adults to promote healthy social and emotional development through the *Nurturing Assets, Producing Achievements, Building Accomplishments*⁴⁵ training program. This program helps adults learn the positive assets approach to serving children and youth.

Out-of-School-Time. Stay updated on the progress of DHR's collaboration with the Georgia Afterschool Investment Council (formerly Georgia Partnership for Youth Investment), which is working to assure children have quality and affordable after-school programs. Promote after

⁴⁵ *Nurturing Assets, Producing Achievements, Building Accomplishments* training program. Atlanta: Georgia Department of Human Resources, Division of Public Health, Office of Adolescent Health and Youth Development with The Institute on Human Development and Disability at the University of Georgia, 2002.

school, out-of-school-time programs. This work supports the Georgia Afterschool Investment Council goals that Georgia's children are healthy, safe, connected, educated, and employable.

Anticipatory Guidance. Continue to expand the use of *Bright Futures* by medical professionals, so they can use best practices in health supervision and anticipatory guidance with parents and children.

Medical and Dental Homes.

- Assess the availability of medical and dental homes for children in middle childhood, and Georgia's ability to develop additional medical and dental homes where needed.
- Assess access to affordable, ongoing care, including Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT), which is called Health Check in Georgia.

Media Safety and Health Literacy.

- Assess the ability of parents, industry, government, and schools to promote media safety and media literacy for children and adults to reduce early sexualization and childhood exposure to violence.
- Assess children's exposure to media and its impact on physical activity, safety, and ability of children to play with each other.

Injury Prevention.

- Assess Georgia's progress in use of motor vehicle child restraints (booster seats), pedestrian safety, bicycle safety, firearm safety, and drowning safety.
- Falls and other unintended injuries are second to asthma as causes of hospitalization, according to Children's Healthcare of Atlanta. Surveillance of fall injuries is not sufficient to permit appropriate intervention programming. There is no surveillance of falls and unintended injuries occurring at school or at school events, revealing a research gap. Public Health should propose and adopt a definition of "falls" and work with schools to collect and report data on falls and other unintentional injuries
- Determine if parents are properly informed that a seat belt is not an effective restraint for a child under a height of four feet, nine inches, and that seat belts are designed to fit adults, not children. Determine if current practice follows the recommendation that booster seats are the appropriate transition from child restraints with harnesses, to vehicle lap and shoulder belts for children between 30 and 100 pounds.

Immigrant Services.

There is a need to assess the availability of culturally appropriate services in education, mental health, physical health, after-school care, asset development, and social services for Georgia's immigrant population, which is rapidly expanding. Children in this age group may be subjected to additional stressors related to prejudices in the community, language barriers, and assimilation into a new culture.

C. SPECIAL POPULATIONS

Children with Special Health Care Needs

Children with special health care needs are those with chronic, physical, developmental, behavioral, or emotional conditions who generally spend more days sick in bed, miss more school days, are hospitalized more, and have more unmet health needs than other children.⁴⁶ "While children with special health care needs require the same basic primary preventive health care services that all children need, they also require access to pediatric specialists and tertiary

⁴⁶ The American Pediatric Association, *Pediatrics*, Volume 102, July 1998.

care providers who understand child development. In addition, their families often need family support services, including respite care; nutritional counseling; special education; and related habilitative and rehabilitative services.⁴⁷

The prevalence of children with special needs in Georgia is 12.7 percent of all children, similar to the 12.8 percent in the United States as a whole.⁴⁸

The major groupings for child disability are:

- Attention Deficit/Hyperactivity Disorder
- Autism and Pervasive Developmental Disorder: Autism, Rett's Syndrome, Childhood Disintegrative Disorder, Asperger's Syndrome, and Pervasive Development Disorder Not Otherwise Specified
- Cerebral Palsy
- Cystic Fibrosis
- Epilepsy
- Down Syndrome
- Mental Health Disorders, Severe Emotional Disability
- Mental Retardation
- Osteogenesis Imperfecta
- Reading and Learning Disabilities, especially Dyslexia
- Sensory Impairments, including hearing and vision disabilities
- Spina Bifida
- Traumatic Brain Injury

Children with special needs require special attention from medical and educational systems. Prescription medicines are used by almost 79 percent of these children, 39.3 percent use medical services more than other children, almost 25 percent have emotional and developmental problems, 22.6 percent cannot participate in all activities, and 13.5 percent require physical and/or speech therapies.⁴⁹

Children in Foster Care

According to the Georgia Department of Human Resources, Division of Families and Children Services (DFCS), the number of children in foster care increased by 44 percent from 1987 to 1995. In 1999, the rate was 13.4 per 1,000 children.

The chart below presents the special characteristics of Georgia's foster children ages five through nine years. The following are the salient features:

- As of June 2003, there were 5,197 children ages five through nine in foster care in Georgia. Most of these children had experienced more than one removal from home. Neglect, parental drug abuse, physical abuse, inadequate housing, and parental inability to cope were the most frequently occurring reasons for removal from the home.
- Children in foster care often have multiple difficulties, instability in their homes and special medical and/or mental conditions. About 20 percent of children ages five through nine (1,030) in foster care had a diagnosed disability.

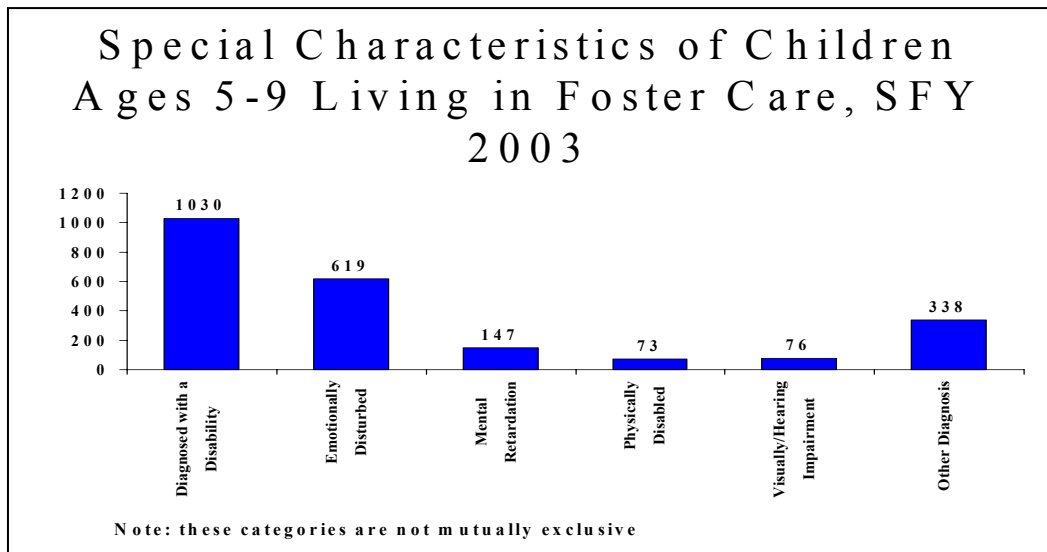
⁴⁷ Ibid. *The Health of Florida's Children and Youth*, p.35.

⁴⁸ *Children with Special Health Care Needs Survey* Georgia Department of Human Resources, Division of Public Health, 2002.

⁴⁹ Ibid.

- According to DFCS, 30 to 85 percent of foster children have a chronic medical condition, 25 percent have at least 3 chronic medical conditions, 35 to 50 percent have significant emotional and behavioral health problems, and more than half have developmental disabilities or delays.
- There are 1,030 children who have been diagnosed with a disability and 619 who are considered emotionally disturbed.
- Over 41 percent of the children were in state custody because of physical abuse, and over one-fourth had been sexually abused.

Table #5



VI. ACCESS TO AND USE OF HEALTH CARE SYSTEM

This section provides information about departments with authority and responsibility for child health in Georgia and information about uninsured children, PeachCare and Medicaid, dental and oral health, Health Check, medical homes, school-based health services, and culturally and linguistically competent health care services.

A. DEPARTMENTS WITH AUTHORITY AND RESPONSIBILITY FOR CHILD HEALTH IN GEORGIA

Georgia statutes provide four departments with significant authority and responsibility for the health of middle childhood-aged children. As with other states, there are also others, e.g., the Department of Juvenile Justice and the Judicial Branch that may serve a small number of five through nine year-olds. Each of the four departments with significant authority and responsibility is divided into several divisions, responsible for different aspects of child health, as follows:

Georgia Department of Human Resources (DHR). This department is responsible for the delivery of health and social services. It is the umbrella organization that includes four divisions, Aging Services; Public Health: Mental Health, Developmental disabilities, and Addictive Diseases (MHDDAD); and Family and Children Services (DFCS). The Division of Aging Services administers a statewide system of services for senior citizens, their families and caregivers. The Division of Public Health and its county health departments provide planning and programs that include Well-Child Services, Children with Special Health Care Needs, Women's Health, Oral Health, Immunizations, Adolescent Health and Youth Development, Injury Prevention, Nutrition, Women, Infants and Children's Supplemental Nutrition Program, School Health, Vital Statistics and Epidemiology. The Division of Mental Health, Developmental Disabilities, and Addictive Diseases and its regional offices provide contact points and services for people who need treatment for mental illness and substance abuse, and support for people with mental retardation. The Division of Family and Children Services and its county offices include the Office of Child Support Enforcement (OCSE), Child Protection Services, Adoptions, Right from the Start Medicaid and PeachCare Enrollment. DFCS is responsible for welfare and employment support, protecting children, foster care and other services to strengthen families. <http://www.dhr.georgia.gov>

Georgia Department of Community Health (DCH). This department has responsibility for PeachCare/Medicaid and Planning, Policy Development and Administration for eligible children and families. <http://dch.georgia.gov>

Georgia Department of Education (DOE). This department provides mandated education Kindergarten through fifth grade, including Special Education, School Health, and School Nutrition. <http://www.doe.k12.ga.us/index.asp>

Georgia Department of Early Care and Learning (DECAL). This department provides Pre-Kindergarten programs, Daycare Regulation and After School Care. <http://www.dec.state.ga.us>

B. UNINSURED CHILDREN

According to a 2001 report by the U.S. Census Bureau, about 11.5 percent of children in the United States, ages six to eleven were uninsured.⁵⁰ This compares to 77,017, or 12 percent of all 583,491 children ages six to ten in Georgia.⁵¹ Children who are poor or who belong to a population group other than white non-Hispanic are least likely to have health insurance, and therefore least likely to have access to and to use health services. These disparities are addressed throughout this report.

Of the children who have health care coverage, many are covered by Medicaid (40 percent) or PeachCare for Kids (13 percent) at some point during the year, and others may be covered by their parents' employer plans or other private plans (67 percent). (The percentage totals greater than 100 percent, due to multiple reporting sources and reporting period overlaps.)

Non-insured working parents, whose employers do not offer group policies, unemployed parents, homeless families, illegal immigrants, and others in vulnerable situations, rely on emergency rooms for their children's primary health care - a costly, "non-medical home" approach.⁵²

Georgia's PeachCare for Kids (S-CHIP) and Medicaid programs serve Georgia's low-income children and youth. DCH works with a wide range of health care providers and organizations to ensure that eligible children and youth receive appropriate services. These providers include private physicians, local health departments, schools, nurse practitioners, dentists, health educators, nutritionists, laboratories, community clinics, nonprofit health agencies, social, and community service agencies.

Georgia works toward providing children and youth with care to reduce unmet health needs. Through the PeachCare for Kids, Medicaid, private healthcare, and free healthcare programs, eligible children and youth receive periodic preventive health assessments (Health Checks). Children with suspected problems are referred for diagnosis and treatment. Many health problems can be prevented or corrected, or the severity reduced, by early detection, prompt diagnosis, and treatment.

DHR, through DPH, DFCS (Right from the Start Medicaid, Foster Care) and other programs provides outreach to assure all eligible children and families are enrolled, receive well child check-ups, and are provided needed health services.

C. DENTAL AND ORAL HEALTH

Dental professional shortages are a significant concern for all ages, as there are 39 Georgia whole counties plus 23 additional partial (population groups) counties that were designated by the Georgia State Office of Rural Health Services in 2003,⁵³ as Health Professional Shortage Areas. Twenty-three counties were designated as low-income population access areas. This means these counties have a shortage of dental health care professionals including dentists, hygienists, and dental auxiliaries (assistants, etc.) and have high proportions of low-income children.

⁵⁰ *Children without health insurance for the entire year by age, race, and ethnicity in 1999 and 2000*. U.S. Census Bureau. Washington, DC: U.S. Bureau of the Census, 2001, Table 4. www.census.gov/hhes/hlthins/hltin00/dtable4.html

⁵¹ *Children's health insurance status Medicaid/SCHIP eligibility and enrollment characteristics of Medicaid-enrolled and uninsured children*. Chicago: American Academy of Pediatrics; Division of Health Policy Research, 2003. <http://www.aap.org/research/2003cps.pdf>

⁵² DCH-DSS Analysis Unit. Atlanta, GA.: Dataprobe CY2001-2002, Ages 6-10 Data Source OASIS, Georgia Department of Human Resources, Office of Health Information and Policy, 2004.

⁵³ *Health professional shortage areas*. Atlanta, GA: Georgia State Office of Rural Health Services, Primary Care Office, 2003.

D. HEALTH CHECK, MEDICAL HOMES, SCHOOL-BASED HEALTH SERVICES

Health Check (EPSDT)

Well child check-ups are recommended at least twice between ages five through nine, per *Bright Futures*. These routine check-ups ensure early identification of health conditions and concerns. For example, with overweight and obesity striking children as young as age four, using BMI test results provides an opportunity for counseling parents about nutrition and physical activity.

Medical Homes

The National Center of Medical Home Initiatives for Children with Special Needs of the American Academy of Pediatrics addressed the topic of medical homes in its 2003 report, saying, "A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care that they need from a pediatrician or physician whom they know and trust. Pediatric health care professionals and parents act as partners in a medical home. Together they identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential."⁵⁴ Further, *The Health of Florida Youth* reports, "Not all families can access a medical home or the providers they may need. Non-English speakers, families without health insurance, mobile families, homeless families, rural families, and children with special health care needs are populations at risk for inability to access providers and services. Specialized providers and hospitals, which are often located in urban areas, are not readily accessible for rural families."⁵⁵

School-Based Health Services

The Georgia Partnership for School Health (formerly Georgia's Coalition for Comprehensive School Health Programs), affirms that "often the school nurse is the only health care provider the child sees for health care, that there are 2.5 million visits to the school nurse for medications, and 3.8 million visits to the school nurse for health problems." The Partnership reports that Georgia has 1,143 school nurses, 795 of whom are Registered Nurses and 348 are Licensed Practical Nurses.⁵⁶

Georgia's school health programs are key contributors to oral health/dental, vision, hearing, and scoliosis screening, as well as health education. However, they are typically unable to provide physical and mental health services as a part of a comprehensive, integrated approach to addressing barriers to student learning and enhancing healthy development. In Georgia, there is a comprehensive school-based health center located in an elementary school and middle school. Currently state funding is not available for these programs.

E. ISSUE: CULTURALLY AND LINGUISTICALLY COMPETENT HEALTH CARE SERVICES

Georgia has recently experienced significant growth in Hispanic and Asian populations and the health care access challenges such growth creates. Outreach, provision of health services, and provision of educational materials in the languages of patient populations are a challenge.

⁵⁴ "What is a medical home?" National Center of Medical Home Initiatives for Children with Special Needs, Chicago, IL: American Academy of Pediatrics, 2003. <http://www.medicalhomeinfo.org/>

⁵⁵ Zervigon-Hakes A. *The health of Florida's children & youth: Atlas of key status indicators, goals and objectives for strategic planning*. Tampa, FL.: University of South Florida, The Lawton and Rhea Childs Center for Healthy Mothers and Babies. 2002.

⁵⁶ Georgia Association of School Nurses, Atlanta, GA: <http://www.gasn.org/files/homeport.cfm?id=1&linkid=100&playlink=yes>

VII. NEXT STEPS

DPH has a three-pronged approach to improving health and systems gaps. These include assessment, introduction of evidence-based policy development and intervention programs, and evaluation. This literature review begins the assessment process for middle childhood.

This review confirms that there is a need to establish widely accepted health and system indicators and benchmarks for children ages five through nine. Examples of significant health and systems concerns include overweight, obesity, physical activity, mental health, and the availability of medical and dental care appropriate for diverse populations. It is also important to develop methodologies to help understand health-related reasons for school absenteeism, as currently these are not collected or classified.

Stakeholders and policy makers may use this review of the health status of middle childhood to begin discussions and set strategic directions for Georgia's youth.

A stakeholders' meeting will be convened in May 2006. During this meeting stakeholders will review the health and system issues of middle childhood, and begin the dialogue about important next steps.

REFERENCES AND SOURCE DOCUMENTS

Assets and Risk Avoidance

Developmental assets in middle childhood. Minneapolis, MN: The Search Institute, 2004. <http://www.search-institute.org/assets> Identifies forty concrete, common sense, positive experiences, and qualities essential to raising successful young people. These assets have the power during critical middle childhood years to influence choices young people make and help them become caring, responsible adults.

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Children with Special Needs

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40 Developmental Assets™ for Elementary-Age Children



Search Institute™ has identified the following building blocks of healthy development that help elementary-age children grow up healthy, caring, and responsible.

Category	Asset Name and Definition
External Assets	Support <ol style="list-style-type: none"> 1. Family Support-Family life provides high levels of love and support. 2. Positive Family Communication-Parents and children communicate positively. Children are willing to seek advice and counsel from their parents. 3. Other Adult Relationships-Children have support from at least one adult other than their parents. Their parents have support from people outside the home. 4. Caring Neighborhood-Children experience caring neighbors. 5. Caring Out-Of-Home Climate-School and other activities provide caring, encouraging environments for children. 6. Parent Involvement in Out-of-Home Situations- Parents are actively involved in helping children succeed in school and in other situations outside the home.
	Empowerment <ol style="list-style-type: none"> 7. Community Values Children-Children feel that the family and community value and appreciate children. 8. Children are Given Useful Roles-Children are included in age-appropriate family tasks and decisions and are given useful roles at home and in the community. 9. Service to Others-Children serve others in the community with their family or in other settings. 10. Safety- Children are safe at home, at school, and in the neighborhood.
	Boundaries & Expectations <ol style="list-style-type: none"> 11. Family Boundaries-The family has clear rules and consequences and monitors children's activities and whereabouts. 12. Out-of-Home Boundaries-Schools and other out-of-home environments provide clear rules and consequences. 13. Neighborhood Boundaries-Neighbors take responsibility for monitoring children's behavior. 14. Adult Role Models-Parents and other adults model positive, responsible behavior. 15. Positive Peer Observation-Children interact with other children who model responsible behavior and have opportunities to play and interact in safe, well-supervised settings. 16. Appropriate Expectations for Growth-Adults have realistic expectations for children's development at this age. Parents, caregivers, and other adults encourage children to achieve and develop their unique talents.
	Constructive Use of Time <ol style="list-style-type: none"> 17. Creative Activities-Children participate in music, art, drama, or other creative activities for at least three hours a week at home and elsewhere. 18. Out-of-Home Activities-Children spend one hour or more each week in extracurricular school activities or structured community programs. 19. Religious Community-The family attends religious programs or services for at least one hour per week. 20. Positive, Supervised Time at Home-Children spend most evenings and weekends at home with their parents in predictable, enjoyable routines.

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Internal Assets	Commitment to Learning	<p>21. Achievement Expectation and Motivation-Children are motivated to do well in school and other activities.</p> <p>22. Children are Engaged in Learning-Children are responsive, attentive, and actively engaged in learning.</p> <p>23. Stimulating Activity-Parents and teachers encourage children to explore and engage in stimulating activities. Children do homework when it's assigned.</p> <p>24. Enjoyment of Learning and Bonding with School-Children enjoy learning and care about their school.</p> <p>25. Reading for Pleasure-Children and an adult read together for at least 30 minutes a day. Children also enjoy reading or looking at books or magazines on their own.</p>
	Positive Values	<p>26. Caring-Children are encouraged to help other people.</p> <p>27. Equality and Social Justice- Children begin to show interest in making the community a better place.</p> <p>28. Integrity-Children begin to act on their convictions and stand up for their beliefs.</p> <p>29. Honesty-Children begin to value honesty and act accordingly.</p> <p>30. Responsibility-Children begin to accept and take personal responsibility for age-appropriate tasks.</p> <p>31. Healthy Lifestyle and Sexual Attitudes-Children begin to value good health habits and learn healthy sexual attitudes and beliefs as well as respect for others.</p>
	Social Competencies	<p>32. Planning and Decision Making Practice-Children begin to learn how to plan ahead and make choices at appropriate developmental levels.</p> <p>33. Interpersonal Skills-Children interact with adults and children and can make friends. Children express and articulate feelings in appropriate ways and empathize with others.</p> <p>34. Cultural Competence-Children know about and are comfortable with people of different cultural, racial, and/or ethnic backgrounds.</p> <p>35. Resistance Skills-Children start developing the ability to resist negative peer pressure and dangerous situations.</p> <p>36. Peaceful Conflict Resolution -Children try to resolve conflicts nonviolently.</p>
	Positive Identity	<p>37. Personal Power-Children begin to feel they have control over things that happen to them. They begin to manage frustrations and challenges in ways that have positive results for themselves and others.</p> <p>38. Self-Esteem-Children report having high self-esteem.</p> <p>39. Sense of Purpose-Children report that their lives have purpose and actively engage their skills.</p> <p>40. Positive View of Personal Future-Children are hopeful and positive about their personal future.</p>

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