2004 Rhode Island Kids Count Factbook

Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action. Funding for Rhode Island KIDS COUNT is provided by The Rhode Island Foundation, The Annie E. Casey Foundation, Prince Charitable Trusts, United Way of Rhode Island, Ewing Marion Kauffman Foundation, The Robert Wood Johnson Foundation, The David and Lucile Packard Foundation, Ford Foundation, CVS Charitable Trust, Hasbro Charitable Trust, and other corporate, foundation and individual sponsors.

The annual *Rhode Island KIDS COUNT Factbook* is one of fifty state-level projects designed to provide a detailed community-by-community picture of the condition of children. A national Factbook with comparable data for the U.S. is produced annually by The Annie E. Casey Foundation.

Additional copies of the *2004 Rhode Island KIDS COUNT Factbook* are available for $15.00 per copy. Reduced rates are available for bulk orders. To receive copies of the *2004 Factbook*, please contact:

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2004 Rhode Island KIDS COUNT Factbook

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Table of Contents

**New Indicator*

Overview

Give Me Your Name!

Give me your name, and I will...
whisper it into the forests,
spell it out in the sands,
I'll shout it over the thunder,
breathe it away on the wind.
I'll spill it over the mountains,
let it echo through the rain;
I'll sing it into a seashell,
if you give me your name.

by Judith Nicholls

The *2004 Rhode Island KIDS COUNT Factbook* is the tenth annual profile of the well-being of children in Rhode Island. The annual Factbook is an important tool for planning and action by community leaders, policy makers, advocates, and others working toward changes that will improve the quality of life for all children.

The annual Factbook tracks progress across five areas of child well-being. All areas of child well-being are interrelated and critical throughout a child's development. A child's safety in his family and community affects his school performance; a child's economic security affects her health and education. The *2004 Rhode Island KIDS COUNT Factbook* reflects these interrelationships and builds a framework to guide policy, programs for children, and individual service on behalf of children.

The *2004 Rhode Island KIDS COUNT Factbook* provides a statistical portrait of the status of Rhode Island's children. Information is presented for the state of Rhode Island, each city and town, and an aggregate of the six cities in which more than 15% of the children live in poverty. These cities — referred to as the core cities in the Factbook — are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The Factbook provides community-level information on each indicator in order to emphasize the significance of the surrounding physical, social, and economic environment in shaping outcomes for children. Communities and neighborhoods do matter - the actions of community leaders, parents, individuals, businesses, government leaders, and elected officials greatly influence children's chances for success and the challenges they will face.

By examining the best available data statewide and in Rhode Island's 39 cities and towns, Rhode Island KIDS COUNT provides an information base that can result in more effective policy and community action on behalf of children. Tracking changes in selected indicators can help communities to set priorities, identify strategies to reverse negative trends, and monitor progress.

The *2004 Rhode Island KIDS COUNT Factbook* examines fifty-four indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. Two new indicators are included in this edition of the Factbook. The most current and reliable data available are presented for each indicator.

Family Economic Security

Children most at risk of not achieving their full potential are children in poverty. Despite overall economic growth in the past decade, many Rhode Island families have experienced income losses since the late 1980s. The child poverty rate has increased from 14% in 1990 to 17% in 2000. Nearly half of Rhode Island's 40,177 poor children live in extreme poverty - with a family income less than $9,330 (half of the federal poverty level of $18,660 for a family of four). Even those with incomes above the official poverty level have a difficult time meeting the high costs of housing, utilities, child care, and health care. Child care subsidies, health insurance, affordable housing, and tax policies that support working families are critical tools to ensure the economic well-being of Rhode Island families.

Educational Attainment

Improving student achievement and high school graduation rates in Rhode Island requires that all sectors work together to provide opportunities for infants, young children, and teens in the state's high poverty neighborhoods. Children who participate in high-quality preschool programs and read at grade level by fourth grade are more likely to complete high school. Student achievement can be improved when schools have high expectations for all students, effective curricula and teaching methods, adequate accountability methods, and prepared and sufficiently supported teachers. Young people who complete high school prepared to go on to higher education or to enter the workforce are more likely to be capable adults who contribute to the community.

Results for All Children

Significant racial and ethnic disparities in child outcomes continue to exist in Rhode Island. Black, Hispanic, Asian and Native American children are three times more likely than White, non-Hispanic children to be poor and more likely to live in Rhode Island's poorest urban neighborhoods. Strategic efforts that engage diverse leadership can ensure that all Rhode Island children have the resources they need to thrive, including economic security, effective schools, quality child care, quality health care, affordable housing, and caring communities.

Family and Community

Knoxville, Tennessee

I always like summer
best
you can eat fresh corn
from daddy's garden
and okra
and greens
and cabbage
and lots of
barbecue
and buttermilk
and homemade ice-cream
at the church picnic
and listen to
gospel music
outside
at the church
homecoming
and go to the mountains with
your grandmother
and go barefooted
and be warm
all the time
not only when you go to bed
and sleep

by Nikki Giovanni

Child Population

DEFINITION

Child population is the total number of children under age 18 and the percentage change between 1990 and 2000 in the total number of children under age 18.

SIGNIFICANCE

In 2000, the number of family households with children under age 18 in Rhode Island was 124,867, comprising almost a third (31%) of all Rhode Island households.[1] According to the decennial census of April 2000, there were 1,048,319 Rhode Island residents. Of these, 24% or 247,822 were children under age 18.

The number of U.S. children recorded by Census 2000 was the largest in history at 72.3 million.[2] This represents a substantial increase in the child population over the decade of the 1990s. Children now make up 26% of the U.S. population.[3]

In general, children in Rhode Island at the start of the 21st century are older and more ethnically diverse than those children living in the state in the previous decade. The largest increase in any age category between 1990 and 2000 was in the number of children in early adolescence (ages 10 to 14). The number of Rhode Island children between the ages of 10 and 14 increased by 20% in the decade, increasing from 59,406 to 71,370.[4] In contrast, the number of children under age 5 living in Rhode Island dropped by nearly 5%, decreasing from 66,969 in 1990 to 63,896 in 2000.[5]

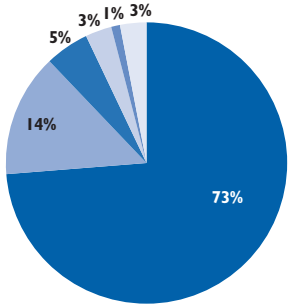
Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. Nationally, and in Rhode Island, the increase in the child population was led by minority children.[6] In Rhode Island, the number of White, non-Hispanic children declined over the decade of the 1990s by nearly 9,000 children, while the number of minority children increased by 31,000 to nearly 68,000.[7]

Many of Rhode Island's children speak languages other than English and may face language barriers. In 2000, 4,372 children ages 5 to 17 spoke English less than "well," while 11,484 lived in a linguistically-isolated household, meaning that no one in the household over the age of 13 speaks English "very well." According to the 2000 Census, 23,615 Rhode Island children spoke Spanish at home.[8]

Rhode Island's Children, 2000

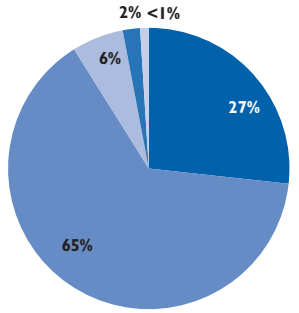
By Race/Ethnicity*

73%	White
14%	Hispanic
5%	African American
3%	Asian and Pacific Islander
1%	Some Other Race
3%	Two or More Races



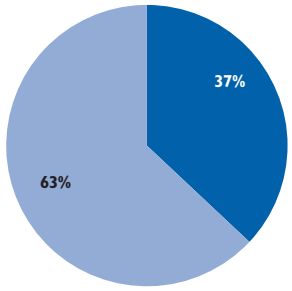
By Family Structure

27%	Single Parent Families**
65%	Married Couple Families**
6%	Other Relatives
2%	Unrelated Individuals
<1%	Group Quarters



By Residence

37%	Core Cities***
63%	Remainder of State



n = 247,822

**Hispanics are not included in any other racial group. Two or more races was not possible as a selection in the 1990 census.*

***Includes only children who are related to the head of household by birth or adoption.*

****According to Census 2000, there are now six core cities in Rhode Island, i.e., communities in which 15% or more of the children live in families with income below the federal poverty level. There are 91,945 children who live in one of the six core cities: Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.*

Source: U.S. Census Bureau, Census 2000.

Child Population

Child Population, Rhode Island, 1990 and 2000

Table 1.

CITY/TOWN	1990 TOTAL POPULATION UNDER AGE 18	2000 TOTAL POPULATION UNDER AGE 18	CHANGE IN POPULATION UNDER AGE 18	% CHANGE IN POPULATION UNDER AGE 18
Barrington	3,912	4,745	833	21%
Bristol	4,380	4,399	19	0%
Burrillville	4,479	4,043	-436	-10%
Central Falls	4,810	5,531	721	15%
Charlestown	1,575	1,712	137	9%
Coventry	7,626	8,389	763	10%
Cranston	14,673	17,098	2,425	17%
Cumberland	6,427	7,690	1,263	20%
East Greenwich	2,913	3,564	651	22%
East Providence	10,657	10,546	-111	-1%
Exeter	1,521	1,589	68	5%
Foster	1,185	1,105	-80	-7%
Glocester	2,526	2,664	138	6%
Hopkinton	1,839	2,011	172	9%
Jamestown	1,123	1,238	115	10%
Johnston	5,332	5,906	574	11%
Lincoln	3,890	5,157	1,267	33%
Little Compton	750	780	30	4%
Middletown	4,676	4,328	-348	-7%
Narragansett	2,869	2,833	-36	-1%
New Shoreham	163	185	22	14%
Newport	5,756	5,199	-557	-10%
North Kingstown	6,076	6,848	772	13%
North Providence	5,655	5,936	281	5%
North Smithfield	2,332	2,379	47	2%
Pawtucket	16,719	18,151	1,432	9%
Portsmouth	4,175	4,329	154	4%
Providence	37,972	45,277	7,305	19%
Richmond	1,565	2,014	449	29%
Scituate	2,426	2,635	209	9%
Smithfield	3,898	4,019	121	3%
South Kingstown	4,770	6,284	1,514	32%
Tiverton	3,166	3,367	201	6%
Warren	2,452	2,454	2	0%
Warwick	18,322	18,780	458	3%
West Greenwich	915	1,444	529	58%
West Warwick	6,560	6,632	72	1%
Westerly	4,988	5,406	418	8%
Woonsocket	10,617	11,155	538	5%
Core Cities	*82,434*	*91,945*	*9,511*	*12%*
Remainder of State	*143,256*	*155,877*	*12,621*	*9%*
Rhode Island	*225,690*	*247,822*	*22,132*	*10%*

Source of Data for Table/Methodology

U.S. Census Bureau, 1990 Census of the Population and Census 2000, Summary File 1.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1] U.S. Bureau of the Census, Census 2000, Summary File 1.

[2,6,7] O'Hare, W. (June 2001). *The Child Population: First Data from the 2000 Census.* Baltimore, MD: The Annie E. Casey Foundation and The Population Reference Bureau.

[3] *America's Children: Key National Indicators of Well-Being 2003.* (2003). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[4,5] U.S. Bureau of the Census, 1990 Census of Population and Census 2000.

[8] U.S. Bureau of the Census, Census 2000, Summary File 3 and Summary File 4.

Children in Single-Parent Families

DEFINITION

Children in single-parent families is the percentage of children under age 18 who live in families headed by a person – male or female – without a spouse present in the home. These numbers include own children defined as never-married children under age 18 who are related to the family head by birth, marriage, or adoption.

SIGNIFICANCE

Children living in single-parent families are at increased risk of living in poverty compared to children living in two-parent families. In 2002, 33% of single-parent families with children under age 18 were living below the poverty level compared to only 5% of married-couple families.[1] Of the 67,978 Rhode Island children who lived in single-parent families in 2000, 83% lived in households headed by a female.[2]

Most of the 247,822 children in Rhode Island live in family households (92%). The remainder live with other relatives (6%), other unrelated individuals (2%), or in group quarters, including juvenile detention facilities, hospitals and group homes (less than 1%).[3]

Following the national trend, more Rhode Island children are growing up in single-parent households than at any time since the census began collecting information on household living arrangements. In 1970, only 12% of children in Rhode Island lived in single-parent families, compared to 23% in 1990 and 30% in 2000.[4]

Of all Rhode Island children living with at least one biological or adoptive parent, 70% lived in married-couple families and the remaining 30% (67,978) lived in single-parent families.[5] White children and Asian children are far more likely to live in married-couple families than are Black, Hispanic and Native American children.[6] The core cities, those with child poverty rates higher than 15%, continue to have the highest rates of children living in single-parent families.[7]

Single-Parent Families

	1990	2000
RI	23%	29%
US	24%	28%
National Rank*		*32nd*
New England Rank**		*6th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *KIDS COUNT DATA BOOK: State Profiles of Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

Single-Father Families

◆ In 2000, 11,514 Rhode Island children lived in single-father families. This represents 5% of all children under age 18 in the state and 17% of all children in single-parent families. In 29% of single-father families with their own children, all children were under age six.[8]

◆ 67% of Rhode Island children living in single-father families in 2000 were White, 17% were Hispanic, 8% were Black, and 3% were Asian.[9]

◆ The median family income for single fathers in Rhode Island in 1999 was significantly higher than the median income for single mothers ($29,776 versus $17,252), but far lower than the income of a married-couple family with children ($63,706).[10]

◆ In comparison to poor families headed by single mothers, single-father-headed families in poverty were less likely to receive SSI or public assistance. In 1999, in the U.S. 27% of poor single father-headed families received SSI or public assistance, versus 50% of poor single mother-headed families.[11]

◆ Children in single-parent families are at higher risk for poor outcomes than are children living in households headed by two-parents in a low-conflict marriage.[12]

Table 2.

Children's Living Arrangements, Rhode Island, 2000

CITY/TOWN	ALL CHILDREN LIVING IN FAMILY HOUSEHOLDS	NUMBER OF CHILDREN UNDER 18 YEARS			
		TWO-PARENT FAMILIES		SINGLE-PARENT FAMILIES	
		N	%	N	%
Barrington	4,592	4,091	89%	501	11%
Bristol	4,092	3,222	79%	870	21%
Burrillville	3,737	3,077	82%	660	18%
Central Falls	4,977	2,607	52%	2,370	48%
Charlestown	1,586	1,305	82%	281	18%
Coventry	7,807	6,287	81%	1,520	19%
Cranston	15,626	11,817	76%	3,809	24%
Cumberland	7,273	6,049	83%	1,224	17%
East Greenwich	3,476	3,042	88%	434	12%
East Providence	9,682	6,919	71%	2,763	29%
Exeter	1,461	1,248	85%	213	15%
Foster	1,037	914	88%	123	12%
Glocester	2,453	2,082	85%	371	15%
Hopkinton	1,893	1,576	83%	317	17%
Jamestown	1,194	1,018	85%	176	15%
Johnston	5,440	4,303	79%	1,137	21%
Lincoln	4,895	3,930	80%	965	20%
Little Compton	740	627	85%	113	15%
Middletown	4,150	3,363	81%	787	19%
Narragansett	2,641	2,002	76%	639	24%
New Shoreham	171	139	81%	32	19%
Newport	4,835	2,723	56%	2,112	44%
North Kingstown	6,546	5,255	80%	1,291	20%
North Providence	5,411	3,973	73%	1,438	27%
North Smithfield	2,221	1,922	87%	299	13%
Pawtucket	16,525	9,537	58%	6,988	42%
Portsmouth	4,136	3,476	84%	660	16%
Providence	40,267	19,721	49%	20,546	51%
Richmond	1,867	1,590	85%	277	15%
Scituate	2,490	2,179	88%	311	12%
Smithfield	3,800	3,184	84%	616	16%
South Kingstown	5,887	4,789	81%	1,098	19%
Tiverton	3,121	2,598	83%	523	17%
Warren	2,288	1,657	72%	631	28%
Warwick	17,276	13,571	79%	3,705	21%
West Greenwich	1,368	1,198	88%	170	12%
West Warwick	6,084	4,101	67%	1,983	33%
Westerly	5,077	3,759	74%	1,318	26%
Woonsocket	10,269	5,562	54%	4,707	46%
Core Cities	*82,957*	*44,251*	*53%*	*38,706*	*47%*
Remainder of State	*145,434*	*116,162*	*80%*	*29,272*	*20%*
Rhode Island	*228,391*	*160,413*	*70%*	*67,978*	*30%*

Note to Table

The denominator is the number of children under age 18 living in family households according to the census. A family household is defined by the U.S. Census Bureau as consisting of a householder and one or more people living together in the same household who are related to the householder by birth, marriage or adoption - it may also include others not related to the householder.

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population and Census 2000. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1] U.S. Bureau of the Census, Current Population Survey, 2001 to 2003 average.

[2,3,4,5,7] U.S. Bureau of the Census, Census 2000, Summary File One.

[6] Census Data Online, http:// www.aecf.org/kidscount/census. (January 2001). Baltimore, MD: The Annie E. Casey Foundation.

[8,10,11] U.S. Bureau of the Census, Census 2000, Summary File Three.

[9] U.S. Bureau of the Census, Census 2000, Summary File Four.

[12] Anderson Moore, K., et al. (June 2002). *Marriage from a Child's Perspective: How Does Family Structure Affect Children, and What Can We Do About It?* Washington, DC: Child Trends.

Grandparents Caring for Grandchildren

DEFINITION

Grandparents caring for grandchildren is defined by the U.S. Census Bureau as a grandparent who is financially responsible for food, shelter, clothing, day care, etc. for any or all grandchildren under 18 years old living in the household.

SIGNIFICANCE

Grandparents can provide continuity and family support for children in vulnerable families. Children may be in grandparent care because they have a parent who is unemployed, abusive, neglectful, incarcerated, ill, or has a substance abuse problem.[1]

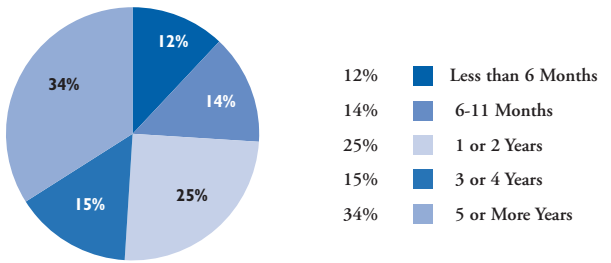
Grandparent caregivers are at risk of living in poverty since many have fixed incomes. In fact, grandparent caregivers are more likely to live in poverty than other grandparents.[2]

Often, grandparent caregivers do not receive the support or services that they need and for which they are eligible. Nearly all grandparent caregivers are eligible for either foster care payments or child-only Temporary Assistance for Needy Families (TANF) payments, as well as Medicaid for the children in their care, but few receive this assistance.[3] In 1999 in the U.S., 29% of children in grandparent care received foster care or TANF payments and 47% received Medicaid.[4]

Grandparent caregivers are at risk for poor physical and mental health.[5] They may face legal barriers when enrolling children in school, or when seeking health insurance or medical care for the children.[6] Grandparents make up the largest percentage of relative caregivers, but other relative caregivers, including aunts, uncles, cousins, and siblings, may face similar obstacles.[7]

The majority of children in relative care are in private care, meaning that they have not been involved with a child welfare agency. For this reason, relative caregivers receive less training, information, and supervision than licensed non-kin foster parents.[8] Studies indicate that kinship caregivers are more likely to be poor, single, older, and have less education than non-kin foster parents.[9] Therefore, kinship caregivers may require more services than non-kin foster parents. Children in relative care are less likely to obtain permanent status such as adoption or guardianship; many relatives do not receive guidance on these issues.[10]

Rhode Island Grandparents Financially Responsible for Their Grandchildren, by Length of Time Responsible, 2000



n = 5,060

Source: U.S. Census Bureau, Census 2000.

◆ In Rhode Island, the 5,060 grandparents financially responsible for their grandchildren make up 4% of all family households with children. Nationwide, grandparents financially responsible for their grandchildren make up 7% of family households with children.[11]

◆ Nearly half (49%) of Rhode Island grandparents who are financially responsible for their grandchildren have been responsible for the children for three or more years.[12]

◆ Grandparent caregivers account for 30% of grandparents living with their grandchildren in Rhode Island. In 2000, there were 16,957 grandparents living in households with their grandchildren under the age of 18. This is 14% of all family households with children in the state. Nationwide, grandparents living with grandchildren make up 17% of family households with children.[13]

◆ Rhode Island regulations state that the Department of Children, Youth and Families must give priority to kin when placing a child in out-of-home care.[14] In April 2002, 21% of Rhode Island's children in out-of-home placements were with kin.[15] This is the highest percentage of kinship placements in New England.[16]

Table 3.

Grandparents Caring for Grandchildren, Rhode Island, 2000

CITY/TOWN	TOTAL FAMILY HOUSEHOLDS WITH CHILDREN UNDER AGE 18	GRANDPARENTS IN HOUSEHOLDS WITH THEIR GRANDCHILDREN UNDER AGE 18		GRANDPARENTS FINANCIALLY RESPONSIBLE FOR GRANDCHILDREN UNDER AGE 18	
		NUMBER	% OF ALL HOUSEHOLDS WITH CHILDREN	NUMBER	% OF ALL HOUSEHOLDS WITH CHILDREN
Barrington	2,421	176	7%	59	2%
Bristol	2,345	373	16%	88	4%
Burriville	2,037	175	9%	53	3%
Central Falls	2,607	313	12%	81	3%
Charlestown	899	126	14%	49	5%
Coventry	4,375	569	13%	89	2%
Cranston	8,873	1,283	14%	386	4%
Cumberland	4,049	614	15%	149	4%
East Greenwich	1,796	72	4%	27	2%
East Providence	5,562	839	15%	189	3%
Exeter	792	135	17%	79	10%
Foster	553	79	14%	0	0%
Glocester	1,351	115	9%	20	1%
Hopkinton	1,043	124	12%	29	3%
Jamestown	667	66	10%	0	0%
Johnston	3,113	491	16%	165	5%
Lincoln	2,691	333	12%	71	3%
Little Compton	409	29	7%	0	0%
Middletown	2,300	178	8%	54	2%
Narregansett	1,506	206	14%	69	5%
New Shoreham	101	7	7%	2	2%
Newport	2,643	309	12%	137	5%
North Kingstown	3,630	305	8%	92	3%
North Providence	3,214	796	25%	195	6%
North Smithfield	1,226	258	21%	118	10%
Pawtucket	9,179	1,264	14%	317	3%
Portsmouth	2,225	211	9%	70	3%
Providence	20,174	3,322	16%	1,219	6%
Richmond	1,019	117	11%	44	4%
Scituate	1,367	172	13%	29	2%
Smithfield	2,133	349	16%	69	3%
South Kingstown	3,155	320	10%	95	3%
Tiverton	1,797	290	16%	109	6%
Warren	1,290	204	16%	75	6%
Warwick	9,731	1,389	14%	376	4%
West Greenwich	746	56	8%	0	0%
West Warwick	3,496	344	10%	71	2%
Westerly	2,790	268	10%	120	4%
Woonsocket	5,532	680	12%	265	5%
Core Cities	*43,631*	*6,232*	*14%*	*2,090*	*5%*
Remainder of State	*81,236*	*10,725*	*13%*	*2,970*	*4%*
Rhode Island	*124,867*	*16,957*	*14%*	*5,060*	*4%*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2000.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References

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[10] Child Welfare League of America web-site: www.cwla.org/programs/kinship/kinshipaboupage.htm (December 2003).

[11,12,13] U.S. Census Bureau, Census 2000, Summary File 3.

[14,15,16] *Grandparents and Other Relatives Raising Children.* (August 2002). Washington, DC: Children's Defense Fund.

Mother's Education Level

DEFINITION

Mother's education level is the percentage of total births to women with less than a high school diploma. Data are self-reported at the time of the infant's birth. Although a father's education level has a major impact on his child's development, this indicator uses mother's education level because a significant number of birth records lack information on father's education level.

SIGNIFICANCE

The level of parental educational attainment can affect many aspects of child well-being. Research shows that there are strong links between parental education levels and a child's school readiness, health in adolescence and the level of education that the child will ultimately achieve.[1] Higher education levels of parents have been shown to contribute to a more supportive home learning environment for children.[2]

Children of parents with higher education levels are much less likely to grow up in economically-disadvantaged households. In the US in 2001, people without a high school diploma earned two-thirds of the earnings of a high school graduate, and one-third of the earnings of an individual with a bachelor's degree.[3]

Children of immigrants and children of color are least likely to have parents with high educational levels.[4,5] Higher educational attainment increases earnings across all racial and ethnic categories.[6]

Rhode Island has education levels nearly equal to U.S. averages but lags behind other New England states on almost all levels of educational attainment. Compared to the other New England states, Rhode Island has the highest percentage of residents without a high school diploma.[7] There are currently 153,086 adults 25 years and older in Rhode Island with less than a high school diploma.[8] Of these adults, 37% have less than a 9th grade education.[9]

Of the 9,260 Rhode Island children born to mothers with less than a high school diploma between 1998 and 2002, 100 were to teen mothers under the age of 15 and 1,675 were to mothers from 15 to 17 years old.[10] Teen mothers are far less likely to complete high school than teenage women who did not give birth.[11]

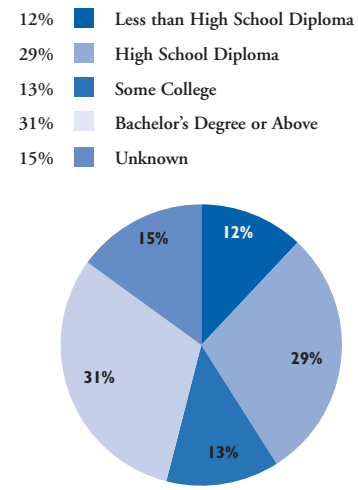
Percent of Total Births to Mothers with Less than 12 Years of Education

	1990	2001
RI	19%	15%
US	24%	22%
National Rank*		*17th*
New England Rank**		*6th*

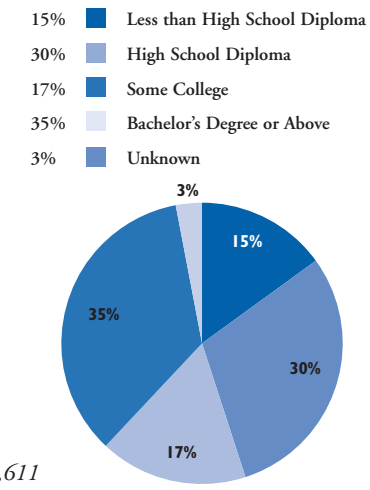
**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *The Right Start for America's Newborns: City and State Trends.* (January 2004). Baltimore, MD: The Annie E. Casey Foundation.

Births by Paternal Education Level, Rhode Island, 1998-2002



Births by Maternal Education Level, Rhode Island, 1998-2002



n = 62,611

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1998-2002 average. Data for 2001 and 2002 are provisional.

◆ In Rhode Island between 1998 and 2002, 12% of infants were born to fathers without a high school diploma, and 15% were born to mothers without a high school diploma.[12]

Adult Education and Literacy in Rhode Island

◆ According to a study of literacy in New England, Rhode Island has the highest percentage of residents below basic literacy standards. Almost one in five (19%) Rhode Islanders read at the lowest literacy level.[13,14]

◆ Adults with the lowest literacy levels are more likely to live in poverty, be unemployed or be underemployed. Children of adults who participate in literacy programs improve their grades and test scores, improve their reading skills, and are less likely to drop out of school.[15]

Births by Education Level of Mother, Rhode Island, 1998-2002

Table 4.

CITY/TOWN	ALL BIRTHS	BACHELOR'S DEGREE OR ABOVE		SOME COLLEGE		HIGH SCHOOL DIPLOMA		LESS THAN HIGH SCHOOL DIPLOMA	
		N	%	N	%	N	%	N	%
Barrington	825	644	78%	98	12%	67	8%	6	<1%
Bristol	1,069	477	45%	214	20%	292	27%	75	7%
Burrillville	795	279	35%	169	21%	257	32%	62	8%
Central Falls	1,795	149	8%	219	12%	650	36%	701	39%
Charlestown	456	185	41%	118	26%	107	24%	37	8%
Coventry	2,004	852	43%	398	20%	603	30%	135	7%
Cranston	4,209	1,835	44%	829	20%	1,129	27%	350	8%
Cumberland	1,744	934	54%	327	19%	359	21%	91	5%
East Greenwich	582	401	69%	80	14%	80	14%	17	3%
East Providence	2,452	831	34%	474	19%	839	34%	266	11%
Exeter	339	177	52%	50	15%	82	24%	27	8%
Foster	195	87	45%	40	21%	57	29%	8	4%
Glocester	467	205	44%	119	26%	108	23%	29	6%
Hopkinton	458	174	38%	91	20%	165	36%	21	5%
Jamestown	206	157	76%	19	9%	20	10%	5	2%
Johnston	1,500	600	40%	301	20%	460	31%	119	8%
Lincoln	974	481	49%	185	19%	216	22%	59	6%
Little Compton	176	117	67%	26	15%	26	15%	4	2%
Middletown	1,077	475	44%	251	23%	298	28%	50	5%
Narragansett	618	368	60%	99	16%	106	17%	32	5%
New Shoreham	56	30	54%	15	27%	9	16%	1	2%
Newport	1,609	572	36%	289	18%	441	27%	296	18%
North Kingstown	1,525	923	61%	229	15%	273	18%	71	5%
North Providence	1,571	601	38%	345	22%	471	30%	126	8%
North Smithfield	521	272	52%	84	16%	122	23%	28	5%
Pawtucket	5,119	1,010	20%	918	18%	1,887	37%	1,148	22%
Portsmouth	906	527	58%	171	19%	174	19%	27	3%
Providence	13,980	2,927	21%	1,809	13%	4,834	35%	3,722	27%
Richmond	491	232	47%	98	20%	130	27%	25	5%
Scituate	488	252	52%	93	19%	114	23%	25	5%
Smithfield	801	450	56%	156	20%	163	20%	18	2%
South Kingstown	1,286	806	63%	179	14%	203	16%	77	6%
Tiverton	670	281	42%	182	27%	167	25%	39	6%
Warren	568	227	40%	133	23%	147	26%	54	10%
Warwick	4,402	1,834	42%	887	20%	1,330	30%	303	7%
West Greenwich	302	174	58%	50	17%	67	22%	9	3%
West Warwick	2,028	525	26%	378	19%	793	39%	308	15%
Westerly	1,321	420	32%	299	23%	442	34%	146	11%
Woonsocket	3,024	371	12%	468	16%	1,214	40%	742	25%
Core Cities	*27,555*	*5,554*	*20%*	*4,081*	*15%*	*9,819*	*36%*	*6,917*	*25%*
Remainder of State	*35,054*	*16,308*	*47%*	*6,809*	*19%*	*9,083*	*26%*	*2,342*	*7%*
Rhode Island	*62,609*	*21,862*	*35%*	*10,890*	*17%*	*18,902*	*30%*	*9,259*	*15%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1998-2002. Data for 2001-2002 are provisional. Data are self-reported and reported by the mother's place of residence, not the place of the infant's birth. Data may not include all births among Rhode Island residents that occurred out of state.

Note that for 1,696 births between 1998 – 2002, the education level of the mother was unknown and for 2 births the place of residence was unknown.

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Racial and Ethnic Diversity

DEFINITION

Racial and ethnic diversity is the number of children under age 18 by racial and ethnic categories as defined by the U.S. Census Bureau for the 2000 U.S. Census of the Population. For children living in households, racial and ethnic categories are chosen by the head of household or person completing the census form.

SIGNIFICANCE

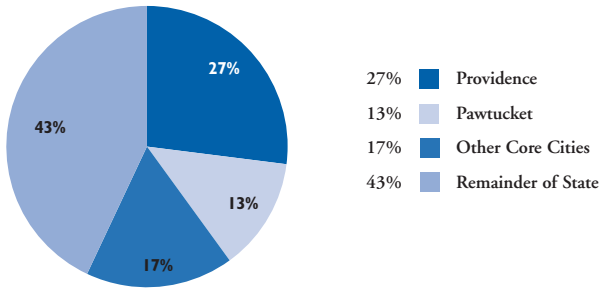
Racial and ethnic diversity has increased significantly in the United States over the last several decades. Diversity is projected to continue to rise in the future.[1] Nationally, minority children (all those except White, non-Hispanic children) accounted for 98% of the growth in the child population during the 1990s.[2] In 1980, nearly three quarters (74%) of all U.S. children under age 18 were White, non-Hispanic. This number has dropped to less than two-thirds (64%) in 2000. By 2020, slightly more than half (55%) of all children in the United States are projected to be White, non-Hispanic.[3]

In Rhode Island, 73% of children in the state were White, non-Hispanic in 2000, compared to 84% in 1990.[4,5] The number of children of color nearly doubled from 36,867 in 1990 to nearly 67,747 in 2000. The number of White, non-Hispanic children dropped by 8,748 during the same time period.[6,7] Minority children are highly concentrated in the core cities. More than half (58%) of the 91,945 children living in the core cities are minority children. More than three-quarters (78%) of all minority children in Rhode Island live in these six communities.[8]

Immigrant children are also more likely to live in one of the core cities. There are 30,176 households in Rhode Island headed by immigrant parents of children under age 18.[9] Compared to children born in the U.S., children in immigrant families are more likely to live in two-parent working households but more likely to be poor and have health problems. In addition, their families are less able to access community resources including extracurricular activities, food, health, mental health and housing assistance in times of need.[10]

Diversity presents opportunities and challenges to schools, child care centers, health care providers, social service agencies and other community service providers. Programs will need to adapt their current practices to meet the needs of a changing population.[11]

Multiracial Children in Rhode Island, By Residence



n = 8,149

Source: U.S. Census Bureau, Census 2000

◆ Multiracial children are concentrated in Rhode Island's urban core. More than one-quarter (27%) of the state's multiracial children live in Providence and 30% live in the other five core cities, while 43% live in the remainder of Rhode Island's communities.[12]

◆ Multiracial children are defined here as "two or more races" according to the U.S Census Bureau. "Two or more races" refers to the combination of two or more of the following race categories: White, Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, or some other race.[13]

◆ In 2000, 8,149 Rhode Island children were identified in Census 2000 as being of two or more races. This equals 3% of the state's child population.[12] Nationwide, 4% of children were identified as two or more races.[14]

◆ In the U.S., multiracial individuals are more mobile than the general population. In 1999, 52% of multiracial individuals lived in a different house than in 1995, in contrast to 42% of all individuals.[15]

Table 5.

Child Population, by Race and Ethnicity, Rhode Island, 2000

CITY/TOWN	UNDER AGE 18 BY RACE AND ETHNICITY								2000 POPULATION UNDER AGE 18
	HISPANIC OR LATINO	WHITE	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN AND ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	SOME OTHER RACE	TWO OR MORE RACES	
Barrington	59	4,479	29	8	106	0	4	60	4,745
Bristol	88	4,183	30	3	21	4	3	67	4,399
Burrillville	59	3,915	11	8	6	0	11	33	4,043
Central Falls	3,122	1,574	292	29	22	0	225	267	5,531
Charlestown	38	1,597	7	26	12	0	1	31	1,712
Coventry	151	7,975	47	8	46	2	10	150	8,389
Cranston	1,213	14,041	513	59	796	5	71	400	17,098
Cumberland	231	7,185	65	5	70	3	38	93	7,690
East Greenwich	59	3,308	30	1	106	0	11	49	3,564
East Providence	360	8,366	681	48	114	4	323	650	10,546
Exeter	36	1,484	9	9	8	0	0	43	1,589
Foster	17	1,054	2	1	11	2	3	15	1,105
Glocester	31	2,573	15	2	10	0	1	32	2,664
Hopkinton	35	1,889	11	27	10	0	3	36	2,011
Jamestown	19	1,183	14	4	4	0	0	14	1,238
Johnston	203	5,425	63	9	93	1	21	91	5,906
Lincoln	151	4,694	73	2	116	1	21	99	5,157
Little Compton	12	756	1	0	2	0	0	9	780
Middletown	201	3,549	246	23	104	1	15	189	4,328
Narragansett	69	2,566	27	52	25	0	5	89	2,833
New Shoreham	3	175	3	0	3	0	0	1	185
Newport	602	3,485	555	86	55	7	51	358	5,199
North Kingstown	210	6,286	70	37	76	0	11	158	6,848
North Providence	377	5,033	208	12	122	3	48	133	5,936
North Smithfield	17	2,305	13	8	15	0	1	20	2,379
Pawtucket	3,820	10,090	1,776	53	131	7	1,251	1,023	18,151
Portsmouth	114	4,016	55	5	58	0	8	73	4,329
Providence	20,350	10,858	7,606	621	3,043	19	575	2,205	45,277
Richmond	32	1,916	7	19	8	0	0	32	2,014
Scituate	30	2,535	10	1	24	1	5	29	2,635
Smithfield	50	3,880	18	2	29	0	2	38	4,019
South Kingstown	128	5,561	87	126	169	0	19	194	6,284
Tiverton	46	3,234	15	4	18	0	8	42	3,367
Warren	36	2,294	38	4	11	1	6	64	2,454
Warwick	516	17,220	217	50	322	1	35	419	18,780
West Greenwich	13	1,396	4	3	7	0	5	16	1,444
West Warwick	384	5,792	86	29	102	3	26	210	6,632
Westerly	96	4,931	45	45	143	0	11	135	5,406
Woonsocket	2,024	7,272	606	29	591	5	46	582	11,155
Core Cities	*30,302*	*39,071*	*10,921*	*847*	*3,944*	*41*	*2,174*	*4,645*	*91,945*
Remainder of State	*4,700*	*141,004*	*2,664*	*611*	*2,665*	*29*	*700*	*3,504*	*155,877*
Rhode Island	*35,002*	*180,075*	*13,585*	*1,458*	*6,609*	*70*	*2,874*	*8,149*	*247,822*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2000 Redistricting File. All categories are mutually exclusive. If Hispanic was selected as ethnicity, individuals are not included in other racial categories. Likewise, if more than one race was selected, individuals are included in two or more races and not in their individual race categories.

The core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

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Racial and Ethnic Disparities

DEFINITION

Racial and ethnic disparities is the gap that exists in outcomes for children of different racial and ethnic groups in Rhode Island. Child well-being outcome areas include economic security, health, education, and safety.

SIGNIFICANCE

Rhode Island's children are diverse in race, ethnic background, language, and country of origin. During the 1990s, the percentage of children of color in Rhode Island increased from 16% to 27%, with a particularly large increase in the number of Hispanic children.[1] Although there have been substantial improvements in child well-being over the last century across racial and ethnic lines, large disparities still exist between White, non-Hispanic children and children from other racial and ethnic groups.

The growing diversity of Rhode Island's children is not evenly distributed. Increasingly, minority children are concentrated in core urban communities which also have increasingly high rates of child poverty.[2] More than three-quarters (78%) of Rhode Island's minority children live in one of the six core cities where child poverty rates are more than 15%.[3] Approximately three-quarters of the children in Providence (76%) and in Central Falls (72%) are of minority racial and ethnic backgrounds.[4] In several neighborhoods of Providence, minority children now comprise more than 90% of all children. These neighborhoods have some of the highest child poverty rates in the state.[5]

Research demonstrates a significant relationship between residence in low-income or poor neighborhoods and increased teen pregnancy and high school drop-out rates.[6] When compared with White, non-Hispanic children in poverty, Hispanic and Black children living in families with income below the poverty line are more likely to live in neighborhoods in which 40% or more of the residents live in poor families.[7] Rhode Island has the country's largest percentage of Hispanic children (79%) and fourth largest percentage of Black children (71%) living in neighborhoods in which more than 18% of persons are in poverty.[8]

The racial and ethnic segregation of U.S. neighborhoods has generally diminished over the past three decades. Yet, residential segregation for the child population has shown a less substantial decrease and has been countered by increased school segregation.[9] The Providence-Warwick-Fall River, MA metropolitan area was the second most segregated large metropolitan area in the nation for Hispanics in 2000, and was also the metropolitan area with the largest increase in segregation between 1980 and 2000.[10]

Rhode Island's Latino Children

◆ According to Census 2000, there were 35,002 Latino children living in Rhode Island. Three-quarters of the Latino children in Rhode Island live in Central Falls, Pawtucket, and Providence.[11]

Economics

◆ Among all 50 states, Rhode Island has the highest percentage of Latino children living in poverty, with a rate of 47% compared to the national rate of 28%.[12] Rhode Island Latinos have the lowest median family income of all Latinos in the United States.[13]

◆ Rhode Island has the country's highest percentage (63%) of female-headed Latino families living in poverty and the highest percentage (82%) of Latino children living in neighborhoods where more than 35% of families are female-headed households (no spouse present).[14]

Health

◆ In Rhode Island, 13% percent of Latino women who give birth receive delayed prenatal care, compared to 9% of all races.[15] Latino teens are nearly three times as likely to give birth between the ages 15 and 17 as non-Hispanic White teens (61.7 per 1,000 teen girls compared to 21.5 per 1,000 teen girls).[16]

Education

◆ Latinos in Rhode Island have lower educational attainment levels than the population overall. Only 66% of Latino youth graduate from high school compared to 81% of all youth in the state.[17] According to Census 2000, 9% of Latinos 25 years of age and over hold a bachelor's degree or higher, compared to 26% of all Rhode Islanders.[18]

Economic Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Children in Poverty	8%	47%	38%	26%	51%	17%
% Births to Mothers with < 12 years Education	14%	33%	22%	17%	34%	15%
% Children with All Parents in the Workforce	65%	49%	63%	54%	50%	62%
Median Household Income	$45,314	$22,851	$24,973	$36,473	$22,813	$42,090
Homeownership	71%	24%	33%	48%	34%	60%

Source: U.S. Census Bureau, Census 2000 with the exception of Maternal Education Levels from Rhode Island Department of Health, Maternal and Child Health Database, 1998-2002. All Census 2000 data refers to only those individuals who selected one race. Black, Asian and Native American categories include both those individuals who identified themselves as Hispanic and those who identified themselves as non-Hispanic.

◆ In 2000, there were 40,177 poor children in Rhode Island. Sixty-four percent of Rhode Island's poor children and 78% of the core cities' poor children are children of color. Rhode Island's child poverty rates for Hispanic and Asian children are significantly higher than the U.S. rates for these racial and ethnic groups.[19]

◆ Children living in single-parent families are much more likely to be poor. Native American, Black, and Hispanic children in Rhode Island are more than twice as likely to live in a single-parent family as their White counterparts. In 2000, in Rhode Island 53% of Native American children, 52% of Black children, 47% of Hispanic children, and 21% of White children, lived in single parent families.[20]

Health Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Women with Delayed Prenatal Care	8.0%	12.9%	15.8%	15.2%	17.2%	9.1%
Births to Teens Ages 15 – 17 (per 1,000 teens)	21.5	61.7	49.5	39.5	88.9	21.3
Infants Born Low Birthweight	6.9%	7.3%	11.8%	9.3%	10.7%	7.5%
Children Under Age 6 with High Lead Levels (>= 10ug/dL)	5%	10%	18%	12%	NA	7%

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database 1998-2002 (prenatal care, teen births, low birth-weight). Information based on self-reported race and ethnicity. Rhode Island Department of Health, Childhood Lead Poisoning Prevention Program based on highest lead test result during calendar year 2002. Data for Native American children not reported because only 27 children were tested.

◆ Although progress has been made on many health indicators, racial and ethnic disparities still exist for a number of child outcomes. Minority women are far more likely to have delayed prenatal care and are much more likely to give birth while still teenagers.[21]

◆ In 2002 in the United States, 8% of White children under 18 years of age were not covered by health insurance, as compared with 23% of Hispanic children, 14% of Black children, 12% of Asian children, and 23% of American Indian and Native Alaskan children.[22]

Racial and Ethnic Disparities

Safety Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Juveniles at the Training School (per 1,000)	2.7	7.0	14.9	NA	NA	4.3
Children of Incarcerated Parents (per 1,000)	10.4	25.5	93.4	NA	NA	16.6
Children in Out of Home Placement (per 1,000)	3.6	6.1	18.0	3.3	13.5	4.9

Source: *Juveniles in the Training School:* Rhode Island KIDS COUNT analysis of Rhode Island Department of Children Youth and Families, based on children who passed through the RITS between 1/1/03 – 12/31/03. *Children of Incarcerated Parents:* Rhode Island KIDS COUNT analysis of data from the Rhode Island Department of Justice, 2003. *Children in Out-of-Home Placement:* Rhode Island KIDS COUNT analysis of data from the Department of Children Youth and Families RICHIST Database from January 2002, January 2003, and January 2004. Out-of-Home Placement includes licensed and pending-license non-relative foster homes, licensed and pending-license relative foster homes, and private agency foster care. All denominators based on population under age 18 by race from Census 2000. Information not reported for Native American and Asian children because two years of data do not produce statistically significant rates.

◆ Racial and ethnic minority groups continue to be disproportionately represented in the child welfare and juvenile justice systems. Research shows that minority youth are treated more harshly than White, non-Hispanic youth for the same type and severity of offenses at every critical point in the justice system, from detention and formal processing in juvenile court, to sentencing and incarceration in juvenile and adult facilities.[23] In the U.S., Black youth adjudicated for drug offenses with no prior admissions were incarcerated 48 times as often as their White counterparts. Similarly, Latino youth adjudicated for violent offenses remained in state institutions for 150 days longer than White youth adjudicated for the same offenses.[24]

◆ Children of color comprise 33% of the child population in the United States and more than 55% of children in foster care. This disproportion most affects Black children, comprising 15% of the child population and 38% of children in foster care. Higher poverty rates among families of color contribute to this trend.[25] National data indicate that low-income families and families of color are more likely to have their child removed and placed in foster care.[26]

Education Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
% of Children Attending Schools In Need of Improvement						
Attending Schools Making Progress	10%	6%	10%	7%	12%	9%
Attending Schools With Insufficient Progress	28%	74%	62%	54%	43%	39%
4th Grade Children Meeting the Standard for Reading						
Basic Understanding	80%	45%	49%	66%	72%	70%
Analysis and Interpretation	68%	31%	36%	55%	59%	57%
High School Graduation Rate	85%	66%	71%	81%	62%	81%
% of Adults Over Age 25 with a Bachelor's Degree or Higher	27%	9%	17%	36%	14%	26%

Source: *Percentage Attending Schools In Need of Improvement:* Rhode Island KIDS COUNT analysis of Rhode Island Department of Elementary and Secondary Education, 2003 School Performance Classification. Denominator is school enrollment by race 2002 – 2003 school year. *4th Grade Reading Scores:* Rhode Island State Assessment Program, Report of Student Performance by Demographic Characteristics, State Report Grade 4, Spring 2003 Data. *High School Graduation Rate*: Rhode Island Department of Elementary and Secondary Education. Adult Educational Attainment: Census 2000.

◆ Currently in Rhode Island, Hispanic and Black children are twice as likely as White children, to attend schools in need of improvement based on 2003 school performance data.[27]

◆ In the 2000-2001 school year, Black, Hispanic, and Asian students were under-represented in special education placements.[28] Within the population of students in special education, however, Black and Hispanic children are disproportionately likely to be identified as mentally retarded and disproportionately unlikely to be identified as speech or hearing impaired or autistic.[29]

Immigrant Children

◆ In 2003, Rhode Island was home to 12,597 children under age 18 who were born outside the United States, 5% of all children in the state.[30] This represents an increase since 1998, when 4,888 immigrant children constituted 2% of Rhode Island's child population.[31] These numbers are likely to be an underestimate as immigrant children are among the most likely to be undercounted by population estimates.

◆ In 2003, 30,176 Rhode Island households with children under age 18 were headed by immigrants.[32] Children of immigrants are the fastest growing segment of the United States population under age 18.[33] Nationally, over half (52%) of all children of immigrants lived in families with incomes below 200% of the Federal Poverty threshold.[34]

◆ Children of immigrants living in two-parent working families are substantially more likely to be low-income than their native-born counterparts. Lower wages, not employment levels, account for most of this income disparity.[35] Children of immigrants are more likely than children of natives to: be in fair or poor health and lack health insurance; live in families with problems affording food but receive no food stamps; and live in crowded housing but receive no housing assistance.[36]

◆ In Rhode Island, the poverty rate for immigrants is 20% compared with a statewide rate of 12%.[37] Two out of three (62%) immigrants live in the core cities; of these, 82% live in Providence and Pawtucket.[38] Immigrants tend to live in poorer neighborhoods within these cities and to live in more crowded housing units.[39]

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Economic Well-Being

Give Me the Splendid Silent Sun

Give me the splendid silent sun with all its beams full-dazzling,
Give me the juicy autumnal fruit ripe and red from the orchard,
Give me a field where the unmowed grass grows,
Give me an arbor, give me the trellised grape.
Give me fresh corn and wheat, give me serene-moving animals
teaching content.
Give me nights perfectly quiet as on high plateaus west of the
Mississippi, and I am looking up at the stars,
Give me odorous at sunrise a garden of beautiful flowers where I
can walk undisturbed.

By Walt Whitman

Median Household Income

DEFINITION

Median household income is the median annual income for all Rhode Island households. The median income is the dollar amount which divides the income distribution into two equal groups – half with income above the median and half with income below the median.

SIGNIFICANCE

Median household income provides one measure of the ability of Rhode Island's families to meet the costs of food, clothing, housing, health care, transportation, child care, and higher education. According to Census 2000, one-half of all Rhode Island families with children under age 18 earned less than $50,557 and one-half earned more. The 1999 median income for all households in Rhode Island – including those without children – was $42,090.[1]

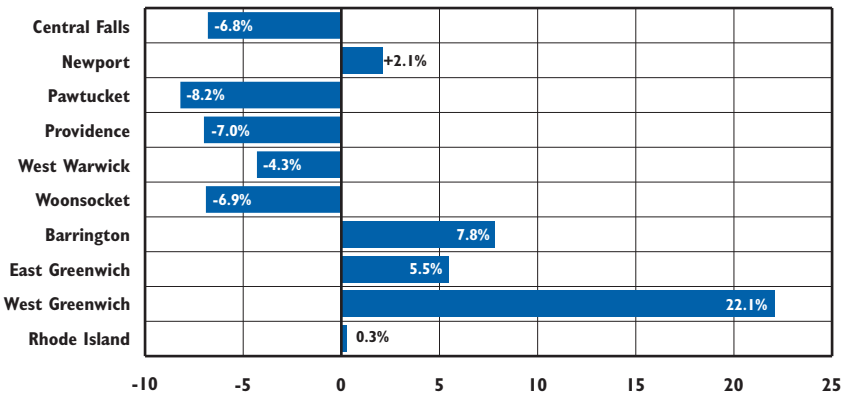
After reaching an all time high in 2000, the U.S. median household income has decreased for the second consecutive year. In 2002 the U.S. median household income fell from $42,909, or 1.1%, to $42,409.[2] The drop in the U.S. median income was concentrated among minorities. Median household income declined for all racial groups, except those identifying themselves as White or Asian only.[3,4] In 2002, the Rhode Island median household income decreased for all races.[5]

According to the Census Bureau there was no significant change in income inequality in both the U.S. and Rhode Island between 2001 and 2002.[6] However, between the 1980s and the 1990s Rhode Island was among the ten states where income inequality between the top and bottom of the income distribution grew most.[7]

Communities with above-average income inequality have higher mortality rates than communities with comparable incomes but lower inequality.[8] Increased income disparities lead to geographic segregation as wealthier families move to the suburbs. This can result in unequal school funding from property taxes.[9,10]

Due to the tight labor market and the increase in the minimum wage, very low-paid workers experienced slight wage increases in the late 1990s.[11] In 2001, the wage for a low-wage worker in Rhode Island (those in the bottom fifth of the wage scale) was $8.61.[12] Between 2001 and 2002 in the United States, the median earnings of men who worked full-time and year-round was $39,429, while the median earnings of women with comparable work experience was $30,203. Women still earn less than men at seventy-seven cents to the dollar.[13]

Change in Median Household Income, 1989 – 1999, Core Cities, Three Highest Income Communities, and Rhode Island



Source: U. S. Bureau of the Census, Census 2000. Percentage change is based on median household income for 1989 and 1999 adjusted to 1999 dollars.

◆ After adjusting for inflation, Rhode Island's highest income communities experienced significant increases in median household income between 1989 and 1999 while the lowest income communities had real declines in income.[14]

◆ Of the six core cities, only Newport experienced an increase in real income over the decade of the 1990s. The median income in the six core cities in 1999 ranged from a low of $22,008 in Central Falls to a high of $43,125 in Newport.[15]

◆ According to the Poverty Institute's 2003 Rhode Island Standard of Need, a two-parent family with two young children in which both parents are working needs an income of $48,096 to pay for basic living expenses, including housing, food, clothing, health insurance, child care and transportation.[16]

◆ Income supports including RIte Care, child care subsidies, Food Stamps and the Earned Income Tax Credit are critical to the well-being of low-income and moderate-income working families.

Median Household Income

Table 6.

Adjusted Median Household Income, Rhode Island - 1989* and 1999

CITY/TOWN	ADJUSTED 1989 MEDIAN HOUSEHOLD INCOME*	1999 MEDIAN HOUSEHOLD INCOME	1999 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18
Barrington	$69,222	$74,591	$88,794
Bristol	$44,573	$43,689	$53,328
Burrilville	$48,476	$52,587	$55,085
Central Falls	$24,289	$22,628	$22,008
Charleston	$47,020	$51,491	$55,080
Coventry	$48,572	$51,987	$61,355
Cranston	$45,047	$44,108	$56,904
Cumberland	$53,077	$54,656	$68,291
East Greenwich	$66,401	$70,062	$108,555
East Providence	$40,453	$39,108	$48,875
Exeter	$49,810	$64,452	$73,239
Foster	$53,223	$59,673	$63,385
Glocester	$52,186	$57,537	$60,938
Hopkinton	$47,929	$52,181	$59,069
Jamestown	$54,166	$63,073	$79,574
Johnston	$42,526	$43,514	$56,641
Lincoln	$48,379	$47,815	$64,470
Little Compton	$53,735	$55,368	$56,679
Middletown	$45,960	$51,075	$55,301
Narragansett	$46,374	$50,363	$68,250
New Shoreham	$41,059	$44,779	$54,844
Newport	$39,836	$40,669	$43,125
North Kingstown	$52,733	$60,027	$66,785
North Providence	$42,168	$39,721	$50,493
North Smithfield	$54,076	$58,602	$71,066
Pawtucket	$34,627	$31,775	$33,562
Portsmouth	$55,414	$58,835	$67,375
Providence	$28,894	$26,867	$24,546
Richmond	$53,458	$59,840	$63,472
Scituate	$58,931	$60,788	$69,135
Smithfield	$55,478	$55,621	$67,050
South Kingstown	$47,595	$56,325	$68,265
Tiverton	$47,189	$49,977	$63,820
Warren	$41,275	$41,285	$53,542
Warwick	$46,688	$46,483	$57,038
West Greenwich	$53,817	$65,725	$70,150
West Warwick	$41,260	$39,505	$41,830
Westerly	$45,459	$44,613	$51,974
Woonsocket	$33,090	$30,819	$34,465
Core Cities	*NA*	*NA*	*NA*
Remainder of State	*NA*	*NA*	*NA*
Rhode Island	*$41,985*	*$42,090*	*$50,557*

**Adjusted to 1999 dollars*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2000.

Median household income data includes households with both related and unrelated individuals. Median family income data includes only households with children under age 18 who meet the Census Bureau's definition of a family. The Census Bureau defines a family as a household that includes a householder and one or more people living in the same household who are related to the household by birth, marriage or adoption. The 1989 adjusted median household income data is adjusted to 1999 constant dollars by multiplying 1989 dollar values by 1.304650 as recommended by the U.S. Census Bureau.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

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Cost of Rent

DEFINITION

Cost of rent is the percentage of income needed by a very low-income family to cover the average cost of rent, including heat. A very low-income family is defined as family income less than 50% of the median. A cost burden exists when more than 30% of a family's monthly income is spent on housing.

SIGNIFICANCE

Inadequate, costly or crowded housing has a negative impact on children's health, safety, education and emotional well-being. Nationwide over the last three decades, the percentage of families with a cost burden rose from 15% in 1978 to 28% in 2001. The percentage with severe cost burdens, paying more than 50% of their income for housing, rose from 6% to 11%.[1]

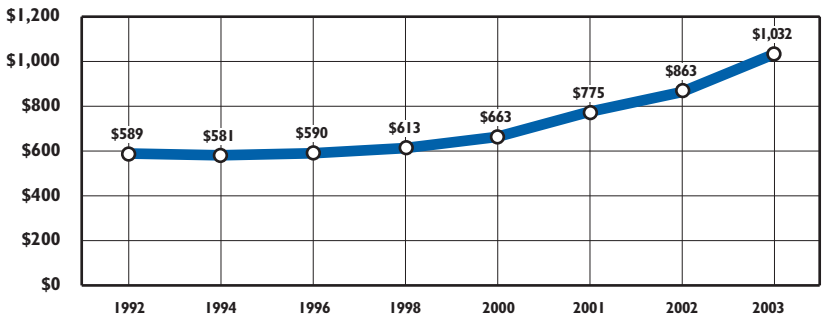
Families with cost burdens are likely to go without other basic necessities such as food, medicine, and clothing in order to pay their rent (or mortgage) and utilities.[2] Between 1989 and 1999 the percentage of Rhode Island households with cost burdens increased from 55% to 58% of renters and 41% to 58% of homeowners.[3]

Severe financial strain can hinder effective parenting, heighten conflict and contribute to the break-up of families.[4] Severe cost burdens disproportionately fall on minority and single-parent households, with nearly one in three spending more than 50% of their income on housing.[5]

It is estimated that 9,900 of Rhode Island's rental units have physical defects, which may include roach and rodent infestation, lead exposure, faulty wiring, inadequate heating systems, plumbing problems or lack of major appliances. Eighty percent of these are located in urban communities.[6] Research shows that there are strong links between substandard housing and educational disadvantages.[7,8]

The decline in federal housing subsidies and the growth in income inequality in Rhode Island over the last decade have contributed to the housing crisis for low-income and moderate-income families. Total federal funding for housing in Rhode Island decreased from $56 billion in 1980 to $29 billion in 2003.[9] Income inequality has led to an emphasis on high-end housing construction in the suburbs and luxury condominiums in urban areas. Lack of construction of middle-income and low-income units statewide has increased competition for low-income housing, resulting in rising rents for often substandard housing.[10]

Average Rent, Two Bedroom Apartment, Rhode Island, 1992 – 2003



Source: Rhode Island Housing and Mortgage Finance Corporation Annual Rent Surveys. Information not available for 1993, 1995, 1997, 1999. 2003 rent includes cost of heat, cooking fuel, electricity and hot water. All prior years' rents include only cost of heat and hot water. Adjustment for utilities varies according to each year's utility allowances.

◆ The cost of renting an average two-bedroom apartment in Rhode Island increased from $589 per month in 1990 to $1,032 in 2003. To be able to afford this rent, a worker would have to earn $19.85 per hour for forty hours per week. This is nearly three times the state's new minimum wage of $6.75 per hour.[11]

Cost of Heat and Electricity

◆ High energy costs put affordable housing even further out of reach for very low-income families. The Low-Income Home Energy Assistance Program (LIHEAP) is a federally-funded program that provides heating assistance to eligible low-income households (60% of the state median income for a 4-person family).[12] In 2001 in Rhode Island, residential energy costs for low-income households averaged $1,614, while the average LIHEAP benefit payment was $380 for heating.[13]

◆ In 2001 in Rhode Island, LIHEAP heating assistance was provided to only 26% of the 95,922 low-income households that were eligible for benefits.[14] Twenty percent of heating benefits went to households with at least one young child.[15]

◆ In 2003 in Rhode Island, 21,446 households lost utilities for non-payment.[16] Ninety-nine percent of the shutoffs occurred between April and October, the months when the moratorium for utility shutoffs is lifted.[17] More than one-third (36%) of these households had not had utilities restored as of December 2003.[18]

Table 7.

Cost of Rental Housing for Low-Income Families, Rhode Island, 2003

CITY/TOWN	2003 AVERAGE MONTHLY RENT 2-BEDROOM	2003 POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT, POVERTY LEVEL FAMILY OF THREE	2003 VERY LOW-INCOME RENTER	% INCOME NEEDED FOR RENT, VERY LOW-INCOME RENTER
Barrington	$1,198	$15,260	94%	$30,300	47%
Bristol	$1,206	$15,260	95%	$30,300	48%
Burrillville	$678*	$15,260	53%	$30,300	27%
Central Falls	$796	$15,260	63%	$30,300	32%
Charlestown	$917*	$15,260	72%	$30,300	36%
Coventry	$919	$15,260	72%	$30,300	36%
Cranston	$1,002	$15,260	79%	$30,300	40%
Cumberland	$987	$15,260	78%	$30,300	39%
East Greenwich	$1,210	$15,260	95%	$30,300	48%
East Providence	$980	$15,260	77%	$30,300	39%
Exeter	$917*	$15,260	72%	$30,300	36%
Foster	$678*	$15,260	53%	$30,300	27%
Glocester	$678*	$15,260	53%	$30,300	27%
Hopkinton	$797*	$15,260	63%	$30,950	31%
Jamestown	$918*	$15,260	72%	$30,300	36%
Johnston	$895	$15,260	70%	$30,300	35%
Lincoln	$972	$15,260	76%	$30,300	38%
Little Compton	$918*	$15,260	72%	$30,300	36%
Middletown	$1,276	$15,260	100%	$30,300	51%
Narragansett	$917*	$15,260	72%	$30,300	36%
New Shoreham	$917*	$15,260	72%	$30,400	36%
Newport	$1,209	$15,260	95%	$30,300	48%
North Kingstown	$1,133	$15,260	89%	$30,300	45%
North Providence	$964	$15,260	76%	$30,300	38%
North Smithfield	$1,021	$15,260	80%	$30,300	40%
Pawtucket	$924	$15,260	73%	$30,300	37%
Portsmouth	$1,255	$15,260	99%	$30,300	50%
Providence	$1,012	$15,260	80%	$30,300	40%
Richmond	$917*	$15,260	72%	$30,300	36%
Scituate	$678*	$15,260	53%	$30,300	27%
Smithfield	$955	$15,260	75%	$30,300	38%
South Kingstown	$1,082	$15,260	85%	$30,300	43%
Tiverton	$1,032	$15,260	81%	$30,300	41%
Warren	$950	$15,260	75%	$30,300	38%
Warwick	$990	$15,260	78%	$30,300	39%
West Greenwich	NA	$15,260	NA	$30,300	NA
West Warwick	$902	$15,260	71%	$30,300	36%
Westerly	$797*	$15,260	63%	$30,950	31%
Woonsocket	$932	$15,260	73%	$30,300	37%
Core Cities	*$963*	*$15,260*	*76%*	*$30,300*	*38%*
Remainder of State	*$1,619*	*$15,260*	*127%*	*$30,300*	*64%*
Rhode Island	*$1,032*	*$15,260*	*81%*	*$30,300*	*41%*

Source of Data for Table/Methodology

Rhode Island Housing and Mortgage Finance Corporation, January-December 2003 Rent Survey and the Department of Housing and Urban Development (HUD). Average rents are based on a survey of rents in Rhode Island between January and December 2003. All 2003 rents have been adjusted using current HUD utility allowances to include heat, cooking fuel, electricity and hot water. A very low-income family is defined by the U.S. Department of Housing and Urban Development as a family with income 50% of the median family income and is calculated separately for Hopkinton, Middletown, New Shoreham, Newport, Portsmouth and Westerly.

* Rhode Island Housing 2003 Rent Survey data are not available for these communities. Average rent used for these communities is the HUD 2003 Fair Market Rent as reported in *Out of Reach 2003.* (2003). Washington, DC: National Low-Income Housing Coalition.

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Parental Employment

DEFINITION

Parental employment is the percentage of children living with at least one parent who has full-time, year-round employment.

SIGNIFICANCE

Secure parental employment can have positive impacts on child well-being that go beyond reducing poverty and increasing median household income. Children with parents who have steady employment are more likely to have access to health care and stable, regular child care.[1] Secure parental employment is also likely to improve family functioning by reducing the stress brought on by unemployment and underemployment of parents.[2]

In Rhode Island in 2000, there were approximately 52,043 Rhode Island children with no parent working full time, year round.[3] This is slightly less than one quarter of Rhode Island children.[4]

In 2003 the Rhode Island unemployment rate was 5.2%; lower than the national annual average of 6.0%.[5] Unemployment rates vary significantly across cities and towns in the state from a high of 8.7% in Central Falls and 8.6% in New Shoreham to a low of 2.6% in Richmond and 2.9% in Barrington.[6]

Parental employment is not the only determinant of whether or not children will be poor.[7] When families work in low-wage jobs, many remain below the poverty level and many more are low-income. The likelihood of having one parent with full-time year-round employment and remaining poor has increased in recent years from 21% of poor children in 1993, to 32% of poor children in 2001.[8] Between 1990 and 2000 in Rhode Island, the number of children living in low-income working families (full-time work and income below 200% of the federal poverty line) increased 18%, from 28,000 children to 33,000 children. This is 15% of all Rhode Island children, lower than the national average of 19%.[9]

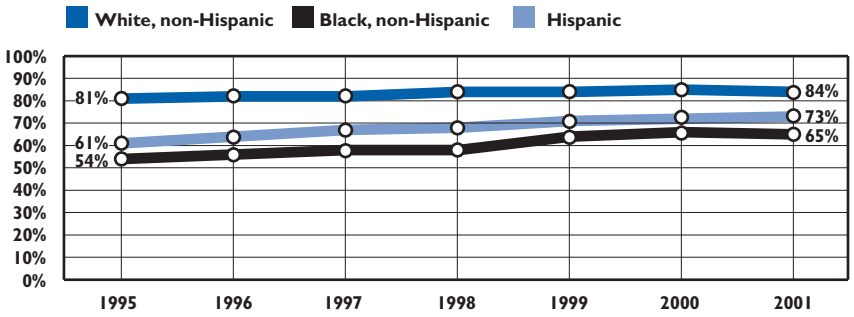
Parental Employment

	1990	2000
RI	75%	79%
US	70%	76%
National Rank*		*17th*
New England Rank**		*3rd*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *KIDS COUNT Data Book: State Profiles of Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation. *Percentages include only those who are employed full-time, year-round.*

Parental Employment, by Race and Ethnicity, United States, 1995 to 2001



Note: Parental employment is the percentage of children living with at least one parent working full-time, year-round.

◆ Parental employment increased for White, Black, and Hispanic children in the U.S. between 1995 and 2001. Black, non-Hispanic children and Hispanic children have seen the largest increase.

◆ Black, non-Hispanic and Hispanic children in the U.S. continue to be less likely than White, non-Hispanic children to live with at least one parent with full-time, year-round employment.

◆ Much of the increase in parental employment during the 1990s was due to the increase in the percentage of children living with single mothers who are employed full time year round, which increased from 38% in 1995 to 48% in 2001.

Source: *America's Children: Key National Indicators of Well-Being.* (2003).Washington, DC: Federal Interagency Forum on Child and Family Statistics.

Housing and Secure Employment

◆ High housing costs, low-wage work, and less secure jobs increase homelessness. Among families seeking emergency shelter in Rhode Island in 2003, more than a quarter (27%) cited housing costs as the reason why shelter was needed.[10]

◆ Research indicates that affordable housing helps to promote secure parental employment. Having a permanent address increases a parent's ability to gain and maintain employment and provides parents with stability that affects parental success in the workplace.[11]

◆ Families without stable housing typically have to move often, making job retention difficult and increasing the frequency of student mobility which can affect student performance and behavior.[12,13]

◆ Housing assistance programs, such as Section 8 housing vouchers and public housing projects, help low-income families to overcome barriers to employment, increase job retention and advancement, and enhance child academic success. In fact, employment and earnings increase more for residents of subsidized housing than for poor working families not receiving housing assistance.[14]

◆ Long waiting periods for subsidized housing are common due to high demand and limited resources.[15] Nationally in 1999, there were only 4.9 million affordable rental units available to 7.7 million low-income renter households. This shortage of 2.8 million units has only increased as low-rent units disappear from the market because of abandonment, demolition, or expensive condominium conversions.[16]

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Rhode Island Earned Income Tax Credit

◆ Rhode Island is one of seventeen states that have established state Earned Income Tax Credit (EITC) programs that help to bring low-wage workers out of poverty. Refundable EITC programs exist in 13 states and maximize economic benefits to the lowest-income families.[17]

◆ In 2003, Rhode Island passed legislation enacting a small refundable EITC that enables 42,000 Rhode Islanders with very low income to be eligible for a credit of up to $50.[18]

◆ Increasing the state EITC refundable amount to 5% of the federal EITC refund would provide a maximum benefit of $210 to very low-income Rhode Islanders.[19] All other states, including the District of Columbia, offering refundable EITC's have implemented rates of at least 5%, and as high as 50%, of the federal EITC.[20]

◆ When a state EITC is refundable, the family receives a refund check if the size of its EITC exceeds its tax bill. In 2002, single parent families of three in Rhode Island had no state income tax liability until they reached an annual income of $26,000, while two parent families of four had no state income tax liability until they reached $28,200.[21]

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Children Receiving Child Support

DEFINITION

Children receiving child support is the percentage of non-custodial parents in the Rhode Island Child Support Enforcement System who pay child support on time and in full. The percentage does not include cases in which paternity has not been established or cases where the non-custodial parent lacks a court order because he/she cannot be located. Court orders for child support require establishment of paternity first.

SIGNIFICANCE

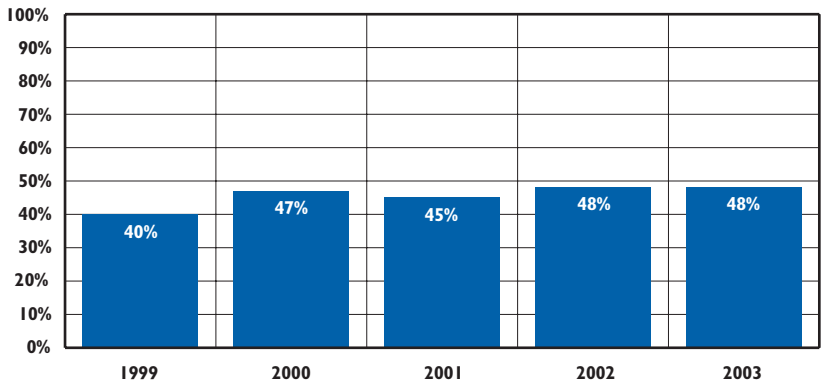
The receipt of child support payments can significantly improve the economic status of a child growing up in a family with a non-resident parent. Child support is an essential source of financial support for low-income families, often making up a significant portion of their income.[1] Nationally, approximately 59% of custodial parents had child support agreements in 2002.[2]

The goal of the child support system is to collect money from non-custodial parents so that their children can have adequate financial security as they grow up.[3] To collect child support on behalf of a child, the non-custodial parent must be identified, located and provided with due process, paternity must be established, and a support order must be entered.[4]

The failure of a non-custodial parent to pay child support has significant economic consequences for the custodial parent and for the child. Nationally, children who live with custodial parents who do not receive child support payments are more than one and a half times as likely to live in poverty as children whose families receive child support payments in full.[5] In the U.S., low-income mothers, Black or Hispanic mothers, never-married mothers, and mothers with less than a college education are least likely to receive the child support due under court order.[6]

Even when there is a child support order in place, child support payments tend to be low and unreliable. Low-income non-custodial parents often experience low wages and high rate of joblessness, making it difficult to fulfill their child support obligations.[7] Non-custodial parents often encounter the same barriers to employment that many low-income parents face, including lack of education and limited work experience.[8] Research shows that providing education and job training that increases non-custodial parents' ability to pay child support also increases parental contact with their children.[9]

Non-custodial Parents with Court Orders Who Pay Child Support On Time and In Full, Rhode Island 1999 – 2003



Source: Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, 1999 - 2003.

◆ In 2003 in Rhode Island, 48% of the non-custodial parents under court order paid child support on time and in full, compared to 40% in 1999.[10]

◆ As of December 2003, there were 94,436 Rhode Island children in the State's Child Support Enforcement System.[11] Of these, 21,261 (23%) had not yet had paternity established and therefore were not yet eligible for a child support award.[12]

◆ As of December 31, 2003, the amount of past due court-ordered child support in Rhode Island totaled $167 million.[13]

◆ In Rhode Island in 2000, 54,648 children lived in a household headed by a single mother.[14] Of the Rhode Island families headed by a single female, 32% received child support or alimony payments in 2000, compared to 36% nationally.[15]

◆ Reasons that parents do not have legal court orders in place for child support include not feeling the need to make agreements legal, knowing that the other parent could not afford to pay, and not wanting to have contact with the other parent.[16]

Child Support and the Family Independence Program

◆ Research suggests that welfare recipients receiving child support are more likely to leave welfare for work, remain off welfare and have income above the federal poverty line.[17]

◆ In Rhode Island as of December 2003, 14,727 (56%) of the 26,188 children enrolled in the Family Independence Program were in the Child Support Enforcement System and had paternity established.[18,19]

◆ In 2003, the average child support obligation to children enrolled in FIP was $243 per month, as compared to an average child support obligation of $311 per month for non-FIP families.[20]

◆ Research suggests that child support "pass-through programs" encourage paternity establishment, higher payments by low-income parents and cooperation by TANF recipients.[21,22] In Rhode Island, the first $50 of child support paid on time each month on behalf of a child receiving FIP cash assistance goes to the custodial parent caring for the child and the remainder goes to the state. An average of 3,100 Rhode Island families enrolled in FIP each month received the $50 child support pass-through in 2003.[23]

Medical Child Support

◆ Rhode Island General law, Title 15 Chapter 29, requires that any child support order issued by the family court require any parent owing a duty of support to a child to obtain health insurance coverage for the child when insurance is available at either parent's place of employment at reasonable cost.[24]

◆ Rhode Island defines reasonable cost for health coverage as 5% of the gross monthly income of the individual providing the coverage.[25] If the cost of health coverage is 5% or lower, the non-custodial parent is ordered to obtain and/or maintain the coverage.

◆ If the cost of providing coverage exceeds 5% of the non-custodial parent's gross income, the court will order the non-custodial parent to pay 5% of his/her gross income as a cash medical order, in addition to the weekly child support order. If the child receives RIte Care or RIte Share, the state will retain the medical order to defray the cost of coverage. If the custodial parent pays for private insurance, the weekly cash medical order is sent to the custodial parent.[26]

References for Indicator

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[24,26] Rhode Island Law, Title 15, Chapter 29, Section 1, 15-5-16.2 (2).

[25] Rhode Island Family Court, Administrative Order.

See Methodology, pg 133.

Children in Poverty

DEFINITION

Children in poverty is the percentage of related children under age 18 who live in families below the federal poverty threshold, as defined by the U.S. Office of Management and Budget. "Related children" include the family head's children by birth, marriage and adoption, as well as other persons under age 18 who are related to and live with the family head, such as nieces and nephews.

SIGNIFICANCE

Poverty is related to every KIDS COUNT indicator. Children in poverty, especially those in poverty for extended periods of time, are more likely to have health and behavioral problems, experience difficulty in school, become teen parents, earn less as adults and be unemployed more frequently.[1,2] Children in low-income communities are more likely to attend schools that lack resources and rigor; have limited access to high quality child care programs; and have fewer opportunities to participate in extracurricular activities, such as sports and recreations programs, clubs, and lessons such as music and computers.[3,4]

Children of color and children of immigrants are more likely to grow up poor.[5] Single parenthood, low educational attainment, part-time or no employment and low wages of parents place children at risk of being poor.[6]

The 2003 federal poverty threshold for a family of three with two children is $14,824. The poverty threshold for a family of four with two children is $18,660.[7] Historically, the poverty threshold fails to include the cost of basic goods such as housing, taxes, work related expenses, medical expenses by region, and child care. The poverty threshold also fails to account for increased expenses that occur as family size increases. Under recommendation from the National Academy of Sciences, the Census Bureau has begun to conduct research and examine six alternative measurements of poverty and income.[8]

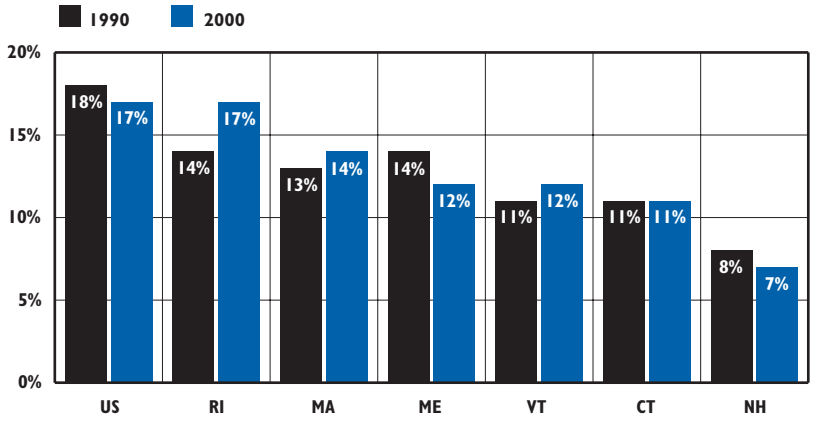
Children in Poverty

	1990	2000
RI	14%	17%
US	18%	17%
National Rank*		*30th*
New England Rank**		*6th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *Children at Risk: State Trends: 1990-2000.* (2002). Baltimore, MD: The Annie E. Casey Foundation.

Children Living Below the Federal Poverty Threshold, New England and the U.S., 1990 and 2000



Source: *Children at Risk: State Trends: 1990-2000.* (2002). Baltimore, MD: The Annie E. Casey Foundation.

◆ Between 1990 and 2000 the percentage of children living below the federal poverty threshold decreased nationally and in two New England states, Maine and New Hampshire. Rhode Island, Massachusetts, and Vermont all experienced increases in the percentage of children living below the federal poverty threshold, while Connecticut remained constant. The percentage of children living below the federal poverty threshold in Rhode Island increased from 14% in 1990 to 17% in 2000.[9]

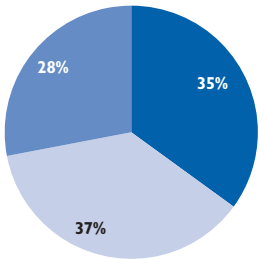
◆ Rhode Island now has the highest percentage of children living below the federal poverty threshold in New England.[10] According to the Census, in 2000 there were 40,117 children living below the federal poverty threshold in Rhode Island.[11]

◆ Rhode Island has the largest percentage of Latino children living below the federal poverty threshold (47%), compared to the national rate of (28%).[12] Rhode Island also has the highest percentage of African American children living below the federal poverty threshold (38%) in New England.[13]

Rhode Island's Children Living Below the Federal Poverty Threshold, 2000

By Age

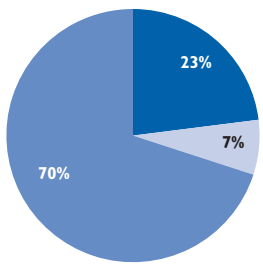
35%	Ages 5 and younger
37%	Ages 6 to 11
28%	Ages 12 to 17



n = 41,162 (includes unrelated children living in households)

By Family Structure

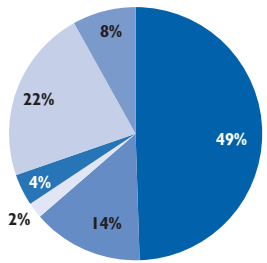
23%	Married Couple Family
7%	Male Householder Only
70%	Female Householder Only



n = 40,117

By Race*

49%	White
14%	Black
2%	Asian
4%	American Indian
22%	Some Other Race
8%	Two or More Races

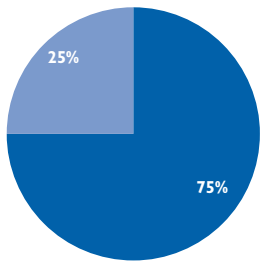


n = 40,117

**Hispanic children may be included in any race category. Of Rhode Island's 40,117 poor children, 15,750 (39%) are Hispanic.*

By Residence

75%	Core Cities
25%	Remainder of State



n = 40,117

Source: U.S. Bureau of the Census, Census 2000. Except where otherwise noted, population includes related children under age 18, who are living in households for whom poverty status was determined and are somehow related to the householder. This could include nieces, nephews, step children, adopted children, etc.

Children Living in Extreme Poverty

◆ Families with income below 50% of the federal threshold level are considered to be living in extreme poverty.[14] The extreme poverty level in 2003 is family income below $7,412 for a family of three with two children and $9,330 for a family of four with two children.[15]

◆ Of the 40,117 children living in poverty in Rhode Island, nearly half live in extreme poverty. In 2000, 8% (19,773) of all children in Rhode Island lived in extreme poverty.[16]

◆ Children who live in deep, long term poverty experience the worst health outcomes, such as child asthma and malnutrition, as a result of their family's income status.[17]

Young Children Under Age 6 in Poverty in Rhode Island

◆ Research shows that increased exposure to risk factors associated with poverty compromise children's emotional and intellectual development. Risk factors associated with poverty include: inadequate nutrition, environmental toxins, maternal depression, trauma and abuse, lower quality child care and parental substance abuse.[18]

◆ In 2000, 19% (14,548) of Rhode Island children under 6 were living in poverty, compared to 18% nationally.[19] Of these children, half (7,230) were extremely poor.[20]

◆ As of December 1, 2003 there were 5,709 children under age 3 and 4,906 children ages 3 to 5 in families receiving cash assistance from the Family Independence Program. Of all children in the Family Independence Program, 46% are age 6 or under.[21]

Children in Poverty

Building Blocks of Economic Security

Access to Health Care

◆ Many workers in low-wage jobs are often not offered affordable employer-sponsored health insurance. Access to health insurance improves the likelihood of having a regular and affordable source of health care.[22]

Affordable Quality Child Care

◆ The quality and stability of the child care setting is critical to a parent's ability to work and to the child's development.[23] Child care costs represent a significant part of the budget of low-income families and are associated with a mother's refusal or termination of employment.[24]

Income Supports

◆ Income supports include the FIP Earned Income Disregard, Food Stamps, the Earned Income Tax Credit, child care subsidies, health care subsidies, and Energy Assistance programs. Income supports help to ensure that low-income working families have adequate resources to meet their basic needs.[25]

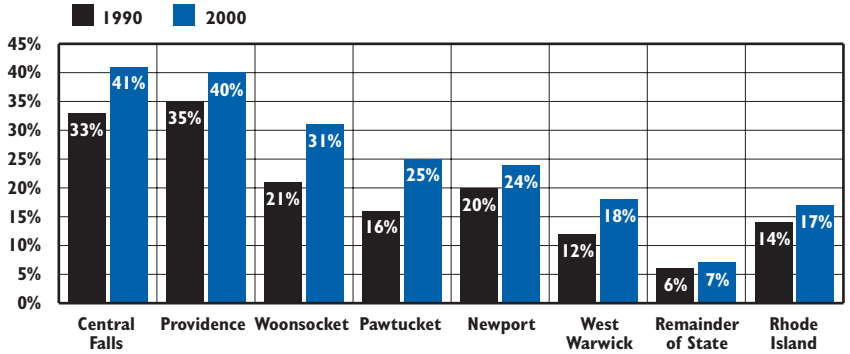
Affordable Housing

◆ Stable housing is a critical requirement for job retention and performance.[26] In 2003, the average rent for a two bedroom apartment in Rhode Island is $1,032, more than double the amount that is considered affordable for a family of three with income below the poverty level.[27]

Educational Attainment

◆ Individuals with higher education generally have more job opportunities, higher wages and greater job security than those with lower levels of education.[28]

Rate of Children Living Below the Federal Poverty Threshold, 1990 and 2000, Core Cities, Remainder of State and Rhode Island



Source: U.S. Census Bureau, 1990 and 2000 Census of the Population.

◆ The rate of Rhode Island children living below the federal poverty threshold increased from 14% to 17% over the decade of the 1990s. The child poverty rate increased in each of the core cities between 1990 and 2000. For the core cities overall, the child poverty rate increased from 26% to 33% during the 1990s even as it remained relatively stable at 6% to 7% in the remainder of the state.[29]

◆ Rhode Island KIDS COUNT defines core cities as those communities in which 15% or more of the children live in families with income below the federal poverty threshold. Three-quarters (75%) of Rhode Island's poor children live in one of the six core cities.[30]

◆ Because of increases in child poverty between 1990 and 2000, West Warwick is now a core city with 18% of children living below the federal poverty threshold.[31] Providence now has the third highest child poverty rate (40%) in the country among cities with a population of 100,000 or more. Central Falls has the highest child poverty rate (41%) of any city or town in Rhode Island.[32]

Table 8. **Children Living Below the Federal Poverty Threshold, Rhode Island, 2000**

	FAMILIES WITH CHILDREN BELOW POVERTY		CHILDREN UNDER 6 BELOW POVERTY		CHILDREN UNDER 18 BELOW POVERTY	
CITY/TOWN	N	%	N	%	N%	%
Barrington	56	2.3%	23	1.9%	116	2.5%
Bristol	216	8.7%	157	11.4%	396	9.2%
Burrillville	106	5.0%	80	7.9%	236	6.0%
Central Falls	988	34.6%	740	42.7%	2,189	40.8%
Charlestown	42	4.2%	18	3.7%	78	4.7%
Coventry	232	5.1%	149	6.4%	455	5.6%
Cranston	794	8.4%	437	8.6%	1,417	8.6%
Cumberland	162	3.8%	89	3.6%	237	3.1%
East Greenwich	65	3.6%	57	6.1%	147	4.1%
East Providence	613	10.2%	452	14.5%	1,109	10.7%
Exeter	49	5.6%	69	16.3%	112	7.5%
Foster	18	3.1%	-	0.0%	32	2.9%
Glocester	76	5.2%	37	5.7%	171	6.4%
Hopkinton	64	5.5%	55	8.9%	107	5.5%
Jamestown	9	1.3%	-	0.0%	17	1.4%
Johnston	287	8.2%	183	9.5%	527	9.0%
Lincoln	178	6.3%	76	5.6%	316	6.2%
Little Compton	8	1.9%	8	3.5%	8	1.0%
Middletown	161	6.7%	70	5.0%	264	6.2%
Narragansett	133	7.8%	50	6.5%	230	8.4%
New Shoreham	14	13.0%	3	4.8%	19	10.2%
Newport	654	22.4%	628	34.3%	1,223	23.8%
North Kingstown	362	9.4%	239	11.1%	657	9.6%
North Providence	327	9.0%	212	12.0%	559	9.8%
North Smithfield	38	2.9%	45	6.3%	67	2.8%
Pawtucket	2,229	22.7%	1,711	29.2%	4,353	24.5%
Portsmouth	65	2.8%	63	5.0%	118	2.8%
Providence	7,651	34.3%	6,137	42.5%	17,714	40.1%
Richmond	38	3.4%	17	2.4%	82	4.2%
Scituate	52	3.7%	30	4.2%	113	4.3%
Smithfield	85	3.7%	11	1.0%	153	3.9%
South Kingstown	166	5.0%	82	4.6%	297	4.9%
Tiverton	62	3.2%	48	5.4%	90	2.7%
Warren	104	7.3%	60	7.6%	198	8.1%
Warwick	642	6.1%	386	6.8%	1,175	6.4%
West Greenwich	7	0.9%	18	3.7%	40	2.7%
West Warwick	604	16.1%	606	26.8%	1,170	17.9%
Westerly	204	7.0%	141	8.0%	512	9.6%
Woonsocket	1,581	26.8%	1,361	35.0%	3,413	31.3%
Core Cities	*13,707*	*28.8%*	*11,183*	*37.3%*	*30,062*	*33.4%*
Remainder of State	*5,435*	*6.3%*	*3,365*	*8.0%*	*10,055*	*6.6%*
Rhode Island	*19,142*	*14.2%*	*14,548*	*20.2%*	*40,117*	*16.5%*

Source of Data for Table/Methodology

Data are from the U.S. Bureau of the Census, Census 2000.

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continued on page 136

Children in the Family Independence Program

DEFINITION

Children enrolled in the Family Independence Program is the percentage of children less than age 18 who were living in families receiving cash assistance through the Family Independence Program (FIP) on December 1, 2003. These data measure the number of children and families enrolled in FIP at one point in time. They do not count the additional children and families who qualified for the program at other points in the year but were not enrolled on December 1, 2003.

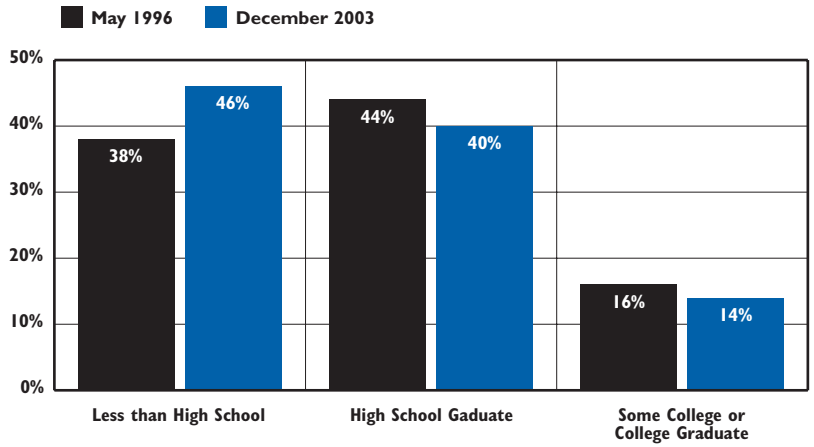
SIGNIFICANCE

Rhode Island's Family Independence Program (FIP) seeks to help families make successful transitions to work by providing the cash assistance and work supports, including health insurance and subsidized child care, that families need to obtain and keep a job. In addition, the program provides cash assistance for children living in families where adults are unable to work.[1] As of December 1, 2003 there were 917 families enrolled in FIP who were unable to work due to illness or advanced age, and 2,128 who were exempt from work because they were in their third trimester of pregnancy or had children under age one.[2] If a family has no earned income, the maximum monthly FIP benefit for a Rhode Island family of three is $554 per month.[3] With an additional $371 per month in Food Stamps, this amount is 73% of the federal poverty line and well below the amount of income families need to pay basic living expenses.[4] The FIP monthly payment has not increased in 15 years.[5]

Since the implementation of welfare reform in 1997, caseloads have declined across the country; however the rate of decline has steadily slowed.[6] Rhode Island experienced a more gradual caseload reduction than other states because of policies that allow more time for education and training before beginning work and higher income disregards.[7] Since the start of the economic recession in March 2001, Rhode Island is one of the few states that continues to see caseloads decline.[8]

As of December 2003, there were 11,727 adults and 26,168 children in Rhode Island enrolled in the Family Independence Program.[9] More than two-thirds (69%) of all FIP beneficiaries are children under the age of 18.[10] Three out of four children receiving cash assistance through FIP are ages 12 and under.[11] In Rhode Island, nearly 80% of children receiving FIP cash assistance lived in the six core cities (those cities with 15% or more of children living in poverty). In 2003, half (50%) of all children receiving FIP lived in Providence.[12]

Education Level, Families Enrolled in the Family Independence Program, 1996 and 2003



Source: Rhode Island Department of Human Services, INRHODES Database, May 1996 and December 2003.

◆ In December 2003, almost half (46%) of FIP heads of households had less than a high school education.[13]

◆ Compared to 1996, adults enrolled in FIP in 2003 were more likely to have low literacy levels, not have at least a high school diploma, and have limited English-speaking skills.[14]

◆ A growing number of jobs in today's labor market require a certain level of skill and/or credentials. Recent research found that the skill levels of an average high school dropout will qualify for 10% of all new jobs between 2000 and 2010, while people possessing the skills of a typical high school graduate will qualify for 22% of all new jobs.[15]

◆ For the first 24 months of enrollment, FIP permits adults receiving cash assistance to get necessary education or basic skills training before beginning work. Evaluations of FIP have found that adults who opted for training or education before they looked for jobs were more likely to be employed and have family earnings higher than before the training.[16,17]

Employment of Families Enrolled in FIP

◆ The percentage of FIP cases with 13 or more months of employment history while receiving cash assistance has more than doubled, from 10.7% in 1997 to 27.1% in 2003.[18]

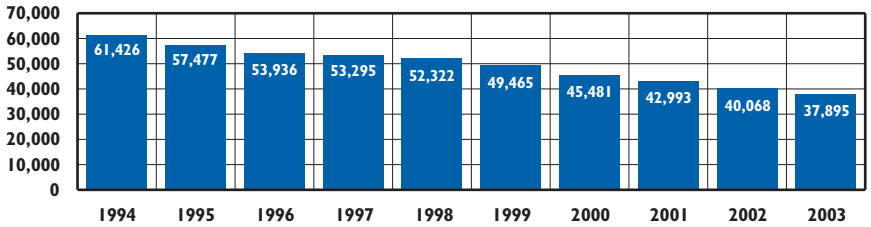
◆ As of December 1, 2003 in Rhode Island, 11,246 adults had FIP work plans in place. Of the adults receiving FIP cash assistance, 2,298 (22%) were employed, nearly double the 1997 percentage of 14%.[19,20] In 2003, employed adult FIP recipients earned an average wage of $7.95 per hour.[21]

◆ Among FIP cases leaving welfare, those who recieved post secondary education or vocational education or skills training as part of their FIP plan earned an average wage of $10.31 per hour while the average wage for those without this education was $8.56 per hour.[22]

◆ Nationally, 78% of employed low-income single parents were concentrated in low-wage occupations, including: service and operators, fabricators, and laborers.[23] Wages for young parents and parents with limited education are less than full-time workers earned a decade ago, and work — no matter how low the wage — increases expenses for child care, workplace appropriate clothing, and transportation.[24]

◆ Recent research demonstrates that children in low-income families have better academic and social outcomes when parents have access to work supports and subsidies, including: child care; job assistance; earnings supplements and health care.[25]

Adults and Children Enrolled in AFDC/Family Independence Program, 1994 to 2003



Source: Rhode Island Department of Human Services, INRHODES Database, 1994 to 2003.

Note: Prior to May 1, 1997, the Family Independence Program was AFDC (Aid to Families with Dependent Children). More than two-thirds of FIP recipients are children under age 18.

◆ In 2003, there were 37,895 adults and children enrolled in the Family Independence Program. This is a 38% decline in cash assistance recipients since 1994.

Supporting Low-Income Families

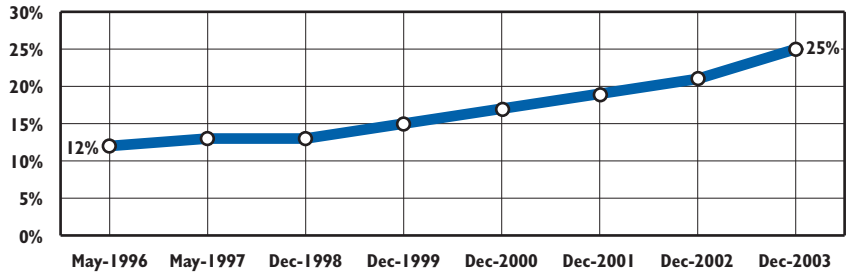
◆ Low-wage work alone is insufficient to move families to an income level that allows them to meet their families basic needs.[26] According to the 2003 Rhode Island Standard of Need, developed by the Poverty Institute at Rhode Island College, a single parent family with two children would need $11.00 per hour with child care subsidies and health insurance through RIte Care in order to make ends meet, compared to more than $21.00 per hour without these programs.[27]

◆ Income supports including Medicaid, child care subsidies, Food Stamps and the Earned Income Tax Credit are critical in helping families successfully transition from welfare to work.[28]

◆ Rhode Island has one of the lowest rates of uninsured children in the country and is the only state that provides an entitlement to child care for income-eligible families.[29]

Children in the Family Independence Program

Child Only Cases as a Percentage of Total AFDC/Family Independence Program Cases, Rhode Island, 1996-2003



Source: Rhode Island Department of Human Services, INRHODES Database, 1996 to 2003, and Witte, Ann and M. Queralt. (August 2001). *Study of the Cash Assistance Program: May 1996-April 2000.* Rhode Island Department of Human Services. Wellesley, MA: Wellesley College, Department of Economics, Wellesley Child Care Research Partnership.

Note: Prior to May 1, 1997, The Family Independence Program was AFDC (Aid to Families with Dependent Children).

◆ As of December 2003 there were 3,475 child-only cases in the Family Independence Program.[29] Child-only cases are those that receive cash assistance only for the children in the family because the child is living with a grandparent or other non-parent relative, the parent has reached their five-year time limit, the parent is disabled and receiving Supplemental Security Income, or the parent is not a U.S. citizen.[30]

◆ Child-only cases have increased from 12% of all FIP cases in May 1996 to 25% of all FIP cases in December 2003.[31,32] The percentage of all cases that are child only cases will continue to increase as adults in the family reach five-year time limits. As of December 2003, 863 adults have reached their time limits.[33]

Welfare and Mental Health

◆ Compared to the general population, welfare recipients have higher-than-average rates of mental health disorders. Nationally, between one-quarter and one-third of welfare recipients have a mental disorder.[34]

◆ Depression is the most common mental health problem among welfare recipients with rates ranging from 25%-53%, compared to 13% for the general population. Post-traumatic stress disorder (15%) and anxiety disorder (7%-10%) are also more commonly found among the welfare population.[35]

◆ There is a strong correlation between mental health and employment. People with mental health conditions are more likely to have sporadic work histories, be unemployed, and to be receiving cash assistance.[36] Nationally, between 70% and 90% of adults of working age with serious mental disorders are unemployed.[37,38]

◆ Two years after exiting FIP, 19% of Rhode Island welfare leavers reported poor mental health as a barrier to employment.[39]

◆ In Rhode Island, adults enrolled in FIP may be exempt from participating in work requirements because of physical or mental disabilities. FIP recipients are eligible for RIte Care or RIte Share, which covers a basic range of services for treating mental health conditions.

◆ A Rhode Island study indicates that families still enrolled in FIP are more likely to have children with health and developmental problems (mental health, short-term illness, chronic illness, school attendance, behavior and learning disabilities, and developmental disabilities) and to miss work or training activities due to their children's needs.[40]

Children in the Family Independence Program

Table 9.

Children Enrolled in the Family Independence Program (FIP), Rhode Island, December 1, 2003

CITY/TOWN	All Children Under 18	Number Receiving FIP Cash Assistance		FIP Children as % of All Children Under 18
		Families	Children	
Barrington	4,745	19	28	1%
Bristol	4,399	77	125	3%
Burrillville	4,043	64	109	3%
Central Falls	5,531	771	1,539	28%
Charlestown	1,712	37	69	4%
Coventry	8,389	160	234	3%
Cranston	17,098	566	958	6%
Cumberland	7,690	100	160	2%
East Greenwich	3,564	33	45	1%
East Providence	10,546	417	656	6%
Exeter	1,589	23	39	2%
Foster	1,105	14	24	2%
Glocester	2,664	19	29	1%
Hopkinton	2,011	26	49	2%
Jamestown	1,238	12	19	2%
Johnston	5,906	202	310	5%
Lincoln	5,157	82	144	3%
Little Compton	780	5	5	1%
Middletown	4,328	74	104	2%
Narragansett	2,833	48	72	3%
New Shoreham	185	0	0	0%
Newport	5,199	411	816	16%
North Kingstown	6,848	138	224	3%
North Providence	5,936	224	375	6%
North Smithfield	2,379	28	41	2%
Pawtucket	18,151	1,586	2,792	15%
Portsmouth	4,329	42	58	1%
Providence	45,277	6,611	12,993	29%
Richmond	2,014	21	23	1%
Scituate	2,635	36	49	2%
Smithfield	4,019	37	56	1%
South Kingstown	6,284	94	186	3%
Tiverton	3,367	74	103	3%
Warren	2,454	78	134	5%
Warwick	18,780	448	736	4%
West Greenwich	1,444	13	18	1%
West Warwick	6,632	303	513	8%
Westerly	5,406	119	193	4%
Woonsocket	11,155	1,106	2,140	19%
Core Cities	*91,945*	*10,788*	*20,793*	*23%*
Remainder of State	*155,877*	*3,330*	*5,375*	*3%*
Rhode Island	*247,822*	*14,118*	*26,168*	*11%*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, InRhodes Database, December 2003. The denominator is the total number of children under age 18 from Census 2000.

Core Cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

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Children Receiving Food Stamps

DEFINITION

Children receiving Food Stamps is the percentage of income-eligible children under age 18 who participate in the Food Stamp program.

SIGNIFICANCE

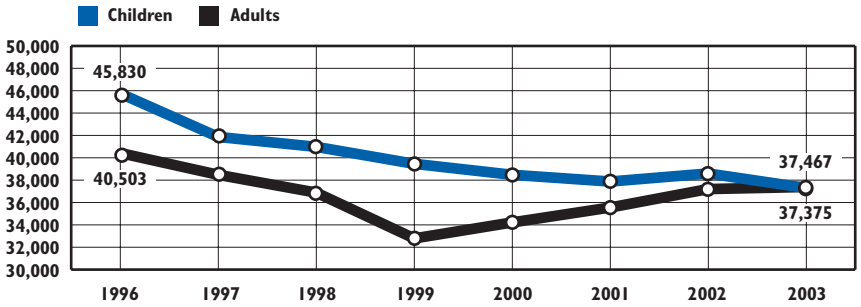
The Food Stamp program provides low-income families with the ability to obtain better nutrition through monthly benefits that can be used to purchase food at retail stores.[1] Research shows that hunger and lack of regular access to sufficient food are linked to serious health, psychological, emotional and academic problems in children and can impede their healthy growth and development.[2]

The Food Stamp program is an entitlement, meaning that federal funding is provided to all applicants who meet the eligibility requirements. Food Stamps is not time-limited and can be used as long as the person maintains their certification.[3,4] One of the strengths of the Food Stamp program is its flexibility. The program is structured to respond to changes in need brought on by economic cycles or natural emergencies.[5] Many working families are unaware of their eligibility for Food Stamps. The benefit level for each eligible household is adjusted according to income, and the monthly benefit level decreases as household income increases.[6] Nearly one in five (19%) Food Stamp cases in Rhode Island has some earned income.[7]

To qualify for Food Stamps, a household's gross income must be less than 130% of the federal poverty level for that family size and meet requirements that limit the value of cash assets.[8] For example, a family of three with a gross annual income less than $19,848 (monthly income less than $1,654) will qualify for Food Stamps if they meet the assets guidelines.[9]

The maximum monthly Food Stamp benefit for a Rhode Island family of three is $371. This is $5 higher than last year's maximum. The average monthly benefit for a family of three in the state is $232, a decrease from the 1997 monthly average of $270.[10] As of December 1, 2003 there were 37,375 children in Rhode Island who received benefits from the Food Stamp program. Half of all food stamp recipients in Rhode Island are children under age 18.[11]

Food Stamp Participation, Children under Age 18 and Adults, Rhode Island, 1996-2003



Source: Rhode Island Department of Human Services, InRhodes Database, 1996 – 2003. Data represents children and adults as of December 1 of each year.

◆ The number of children participating in the Food Stamp program declined from 45,830 in 1996 to 37,375 in 2003, an 18% decrease. During the same time period, the number of adults on the Food Stamp program decreased from 40,503 to 37,467, a 7% decrease.[12]

◆ In 2001, the USDA estimated that only 60% of those eligible for Food Stamps in the U.S. were enrolled. In Rhode Island, the USDA estimated that between 61% and 73% of people who were eligible for the Food Stamp Program participated in 2001.[13]

◆ Based on estimates of the number of children ages birth to 18 living in families with incomes below 130% of the federal poverty threshold according to the 2000 Census, there are an estimated 53,697 income-eligible children able to participate in the Food Stamp program in Rhode Island. As of October 1, 2003, 72% (38,738) were participating.[14,15]

◆ Participation rates vary across the state. Overall, low-income children in the core cities are more likely to receive Food Stamps, with 77% of income-eligible children participating as compared to 59% of eligible children participating in the remainder of the state.[16,17]

◆ In October 2003, Rhode Island implemented an Automobile Exclusion Policy. The new policy allows for one automobile per adult (for up to two adults per household) to be excluded from resource consideration for food stamp eligibility, regardless of the value of the vehicle.[18]

Table 10. **Children Under Age 18 Receiving Food Stamps, Rhode Island, October 1, 2003**

CITY/TOWN	ESTIMATED NUMBER INCOME-ELIGIBLE	NUMBER PARTICIPATING	% OF INCOME-ELIGIBLE PARTICIPATING
Barrington	155	43	28%
Bristol	607	204	34%
Burrillville	356	229	64%
Central Falls	2,840	2,224	78%
Charlestown	173	97	56%
Coventry	654	427	65%
Cranston	2,057	1,425	69%
Cumberland	485	275	57%
East Greenwich	242	110	45%
East Providence	1,687	1,081	64%
Exeter	169	73	43%
Foster	66	43	65%
Glocester	225	75	33%
Hopkinton	228	104	46%
Jamestown	36	19	53%
Johnston	733	498	68%
Lincoln	404	244	60%
Little Compton	21	6	29%
Middletown	404	156	39%
Narragansett	310	119	38%
New Shoreham	19	3	16%
Newport	1,731	1,170	68%
North Kingstown	818	404	49%
North Providence	802	526	66%
North Smithfield	92	52	57%
Pawtucket	5,948	4,271	72%
Portsmouth	187	102	55%
Providence	22,395	18,304	82%
Richmond	118	48	41%
Scituate	157	65	41%
Smithfield	239	96	40%
South Kingstown	485	252	52%
Tiverton	150	162	100%
Warren	333	200	60%
Warwick	1,712	1,260	74%
West Greenwich	81	28	35%
West Warwick	1,610	858	53%
Westerly	843	451	53%
Woonsocket	4,125	3,032	74%
Core Cities	*38,649*	*29,859*	*77%*
Remainder of State	*15,048*	*8,877*	*59%*
Rhode Island	*53,697*	*38,736*	*72%*

Note to Table

Because of a change in methodology, Food Stamp participation rates in this Factbook can not be compared with Factbooks before 2003. This year's estimates for the percentage of eligible participating in the Food Stamp program in Rhode Island cities and towns are based on the total number of children ages birth to 18 living in families with incomes below 130% of the federal poverty level from the 2000 Census. Past estimates were based on the percent of children eligible for the free school lunch program. Some children who are eligible for free School Breakfast may not be eligible for Food Stamps because they do not meet other program requirements.

Source of Data for Table/Methodology

Food Stamp program participation data are from the Rhode Island Department of Human Services, INRHODES Database, October 1, 2003.

Note: October 1 data has been substituted for December 1 data to avoid including participation numbers that may be misrepresented due to holidays. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

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Children Participating in School Breakfast

DEFINITION

Children participating in school breakfast is the percentage of low-income public school children who participate in the School Breakfast Program. Children are counted as low-income if they are eligible for and enrolled in the free or reduced price lunch program.

SIGNIFICANCE

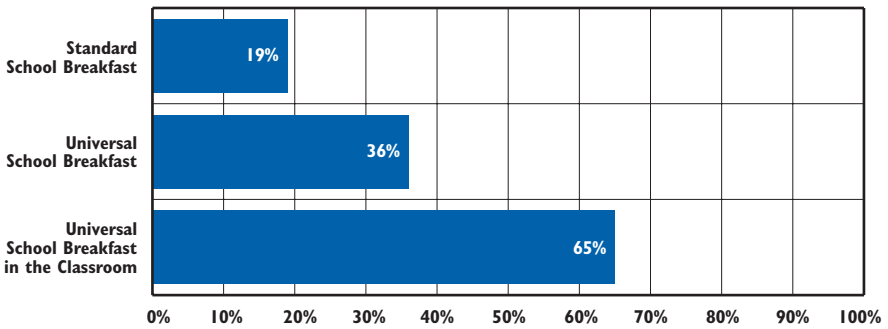
Children who suffer from undernutrition have poorer overall health status than well-nourished children, miss more days of school and are less ready to learn when they do attend.[1] Students who eat breakfast have significantly higher math and reading scores, fewer absences, improved attentiveness and lower incidences of social and behavioral problems.[2]

Low-income students are more likely than other students to arrive at school without an adequate breakfast. Research shows that when there is a school breakfast program available, low-income students are significantly more likely to consume a breakfast.[3] The School Breakfast Program offers nutritious meals, providing children who participate with one-fourth or more of their Recommended Daily Allowance for key nutrients.[4]

In Rhode Island, one in three households with children did not have enough food to meet basic needs at all times during the year in 2000.[5] Rhode Islanders who are Hispanic, have children under the age of 6, are single parents or have not finished high school are the most likely to report that they did not have enough food to meet their basic needs.[6] For other children, long commute times and rushed family schedules make having time for eating breakfast before school difficult and put children at a disadvantage in their ability to concentrate and arrive in class ready to learn.[7]

In 1995, almost two-thirds (62%) of Rhode Island public schools did not offer the breakfast program.[8] Rhode Island state legislation now requires all public schools to provide students with access to school breakfast.[9] Federal and state funds are available to support the costs of the School Breakfast Program. To receive a reduced-price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall below 130% of poverty. Children in Food Stamp and Family Independence Program households are automatically eligible for free meals.[10] In October 2003, an average of 19,659 breakfasts was served daily across Rhode Island. Of these, 79% were to low-income children eligible for free or reduced price meals.[11]

Participation Rates in School Breakfast for Three Different Program Models



Source: *Evaluation of the Universal School Breakfast Program Pilot Project: Key Interim Report Findings from the First Year of Implementation.* (November 2002). Washington, DC: Food Research and Action Center.

◆ Universal School Breakfast Programs offer school breakfast free to all students, regardless of family income. Universal programs increase school breakfast participation dramatically, especially among low-income students. When schools offer breakfast in the classroom at the start of the school day, participation increases three-fold.[12]

◆ Providing free school breakfast to all students can significantly improve the number of low-income children who access the program by removing the stigma that arises when the program is only offered to low-income students. Schools save money by providing universal free breakfast through eliminating paperwork and increased economies of scale as the total number of breakfasts served increases.[13]

◆ Rhode Island ranks 33rd in the country for participation in school breakfast by low-income students. In Rhode Island, there are only 38 low-income students participating in school breakfast for every 100 low-income students participating in school lunch.[14]

◆ In March 2003, Pawtucket joined Cranston, Central Falls and Providence as the fourth school district in the state to offer universal free school breakfast to every student in the public schools.[15] Efforts are currently underway to develop universal free school breakfast programs in the remaining core cities.[16]

Table 11. **Children Participating in School Breakfast, Rhode Island, Fall 2003**

SCHOOL DISTRICT	2003 FALL ENROLLMENT	DISTRICT WIDE AVERAGE DAILY PARTICIPATION IN BREAKFAST	PERCENT OF ALL CHILDREN PARTICIPATING IN BREAKFAST	NUMBER OF LOW-INCOME STUDENTS	LOW-INCOME AVERAGE DAILY PARTICIPATION IN BREAKFAST	PERCENT OF ALL LOW-INCOME CHILDREN PARTICIPATING IN SCHOOL BREAKFAST
Barrington	3,325	31	1%	84	6	7%
Bristol Warren	3,579	196	5%	901	166	18%
Burrillville	2,515	105	4%	526	64	12%
Central Falls	3,631	1,010	28%	3,003	833	28%
Chariho	3,685	95	3%	515	66	13%
Coventry	5,613	539	10%	954	259	27%
Cranston	10,831	1,333	12%	2,408	698	29%
Cumberland	5,161	261	5%	653	176	27%
East Greenwich	2,379	50	2%	126	36	29%
East Providence	6,210	467	8%	2,013	414	21%
Exeter-West Greenwich	2,096	61	3%	217	32	15%
Foster	344	37	11%	53	23	43%
Foster-Glocester	1,693	62	4%	158	34	22%
Glocester	735	21	3%	102	18	18%
Jamestown	545	3	1%	34	2	6%
Johnston	3,189	185	6%	778	146	19%
Lincoln	3,452	144	4%	356	134	38%
Little Compton	312	0	0%	20	0	0%
Middletown	2,768	116	4%	489	96	20%
Narragansett	1,644	33	2%	211	23	11%
New Shoreham	151	11	7%	14	7	50%
Newport	2,754	525	19%	1,303	498	38%
North Kingstown	4,492	174	4%	537	138	26%
North Providence	3,352	262	8%	809	205	25%
North Smithfield	1,926	27	1%	185	8	4%
Pawtucket	9,350	1,989	21%	6,215	1,649	27%
Portsmouth	2,945	73	2%	210	33	16%
Providence	27,471	8,544	31%	22,882	7,288	32%
Scituate	1,731	35	2%	164	20	12%
Smithfield	2,611	102	4%	184	54	29%
South Kingstown	4,010	124	3%	467	104	22%
Tiverton	2,149	113	5%	320	58	18%
Warwick	11,537	695	6%	2,325	495	21%
West Warwick	3,684	393	11%	1,269	301	24%
Westerly	3,674	392	11%	787	225	29%
Woonsocket	6,729	1,451	22%	4,207	1,257	30%
Core Cities	*53,619*	*13,912*	*26%*	*38,879*	*11,826*	*30%*
Remainder of State	*98,654*	*5,747*	*6%*	*16,600*	*3,740*	*23%*
Rhode Island	*152,273*	*19,659*	*13%*	*55,479*	*15,566*	*28%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, October 2002 and October 2003. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

Fall enrollment is the public school enrollment as of October 1, 2003. Average daily participation in breakfast is the number of students eating breakfast in school on average in the month of October 2003. Number of low-income students is the number of students eligible for and enrolled in free or reduced price lunches in the month of October 2003. Low-income average daily participation in breakfast is the number of students eligible for and enrolled in free or reduced price lunches, eating breakfast in school on average in the month of October 2003. Private schools and residential child care facilities may offer the School Breakfast Program, but are not included in these calculations.

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Health

The Swing

How do you like to go up in a swing,
    Up in the air so blue?
Oh, I do think it the pleasantest thing
    Ever a child can do!

Up in the air and over the wall,
    Till I can see so wide,
Rivers and trees and cattle and all
    Over the countryside –

Till I look down on the garden green,
    Down on the roof so brown –
Up in the air I go flying again,
    Up in the air and down!

By Robert Louis Stevenson

Children's Health Insurance

DEFINITION

Children's health insurance is the percentage of children below age 19 who are covered by any kind of public or private health insurance including Medicaid during the previous calendar year.

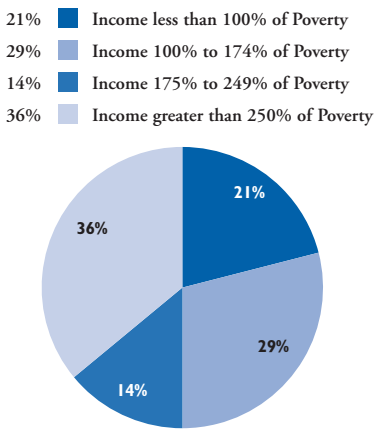
SIGNIFICANCE

Children's health insurance status is the major determinant in whether children have access to care.[1] Children who lack insurance coverage are more likely to have poorer health outcomes at birth, have fewer well-child visits, and are more likely to delay seeking medical care.[2] Insured children are more likely than uninsured children to receive medical care for common conditions like asthma and ear infections – illness that if left untreated can have life-long consequences and lead to more serious health problems.[3,4] Children without insurance often have poorer school attendance and lower school achievement.[5]

When parents are insured and have access to health care, their children are also more likely to use health care.[6] Children's health insurance status is also linked to parental access to employer-sponsored insurance.[7]

RIte Care/RIte Share, Rhode Island's Medicaid managed care health insurance program, is available to children and families who qualify based on family income. RIte Care also serves as the health care delivery system for specific groups of children who qualify for Medical Assistance based on a disability or because they are in foster care or receiving an adoption subsidy. As of December 31, 2003 nearly two-thirds (76,152) of the RIte Care members who qualify based on family income were children under age 19. There were 43,427 low-income parents enrolled in RIte Care as of December 31, 2003. Of these parents, 11,727 (27%) received RIte Care because they were enrolled in the Family Independence Program (FIP).[8]

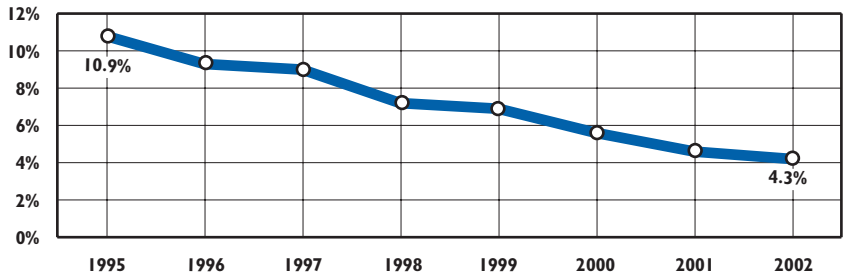
Children Under Age 19 Without Health Insurance, by Poverty Level, Rhode Island, 2002



n = 14,000

Source: U.S. Bureau of Census, Current Population Survey, 2001-2003 average. Compiled by The Annie E. Casey Foundation. These data reflect only those who were uninsured through the entire year and do not include those who were insured for only part of the year.

Children Without Health Insurance, Rhode Island, 1995 - 2002



Source: US Census Bureau, Current Population Survey, 1994-2003, 3 year averages, compiled by Rhode Island KIDS COUNT.

◆ As of 2002, 4.3% of Rhode Island's children under age 18 were uninsured. Nationally, 11.8% of children under age 18 were uninsured.[9] The rate of uninsured children in Rhode Island has been reduced by 60% since 1995.[10]

◆ Like many other states, Rhode Island also provides health insurance to children up to their 19th birthday. In Rhode Island, 5.4% of children under age 19 were uninsured in 2002, as compared to 12.1% nationally.[11]

◆ As of 2002, there were 14,000 uninsured children under age 19 in Rhode Island. Of these, an estimated 9,000 Rhode Island children were eligible for RIte Care but uninsured. Sixty-four percent of Rhode Island's uninsured children live in working families.[12]

◆ During 2003, RIte Share included 1,824 adults and 3,182 children.[13] RIte Share, Rhode Island's health insurance premium assistance program, enables eligible families with access to employer-sponsored insurance to participate in their employer's insurance plan. RIte Share pays the employee's share of the cost for enrolling in an approved employer-sponsored family or individual health insurance plan and provides wrap-around benefits through Medical Assistance.[14]

Table 12.

Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 2003

CITY/TOWN	RIte Care FIP	RIte Care Non-FIP	SSI	Katie Becket Provision	Adoption Subsidy	Foster Care	Other	Total
Barrington	44	179	9	38	10	5	4	289
Bristol	168	521	27	15	19	4	6	760
Burrillville	135	504	39	27	58	64	1	828
Central Falls	1,772	2,587	251	3	9	13	0	4,635
Charlestown	81	219	10	10	13	6	1	340
Coventry	294	1,085	66	57	89	32	1	1,624
Cranston	1,107	2,895	196	123	81	43	9	4,454
Cumberland	193	777	56	71	47	23	3	1,170
East Greenwich	50	204	16	52	12	7	1	342
East Providence	878	1,896	132	58	54	45	3	3,066
Exeter	38	137	4	8	17	8	1	213
Foster	27	87	0	8	22	8	2	154
Glocester	41	262	19	13	40	19	1	395
Hopkinton	57	267	14	6	6	0	1	351
Jamestown	21	70	5	7	12	2	1	118
Johnston	372	991	69	19	23	18	1	1,493
Lincoln	176	526	36	34	25	10	3	810
Little Compton	5	54	3	3	1	0	0	66
Middletown	123	451	38	26	9	22	3	672
Narragansett	89	299	17	18	13	33	1	470
New Shoreham	0	11	1	0	0	0	0	12
Newport	889	1,069	104	18	19	26	1	2,126
North Kingstown	263	752	40	63	18	6	2	1,144
North Providence	425	991	71	26	35	40	1	1,589
North Smithfield	50	182	13	22	15	19	1	302
Pawtucket	3,328	5,396	499	43	70	93	5	9,434
Portsmouth	72	328	10	38	14	8	2	472
Providence	14,469	16,282	1,925	68	1,184	1,250	10	35,188
Richmond	29	162	11	8	10	22	0	242
Scituate	69	262	12	27	21	11	2	404
Smithfield	64	285	19	28	17	9	1	423
South Kingstown	219	617	48	48	41	15	2	990
Tiverton	122	396	28	16	12	11	1	586
Warren	167	350	22	17	19	5	0	580
Warwick	918	2,763	193	136	119	65	12	4,206
West Greenwich	21	135	2	12	12	8	2	192
West Warwick	566	1,513	97	20	68	16	2	2,282
Westerly	249	918	54	30	10	11	3	1,275
Woonsocket	2,405	2,851	384	30	88	93	6	5,857
Out of State/Unknown	*12*	*16*	*44*	*0*	*1*	*1*	*0*	*74*
Core Citites	*23,429*	*29,698*	*3,260*	*182*	*1,438*	*1,491*	*24*	*59,522*
Remainder of State	*6,567*	*19,576*	*1,280*	*1,064*	*894*	*579*	*72*	*30,032*
Rhode Island	*30,008*	*49,290*	*4,584*	*1,246*	*2,333*	*2,071*	*96*	*89,628*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, MMIS Database, December 31, 2003.

Core Cities are Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

The column labeled "RIte Care/FIP is the number of children enrolled in RIte Care as of December 31, 2003 who also participate in the Family Independence Program. The "RIte Care/Non-FIP" column includes other RIte Care participants under the age of 19 and pregnant women. "SSI" is the children enrolled in Medical Assistance because they receive SSI. "Katie Beckett" is children enrolled in Medical Assistance because they qualify for the Katie Beckett provision. "Adoption Subsidy" is children enrolled in Medical Assistance because they have been adopted through the state and their families receive an adoption subsidy. "Foster Care" is children enrolled in RIte Care and living in state substitute care placements. "Other" includes non-SSI children with disabilities receiving fee-for-service Medical Assistance and living in long-term care institutional or residential placements.

In September 2003, the Rhode Island Department of Human Services (DHS) began to transition some children with special health care need from fee-for-service Medicaid to managed care through RIte Care. DHS expects to complete the transition by early 2004, although not all children with special health care needs will be included in the transition. The columns "SSI, Katie Beckett, and Adoption Subsidy" include children in fee-for-service Medicaid and (managed care) RIte Care. The Providence numbers may include some foster children who live in other towns because the DHS database lists foster children as Providence residents for administrative purposes.

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continued on page 136

Childhood Immunizations

DEFINITION

Childhood immunizations is the percentage of children ages 19 months - 35 months who have received the entire 4:3:1:3:3 Series of vaccinations as recommended by the Advisory Committee on Immunization Practices (ACIP). The Series includes 4 doses of Diphtheria, Tetanus and Pertussis (DTaP); 3 doses of Polio; 1 dose of Measles, Mumps, Rubella (MMR); 3 doses of Haemophilus influenzae type b (Hib); and 3 doses of Hepatitis B vaccines. The ACIP has also added pneumococcal disease and varicella (chickenpox) vaccines to its recommendations, but they are not included in the 4:3:1:3:3 Series.

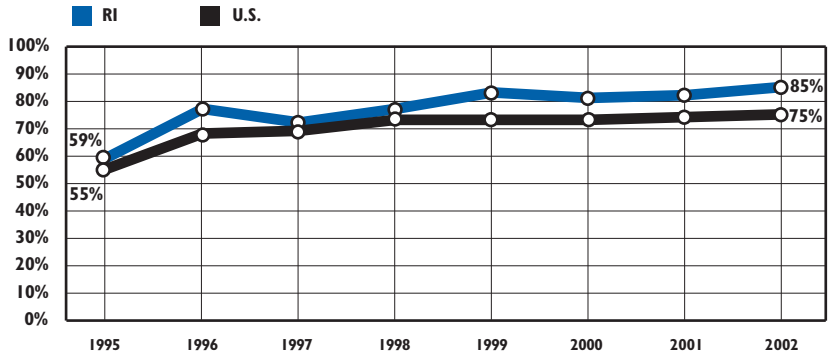
SIGNIFICANCE

Adequate immunization protects children against several diseases that killed or disabled children in past decades.[1] Vaccines interact with the immune system to produce antibodies that protect the body if exposed to the disease in the future.[2] Individual benefits of vaccination include protection from illness, improved quality of life and productivity, and prevention of death. Societal benefits include creation and maintenance of community immunity, prevention of disease outbreaks, and reduction of health-related costs.[3] Although many of the diseases children are vaccinated for are rare, it is important to continue to immunize them until the diseases are completely eradicated.[4]

Vaccines are one of the most cost-effective tools in preventing disease.[5] In order to eliminate cost as a barrier to vaccination, the federal Vaccines for Children (VFC) program allows states to purchase vaccines at a discounted price. Providers then administer the vaccines at no cost to eligible children including those who are uninsured, underinsured, or Medicaid eligible.[6,7]

Rhode Island is one of a few states that purchases all vaccines for children and distributes them to providers. In order to ensure that vaccines reach all children, the Rhode Island Department of Health works in partnership with Rhode Island health plans to maintain and share KIDSNET immunization data.[8] In accordance with national recommendations, Rhode Island requires vaccination against the following diseases prior to entry into child care, Head Start or kindergarten: Diphtheria, Tetanus and Pertussis (DTaP); Hepatitis B; Haemophilus influenzae type b (Hib); Measles, Mumps, Rubella (MMR); Polio; and Varicella (chickenpox).[9]

Immunized Children, Ages 19 Months – 35 Months, United States and Rhode Island, 1995-2002



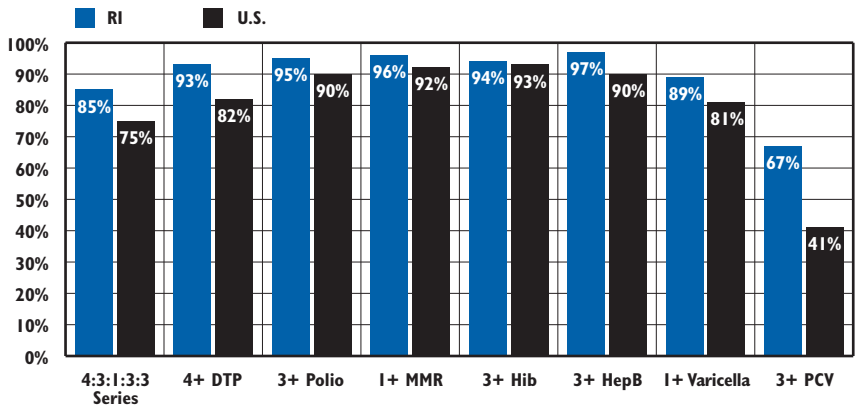
Source: Centers for Disease Control and Prevention, National Immunization Survey, 1995-2002.

◆ In 2002, 85% of Rhode Island children ages 19-35 months were fully immunized with the 4:3:1:3:3 Series, compared to 75% nationally. Immunization rates increased by 44% in Rhode Island between 1995 and 2002, compared to a 36% increase nationwide.[10]

◆ Despite the improvement of vaccination rates overall, racial and ethnic disparities persist. In the United States during 2002, 82% of Asian children were fully immunized, compared to 78% of White children, 73% of Hispanic children and 68% of Black children.[11]

◆ Nationally in 2002, children at or above the poverty level had a 76% vaccination rate while children below the poverty level had a 69% vaccination rate. In contrast, in Rhode Island in 2002, children below the poverty level actually had a higher vaccination rate (90%) than children at or above the poverty level (84%).[12]

Vaccination Coverage Among Children Ages 19 Months - 35 Months, United States and Rhode Island, 2002



Source: Centers for Disease Control and Prevention, National Immunization Survey, 2002.

◆ In 2002 Rhode Island ranked among the top ten states on vaccination rates for every childhood vaccine except Hib. Rhode Island had the best vaccination rates in the nation for five standard vaccines.[13]

◆ Pneumococcal vaccine (PCV) was added to the national ACIP recommendations in 2000. The vaccine protects against pneumonia, bacteremia, sinusitis and acute otitis media (ear infection).[14] In 2002, Rhode Island ranked first in the nation for the percentage of 19-35 month olds vaccinated with PCV (67%).[15]

◆ The Rhode Island Immunization Program conducts an annual statewide school immunization survey to assess immunization levels of children entering kindergarten, 7th grade, and attending licensed child care centers and Head Start programs. The 2002-2003 Rhode Island School Immunization Survey included 44,290 children over the age of 19 months across 795 sites. Immunization rates for each of the vaccines included in the survey were at least 95% for children in child care, Head Start and kindergarten.[16]

Adolescent Immunization

◆ Many adolescents are affected by diseases that are preventable with proper vaccination. Adolescents who have not been previously vaccinated against varicella (chicken pox) and hepatitis B or have not received a second dose of measles, mumps and rubella (MMR) need to be immunized and all adolescents require a booster dose for tetanus and diphtheria (Td).[17]

◆ In order to ensure that all teenagers are appropriately vaccinated before they leave school, the Rhode Island Department of Health's Immunization Program has partnered with the Rhode Island Childhood Immunization Action Coalition to create Vaccinate Before You Graduate (VBYG). The program informs parents and educates students on the importance of immunization and then holds vaccination clinics throughout the year at each participating school. The immunizations are funded through the state's Vaccine for Children Programs and are offered at no cost to students.[18]

◆ During the 2002-2003 school year, 49 schools participated in the program. Of the 1,640 students who enrolled in the program, 94% received immunizations and 84% completed all the immunizations for which they were enrolled.[19]

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Access to Dental Care

DEFINITION

Access to dental care is the percentage of children under age 21 who were enrolled in RIte Care, RIte Share or Medicaid fee-for-service on September 30, 2002 and had received dental services at any point during the previous Federal Fiscal Year (October 1, 2001 - September 30, 2002).

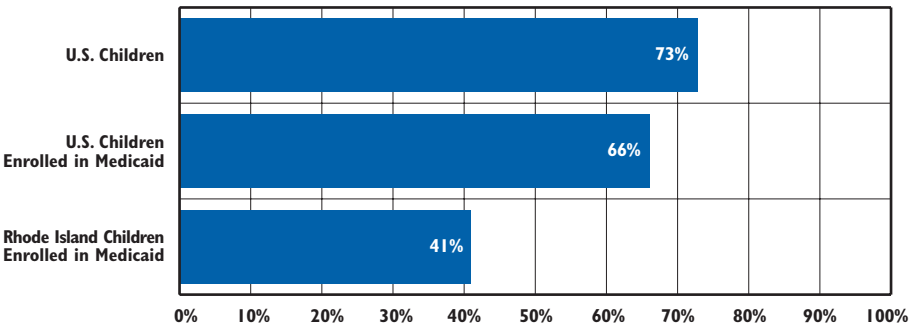
SIGNIFICANCE

Dental caries (tooth decay) is the most common disease among children 5 to 17 years old.[1] Preschool children with untreated dental caries are more likely to develop poor eating habits, to have difficulty socializing with peers, and to have speech problems. Children with poor dental health are at increased risk for future dental caries in their permanent teeth.[2] Chronic dental problems in school-age children and adolescents can lead to poor self-image, difficulty concentrating, absenteeism, and reduced school performance.[3]

Children without dental insurance are three times as likely as privately-insured children to be unable to access dental care when needed.[4] In 1999 in Rhode Island, fewer than half (45%) of employers offered dental insurance as a benefit.[5] National estimates indicate that for every child without medical insurance there are 2.6 children without dental insurance.[6] Minority families, low-income families, and families with low education levels are the most likely to be uninsured for dental care.[7]

For children in low-income families, the efficacy of public dental insurance is a critical factor in access to dental prevention and treatment.[8] The federal Medicaid program mandates that states provide comprehensive dental services to eligible children up to age 21 including preventive dental care, dental treatment services, translation services, and transportation.[9] Barriers to obtaining oral health services for children enrolled in RIte Care, RIte Share or Medicaid fee-for-service include difficulty finding a provider who will accept Medical Assistance, inadequate financial resources to pay for dental care, and lack of parental education on the need for dental prevention and treatment services.[10] Obtaining services from dental specialists is especially difficult for children covered through public health insurance programs.[11] Children with disabilities or special health care needs may also have problems accessing providers who are equipped to address their special needs.[12]

Percentage of Children with a Dental Visit in the Previous Year, United States and Rhode Island



Age ranges for U.S. data are children 2-17 years old and Rhode Island data are for children under age 21. Rhode Island data include RIte Care, RIte Share, and Medicaid fee-for-service.

Source: Centers for Disease Control and Prevention, Summary Health Statistics for U.S. Children: National Health Interview Survey, 2001 and Rhode Island Department of Human Services, Federal Fiscal Year 2002.

◆ In the United States in 2001, approximately 73% of all children and 66% of children enrolled in Medicaid or other public insurance had seen a dentist in the past year.[13] Among Rhode Island children under age 21 enrolled in public insurance programs, 41% accessed dental diagnostic, prevention, and/or treatment services during Federal Fiscal Year 2002.[14]

◆ Children in families with incomes below the poverty line and minority children have the greatest extent of untreated dental problems. In the U.S., 80% of the tooth decay occurs in 25% of the children.[15] Children eligible for Medicaid services experience twice the ratio of untreated dental disease as more affluent children.[16]

◆ As few as 3% of poor children have dental sealants compared with the national average of 23%. The Healthy People 2010 goal is for 50% of children to have these protective barriers against dental decay.[17]

◆ Nationally, 36% of African American children and 43% of Hispanic children aged 6 to 8 years have untreated dental caries, compared to 26% of White children.[18]

Reimbursement Rates

◆ The reluctance of many dentists to accept patients with Medicaid coverage compounds a general shortage of dentists nationwide, especially in urban areas. Low reimbursement rates that fail to cover the cost of services and administrative difficulties are two reasons cited by dentists for limiting or not serving Medicaid patients.[19] State efforts to attract more dentists to Medicaid by paying higher fees and streamlining administrative requirements have resulted in increased access to dental care services.[20]

◆ Rhode Island's Medicaid dental reimbursement rates were last increased in 1992.[21] As of November 2001, for the 50 most frequently provided dental procedures, Medicaid reimbursement was 45% of Rhode Island dentists' average fees, compared with a reported reimbursement rate of 75% by commercial insurers.[22] National estimates indicate that overhead costs for dentists average 55%.[23]

◆ When comparing Rhode Island's Medicaid payment rates and average fees charged by dentists in the New England region, 14 out of 15 of Rhode Island's rates rank at or below the 4th percentile. This means that only 4% or fewer dentists in the New England region report the Medicaid rate as being equal to or greater than their current charge. Rhode Island's Medicaid reimbursement rates rank at or below the 1st percentile regionally on five of the 15 procedures.[24]

◆ In Federal Fiscal Year (FFY) 2003, 55% of the 672 Rhode Island licensed dentists were paid for providing at least one service to at least one Medicaid recipient, down from 59% in the previous FFY. Thirty percent (30%) of dentists provided service to at least 50 unduplicated Medicaid recipients.[25]

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Children's Mental Health

DEFINITION

Children's mental health is the percentage of Rhode Island children through age 21 enrolled in RIte Care or fee-for-service Medicaid who received a Medicaid-funded mental health service in Rhode Island during state fiscal year 2002 (July 1, 2001 – June 30, 2002).

SIGNIFICANCE

Mental health in childhood and adolescence is defined by the U.S. Surgeon General as the achievement of expected developmental cognitive, social and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills.[1] One in five U.S. children ages 9 to 17 has a diagnosable mental or addictive disorder. One in ten children suffer significant functional impairments at home, at school and with peers as a result of their disorder.[2]

Mental health problems affect children of all backgrounds. Children most at risk for mental disorders and problems with social-emotional development include those experiencing poverty, deprivation, abuse and neglect, unsatisfactory relationships, or exposure to traumatic events; children of a parent with a mental health or substance abuse disorder; children exposed to alcohol, drugs, and tobacco during prenatal development; and children born with low birth weight, difficult temperament, or an inherited predisposition to a mental disorder.[3,4]

There is increasing recognition that mental health problems, whether arising from biological or psycho-social causes or both, affect the physical functioning of the brain and are treatable.[5] The mental health status of children directly influences their behavior at home and at child care or school, their academic performance, and their ability to participate in community life.[6] Parental mental health problems, substance abuse and maternal depression are common and have significant negative effects on children's social and emotional development.[7]

Access to health insurance that covers appropriate services is critical to effective mental health treatment.[8,9] In Rhode Island, during state fiscal year 2002, 9% of children and youth who were enrolled in Medicaid (including RIte Care or fee-for-service Medicaid) received a Medicaid-funded mental health service.[10] Both nationally and in Rhode Island, mental health systems tend to be crisis-driven with disproportionate spending on high-end hospital care and inadequate investment in prevention and in a continuum of community services.[11,12,13]

Rhode Island's Community Mental Health Centers

◆ The eight Community Mental Health Centers (CMHCs) in Rhode Island are a primary source of mental health treatment services available in the state. During 2003, 7,593 children were treated at mental health centers.[14] As of December 31, 2003, there were 3,249 children receiving services through the mental health centers.[15]

◆ The Rhode Island Child and Adolescent Service System (CASSP) is a statewide system that helps parents and communities plan services for children with emotional, behavioral and/or mental health challenges. CASSP services are carried out through eight Local Coordinating Councils (LCCs) managed by the community mental health centers.

Hospitals

◆ In fiscal year 2003, Bradley Hospital provided 11,705 outpatient psychiatric visits to children and 854 children were admitted to the hospital. An average of 40 families were served through Bradley's home-based program. An average of 183 students per day were served at Bradley's schools for children with mental illness and developmental disabilities. Bradley Hospital also serves children in partial hospital and residential treatment programs.[16]

◆ In calendar year 2003, Rhode Island Hospital provided 9,786 child psychiatry outpatient visits.[17]

◆ In 2003, Butler Hospital provided services to 756 children and youth age 18 and under. Of these 756 children, 636 were admitted to the hospital and the remaining 120 were in partial hospital or outpatient programs. Youth between ages 13 and 18 accounted for 78% of services provided.[18]

Early Childhood and School Settings

◆ Child care settings and schools are important sites for the identification of children with mental health needs and provide opportunities for early intervention.[19]

◆ In Rhode Island in 2003, child care providers reported expulsions of 75 children due to behavioral problems.[20] The Child Care Support Network assists child care providers serving children with special needs, particularly mental health and behavioral disorders, through technical assistance and consultation.[21]

◆ During the 2002-03 school year in Rhode Island there were 3,102 children enrolled in special education due to an emotional disturbance. There were 722 suspensions of children with an emotional disturbance.[22]

◆ School-based mental health programs have been shown to reduce the need for disciplinary actions, increase attendance and improve child performance.[23] In Rhode Island in 2002-2003, school-based health centers provided 1,116 behavioral health services.[24]

Youth at the Rhode Island Training School

◆ At the Rhode Island Training School for Youth on December 1, 2003, 46% of adjudicated youth were receiving special education services. This is more than twice the statewide rate of 21%.[25]

◆ Three-quarters (74%) of the Training School youth with special education needs were receiving these services due to behavior disorders.[26]

◆ Seventeen percent of youth at the Training School were receiving psychiatric services and 60% were receiving substance abuse treatment.[27]

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Children with Special Needs

DEFINITION

Children with special needs are those who have a chronic disease or disability that requires educational services, health care, and/or related services of a type or amount beyond that required by children generally. Special needs can be physical, developmental, behavioral, and/or emotional. This indicator measures the number of children enrolled in Early Intervention, Special Education, Supplemental Security Income (SSI) and Medical Assistance (due to special health care needs) in 2003.

SIGNIFICANCE

As many as 18% of children nationwide have a chronic physical, developmental, behavioral or emotional condition that requires specialized health care and related services.[1] Some chronic and disabling conditions among children include mental retardation, attention deficit disorder, asthma, autism, hearing impairment, communication disorders, seizure disorders, and congenital diseases.[2,3]

Children with special needs are a heterogeneous group, varying by the type and severity of the chronic disease or disability. Needs vary based on the age of the child, as well as by the many differences in the population at large — such as family income, race, ethnicity, primary language, and parents' educational level.[4] Children with chronic or disabling conditions are likely to have functional limitations or impairments in physical, social, emotional or behavioral functioning in comparison with their peers of the same age.[5] In Rhode Island, youth with special needs are much less likely than their non-disabled peers to finish high school, go on to postsecondary education, find employment, earn an adequate wage and live independently.[6]

There are some issues of common concern to families of children with chronic or disabling conditions. Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, family support, child care, recreation, and career preparation. For many parents, having a child with special needs has a significant impact on their finances, their jobs, and their family life.[7,8]

Children with special needs require access to services that are appropriate to their individualized health, education, and social-emotional needs in order to reach their full potential and minimize the likelihood of life-long dependence.[9,10] Some children with disabilities may require costly therapeutic and health care services, wheelchairs, assistive technology, or home modifications which may result in serious financial burdens on families.[11]

Medical Assistance Coverage for Children with Special Health Care Needs

◆ Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the federal Supplemental Security Income (SSI) program.[12] As of December 31, 2003, there were 4,584 Rhode Island children receiving Medical Assistance benefits because of their enrollment in SSI.[13]

◆ One national study indicates that many children with special health care needs do not qualify for SSI and that 85% of the children with special needs enrolled in Medicaid did not enter the Medicaid system by reason of SSI eligibility.[14]

◆ In Rhode Island, the Katie Beckett eligibility provision provides Medical Assistance coverage to certain children under the age of 18 who have serious disabling conditions, in order to enable them to be cared for at home instead of in an institution. As of December 2003, there were 1,246 Rhode Island children enrolled in Medical Assistance because of eligibility through the Katie Beckett provision.[15] Another 96 children were receiving Medical Assistance because of institutionalization or participation in a waiver program.[16]

Children in the Child Welfare System

◆ According to the National Survey of American Families, 27% of children in the child welfare system across the U.S. show high levels of behavioral and emotional problems and 28% of all children placed with foster parents or relatives have a physical, learning, or mental health condition that limits their activities.[17]

◆ More than half of young children in foster care experience serious physical problems and over half experience developmental delays. This is four to five times the rate of developmental delay found among children in the general population.[18]

◆ Children who are adopted through the Department of Children, Youth and Families and have special needs may qualify for adoption subsidies, including Medical Assistance. As of December 31, 2003, 2,333 children were receiving Medical Assistance because of special needs adoptions. In addition, 2,071 children in foster care were enrolled in Medical Assistance due to their foster care status.[19]

Children Enrolled in Early Intervention

◆ States are required to provide appropriate Early Intervention services to all children from birth to age 3 who are developmentally delayed or have been diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay.[20] One important focus of the program is on enhancing the capacity of families to meet the needs of their children by supporting the needs of the entire family.[21]

◆ In 2003, the seven Early Intervention programs in Rhode Island served 2,708 children ages birth to three.

◆ In 2003, 61% of these children had significant developmental delays, i.e. physical, cognitive, behavioral, and/or emotional delays of unknown medical origin; 22% had a single established condition affecting development, such as cerebral palsy.

◆ Six percent had multiple established conditions, i.e. evidence of developmental delay in combination with multiple prenatal or early life biological events that put the child at risk of further developmental delays. Risk criteria include teen parents, impoverished home environment, poor nutrition, and others.

Source: Rhode Island Department of Health, December 31, 2003.

Children Enrolled in Special Education

◆ Local school systems are responsible for identifying and evaluating students ages 3 to 21 whom they have reason to believe are students with disabilities and therefore might require special education and related services.

◆ In Rhode Island during the 2002-2003 school year, there were 33,632 public school children enrolled in Special Education, 21% of the public school student population. Forty-six percent of children in special education in Rhode Island have a learning disability.

◆ Early Intervention programs for children birth to age 3 are required to provide transition services for children who may be eligible for Special Education at age 3. In 2003, 515 of the 647 children who reached age 3 while in Early Intervention were referred to Special Education.[22] During the 2002-2003 school year, there were 2,516 children ages 3 to 5 (who were not yet in kindergarten) receiving Special Education services in Rhode Island public schools.

Source: The Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 2003.

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Women and Children Receiving WIC

DEFINITION

Women and children receiving WIC is the percentage of eligible women, infants and children served by the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

SIGNIFICANCE

The Special Supplemental Nutrition Program for Women, Infants and Children is a preventive program providing nutritious food, nutrition education, and improved access to health care.[1] This federally-funded program serves pregnant, postpartum and breastfeeding women, infants, and children under five years of age with household incomes below 185% of the poverty level. In addition, any individual who participates in the Food Stamp program, RIte Care, Medicaid, cash assistance through the Family Independence Program, or is a member of a family in which a pregnant woman or infant receives Medicaid benefits, is deemed automatically income eligible. Participants must have a specified nutritional risk, such as anemia, history of poor pregnancy outcomes or inadequate dietary patterns.[2,3]

WIC is not an entitlement program and is not funded at a level that is sufficient to serve all eligible women, infants, and children.[4] Rhode Island received $14.2 million dollars in federal funding during fiscal year 2003 and served an average of 24,506 people per month.[5,6]

WIC participants purchase a monthly food package – an individually prescribed combination of targeted foods to improve the nutritional quality of their diets – at local retailers with checks or coupons.[7] WIC participants also receive nutrition education and health care referrals through the program.[8] WIC promotes breastfeeding as the optimal method of infant feeding and program eligibility for breastfeeding mothers is extended for up to one year.[9] Between 1993 and 2003, the percentage of WIC infants who were breastfed more than doubled, increasing from 6.4% to 16.2%.[10]

The WIC Farmer's Market Nutrition Program improves participants' intake of fresh fruits and vegetables by providing coupons for purchasing produce at local farmer's markets. In Rhode Island in 2003, 62 farmer's markets provided fresh fruits and vegetables to 19,294 recipients.[11]

WIC participation improves birth outcomes, increases the nutrient intake of preschoolers, increases breastfeeding rates and immunization coverage, improves cognitive development, and increases the likelihood of having a regular medical care provider.[12]

Overweight Children and Childhood Obesity

◆ An estimated one in ten children in the WIC program is overweight, an increase of 20% since 1983. The increase of overweight and obesity among WIC participants may be related to the overall increase in the general population and the higher prevalence of overweight among low-income and minority groups that are served by the program.[13]

◆ Because the goal of the WIC program is to improve nutrition and promote healthy eating, overweight is one of the nutritional risk criteria used to determine eligibility. Participation in WIC provides a unique opportunity for overweight children and their families to improve their health, as WIC foods are more nutritious than typical foods in low-income children's diets. Additionally WIC provides educational counseling to promote healthy food choices and age-appropriate physical activity. Its health referral component increases access to medical intervention for overweight.[14]

Coordination with Primary Care Providers

◆ WIC and primary health care programs share the common goal of improving maternal and child health outcomes. The benefits of improved coordination and service integration between the two include increased access to services, increased client satisfaction, increased staff satisfaction, cost savings, and improved clinical outcomes.[15]

◆ An effective strategy for improving coordination and service integration is collocation - housing WIC programs in or near medical service facilities. In Rhode Island, all WIC programs are collocated at health care sites.[16,17]

Table 13. **Women, Infants and Children Receiving WIC, Rhode Island, August 2003**

CITY/TOWN	ESTIMATED* NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	211	42	20%
Bristol	403	198	49%
Burrillville	427	229	54%
Central Falls	1,642	1,577	96%
Charlestown	105	80	76%
Coventry	592	309	52%
Cranston	1,753	1,007	57%
Cumberland	554	268	48%
East Greenwich	241	55	23%
East Providence	1,205	823	68%
Exeter	13	46	100%*
Foster	10	32	100%*
Glocester	293	35	12%
Hopkinton	33	93	100%*
Jamestown	96	22	23%
Johnston	598	333	56%
Lincoln	360	174	48%
Little Compton	63	8	13%
Middletown	694	287	41%
Narragansett	71	86	100%*
New Shoreham	39	0	0%
Newport	1,332	602	45%
North Kingstown	370	245	66%
North Providence	262	416	100%*
North Smithfield	59	58	98%
Pawtucket	3,198	2,995	94%
Portsmouth	249	113	45%
Providence	11,280	9,770	87%
Richmond	24	85	100%*
Scituate	75	72	96%
Smithfield	174	91	52%
South Kingstown	402	223	55%
Tiverton	260	151	58%
Warren	156	103	66%
Warwick	1,613	908	56%
West Greenwich	38	21	55%
West Warwick	777	689	89%
Westerly	648	358	55%
Woonsocket	2,566	1,869	73%
Unknown Residence	*NA*	*33*	*NA*
Core Cities	*20,795*	*17,502*	*84%*
Remainder of State	*12,091*	*6,971*	*58%*
Rhode Island	*32,886*	*24,506*	*75%*

**Estimated Number Eligible is based on the 1990 Census and does not reflect recent increases in eligible population.*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, WIC Program, August 2003.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The denominator is the number of pregnant and postpartum women, infants and children under age 5 who live in families with an income less than 185% of the poverty level according to the 1990 Census of Population as estimated by the Untied States Department of Agriculture. This is an estimate of the eligible population and does not take into account any increases or decreases in the number of women and children who became income eligible after 1990.

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Breastfeeding

DEFINITION

Breastfeeding is the percentage of newborn infants who are exclusively breastfed at the time of hospital discharge.

SIGNIFICANCE

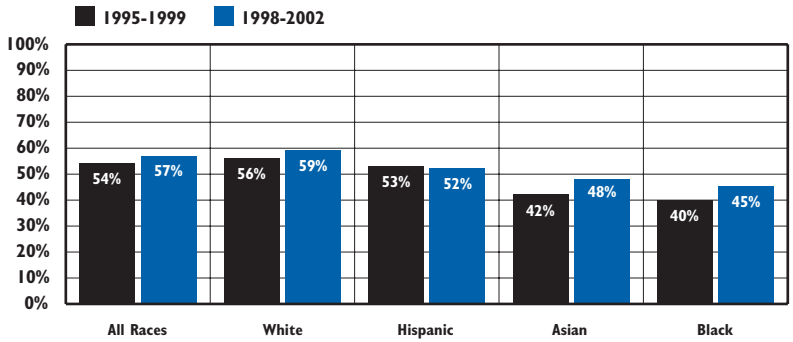
The American Academy of Pediatrics (AAP) identifies breastfeeding as the ideal method of feeding and nurturing infants and recognizes breastfeeding as a critical component in achieving optimal infant and child health, growth and development. The AAP recommends exclusive breastfeeding for approximately 6 months after birth and, in conjunction with appropriate solid foods, for at least 12 months after birth, and thereafter as long as mutually desired.[1] Healthy People 2010, the nation's health agenda, has established target breastfeeding rates of 75% at birth, 50% at 6 months and 25% at one year.[2] The 1998 Healthy People 2010 baseline data shows that United States breastfeeding rates were 64% at birth, 29% at 6 months and 16% at one year.[3]

Breastfeeding provides optimal nutrition for the newborn, and decreases the incidence of diarrhea, lower respiratory infections and ear infections. Breastfeeding has been linked to decreases in sudden infant death syndrome, diabetes, allergies, asthma, lymphoma and other illnesses; improved cognitive development and school performance; a reduced incidence of child abuse; and improved maternal health, including reduced rates of breast and ovarian cancer.[4,5,6] Breastfeeding provides significant social and economic benefits including reduced cost to the family, reduced health care costs and reduced employee absenteeism.[7]

Nationally, the highest rates of breastfeeding, as measured by initiation in the hospital, occur among women who are White, over age 35, and college-educated. The lowest rates occur among women who are Black, less than 20 years old, have less than a 12th grade education, and participate in WIC or Medicaid.[8,9]

Breastfeeding can be effectively promoted by health professionals through culturally appropriate prenatal and postnatal education of the mother, physician support, hospital policies that promote early, exclusive breastfeeding and provide ongoing lactation consultation, timely postpartum follow-up care and home health visits, and links to lactation support networks and resources.[10]

Breastfeeding Rates by Race and Ethnicity, Rhode Island, 1995-2002



Source: Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program, 1995-2002.

◆ Race is a strong predictor of breastfeeding even after controlling for socioeconomic background.[11] During the late 1990s, most racial and ethnic groups in Rhode Island had modest increases in breastfeeding rates. The breastfeeding rates for Black and Asian infants remain significantly lower than the rates for other racial and ethnic groups and the average for all groups.[12]

◆ Healthy People 2010 recommends several strategies for increasing breastfeeding rates among those at highest risk, including increased education for health care providers and new parents, additional support of breastfeeding from employers and the community, and greater media portrayal of breastfeeding as the normal method of infant feeding.[13]

◆ The most significant obstacle to continuing to breastfeed is a mother's need to return to work.[14] In 2003, the Rhode Island General Assembly passed the Nursing Working Mothers Act, which requires employers to provide a safe, private place for an employee to breastfeed her child or pump breast milk. Employers must also work with the employee to develop a mutually acceptable plan for an employee to take breaks for breastfeeding or pumping.[15]

Table 14.

Breastfeeding Rates, Rhode Island, 1998-2002

CITY/TOWN	NUMBER OF BIRTHS	BREASTFEEDING	PERCENT BREASTFEEDING
Barrington	797	653	82%
Bristol	1,022	601	59%
Burrillville	755	419	55%
Central Falls	1,738	892	51%
Charlestown	493	340	69%
Coventry	1,936	1,120	58%
Cranston	3,771	2,029	54%
Cumberland	1,645	1,075	65%
East Greenwich	747	543	73%
East Providence	2,381	1,295	54%
Exeter	307	202	66%
Foster	214	159	74%
Glocester	360	228	63%
Hopkinton	666	452	68%
Jamestown	197	161	82%
Johnston	1,443	717	50%
Lincoln	858	559	65%
Little Compton	115	97	84%
Middletown	1,046	778	74%
Narragansett	537	376	70%
New Shoreham	51	46	90%
Newport	1,621	1,079	67%
North Kingstown	1,598	1,179	74%
North Providence	2,147	1,079	50%
North Smithfield	466	301	65%
Pawtucket	4,882	2,567	53%
Portsmouth	832	635	76%
Providence	13,679	6,776	50%
Richmond	201	131	65%
Scituate	581	403	69%
Smithfield	741	491	66%
South Kingstown	1,395	1,033	74%
Tiverton	368	251	68%
Warren	536	312	58%
Warwick	4,179	2,374	57%
West Greenwich	298	210	70%
West Warwick	1,995	1,006	50%
Westerly	1,128	723	64%
Woonsocket	2,777	1,197	43%
Unknown	*478*	*65*	*NA*
Core Cities	*26,692*	*13,517*	*51%*
Remainder of State	*33,811*	*20,972*	*62%*
Rhode Island	*60,981*	*34,554*	*57%*

Sources of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program Database, 1998-2002. Breastfeeding is defined as intended feeding method at hospital discharge. Births to Rhode Island women that occurred outside Rhode Island are not included.

The denominator is the total number of live births to Rhode Island residents from 1998-2002.

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Women with Delayed Prenatal Care

DEFINITION

Women with delayed prenatal care is the percentage of women beginning prenatal care in the second or third trimester of pregnancy or receiving no prenatal care at all. Data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

Early prenatal care is important to identify and treat health problems and influence health behaviors that can compromise fetal development, infant health and maternal health. Women receiving late or no prenatal care are at increased risk of having infants who are low birthweight, who are stillborn, or who die within the first year of life.[1]

Prenatal care offers the opportunity to screen for and treat conditions that increase the risk for poor birth outcomes. Effective prenatal care also screens for and intervenes with a range of conditions including maternal depression, smoking, substance use, domestic violence, nutritional deficiencies, and unmet needs for food and shelter.[2] Women who receive adequate prenatal care are more likely to obtain preventive health care for their children, such as scheduling well-baby visits, immunizations, and regular health checkups.[3]

Early prenatal care is especially important for women who face multiple risks for poor birth outcomes, including poverty and low maternal education. Several studies indicate that low-income women who receive enhanced prenatal care services experience improved birth outcomes. Enhanced prenatal care services may include outreach, case management, risk assessment, smoking cessation, nutritional and psychosocial counseling, health education, guidance on infant and child development, referrals to social services, and home visits.[4]

Late or No Prenatal Care

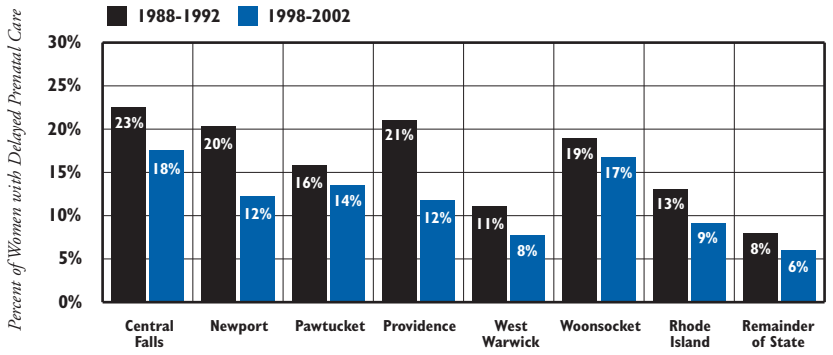
	1990	2001
RI	2.0%	1.1%
US	6.1%	3.7%
National Rank*		*1st*
New England Rank**		*1st*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Late prenatal care is defined as beginning prenatal care in the third trimester.

Source: *The Right Start for America's Newborns.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

Delayed Prenatal Care, Core Cities and Rhode Island, 1988-2002



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1988-2002. Data for 2000-2002 are provisional.

◆ During the 1990s, the rate of delayed prenatal care decreased across Rhode Island, with major improvements in Providence and Newport. However, women in the core cities and in Westerly are twice as likely to receive delayed prenatal care as women in the remainder of the state.[5]

RIte Care's Impact on Prenatal Care

◆ RIte Care, Rhode Island's Medicaid managed care program, has improved access to prenatal care for women using Medicaid. A recent study in the *American Journal of Public Health* states that RIte Care's specific program interventions that addressed and changed organizational and delivery systems barriers resulted in the improvement of adequate prenatal care utilization by women in the program.[6]

◆ Between 1993 and 2000, the percentage of women using Medicaid who began prenatal care in the first trimester increased from 77% to 84%.[7]

◆ In addition to earlier entry into prenatal care, RIte Care has increased the number of women using Medicaid who received "adequate" and "adequate plus" care. Between 1993 and 2000, the percentage receiving high quality care increased from 57% to 73%.[8]

Table 15.

Delayed Prenatal Care, Rhode Island, 1998-2002

City/Town	# Births	# Delayed Care	% Delayed Care
Barrington	825	21	2.5%
Bristol	1,069	84	7.9%
Burrillville	795	60	7.5%
Central Falls	1,795	314	17.5%
Charlestown	456	37	NA
Coventry	2,004	102	5.1%
Cranston	4,209	232	5.5%
Cumberland	1,744	102	5.8%
East Greenwich	582	22	3.8%
East Providence	2,452	196	8.0%
Exeter	339	18	NA
Foster	195	9	NA
Glocester	467	28	NA
Hopkinton	458	52	NA
Jamestown	206	9	NA
Johnston	1,500	81	5.4%
Lincoln	974	60	6.2%
Little Compton	176	19	NA
Middletown	1,077	63	5.8%
Narragansett	618	26	4.2%
New Shoreham	56	9	NA
Newport	1,609	197	12.2%
North Kingstown	1,525	70	4.6%
North Providence	1,571	96	6.1%
North Smithfield	521	25	4.8%
Pawtucket	5,119	689	13.5%
Portsmouth	906	45	5.0%
Providence	13,980	1,647	11.8%
Richmond	491	29	NA
Scituate	488	23	NA
Smithfield	801	34	4.2%
South Kingstown	1,286	65	5.1%
Tiverton	670	62	9.3%
Warren	568	45	7.9%
Warwick	4,402	218	5.0%
West Greenwich	302	11	NA
West Warwick	2,028	156	7.7%
Westerly	1,321	210	15.9%
Woonsocket	3,024	506	16.7%
Unknown	*2*	*0*	*NA*
Core Cities	*27,555*	*3,509*	*12.7%*
Remainder of State	*35,054*	*2,163*	*6.2%*
Rhode Island	*62,611*	*5,672*	*9.1%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1998-2002. Data for 2000-2002 are provisional.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1998-2002.

References for Indicator

[1] *Trends in the Well-Being of America's Children and Youth 2002.* (2003). Washington, DC: U.S. Department of Health and Human Services.

[2] American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health (June 2001). The Prenatal Visit. *Pediatrics,* Vol. 107, No. 6.

[3] *The Right Start State Trends: Conditions of Babies and Their Families Across the Nation 1990-1998,* (2001). Baltimore, MD: The Annie E. Casey Foundation.

[4] *Opportunities to Use Medicaid in Support of Maternal and Child Health Services.* (2000). Rockville, MD: U.S. Department of Health and Human Services, Health Resources & Services Administration.

[5] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1988-2002.

[6] Griffin, J. et al. (1999). The Effect of a Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island. *American Journal of Public Health,* 89.

[7,8] J. Griffin (2002). *The Impact of RIte Care on Adequacy of Prenatal Care and the Health of Newborns, 2000 Update.* Cranston, RI: Rhode Island Department of Human Services, Center for Child and Family Health.

Low Birthweight Infants

DEFINITION

Low birthweight infants is the percentage of infants born weighing under 2,500 grams (5.5 pounds). The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

A baby's birthweight is a key indicator of newborn health and is directly related to infant survival and healthy development. Infants born weighing less than 5.5 pounds are at greater risk for physical and developmental problems than infants of normal weight.[1,2] Babies born with low birthweight may be born prematurely and/or small for their gestational age.[3] Increased risk of low birthweight is strongly associated with poverty, maternal smoking and low levels of educational attainment.[4]

Low birthweight babies are at higher risk of death or long-term illness and disability than infants of normal birthweight.[5] They are 24 times more likely than babies of normal weight to die within the first year of life.[6] Children born low birthweight are significantly more likely than their peers to have developmental delays, poor school performance and special education needs.[7]

At almost all educational levels, socioeconomic levels, and age categories, Black mothers are at greater risk for having a preterm delivery and a low birthweight infant.[8,9] These disparities are not entirely explained by differences in income or health behaviors.[10] In Rhode Island between 1998 and 2002, the percentage of low birthweight among Black infants was nearly double the percentage among White infants and was higher than all other racial/ethnic groups.[11]

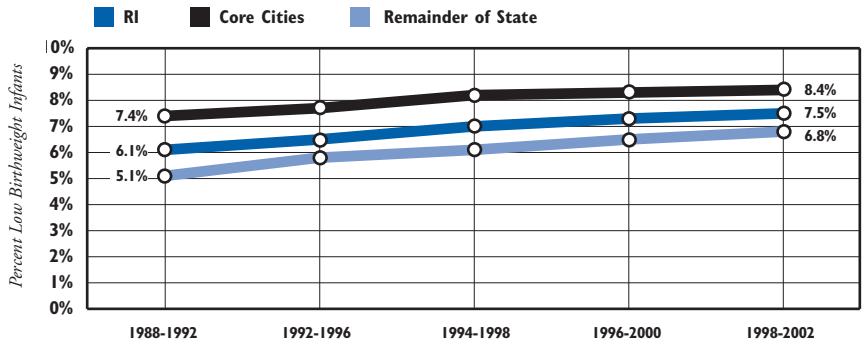
Low Birthweight Infants

	1990	2001
RI	6.2%	7.3%
US	7.0%	7.7%
National Rank*		*20th*
New England Rank**		*5th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *The Right Start for America's Newborns.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

Low Birthweight Infants, Rhode Island, Core Cities and the Remainder of the State, 1988-2002



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1988-1992, 1992-1996, 1994-1998, 1996-2000, 1998-2002. Data for 2000-2002 are provisional.

◆ Over the past decade, the percentage of low birthweight infants has increased for Rhode Island as a whole, in the core cities, and in the remainder of the state. The increase in low birthweight has occurred among all racial and ethnic groups.[12]

◆ One reason for the increase in low birthweight infants is the growing numbers of twin, triplet and higher-order multiple births. Twins and other multiple births are more likely to be low birthweight than singleton births.[13] From 1998 to 2002, 6% of singletons were born low birthweight, compared to 52% of twin births and 96% of triplets and higher-order multiple births in Rhode Island.[14]

◆ Research shows that expanding access to family support programs and health care, including primary health care and mental health services, for pregnant women and for all women of childbearing age are effective in preventing low birthweight.[15]

Table 16. **Low Birthweight Infants, Rhode Island, 1998-2002**

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	825	32	3.9%
Bristol	1,069	64	6.0%
Burrillville	795	70	8.8%
Central Falls	1,795	140	7.8%
Charlestown	456	25	NA
Coventry	2,004	145	7.2%
Cranston	4,209	280	6.7%
Cumberland	1,744	142	8.1%
East Greenwich	582	31	5.3%
East Providence	2,452	168	6.9%
Exeter	339	14	NA
Foster	195	16	NA
Glocester	467	25	NA
Hopkinton	458	40	NA
Jamestown	206	13	NA
Johnston	1,500	113	7.5%
Lincoln	974	66	6.8%
Little Compton	176	17	NA
Middletown	1,077	58	5.4%
Narragansett	618	43	7.0%
New Shoreham	56	2	NA
Newport	1,609	95	5.9%
North Kingstown	1,525	83	5.4%
North Providence	1,571	132	8.4%
North Smithfield	521	45	8.6%
Pawtucket	5,119	415	8.1%
Portsmouth	906	54	6.0%
Providence	13,980	1,270	9.1%
Richmond	491	23	NA
Scituate	488	34	NA
Smithfield	801	51	6.4%
South Kingstown	1,286	71	5.5%
Tiverton	670	31	4.6%
Warren	568	52	9.2%
Warwick	4,402	346	7.9%
West Greenwich	302	13	NA
West Warwick	2,028	143	7.1%
Westerly	1,321	74	5.6%
Woonsocket	3,024	238	7.9%
Unknown	*2*	*0*	*NA*
Core Cities	*27,555*	*2,301*	*8.4%*
Remainder of State	*35,054*	*2,373*	*6.8%*
Rhode Island	*62,611*	*4,674*	*7.5%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1998-2002. Data for 2000-2002 are provisional.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1998-2002.

References for Indicator

[1,6] *KIDS COUNT Data Book: State Profiles of Child Well-Being.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

[2] *Maternal, Infant and Child Health in the United States.* (2001). Washington, DC: March of Dimes.

[3,5,8,13] *America's Children: Key National Indicators of Well-Being 2003.* (2003). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[4] *Child Health USA 2002.* (2002). Rockville, MD: U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

[7] Fewell, R. and Deutscher, B. (Winter 2002). Contributions of Receptive Vocabulary and Maternal Style: Variables to Later Verbal Ability and Reading in Low-birthweight Children. *Topics in Early Childhood Special Education.*

[9, 10,15] Shore, R. (2002). *KIDS COUNT Indicator Brief: Preventing Low Birthweight.* Baltimore, MD: The Annie E. Casey Foundation.

[11,12,14] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1988-2002. Data for 2000-2002 are provisional.

Infant Mortality

DEFINITION

Infant mortality is the number of deaths occurring to infants under one year of age per 1,000 live births. The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

The infant mortality rate is an important measure of the well-being of infants, children, and pregnant women. Infant mortality is associated with a variety of factors, including women's health status, quality and access to medical care, socioeconomic conditions, and public health practices.[1] Communities with multiple problems such as poverty, unemployment, and illiteracy tend to have higher infant mortality rates than more advantaged communities.[2]

In the United States in 2000, one in five infant deaths was caused by a birth defect. Other leading causes of infant mortality include preterm delivery, low birthweight, sudden infant death syndrome (SIDS) and respiratory distress syndrome.[3] Nationally, about a third of infant deaths occur after the first month of life.[4]

Infant mortality has two components: neonatal mortality, deaths of infants younger than 28 days, and postneonatal mortality, deaths between 28 days and one year old.[5] From 1998 to 2002, 414 infants died before their first birthday in Rhode Island. Of these, 312 (75%) were neonatal deaths and 102 (25%) were postneonatal deaths.[6] Risk factors for infant mortality include lack of prenatal care and preventive care, poverty, short intervals between pregnancies, smoking, alcohol and substance abuse, births to teens, unmarried mothers, and mothers with less than 12 years of education.[7,8]

During the past decade, the proportion of infant deaths in Rhode Island attributed to maternal health increased from 50% to 63%.[9] Maternal health includes preconceptional health, perinatal care, and health behaviors.

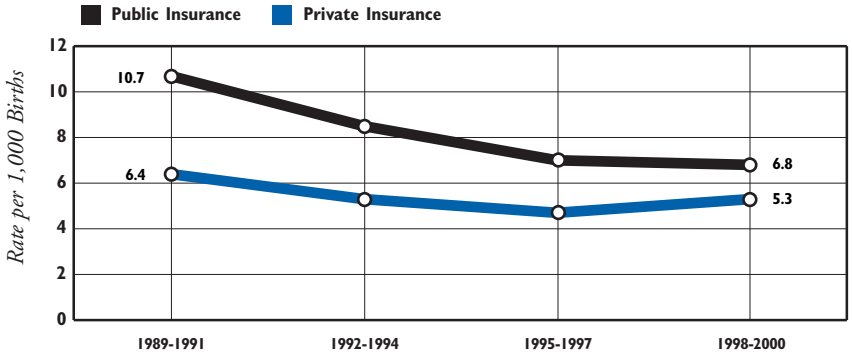
Infant Mortality Rate
(rate per 1,000 live births)

	1990	2000
RI	8.1	6.3
US	9.2	6.9
National Rank*		*14th*
New England Rank**		*5th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *KIDS COUNT DATA BOOK: State Profiles in Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

Infant Mortality Rates by Insurance Status, Rhode Island, 1989-2000



Source: *RI Medicaid Research and Evaluation Reports, Issue Brief #3: Rhode Island's Infant Mortality Rate Drops Significantly in 1990s.* (2002). Cranston, RI: Rhode Island Department of Human Services, Center for Child and Family Health.

◆ During the 1990s, the infant mortality rate dropped 36% for infants with publicly-funded health insurance coverage and 17% for infants with private health insurance coverage. The gap in infant mortality rates between these two groups of infants was reduced by more than half.[10]

◆ The decrease in Rhode Island's infant mortality rate between 1989-1991 and 1998-2002 is partly attributed to increases in health care coverage and improved access to health care created by the expansion of public health insurance, including RIte Care and Medicaid.[11]

Infant Mortality and Race/Ethnicity

◆ At almost all educational levels, socioeconomic levels and age categories, Black mothers are at greater risk for having a pre-term delivery and a low birth weight infant.[12]

◆ Over the past decade, Rhode Island's infant mortality rate declined for White infants, but increased for Asian, Hispanic and Black infants. The Black infant mortality rate is more than twice the rate for White infants and higher than that of any other racial or ethnic group.[13]

Table 17. **Number of Infant Deaths, Rhode Island, 1998-2002**

CITY/TOWN	# BIRTHS	# INFANT DEATHS	RATE/1000 BIRTHS
Barrington	825	1	1.2
Bristol	1,069	5	4.7
Burrillville	795	3	3.8
Central Falls	1,795	11	6.1
Charlestown	456	2	NA
Coventry	2,004	9	4.5
Cranston	4,209	23	5.5
Cumberland	1,744	13	7.5
East Greenwich	582	3	5.2
East Providence	2,452	14	5.7
Exeter	339	1	NA
Foster	195	5	NA
Glocester	467	4	NA
Hopkinton	458	4	NA
Jamestown	206	0	NA
Johnston	1,500	8	5.3
Lincoln	974	10	10.3
Little Compton	176	2	NA
Middletown	1,077	5	4.6
Narragansett	618	3	4.9
New Shoreham	56	1	NA
Newport	1,609	7	4.4
North Kingstown	1,525	2	1.3
North Providence	1,571	15	9.5
North Smithfield	521	1	1.9
Pawtucket	5,119	43	8.4
Portsmouth	906	5	5.5
Providence	13,980	137	9.8
Richmond	491	0	NA
Scituate	488	1	NA
Smithfield	801	2	2.5
South Kingstown	1,286	3	2.3
Tiverton	670	3	4.5
Warren	568	4	7.0
Warwick	4,402	23	5.2
West Greenwich	302	1	NA
West Warwick	2,028	13	6.4
Westerly	1,321	8	6.1
Woonsocket	3,024	19	6.3
Unknown	*2*	*0*	*NA*
Core Cities	*27,555*	*230*	*8.3*
Remainder of State	*35,054*	*184*	*5.2*
Rhode Island	*62,611*	*414*	*6.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1998-2002. Data for 2000-2002 are provisional.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA: Rates were not calculated for cities and towns with less than 500 births, as rates for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1998-2002.

References for Indicator

[1,4] *America's Children: Key National Indicators of Well-Being 2003.* (2003). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2] *KIDS COUNT DATA BOOK: State Profiles in Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

[3] *Perinatal Profiles: Statistics for Monitoring Maternal and Infant Health.* (2003). Washington, DC: March of Dimes.

[5] *Child Health USA 2002.* (2002). Rockville, MD: U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

[6,13] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1990-2002. Data for 2000-2002 are provisional.

[7] *HHS Fact Sheet: Preventing Infant Mortality.* (2001). Washington, DC: U.S. Department of Health and Human Services.

[8] Matthews, T., et al. (2003). Infant Mortality Statistics from the 2001 Period Linked Birth/Infant Death Data Set. *National Vital Statistics Reports,* Vol. 52, No. 2.

[9,10,11] Viner-Brown, S., et al. (January 2003). Infant Mortality in Rhode Island: A Time Trend Analysis. *Medicine & Health / Rhode Island,* Vol. 86, No. 1.

[10,11] *RI Medicaid Research and Evaluation Reports, Issue Brief #3: Rhode Island's Infant Mortality Rate Drops Significantly in 1990s.* (2002). Cranston, RI: Rhode Island Department of Human Services, Center for Child and Family Health.

[12] Shore, R. (2002). *KIDS COUNT Indicator Brief: Preventing Low Birthweight.* Baltimore, MD: The Annie E. Casey Foundation.

Children with Lead Poisoning

DEFINITION

Children with lead poisoning is the percentage of three-year-old children screened for lead poisoning who had elevated blood levels (>10ug/dL) at any time prior to December 31, 2003.[1] These data are for children eligible to enter kindergarten in the fall of 2005 (i.e. born between September 1, 1999 and August 31, 2000).

SIGNIFICANCE

Childhood lead poisoning is one of the most common pediatric health problems, yet it is entirely preventable. Infants, toddlers and preschool age children are most susceptible to the toxic effects of lead and absorb lead more readily than adults.[2] Lead exposure can cause irreversible damage including loss of intelligence, learning disabilities, and behavioral problems including aggression. The most acute poisoning can result in severe illness and death.[3,4,5] The societal costs of childhood lead poisoning include the loss of future earnings due to decreased cognition as well as medical, special education and criminal justice costs.[6,7]

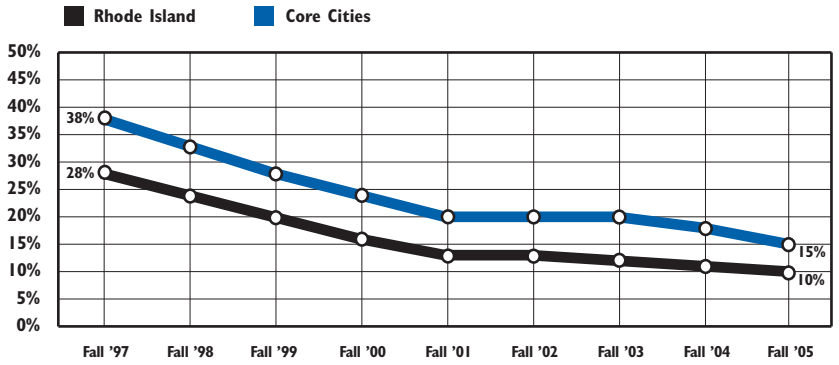
All children living in homes built before 1978 (when lead paint was banned from interior use in the United States) are at risk for lead poisoning. Low-income, minority and urban children are particularly likely to be affected.[8,9] Children in older homes undergoing renovation are also at risk.[10]

The lack of affordable housing in many communities forces many low-income families to live in older dwellings with deteriorating lead paint, placing children at increased risk for exposure to lead.[11] Inadequate nutrition and anemia, which are more common in low-income children, further increase susceptibility to lead poisoning.[12]

The Centers for Disease Control and Prevention have recognized that lead exposure at any level is harmful and recommend a focus on primary prevention of lead exposure.[13,14,15] Prevention efforts should target the systematic reduction of lead paint in housing, especially old, poorly maintained housing, as the most important source of lead exposure in young children.[16]

In Rhode Island, identification of a child as significantly lead poisoned requires that a lead inspection of the child's home be offered.[17] The Department of Health sends certified lead inspectors to determine whether lead hazards are present and to work with property owners to make the property lead-safe. In Rhode Island in 2003, there were 184 inspections offered; of these 115 were performed.[18]

Children Entering Kindergarten with History of Lead Poisoning, Rhode Island and Core Cities, 1997- 2005



Source: Rhode Island Department of Health, Division of Family Health and Division of Environmental Health, Childhood Lead Poisoning Prevention Program, 1995-2003.

◆ Despite declines in lead poisoning rates, kindergarten children living in core cities are still more than twice as likely to have a history of elevated blood lead levels (15%) as those in the remainder of the state (6%).[19] Of the 5 children hospitalized for severe lead poisoning during 2003, 3 resided in Providence and 2 in Central Falls.[20]

◆ In 2002, the Rhode Island General Assembly passed the Lead Hazard Mitigation Act, comprehensive legislation that places a strong emphasis on enforcement mechanisms for lead safety in housing and strengthens tenants' rights. The Lead Hazard Mitigation Act strengthens requirements and penalties for timely abatement by landlords, requires timely referral for prosecution in the event adequate abatement is not undertaken, and creates tenant remedies to enforce the provision of the Act through agency intervention or privately-initiated court action.[21]

◆ The Centers for Disease Control and Prevention recommend a comprehensive, multidisciplinary approach to the treatment of lead poisoning, including repeat blood tests to monitor lead levels, medical management, house inspections, removal of lead hazards, child development and social services, parent education and ongoing monitoring for developmental problems that may arise for children at key transition points.[22,23]

Table 18.

Lead Poisoning in Children Entering Kindergarten in the Fall of 2005

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	# SCREENED POSITIVE >=10 UG/DL	% CHILDREN >=10 UG/DL
Barrington	244	11	4.5%
Bristol	254	18	7.1%
Burrillville	193	15	7.8%
Central Falls	454	76	16.7%
Charlestown	109	3	2.8%
Coventry	449	12	2.7%
Cranston	910	56	6.2%
Cumberland	385	17	4.4%
East Greenwich	152	11	7.2%
East Providence	588	44	7.5%
Exeter	77	2	2.6%
Foster	54	5	9.3%
Glocester	88	8	9.1%
Hopkinton	125	4	3.2%
Jamestown	54	3	5.6%
Johnston	323	23	7.1%
Lincoln	213	10	4.7%
Little Compton	43	3	7.0%
Middletown	208	14	6.7%
Narragansett	175	8	4.6%
New Shoreham	7	2	28.6%
Newport	383	62	16.2%
North Kingstown	395	20	5.1%
North Providence	328	17	5.2%
North Smithfield	115	5	4.3%
Pawtucket	1,193	143	12.0%
Portsmouth	203	13	6.4%
Providence	3,203	586	18.3%
Richmond	116	6	5.2%
Scituate	143	5	3.5%
Smithfield	188	3	1.6%
South Kingstown	366	37	10.1%
Tiverton	177	9	5.1%
Warren	128	10	7.8%
Warwick	980	42	4.3%
West Greenwich	58	2	3.4%
West Warwick	472	30	6.4%
Westerly	266	20	7.5%
Woonsocket	693	80	11.5%
Unknown Residence	*236*	*12*	*5.1%*
Core Cities	*6,398*	*977*	*15.3%*
Remainder of State	*8,114*	*458*	*5.6%*
Rhode Island	*14,748*	*1,447*	*9.8%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health and Division of Environmental Health, Childhood Lead Poisoning Prevention Program.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

Data for children entering kindergarten in the fall of 2005 reflect the number of RI children eligible to enter school in the Fall of 2005 (i.e. born between 9/1/99 and 8/31/00) who screened positive for lead poisoning at any time in their lives prior to the end of December 2003. Data are based on the highest lead test result through December 2003. Data include both venous and capillary tests.

The denominator is the number of children entering school in the fall of 2005 who were screened for lead poisoning.

References for Indicator

[1] Rhode Island Department of Health, Division of Family Health and Division of Environmental Health, Childhood Lead Poisoning Prevention Program. Data are based on the highest lead test result through December 2003. Data include both venous and capillary tests.

[2,12] Farley, D. (January-February, 1998). Dangers of Lead Still Linger. *FDA Consumer.* Washington, DC: U.S. Food and Drug Administration.

[3,8,22] *Screening Young Children for Lead Poisoning: Guidelines for State and Local Public Health Officials.* (November 1997). Atlanta, GA: Centers for Disease Control and Prevention.

[4,10,23] *Managing Elevated Blood Lead Levels Among Young Children.* (2002). Atlanta, GA: Centers for Disease Control and Prevention.

[5,6] Wakefield, J. (October 2002). Lead History – Violent Future? *Environmental Health Perspectives,* Vol. 110, No. 10, 575-580.

[7] Brown, M.J. (November-December 2002). Costs and Benefits of Enforcing Housing Policies to Prevent Childhood Lead Poisoning. *Health Economics.*

[9,11] 2002 Annual Report. (March 2002). Providence, RI: Housing Resources Commission.

[19] Rhode Island Department of Health, Division of Family Health and Division of Environmental Health, Childhood Lead Poisoning Prevention Program. Data are for children entering kindergarten in the fall of 2005. Data are based on the highest lead screening test result at any time in the child's life prior to December 31, 2003. Data include both venous and capillary tests.

[13] Canfield, R. et al. (April 17, 2003). Intellectual Impairment in Children with Blood Lead Concentrations below 10 ug per Deciliter. *The New England Journal of Medicine,* Vol. 348, No.16.

[14] Grosse, S. et al. (June 2002). Economic Gains Resulting from the Reduction in Children's Exposure to Lead in the United States. *Environmental Health Perspectives,* Vol. 110, No. 6.

[15] Personal communication with David Homa, PhD, MPH, Lead Poisoning Prevention Branch, Division of Emergency and Environmental Health Services, Centers for Disease Control and Prevention (February 2004), regarding CDC Policy Statement Regarding Blood Lead Level of Concern.

[16] Department of Health and Human Services and Centers for Disease Control and Prevention. (September 12, 2003). *Morbidity and Mortality Weekly Report,* Vol. 52, No. SS-10.

[17] In Rhode Island, a child is considered to be "significantly lead poisoned" if they have a single venous blood test result of 20 ug/dL or greater or any two tests (capillary or venous) equal to or greater than 15 ug/dL and at least 90 days apart but no more than 365 days apart.

[18,20] Rhode Island Department of Health, Division of Family Health and Division of Environmental Health, Childhood Lead Poisoning Prevention Program, January-December, 2003.

[21] Lead Hazard Mitigation Act. The State of Rhode Island General Assembly. www.rilin.state.ri.us/PublicLaws/law02/law02188.htm.

Children with Asthma

DEFINITION

Children with asthma is the rate of hospitalizations for asthma per 1,000 children under age 18. Data are reported by place of child's residence at the time of hospitalization.

SIGNIFICANCE

Asthma is a chronic lung disease that causes recurrent episodes of wheezing, breathlessness, chest tightness, and cough and can be life threatening.[1,2] Attacks can be triggered by exposure to cigarette smoke, mold and dust in the home, stress, strenuous exercise, allergies, roach infestation, animal dander, indoor and outdoor pollutants, and weather conditions.[3] Childhood asthma in the U.S. has steadily increased over the past two decades.[4] In 2001, 12.6% of children under age 18 had previously been diagnosed with asthma.[5] In 2000 in the United States, for every 10,000 children under age 18 there were 649 asthma outpatient visits, 104 asthma emergency room visits, and 30 asthma hospitalizations.[6]

Asthma is the number one chronic condition in children and the third-ranked cause of hospitalization in children under age 15. Asthma is the leading cause of school absences resulting from chronic illness.[7] Black children are more likely to suffer from asthma than White and Hispanic children. Racial differences in the prevalence of asthma are correlated with poverty, substandard housing, urban air quality, indoor allergens, and lack of access to preventive medical care.[8,9]

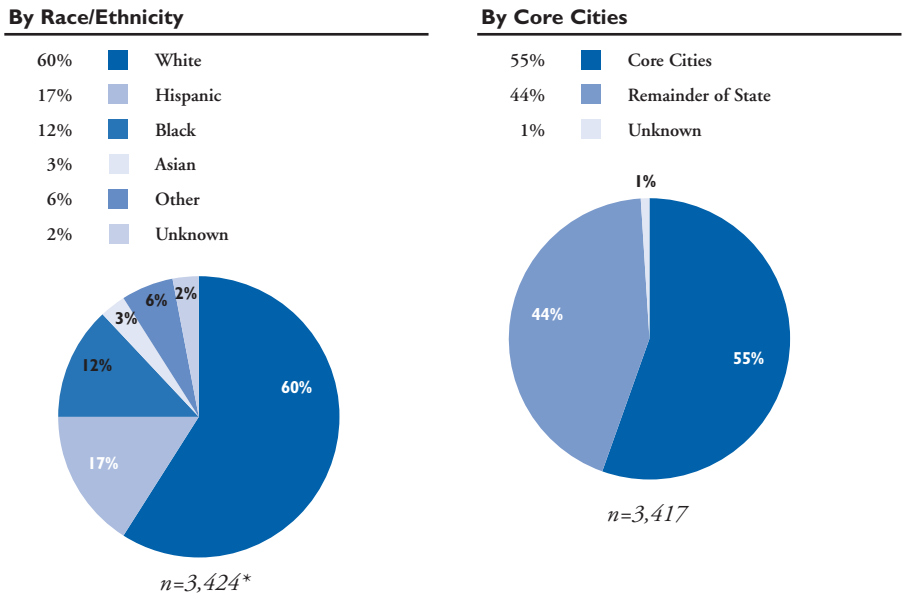
Proper asthma management requires a long-term, multifaceted approach, including patient education, behavior modification, avoidance of asthma triggers, medication to minimize and prevent symptoms, and frequent medical follow-up.[10] Insured children are twice as likely as uninsured children to receive ongoing asthma care from a physician.[11] Low-income and uninsured children are more likely to receive treatment in the emergency department or be hospitalized for conditions that could have been managed with appropriate outpatient care.[12]

Childhood Asthma Hospitalization Rates, Core Cities and Rhode Island, 1998-2002

City/Town	Number of Children Hospitalized	Rate per 1,000 Children
Central Falls	111	4.0
Newport	76	2.9
Pawtucket	272	3.0
Providence	1,098	4.9
West Warwick	109	3.3
Woonsocket	213	3.8
Rhode Island	3,417	2.8

Source: Rhode Island Department of Health, Hospital Discharge Database, 1998-2002.

Asthma Hospitalizations, Children Under Age 18, Rhode Island, 1998-2002



Source: Rhode Island Department of Health, Hospital Discharge Database, 1998-2002.
*Includes 7 non-Rhode Island residents.

Asthma and Access to Health Care

◆ Most cases of childhood asthma can be managed by the child's primary care physician and timely medical care can prevent severe asthma attacks. Hospitalization for asthma may indicate that the child has not had adequate outpatient management of the disease.[13] Asthma symptoms not severe enough to require hospitalization may still prevent a child with asthma from leading a fully-active life.[14]

◆ In Rhode Island between 1998-2002, over half (55%) of all hospitalizations for childhood asthma were children residing in the core cities, where only a third of Rhode Island's children live.[15] Rhode Island's core cities have the highest child poverty rates and the highest rates of children without health insurance in the state.[16]

Table 19. **Asthma Hospitalizations for Children Under Age 18, Rhode Island, 1998-2002**

CITY/TOWN	ESTIMATED NUMBER OF CHILDREN UNDER 18	NUMBER OF ASTHMA HOSPITALIZATIONS	RATE/1000 CHILDREN
Barrington	23,725	29	1.2
Bristol	21,995	48	2.2
Burrillville	20,215	47	2.3
Central Falls	27,655	111	4.0
Charlestown	8,560	34	4.0
Coventry	41,945	80	1.9
Cranston	85,490	193	2.3
Cumberland	38,450	51	1.3
East Greenwich	17,820	24	1.3
East Providence	52,730	130	2.5
Exeter	7,945	5	0.6
Foster	5,525	10	1.8
Glocester	13,320	16	1.2
Hopkinton	10,055	13	1.3
Jamestown	6,190	4	0.6
Johnston	29,530	52	1.8
Lincoln	25,785	43	1.7
Little Compton	3,900	5	1.3
Middletown	21,640	61	2.8
Narragansett	14,165	19	1.3
New Shoreham	925	0	0.0
Newport	25,995	76	2.9
North Kingstown	34,240	58	1.7
North Providence	29,680	76	2.6
North Smithfield	11,895	13	1.1
Pawtucket	90,755	272	3.0
Portsmouth	21,645	38	1.8
Providence	226,385	1,098	4.9
Richmond	10,070	16	1.6
Scituate	13,175	16	1.2
Smithfield	20,095	29	1.4
South Kingstown	31,420	52	1.7
Tiverton	16,835	18	1.1
Warren	12,270	30	2.4
Warwick	93,900	211	2.2
West Greenwich	7,220	13	1.8
West Warwick	33,160	109	3.3
Westerly	27,030	60	2.2
Woonsocket	55,775	213	3.8
Unknown Residence	*NA*	*44*	*NA*
Core Cities	*459,725*	*1,879*	*4.1*
Remainder of State	*779,385*	*1,494*	*1.9*
Rhode Island	*1,239,110*	*3,417*	*2.8*

Source of Data for Table/Methodology

Rhode Island Department of Health, Hospital Discharge Database, 1998-2002.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The denominator is the total number of children under age 18 according to the 2000 Census of Population, multiplied by five to calculate a rate over five years.

References for Indicator

[1,3,7] *Asthma in Children Fact Sheet.* (2003). New York, NY: American Lung Association.

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[14] *Asthma and the Environment: A Strategy to Protect Children.* (2000). Washington, DC: President's Task Force on Environmental Health Risks and Safety Risks to Children.

[15] Rhode Island Department of Health, Hospital Discharge Database, 1998-2002.

[16] Rhode Island Department of Human Services, Medicaid Data Archive and Rhode Island Department of Health, Behavioral Risk Factor Surveillance System, 2002.

Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 17 per 1,000 teen girls. Data are reported by the mother's place of residence, not the place of the infant's birth.

SIGNIFICANCE

Teen pregnancy and parenting threatens the development of teen parents as well as their children. Teen mothers are less likely to have the financial resources, social supports and parenting skills needed for healthy child development.[1] Children born to teen parents are more likely to suffer poor health, experience learning and behavior problems, live in poverty, go to prison, and become teen parents themselves.[2]

While teen pregnancy occurs in families of all income levels, teens who give birth are more likely to come from economically-disadvantaged families and communities.[3] In the U.S., 83% of teens who give birth are from poor or low-income families.[4] Teen moms are more likely to have mothers with low educational attainment and to have mothers or older sisters who became pregnant as an adolescent.[5]

Poor academic achievement is a key predictor of teen pregnancy.[6] Half of teen mothers drop out of school before becoming pregnant.[7] Nationally, only one-third of teen mothers go on to receive a high school diploma.[8] Being a teen parent seriously limits subsequent education and employment prospects.[9] Teen parents are more likely to delay or not finish school, putting them at greater risk of facing unemployment, low-wage jobs, and poverty.[10]

In Rhode Island between 1998 and 2002, there were 117 births to teens ages 12 to 14, 2,099 births to teens ages 15 to 17 and 4,077 births to teens ages 18 and 19. Of all births to teens ages 15 to 17 in Rhode Island from 1998-2002, 72% occurred in the core cities. Between 1998 and 2002 in Rhode Island, 61% of teen pregnancies to girls ages 15 to 19 resulted in live births, 36% resulted in abortion, and 3% resulted in miscarriage.[11]

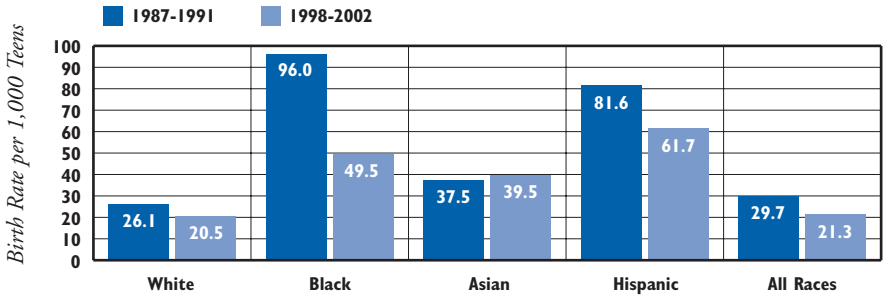
Teen Birth Rate
(births per 1,000 teens ages 15-17)

	1990	2000
RI	32	21
US	37	27
National Rank*		*18th*
New England Rank**		*6th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *KIDS COUNT DATA BOOK: State Profiles in Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

Births to Teens Ages 15-17, by Race and Ethnicity, Core Cities and Rhode Island, 1987-1991 and 1998-2002



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1987-1991 and 1998-2002. Data for 2000-2002 are provisional.

◆ Between the late 1980s and the late 1990s, teen birth rates for Rhode Island girls ages 15 to 17 declined for all racial and ethnic groups except Asian, which increased by 5%. The rate for Black teens decreased by nearly 50%, compared to a 24% decrease for Hispanic teens, and a 21% decrease for White, non-Hispanic teens.[12]

Repeat Births to Teens, Ages 12 to 19, Rhode Island, 1998-2002

Age	Total Number of Births	Number of Repeat Births	Percent
12-14	117	1	<1%
15-17	2,099	199	9%
18-19	4,077	1,089	27%
Total	*6,293*	*1,289*	*20%*

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1998-2002. Data for 2000-2002 are provisional.

◆ Between 1998 and 2002 in Rhode Island, one in five teen births (20%) was to a teen who was already a mother. For girls ages 15 to 17, 9% of births were repeat births and for girls ages 18-19, more than one in four (27%) were repeat births.[13] Repeat births can further impede teen mothers' ability to finish school and keep a job.[14]

Table 20.

Births to Teens, Ages 15-17, Rhode Island, 1998-2002

CITY/TOWN	# OF TEEN GIRLS AGES 15-17	# OF BIRTHS TO TEENS AGES 15-17	1998-2002 RATE PER 1,000 TEENS
Barrington	2,130	2	0.9
Bristol	1,860	17	9.1
Burrillville	1,785	11	6.2
Central Falls	1,875	115	61.3
Charlestown	670	10	14.9
Coventry	3,210	50	15.6
Cranston	6,890	93	13.5
Cumberland	3,125	26	8.3
East Greenwich	1,415	6	4.2
East Providence	4,565	54	11.8
Exeter	725	7	9.7
Foster	445	2	NA
Glocester	1,145	6	5.2
Hopkinton	870	12	13.8
Jamestown	565	2	3.5
Johnston	2,295	19	8.3
Lincoln	2,190	14	6.4
Little Compton	295	0	NA
Middletown	1,370	9	6.6
Narragansett	1,265	10	7.9
New Shoreham	80	0	NA
Newport	1,990	52	26.1
North Kingstown	2,660	14	5.3
North Providence	2,470	35	14.2
North Smithfield	1,015	7	6.9
Pawtucket	6,820	223	32.7
Portsmouth	1,680	10	6.0
Providence	17,055	867	50.8
Richmond	815	7	8.6
Scituate	1,215	7	5.8
Smithfield	1,750	11	6.3
South Kingstown	2,750	23	8.4
Tiverton	1,345	11	8.2
Warren	1,000	7	7.0
Warwick	7,910	90	11.4
West Greenwich	540	2	3.7
West Warwick	2,455	53	21.6
Westerly	2,170	24	11.1
Woonsocket	4,240	191	45.0
Core Cities	*34,435*	*1,501*	*43.6*
Remainder of State	*64,215*	*598*	*9.3*
Rhode Island	*98,650*	*2,099*	*21.3*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1998-2002. Data for 2000–2002 are provisional.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA: Rates were not calculated for cities and towns with less than 500 teen girls ages 15-17, as rates for small denominators are statistically unreliable.

The denominator is the number of girls ages 15 through 17 according to the 2000 Census of Population, multiplied by five to compute a rate over five years, 1998-2002.

References for Indicator

[1,8] *KIDS COUNT DATA BOOK: State Profiles in Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

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[7,14] *Not Just Another Single Issue: Teen Pregnancy Prevention's Link to Other Critical Social Issues.* (February 2002). Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[11,12,13] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1987-2002. Data for 2000-2002 are provisional.

Alcohol, Drug, and Cigarette Use by Teens

DEFINITION

Alcohol, drug and cigarette use by teens is the percentage of 7th-grade, 9th-grade, and 12th-grade students who have used alcohol or marijuana in the past month or are current smokers according to the *2003 Rhode Island Youth Tobacco Survey.*

SIGNIFICANCE

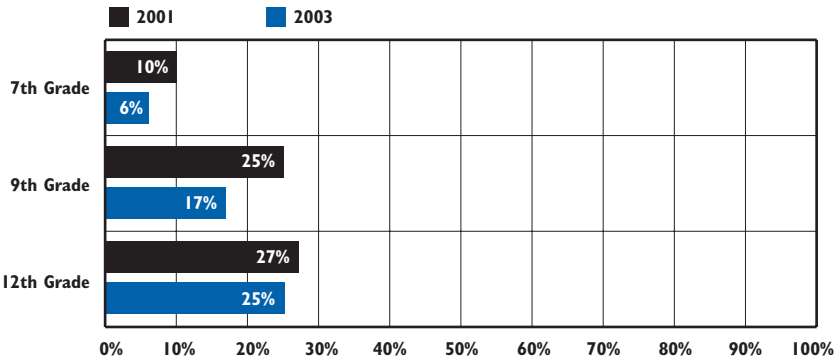
The use of substances threatens the health and safety of children, families, and communities. The number of adolescents using marijuana and tobacco is slowly decreasing both in Rhode Island and nationwide, and the age at first use has been increasing.[1,2,3] The age when young people first start using alcohol, tobacco and illicit drugs is a predictor of later alcohol and drug problems, especially if use begins before age 15.[4]

Research shows that the key risk periods for alcohol, drug and cigarette abuse are during major transitions in children's lives. These include the transition to middle school, which presents new academic and social situations, and the transition to high school, which presents additional social and emotional challenges as well as greater exposure to drugs, substance abusers, and social activities involving drugs and alcohol.[5]

The risk for becoming a substance abuser involves the relationship between risk factors and protective factors, which vary in their effects by age, gender and race/ethnicity. Risk factors include early aggressive behavior, lack of parental supervision, peer substance abuse, academic failure, and poverty. Protective factors include a strong parent-child bond, parental involvement and consistent discipline, academic competence, and a strong neighborhood attachment.[6]

Early intervention with risk factors has a greater impact than interventions that occur later in a child's life. Family intervention can strengthen protective factors among young children by teaching parents better communication skills and appropriate discipline. School programs can begin as early as pre-school by addressing risk factors such as aggressive behavior, poor social skills, and academic difficulties.[7]

Use of Cigarettes by Student Grade Level, Rhode Island, 2001 and 2003



Source: *2003 Rhode Island Youth Tobacco Survey,* Rhode Island Department of Health, Office of Health Statistics. Data are for students who smoked cigarettes in the past month.

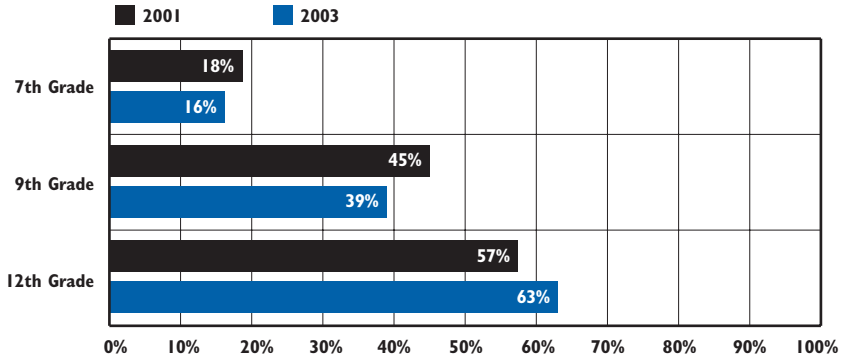
◆ Almost one in five (17%) 9th graders and one in four (25%) 12th graders has smoked cigarettes in the past month according to the *2003 Rhode Island Youth Tobacco Survey*.

◆ Of Rhode Island students who had ever smoked, 12% of high school students and 23% of middle school students smoked their first cigarette before age 11.[8]

◆ Nearly half (45%) of Rhode Island high school students who smoke feel like they need a cigarette every day. Among high school students in Rhode Island, 58% of current smokers want to stop smoking and 58% had tried to quit during the past year.[9]

◆ Among Rhode Island high school students who are current smokers, 67% discussed the dangers of tobacco use with a parent during the past twelve months; 83% think that people can get addicted to using tobacco just like getting addicted to cocaine or heroin; and 35% think it is safe to smoke for a year or two as long as you quit after that.[10]

Use of Alcohol by Student Grade Level, Rhode Island, 2001 and 2003

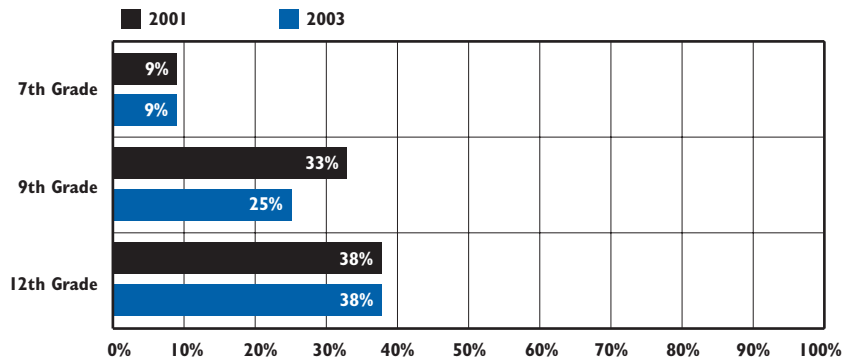


Source: *2003 Rhode Island Youth Tobacco Survey,* Rhode Island Department of Health, Office of Health Statistics. Data are for students who used alcohol in the past month.

◆ In Rhode Island, 16% of 7th grade students, 39% of 9th grade students and 63% of 12th grade students used alcohol in the past month. Nearly 30% of middle school students reported that it would be easy for them to get alcoholic beverages.[11]

◆ Research indicates that 40% of those who start drinking at age 14 or younger will develop alcohol dependence, compared to 10% of those who begin drinking at age 20 or older.[12]

Use of Marijuana by Student Grade Level, Rhode Island, 2001 and 2003



Source: *2003 Rhode Island Youth Tobacco Survey,* Rhode Island Department of Health, Office of Health Statistics. Data are for students who used marijuana in the past month.

◆The likelihood that Rhode Island students used marijuana during the past month nearly tripled between 7th grade and 9th grade, increasing from 9% to 25%.[13] Nationally, thirteen-year-olds are three times as likely to know how to obtain marijuana or to know someone who uses illicit drugs than twelve-year-olds.[14]

References for Indicator

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[4,12,14] *Substance Abuse: The Nation's Number One Health Problem.* (2001). Princeton, NJ: The Robert Wood Johnson Foundation.

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Additional Children's Health Issues

Health Risks and Risk Behaviors Among Rhode Island Public High School Students, 2003

Driving	
Never or rarely wear a seatbelt when riding in a car	16%
Rode in a vehicle during the past 30 days driven by someone who had been drinking alcohol	28%
Suicide	
Felt so sad or hopeless that they stopped doing some usual activities during the past 12 months	24%
Planned a suicide attempt during the past 12 months	11%
Attempted suicide during the past 12 months	8% .
Sexual Behavior	
Ever had sexual intercourse	44%
Had sexual intercourse for the first time before age 13	6% .
Did not use a condom during last sexual intercourse*	37%
Used drugs or alcohol before last sexual intercourse*	21%

Source: *2003 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Office of Health Statistics.
*Question only asked for students who had sexual intercourse during the 3 months prior to the survey.

Teen Dating Violence

◆ Dating violence encompasses the threat or perpetration of any form of sexual assault, physical violence, or verbal or emotional abuse in the context of a dating relationship.[1]

◆ Among Rhode Island high school students, 8% have been hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend and 6% have been physically forced to have sexual intercourse when they did not want to.[2]

Access to Health Care in Schools

◆ In Rhode Island, an estimated 8,000 (4%) school-age children ages 6 to 18 have no health insurance.[3]

◆ Even teens with health insurance can have limited access to health care services. In 2002, (44%) of the children and youth ages 12 to 21 who participated in the Neighborhood Health Plan of Rhode Island managed care plan did not receive a well-child visit.[4]

◆ Health care provided in schools can increase children's access to important prevention and treatment services. School-based health centers (SBHCs) are clinical primary health care sites located within schools. SBHCs offer comprehensive physical and mental health services such as treatment of colds, care for chronic conditions such as asthma and diabetes, mental/behavioral health services, substance abuse services, physical and sports examinations, reproductive health care, dental care, and immunizations. Services are free for students without health insurance.[5]

◆ SBHCs provided over 13,500 services to 9,297 children during the 2002-2003 school year.[6] Of the services provided, 2,024 were behavioral health and social services. Behavioral health and social services in schools can increase a student's ability to receive necessary social and emotional treatment and support.

References

[1] Dating Violence Fact Sheet. (2004). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

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[3] US Census Bureau, Current Population Survey, 2001-2003 average.

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Additional Children's Health Issues

Overweight Children and Youth

◆ According to the Centers for Disease Control and Prevention, children and youth are considered overweight if their weight is above the 95th percentile for their height, age and gender. Children between the 85th and 95th percentiles are considered "at risk" for overweight.[1]

◆ Overweight in children ages 6 to 19 tripled between the early 1960s and 2000.[2] During the same time period, severe overweight almost doubled in children ages 6 to 11 and increased 64% in youth ages 12 to 17.[3]

◆ During 1999-2000 in the US, 15% of children ages 6 to 19 were overweight and another 15% were at risk for being overweight.[4] During 2001 in Rhode Island, 9% of high school students were overweight.[5]

◆ The prevalence of overweight is highest in Hispanic, Black and Native American children.[6] Children with overweight mothers, low family income, and lower levels of cognitive stimulation also have significantly elevated risk of becoming overweight.[7]

◆ Weight gain occurs when more calories are consumed than are expended.[8] On average, overweight children do not consume significantly more calories than their normal weight peers, but demonstrate a slow, consistent weight gain over several years.[9]

◆ Less than 10% of overweight in children is caused by genetic or hormonal problems.[10] Instead, most children become overweight through excessive inactivity, especially television viewing, in combination with consumption of large portions of energy-dense foods.[11]

◆ Overweight causes hypertension, heart disease, stroke, asthma, sleep apnea, type II diabetes, and orthopedic problems.[12,13] Of particular concern, the rate of type II diabetes in children, historically an adult disease, increased five-fold over the past decade.[14] Overweight children are susceptible to psychosocial problems that include depression, low self-esteem and negative self-image.[15]

Schools, Families, and Communities: Preventing Overweight Children

◆ The likelihood that overweight will persist into adulthood increases with the child's age and severity. Between 70% and 80% of overweight adolescents will remain so as adults.[16] Reducing the number of Rhode Island children who are overweight will require a comprehensive, multi-system approach shared among schools, families and communities.

◆ Pediatricians and other health care providers play a key role in early detection and intervention with overweight children. Physician-supervised treatment plans should include a moderate weight loss goal, attention to dietary management, a gradual increase in physical activity and long-term follow up.[17]

◆ Schools can get involved by integrating behavior-focused nutrition education into their curriculum, serving a variety of healthy foods, and increasing opportunities for physical activity with fitness programs, enhanced playgrounds and extracurricular activities.[18]

◆ Family involvement is critical to preventing and reducing overweight in children. Parents who model healthy eating and exercise, encourage physical activity and limit television viewing can significantly improve their children's health.[19]

References

[1] *Body Mass Index-for-Age* (2002). Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.

[2] *Prevalence of Overweight Among Children and Adolescents: United States, 1999-2000* (2002). Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics.

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[11,13,15,18,19] Ebbeling, C. et al (August 2002). "Childhood Obesity: Public Health Crisis, Common Sense Cure" in *The Lancet*, Vol. 360.

[12] *Endocrinology, Nutrition, and Growth Branch: Report to the NACHHD Council* (September 2000). Rockville, MD: National Institute of Child Health & Human Development.

[14] American Diabetes Association (March 2000). "Type 2 Diabetes in Children and Adolescents" in *Diabetes Care*, Vol. 23, No. 3.

Safety

Mother's Song to a Baby

First
this little baby
has been given life
through the medicine man's song
through the medicine man's
  prayer
for this baby the songs
have been sung

Next
the baby's mother
has taken care of him
with the songs of the rain gods

This
little baby
in his cloud-cradle
was watched over
by his mother

It
was
nice
how the clouds
came up like foam
and
as if he
was among them
this little baby
was cared for

By anonymous Native American

Child Deaths

DEFINITION

Child deaths are the number of deaths from all causes to children ages 1 to 14, per 100,000 children. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The child death rate is a reflection of the physical, mental and emotional health of children, the dangers to which children are exposed in the community, access to and use of safety devices and practices (such as bicycle helmets and smoke alarms), and the level of adult supervision children receive.[1] Children living in poverty are at the greatest risk for injury and death. Research indicates that poor children are more likely to die at every age and are five times more likely to die from infectious diseases and parasites.[2]

In Rhode Island, between 1998 and 2002 there were 151 child deaths of children ages 1 to 14. Of these deaths, 98 (65%) were due to disease, 42 (28%) were due to unintentional injuries and 7% were due to intentional injuries (9 homicides and 2 suicides).[3] Between 1998 and 2002, Rhode Island had a child death rate of 15.5 per 100,000 children ages 1 to 14.[4]

Unintentional injuries are the leading cause of death for children ages 1 to 14 in Rhode Island, exceeding deaths from any single disease.[5] These injuries and deaths disproportionately affect poor children, young children, males, children in families with low levels of education and employment, children with developmental disabilities and minority children.[6] In the United States, the child death rate has steadily declined due to constant medical advances and a drop in motor vehicle accidents, the leading cause of injury among children. The death rates for Black and Native American children are higher than the rates for other children.[7]

Many of the injuries that do not result in death are extremely costly both financially and in terms of loss of quality of life. Injuries may leave children temporarily or permanently disabled, result in time lost from school, decrease the child's ability to participate in everyday activities, and affect future ability to work and be self-sufficient.[8]

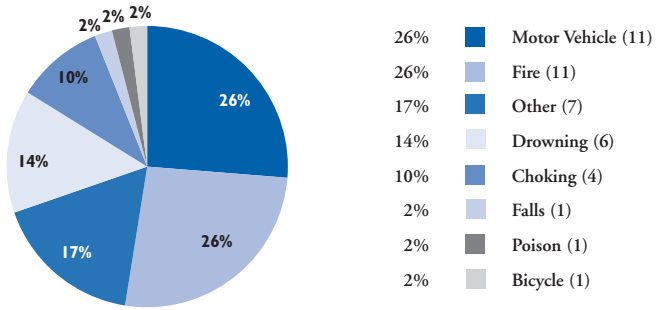
Child Death Rate
(per 100,000 Children Ages 1-14)

	1990	2000
RI	24	17
US	31	22
National Rank*		*7th*
New England Rank**		*5th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

Child Deaths by Cause of Unintentional Injury, Rhode Island, 1998-2002



n=42
** may not total 100% due to rounding*

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1998-2002.

◆ **In Rhode Island, as well as nationally, motor vehicle accidents are the most common unintentional cause of injury deaths to children ages 1 to 14. Between 1998 and 2002 motor vehicle accidents caused 26% of the unintentional injuries that resulted in child deaths in Rhode Island.[9]**

◆ **Effective safety products or changing the child's environment can greatly reduce child deaths. Child restraints in cars, functional smoke alarms, reducing speed in residential areas, wearing safety helmets, locking windows and doors, using child proof tops on bottles and containers and blocking stairs with gates are a few examples of preventive measures.[10,11]**

References for Indicators

[1] *Childhood Injury Fact Sheet.* (July 1999). Washington, D.C.: Centers for Disease Control and Prevention.

[2,7] *KIDS COUNT Data Book 2003: State Profiles of Child Well-Being.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

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Teen Deaths

DEFINITION

Teen deaths are the number of deaths from all causes to teens ages 15 to 19, per 100,000 teens. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The main threats to adolescents' health and safety are risk behaviors, including substance abuse and violence. Teens' emotional health, including self-esteem and mental illness, further impacts their safety. Risk factors for teens include poverty, diminished economic opportunity, neighborhood violence and academic failure. An important factor which protects against risk behaviors is the presence of strong positive relationships with parents, family or other caring adults and engagement in school.[1,2]

According to the *2003 Rhode Island Youth Risk Behavior Survey*, Rhode Island high school students are exposed to numerous risks and frequently engage in risk behaviors. Students report that at least once during the past month, 6% did not go to school because they felt unsafe. During the past year, 5% of students were injured in a physical fight requiring treatment by a health professional and 8% were physically hurt by a boyfriend or girlfriend. Other risk behaviors reported by youth include, attempting suicide in the past year (8%); riding in a vehicle during the past 30 days driven by someone who had been drinking alcohol (28%); and never or rarely wearing a seatbelt when riding in a car (16%).[3]

Between 1998 and 2002, there were 157 deaths of teens ages 15 to 19. Of these, 43 (27%) were due to disease, 49 (31%) were due to intentional injury and 64 (41%) were due to unintentional injuries (accidents). Of the intentional injuries, 31 were homicides and 18 were suicides. More than two-thirds of the accidental deaths involved motor vehicles.[4]

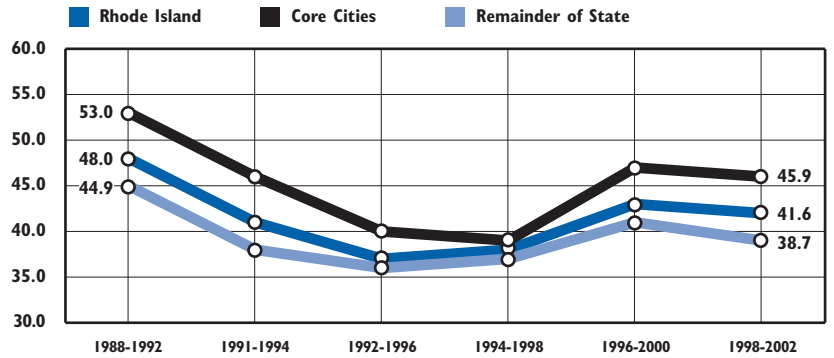
Teen Deaths by Accident, Homicide and Suicide
(deaths per 100,000 Children Ages 15-19)

	1990	2000
RI	35	40
US	71	51
National Rank*		*9th*
New England Rank**		*4th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

Teen Death Rate, Ages 15-19, Rhode Island and Core Cities, 1988-2002



Source: Rhode Island Department of Health, Maternal and Child Health Database, 1988-2002. Data for 2000-2002 are provisional. Data for 1990 are not available. Rates per 100,000 teens age 15-19.

◆ During the late 1980s and early 1990s, the core cities and the remainder of the state experienced a decline in the teen death rate.[5]

◆ The teen death rate for the core cities remained consistently higher than the rate for the remainder of the state between 1988 and 2002. [6]

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[5,6] Rhode Island Department of Health, Hospital Discharge Database, 1988-2002.

Gun Violence

DEFINITION

Gun violence is the number of firearm-related deaths and injuries to Rhode Island children and youth under 20 years of age. The data are reported by place of residence, not place of death or hospitalization.

SIGNIFICANCE

Gun violence affects all children and youth, not only those who are victims and perpetrators. Gun violence threatens the psychological, emotional, and social well-being of individuals and communities.[1] In the late 1980s and early 1990s the accessibility of handguns became a major safety concern for children and youth in the United States. The youth gun violence epidemic peaked in 1994, when 5,833 young people under age 20 died from firearm injuries.[2] Between 1994 and 2000 in the U.S., the number of firearm-related deaths per year decreased by 48% to 3,012.[3] The gun death rate is still cause for concern. In the U.S., 8 children and teens are killed by gunfire every day, and nearly 90,000 children and teens have died from gunshot wounds since 1979.[4]

Research shows a strong correlation between firearm availability and firearm-related deaths and injuries among children and teens. Between 1988 and 1997, a disproportionately high number of 5-14 year olds died by gunfire in states and regions with the highest levels of gun ownership.[5] The availability of guns in the home significantly increases the risk of suicide and unintentional injury for children under 20 years of age. More than 75% of the guns used in youth suicide attempts and unintentional injuries are stored in the residence of the victim, a relative, or a friend.[6] In the late 1990s, it was estimated that 35% to 40% of American households had guns, and as many as 25% had handguns.[7] A reported 1.4 million homes, with 2.6 million children, have firearms that are stored unlocked and loaded or unlocked and unloaded but stored with ammunition.[8]

Between 1995 and 1999 in the U.S., nearly one third (32%) of child handgun homicide victims were murdered by another child.[9] Factors that place young people at risk for violent perpetration include a history of early aggression, neighborhood violence, poor supervision, exposure to violence in the home, parental drug/alcohol abuse, association with peers engaged in high-risk behavior, low commitment to school, poverty, diminished economic opportunity, high levels of transience and family disruption.[10]

Gun Deaths, Children Ages 0-19, Rhode Island, 1993-2002

Year	Number of Deaths	Year	Number of Deaths
1993	10	1998	5
1994	6	1999	8
1995	6	2000	10
1996	6	2001	6
1997	4	2002	7
Total	*32*	*Total*	*36*

Source: Center for Disease Control and Prevention, Rhode Island Injury Mortality Statistics 1990-1996. Rhode Island Department of Health, Office of Health Statistics, 1995-2002.

◆ Compared to the steady annual decline in the national number of youth firearm deaths per year since 1994, the number of firearm deaths to children under age 20 in Rhode Island declined from 10 in 1993 to 4 in 1997, but increased again in 2000 to 10 deaths.[11] In 2002, 7 Rhode Island children under 20 years of age died by gunfire.[12]

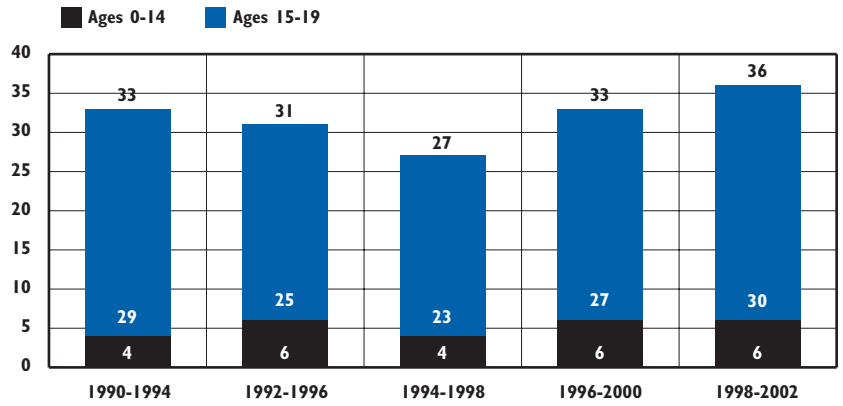
Risk Factors for Gun Violence

◆ Nationally, in 2000, youth ages 17 to 19 were at highest risk for death by firearms in the U.S., with males having a firearm death rate 8 times higher than females.[13]

◆ Nationally, the firearm death rate for Black males between ages 15 and 19 is four times that of White males in the same age group.[14] In 2000, the most common cause of death for all adolescents in the U.S. was motor vehicle traffic injury, except for Black males, who were twice as likely to die from a firearm injury as from a motor vehicle traffic injury.[15]

◆ In the U.S. Black children and youth are more likely than their White counterparts to be victims of firearm homicide. White children and youth are at higher risk for firearm suicide than their Black counterparts.[16]

Gun Deaths, Children Ages 0-14 and 15-19, Rhode Island, 1990-2002



Source: Center for Disease Control and Prevention, Rhode Island Injury Mortality Statistics 1990-1996. Rhode Island Department of Health, Office of Health Statistics, 1995-2002.

◆ Between 1998 and 2002 in Rhode Island, 83% of youth gun deaths were to teens ages 15 to 19, and 17% were to children under the age of 15.[17,18]

◆ Of the six New England states, Rhode Island has the 2nd highest rate of handgun homicide of victims under 18 years of age.[19]

◆ Children and youth residing in New England are at a lower risk for firearm homicide, suicide and unintentional firearm death than children and youth residing in other regions in the U.S.[20] Compared to other regions in the U.S., New England has the second lowest level of handgun ownership (17% of residents).[21]

Gun Hospitalizations

◆ Between 1992 and 1996 in Rhode Island there were 121 hospitalizations of children under age 20 for firearm-related injuries. This number declined to 63 hospitalizations between 1998 and 2002. Of these, 8 victims were younger than age fifteen and 55 were teens ages 15 to 19. Forty-five of the 63 hospitalized youths were victims of assault, 13 were victims of unintentional injuries, and 4 were hospitalized for self-inflicted firearm injuries.[22]

◆ Gun violence disproportionately affects low-income people and imposes significant medical, law enforcement, and other costs on society as a whole.[23] Of the youth hospitalized for gun-related injuries between 1998 and 2002, 73% were residents of the core cities with 62% from Providence, 5% from Central Falls, 5% from Pawtucket, and almost 2% from Woonsocket.[24]

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[10] *Youth Violence in the United States Fact Sheet.* (2003). Atlanta, GA: National Center for Injury Prevention and Control.

[11,12] Rhode Island KIDS COUNT analysis of data from Center for Disease Control and Prevention, Rhode Island Injury Mortality Statistics 1990-1996. Rhode Island Department of Health, Office of Health Statistics, 1995-2002.

[15] *America's Children: Key National Indicators of Well-Being 2003.* (2003). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[17,18] Rhode Island KIDS COUNT analysis of data from Center for Disease Control and Prevention, Rhode Island Injury Mortality Statistics 1990-1996, and Rhode Island Department of Health, Hospital Discharge Database 1990-2002.

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[21] Smith, T.W. and L. Martos. (December 1999). *Attitudes towards and Experiences with Guns: A State-level Perspective.* Chicago: National Opinion Research Center.

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Homeless Children

DEFINITION

Homeless children is the number of Rhode Island children under 13 years old who received emergency housing services at emergency homeless shelters and domestic violence shelters between July 1, 2002 and June 30, 2003.

SIGNIFICANCE

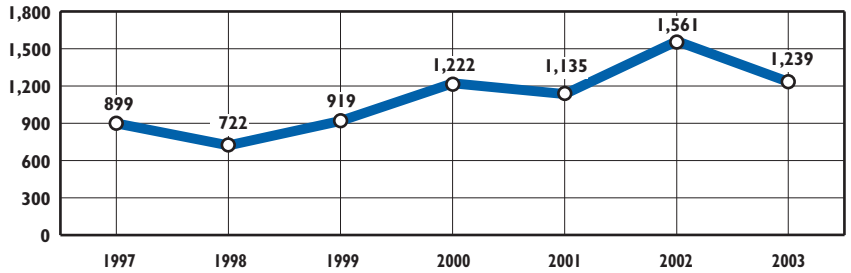
Poverty, low wages, lack of affordable housing and domestic violence are factors in family homelessness.[1,2,3] With a large percentage of family income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness.[4] The shortage of affordable apartments and the dwindling availability of subsidized housing have caused many Rhode Island families to double-up, resulting in overcrowded and unstable living conditions. Almost half of families (43%) with children in the Rhode Island shelter system had been doubled up with family members or friends just before moving to the shelter.[5]

Homeless children are more likely to get sick; develop mental health problems, such as anxiety and depression; have academic problems, including high rates of school mobility and higher rates of learning disabilities diagnoses; and be victims of violence and exhibit delinquent and aggressive behavior than children who are not homeless.[6,7] Homeless children also go hungry at twice the rate of other children and are likely to experience illnesses such as stomach problems, ear infections, and asthma at higher rates.[8] Infants, toddlers and preschoolers who are homeless develop more slowly and may develop emotional problems serious enough to require professional care.[9]

In 2003 in Rhode Island, families represent 40% of the population receiving emergency shelter.[10] More than two out of three families (68%) entering the emergency shelter system in Rhode Island were headed by a single parent, and 91% of families with children had income below $15,000 per year.[11]

Between July 1, 2002 and June 30, 2003, 1,450 children under age 18 received shelter from Rhode Island's emergency shelter system.[12] Nearly half, 697 (48%) were age 5 or under, 542 (37%) were ages 6 to 12, and 211 (15%) were ages 13 to 17.[13] Youth between the ages of 13 and 17 are only admitted into the emergency shelter system if accompanied by a parent or other adult.

Children Under Age 13 Living in Shelters, Rhode Island, 1997 – 2003



Source: Rhode Island Emergency Shelter Information Project 1997 – 2003. Providence, RI: Emergency Food and Shelter Board.

◆ In Rhode Island, 1,239 children under age 13 received emergency housing in a homeless shelter or a domestic violence shelter.[14]

◆ While fewer children are staying in shelters, the number of families seeking emergency shelter has increased 6% from 2002.[15]

◆ The average length of stay in shelters in 2003 was 46 nights, an increase from 34 nights in 2002.[16]

Homeless Children and Domestic Violence

◆ Nationally, approximately half of all women and children experiencing homelessness are fleeing domestic violence. Lack of affordable housing and long waiting lists for assisted housing mean that when many women consider leaving an abusive relationship they must choose between staying with their abuser and ending up homeless.[17]

◆ Among female-headed families seeking emergency shelter in Rhode Island in 2003, the most common reasons for needing shelter were domestic violence (40%) and housing costs (23%).[18]

◆ In 2003, approximately 873 children received services from Rhode Island's six domestic violence shelters. A total of 377 children spent time in a domestic violence shelter during the same year.[19]

Homeless Youth

DEFINITION

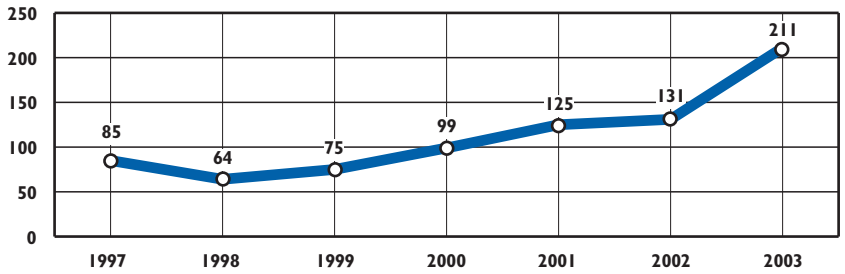
Homeless youth is the number of Rhode Island youth ages 13 to 17 who received emergency housing services at emergency homeless shelters and domestic violence shelters between July 1, 2002 and June 30, 2003.

SIGNIFICANCE

Homelessness among youth has a number of causes, including family problems (such as strained relationships and physical abuse), family homelessness, and residential instability resulting from foster care and institutional placements.[1] Some runaway youth are considered to be throw-aways who were told or forced to leave a household, or were abandoned or deserted by their parents or guardians.[2] Homeless youth are at risk of being physically and/or sexually victimized, abusing drugs and alcohol, attempting suicide, becoming victims or perpetrators of crime, receiving money for sex to meet their basic survival needs, and contracting HIV/AIDS.[3]

Although estimates vary, it is projected that there are between 1 million and 1.3 million U.S. youth who run away from home each year.[4] Rhode Island does not have an overnight shelter for runaway youth.

Homeless Youth Ages 13 - 17, in Rhode Island's Emergency Shelter System, 1997-2003



Source: Rhode Island Emergency Shelter Information Project Annual Reports FY 1997 – FY 2003. Providence, RI: Emergency Food and Shelter Board.

◆ **Between July 1, 2002 and June 30, 2003, 211 youth ages 13 to 17 entered the Rhode Island Emergency Shelter system accompanied by a parent or another adult. This is an increase of 148% since 1997. This is an underestimate of homeless youth in the state because the Emergency Shelter system in Rhode Island does not accept unaccompanied children over the age of 12.[5]**

◆ **During 2003, 728 calls from Rhode Island youth were made to the Traveler's Aid SAFELINE for runaway youth.[6] In 2003 the National Runaway Switchboard received 266 calls from Rhode Island youth, and the Covenant House hotline documented 394 crisis calls from Rhode Island, with approximately 60% coming from youth, youth advocates, or parents of youth.[7,8]**

◆ **As of December 31, 2003, there were 120 individuals under age 19 in DCYF care who were classified as unauthorized absence/runaways.[9]**

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[9] Rhode Island Department of Children, Youth and Families, December 2003.

Juveniles Referred to Family Court

DEFINITION

Juveniles referred to Family Court is the percentage of youth ages 10 to 17 referred to Rhode Island Family Court for all wayward and delinquent offenses.

SIGNIFICANCE

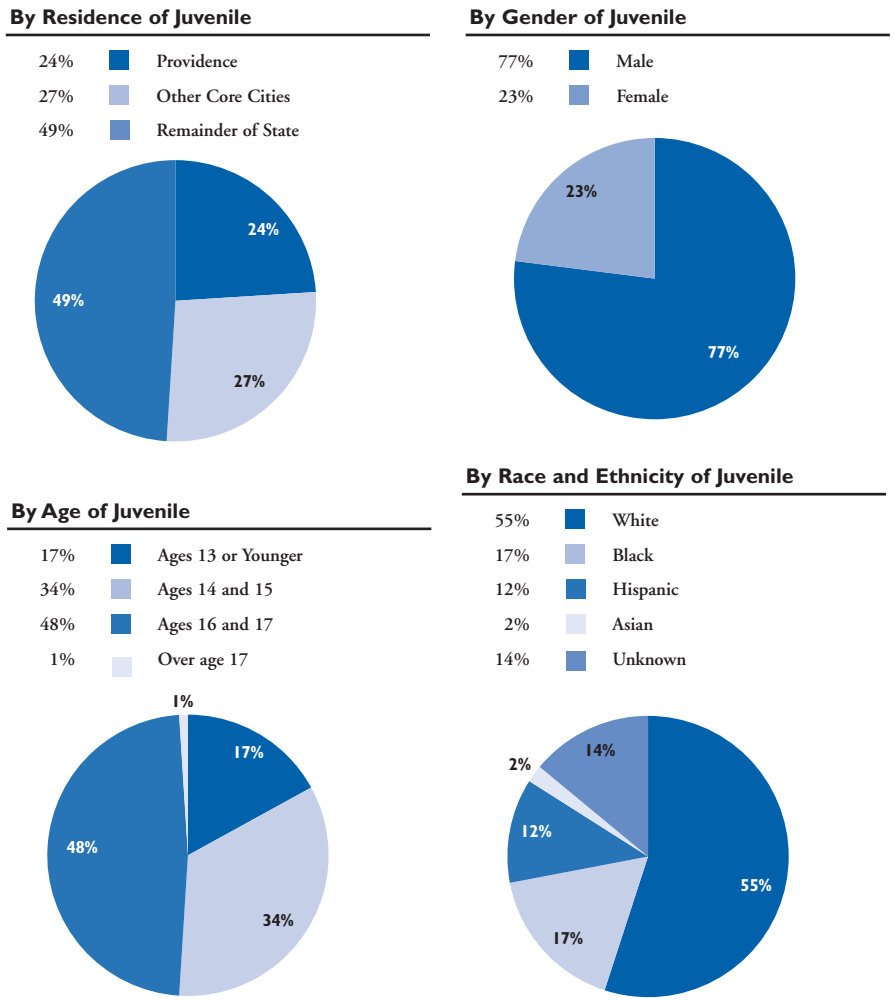
Youth risk factors for involvement in the juvenile justice system include poverty and diminished economic opportunity, family violence, parental substance abuse, youth substance abuse, mental health problems, truancy, learning disabilities, poor school performance, aggression and association with other high-risk youth.[1,2] During 2003 in Rhode Island, 5,338 youth (5% of youth between ages 10 and 17) were referred to Family Court for 9,054 wayward and delinquent offenses. Of these, 517 (6%) involved violent offenses.[3,4]

The Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, except for truancy cases which are referred by local school departments. Approximately one quarter of all cases referred to Family Court are diverted instead of proceeding to a formal court hearing. Juveniles who commit crimes involving drugs may be referred by the Family Court to the Juvenile Drug Court, rather than proceeding through the regular juvenile court system. Juveniles referred to the Drug Court undergo a six-to-twelve-month program that includes intensive court supervision, drug treatment, school performance reviews, job placement, and development of social skills and interests outside the drug culture.[5]

Rhode Island Family Court also administers Juvenile Hearing Boards serving 28 communities and permitting the diversion of juveniles accused of status offenses or misdemeanors. Sanction options in this diversion process include community service, restitution, mental health or substance abuse counseling, and/or a community-based program.[6]

Nine percent of juveniles referred to Family Court for wayward, delinquent and probation violations in 2003 had been referred to Family Court at least twice before.[7] Prevention and early intervention are the most cost-effective approaches to reducing delinquency and recidivism. Successful programs involve highly-trained counselors who work with youth, their families and teachers to promote responsible behavior, implement systems of support and build on assets and strengths.[8,9]

Juvenile Wayward/Delinquent Offenses Referred to Family Court, Rhode Island, 2003



n=9,054 offenses

Source: Rhode Island Family Court, Juvenile Offense Report, 2003.

Juvenile Wayward/Delinquent Offenses Referred to Family Court, by Type of Offense, Rhode Island, 2003

28%	Property Offenses	8%	Traffic Offenses
13%	Status Offenses*	6%	Violent Crimes
16%	Disorderly Conduct	3%	Weapons Offenses
13%	Simple Assault	5%	Other**
9%	Alcohol and Drugs		

n = 9,054

**Status offenses are age-related acts that would not be punishable if the offender were an adult, such as truancy and disobedient conduct.*

***Other includes offenses such as conspiracy, crank/obscene phone calls, and computer crimes.*

Source: Rhode Island Family Court, Juvenile Offense Reports for 2003.

School-Based Strategies for Delinquency Prevention for Youth with Disabilities

◆ Youth with disabilities, particularly those with learning disabilities and serious emotional disorders, are overrepresented in correctional settings.[10] The absence of early intervention programs in schools and increasing pressure to achieve performance standards encourage schools to push out underachieving or difficult to manage youth into juvenile justice and alternative school settings through expulsion, suspension and higher drop out rates.[11]

◆ In Rhode Island, in 2002-2003, 21% of students in public schools were enrolled in special education but 31% of suspensions involved students enrolled in special education. In three school districts more than 40% of suspensions involved students with Individualized Education Plans (IEPs).[12] Twenty-six percent of students with disabilities in Rhode Island drop out.[13]

◆ Effective school-based prevention and delinquency management programming for youth with disabilities is culturally competent, includes low students/teacher ratios, positive behavior management, individualized interventions, structured classrooms, family involvement, and comprehensive services.[14]

Juveniles Tried as Adults

◆ When a juvenile has committed a heinous and/or premeditated felony offense or has a history of felony offenses, the Attorney General may request that the Family Court Judge waive jurisdiction so that the juvenile may be tried as an adult in Superior Court. Waiver is mandatory for juveniles age 17 or older who are charged with murder, first degree sexual assault or assault with intent to commit murder.[15]

◆ A juvenile may also be "certified" allowing a court to sentence the juvenile to age 21 or beyond if there is otherwise an insufficient period of time in which to accomplish rehabilitation. While the child is a minor, the sentence is served at the Training School; upon reaching age 21 the youth is transferred to an adult facility.[16]

◆ In 2003, the Attorney General's Office filed 21 motions to waive jurisdiction to try juveniles as adults. Six of these were mandatory waivers. Five motions to waive were withdrawn, one was denied, and seven juveniles were waived out of Family Court to adult court. In January 2004, there were 8 motions pending before the Family Court.[17]

References for Indicator

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Juveniles at the Training School

DEFINITION

Juveniles at the training school is the number of juveniles up to age 21 who were in the care and custody of the Rhode Island Training School at any time during the 2003 calendar year. The total includes youth who spent time at the Training School and/or in other community placements while in the care and custody of the Training School.

SIGNIFICANCE

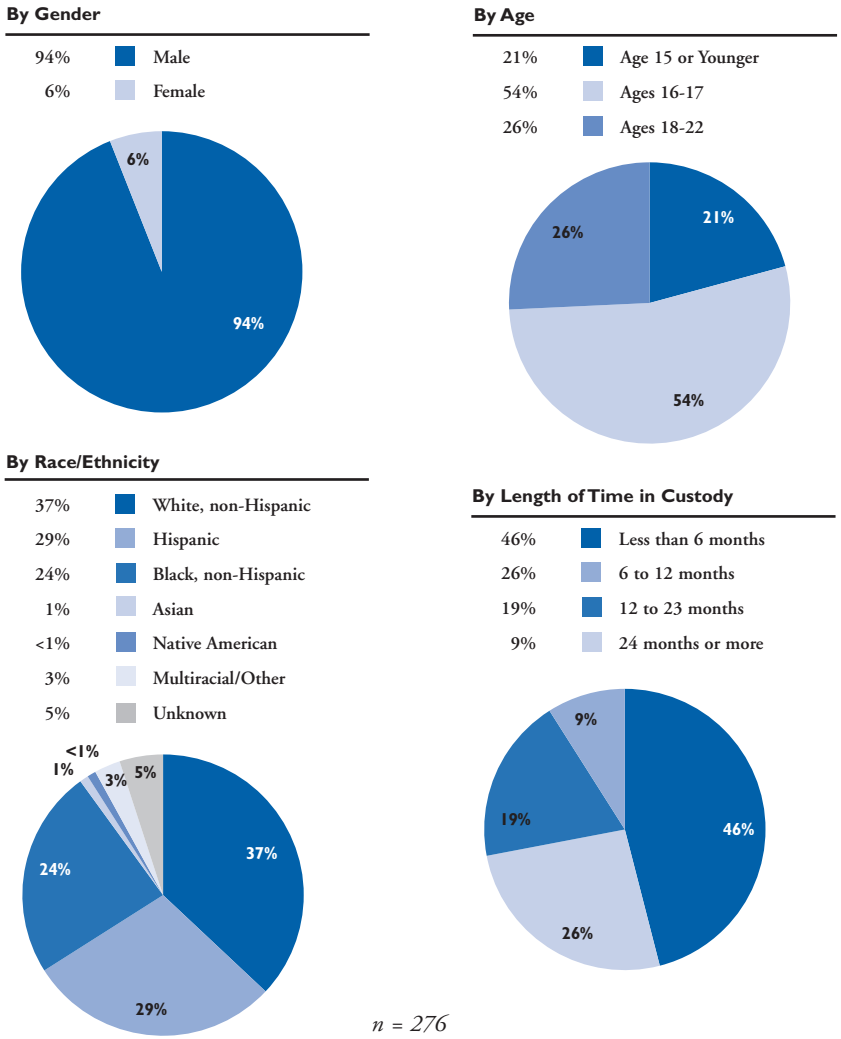
Juvenile detention facilities must balance public safety with the need for treatment and rehabilitation of young offenders.[1] A combination of persistent school problems, family issues, drug use, and/or unmet mental health and special education needs are associated with risk for involvement with the juvenile justice system. Youth who have been violently victimized are more likely to become violent offenders.[2]

Nationwide only a fraction of incarcerated youth are violent and dangerous. Most are incarcerated for drug and property offenses that could be addressed through diversion programs. Black youth are incarcerated at five times the rate of White youth. Increased community placements can help address the large racial disparity among incarcerated youth.[3]

Research indicates that alternatives to incarcerating youth are both more successful in preventing recidivism and are more cost-effective. Successful efforts are comprehensive, community-based and family-focused, with intensive counseling, treatment and transition services for reintegration into the community.[4,5] For some delinquent youth, community-based alternates such as community service, restitution, or diversion to drug court or substance abuse treatment are more effective at reducing re-offending than incarceration.[6,7,8]

The Department of Children Youth and Families operates the Rhode Island Training School for Youth, the state's residential detention facility for adjudicated youth and youth awaiting trial. There were a total of 1,060 youth in the care and custody of the Training School at some point during calendar year 2003. Of these, 18% were female.[9] As of December 31, 2003, there were 189 youth on the grounds at the Training School. Of these, 38 were un-adjudicated (i.e., awaiting trial). An additional 126 youth were within the care and custody of the Training School in temporary home or community placements. Twelve additional youth were classified as runaways.[10]

Juveniles* in the Care and Custody of the Rhode Island Training School for Youth, December 31, 2003



*Data are for adjudicated youth only and include youth in community placements.

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2003.

Rhode Island Youth at the Training School: A History of Risk Factors

School Failure

◆ A survey of educational records of Training School youth confirm significant academic difficulty. Based on a random review of 77 records of adjudicated students on December 1, 2003, 46% (35) had no records available or no records indicative of grades for the past two years. Of the 42 students who had any school records for the previous two years, 19 (45%) had failing grades and 23 (55%) had mixed or passing grades.[11]

◆ During 2003, the average age of students at the Training School was 16. Their average self-reported grade placement was 9th grade and their average reading and math grade level was 6th grade.[12]

Need for Special Education, Mental Health and Substance Abuse Services

◆ The cause of delinquent behavior may be directly related to a child's undetected and/or inadequately treated disability, particularly addictive and mental health disorders.[13,14] At the Rhode Island Training School on December 1, 2003, 46% of adjudicated students were receiving special education services, more than twice the rate of students receiving special education services in Rhode Island public schools in 2003. Most of the Training School students receiving special education services were receiving such services due to behavior disorders (74%) and learning disabilities (18%).[15,16]

◆ On December 1, 2003, 17% of students at the Training School were receiving psychiatric care and 60% were receiving substance abuse treatment.[17]

◆ Appropriate special education and mental health services are critical to both prevent delinquency and assist in rehabilitation. School failure, unexcused absences, chronic disciplinary problems and grade retention may be associated with a disabling condition that has not been detected.[18]

History of Child Abuse and Neglect

◆ Forty-two percent (120) of the adjudicated youth within the care and custody of the Training School on December 31, 2003 had at some point in their childhood been victims of documented child abuse or neglect.[19]

Prevention of Recidivism Among Delinquent Youth

◆ Of the 1,060 youth who were at the Training School at some point during 2003, 23% had been admitted previously. One-third (33%) of the youth who passed through the Training School during 2003 were from Providence, 10% were from Pawtucket, 6% were from Woonsocket, 4% were from Newport, 4% were from Central Falls, and 3% were from West Warwick.[20]

◆ Research indicates that early identification and treatment of youth at risk for chronic delinquency, and immediate, intensive intervention involving the youth and his or her family in counseling, all-day academic programming and substance abuse treatment or counseling are effective in reducing chronic delinquency.[21]

◆ For serious, repeat and violent juvenile offenders, the quality of rehabilitative services is critical, since most will return to the community. A successful model of rehabilitation for serious and violent juveniles includes intensive academic and physical work, earning credit through behavior to hasten release, trained staff and small staff/inmate ratios and groups, and a heavy focus on transition planning and aftercare services.[22]

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[11,12,15,17] Rhode Island Training School for Youth, December 2003.

[14] Teplin, L. (January 2001). *Assessing Alcohol, Drug, and Mental Disorders in Juvenile Detainees, OJDP Fact Sheet.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

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Children of Incarcerated Parents

DEFINITION

Children of incarcerated parents is the number of children with a parent in prison per 1,000 children under age 18. The data are reported by the place of the parent's last residence before entering prison.

SIGNIFICANCE

In the United States, one in forty children has a parent in prison.[1] Nearly 3.6 million parents are under some form of correctional supervision, including parole.[2] Women prisoners account for approximately 7% of all inmates and are the fastest growing group in the prison population.[3]

The increase is partly due to stricter sentencing guidelines and mandatory sentences, particularly for drug-related offenses.[4,5] Fathers are more likely than mothers to be in prison for violent crimes, whereas mothers are more likely to be in prison for drug-related offenses and fraud.[6]

As a result of parental incarceration, and the crimes and arrests that often precede it, most children experience disruption in their homes, a series of temporary caregivers or placement in foster care, financial hardship and lack of contact with their parents.[7] Children of incarcerated parents are at greater risk for many negative behaviors including poor academic achievement, substance abuse, criminal behavior and incarceration.[8,9]

Despite the large and increasing numbers of incarcerated parents, the children they leave behind remain a hidden population with little attention paid to their special needs. The corrections system does not formally recognize these children. Their care arrangements are often handled informally by family members, so they rarely come to the attention of a child welfare agency. While the children may experience problems at school or in other areas of their lives, these problems are often not recognized as being related to the incarceration of a parent.[10,11]

Upon release from prison, a successful transition to the community requires that ex-offenders enhance their education, find stable employment, suitable housing, and health care, as well as receive other supportive services to restore the parent-child relationship.[12,13] Seventy percent of imprisoned parents in the U.S. do not have a high school diploma.[14] Ex-offenders face barriers to earning a living, including limited work histories, the lack of skills and credentials, and discrimination by potential employers.[15,16] Ex-offenders must also deal with pressures from previous peer groups, broken relationships and discrimination.[17]

Incarcerated Parents in Rhode Island

◆ Of the 230 women in Rhode Island who were serving a sentence or awaiting trial at the Rhode Island Department of Corrections as of December 31, 2003, 71% reported they have children. Of the 3,432 incarcerated men serving a sentence or awaiting trial, 50% reported they have children.

◆ Of the 118 women with children who were serving a sentence at the Rhode Island Department of Corrections on December 31, 2003, 58% were serving a sentence for a nonviolent offense and 21% for a drug offense. Another 15% had committed violent offenses and 5% were serving sentences for other reasons. Of the 1,300 sentenced men with children, 17% were serving sentences for nonviolent offenses, 20% for drug offenses, 41% for violent offenses and 23% for breaking and entering, sex offenses or other/unknown offenses.

◆ Of the 1,889 parents incarcerated in 2003, including those awaiting trial in Rhode Island, 49% were White, 29% were Black and 21% were Hispanic.

Source: Rhode Island Department of Corrections, December 2003

Incarcerated Mothers in the United States

◆ Seventy-five percent of women in prison are mothers. Two-thirds of these women are mothers to children under the age of eighteen. At the time of arrest, 72% of these women lived with their children.[18]

◆ Twenty-five percent of adult women in prison reported that they had either given birth at some point during the year prior to their incarceration or were pregnant at the time of arrest. In the United States, fewer than 50% of state prisons have adequate policies focused on providing medical care to pregnant inmates, while only 48% offer prenatal services such as prenatal counseling and help finding placements after their children are born.[19]

Table 21.

Children of Incarcerated Parents, Rhode Island, 2003

CITY/TOWN	# OF INCARCERATED PARENTS	# OF CHILDREN REPORTED*	2000 TOTAL POPULATION UNDER AGE 18	RATE PER 1,000 CHILDREN
Barrington	2	7	4,745	1.5
Bristol	10	23	4,399	5.2
Burrillville	11	19	4,043	4.7
Central Falls	57	132	5,531	23.9
Charlestown	9	19	1,712	11.1
Coventry	33	71	8,389	8.5
Cranston	97	209	17,098	12.2
Cumberland	17	36	7,690	4.7
East Greenwich	7	21	3,564	5.9
East Providence	47	103	10,546	9.8
Exeter	7	13	1,589	8.2
Foster	4	7	1,105	6.3
Glocester	5	9	2,664	3.4
Hopkinton	4	6	2,011	3.0
Jamestown	4	4	1,238	3.2
Johnston	43	87	5,906	14.7
Lincoln	6	10	5,157	1.9
Little Compton	0	0	780	0.0
Middletown	7	20	4,328	4.6
Narragansett	12	26	2,833	9.2
New Shoreham	3	5	185	NA
Newport	56	120	5,199	23.1
North Kingstown	17	33	6,848	4.8
North Providence	27	56	5,936	9.4
North Smithfield	1	5	2,379	2.1
Pawtucket	158	309	18,151	17.0
Portsmouth	6	10	4,329	2.3
Providence	680	1,568	45,277	34.6
Richmond	3	6	2,014	3.0
Scituate	5	7	2,635	2.7
Smithfield	3	4	4,019	1.0
South Kingstown	12	25	6,284	4.0
Tiverton	4	4	3,367	1.2
Warren	8	18	2,454	7.3
Warwick	70	135	18,780	7.2
West Greenwich	1	1	1,444	0.7
West Warwick	50	103	6,632	15.5
Westerly	15	24	5,406	4.4
Woonsocket	118	270	11,155	24.2
Unknown Residence	*148*	*333*	*NA*	*NA*
*Out of State Residence***	*122*	*248*	*NA*	*NA*
Core Cities	*1,119*	*2,502*	*91,945*	*27.2*
Remainder of State	*500*	*1,023*	*155,877*	*6.6*
Rhode Island	*1,889*	*4,106*	*247,822*	*16.6*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Corrections based on self-reports from prisoners and those individuals awaiting trial at the Adult Correctional Institution in Cranston, Rhode Island as of December 31, 2003.

*Data on the number of children are self-reported by the incarcerated parents and may include some children over age 18. Nationally and in Rhode Island, much of the existing research has relied upon self-reporting by incarcerated parents or caregivers.

**Data on Out-of-State Residence reports on those who are under jurisdiction of another state but serving time in Rhode Island and those who are under jurisdiction of Rhode Island, but report an out-of-state address.

NA: Rates were not calculated for cities or towns with less than 500 children under age 18, as rates for small denominations are statistically unreliable.

References for Indicator

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continued on page 136

Children Witnessing Domestic Violence

DEFINITION

Children witnessing domestic violence is the percentage of reported domestic violence incidents in which children under age 18 were present in the home. The data are based on police reports of domestic violence in 2002. Domestic violence is the use of physical force, or threat of force, against a current or former partner in an intimate relationship, resulting in fear and emotional and/or physical suffering.

SIGNIFICANCE

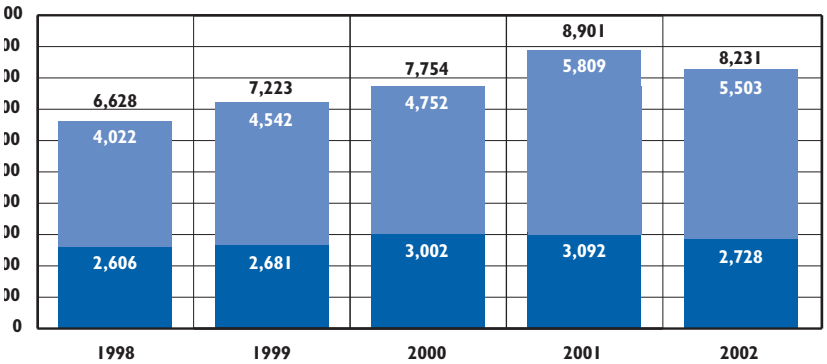
National research indicates that millions of children are exposed to domestic violence each year.[1] In Rhode Island in 2002, police reports indicate that children were present in 33% of domestic violence incidents reported.[2] National surveys of mothers indicate that 80% to 90% of children in homes where there is domestic violence are aware of the abuse.[3]

Children are exposed to domestic violence in several ways. They may witness or hear violent events, become directly involved by trying to intervene, or experience the aftermath of violence by seeing their mother's emotional and physical injuries or damage done to their homes.[4] Children who are exposed to domestic violence are much more likely to be victims of child abuse and neglect. Both child maltreatment and domestic violence occur in an estimated 30% to 60% of families where there is some form of family violence.[5] The greater the intensity of the violence against an adult partner, the more likely it is that children are abused as well.[6]

Exposure to violence in the home impairs cognitive, academic and social functioning. Children who witness domestic violence are more likely to be aggressive and to have behavior problems. They are more prone to depression, anxiety, fear, phobias, sleep disruption, and low self-esteem.[7] Although many children experience these negative effects as a result of exposure to domestic violence, some children emerge from the experience relatively unscathed. A child's age and temperament, the severity and frequency of the violence, and the availability of adults who can emotionally protect or sustain the child greatly affect the child's response.[8]

The effects of exposure to domestic violence can last into adulthood. For males, growing up in a violent home is the strongest predictor of becoming a batterer in the teen and adult years. Both men and women who grow up in violent homes are at increased risk for depression and other trauma-related symptoms.[9]

Domestic Violence Incidents, Rhode Island 1998-2002



Source: Rhode Island Supreme Court Domestic Violence Training Unit, 1998-2002. Includes domestic violence reports from local police and Rhode Island State Police.

◆ The number of domestic violence incidents reported to Rhode Island police increased from 6,628 in 1998 to 8,901 in 2001 and then declined to 8,231 in 2002. The number of reported incidents with children present increased from 2,606 in 1998 to 3,092 in 2001 and then declined to 2,728 in 2002.

◆ Rhode Island's statewide network of six shelters and advocacy programs provides services to victims of domestic violence, including shelter, advocacy, counseling and education. During 2003, 314 women and 377 children spent time in a domestic violence shelter. Rhode Island's domestic violence agencies provided services to 873 children including therapy, individual counseling, expressive arts therapy, and child care. The shelters also provide school-based domestic violence prevention programs.[10]

◆ A recent study indicates that Black and Hispanic women in Rhode Island are overrepresented in police reports of domestic violence, and that Black women in more affluent neighborhoods report incidents of domestic violence to police at higher rates than other women. The reasons for these differences are unclear but may be linked to variation in the availability of alternative avenues of assistance, including access to social supports, private counseling and other resources.[11]

Children Witnessing Domestic Violence

Children and Domestic Violence in Rhode Island

◆ Rhode Island police officers use special reporting forms to document children's exposure to violence. The attending officer may check any combination of three boxes: Were children present during the incident? Did children witness the incident? Did children hear the incident.[12]

◆ In 2002, police officers reported that in 2,014 incidents the children saw their parent being abused and in 2,241 incidents the children heard (but did not see) their parent being abused.[13]

◆ Table 22 under-represents the number of incidents of domestic violence in which a child was present because police reports are not fully completed in all cases. Additionally, many cases of domestic violence are never reported to police.

◆ Table 22 underestimates the total number of children who experienced domestic violence in their homes, since more than one child may be present at an incident.

Table 22.

Domestic Violence Incidents with Children Present, Rhode Island, 2002

CITY/TOWN	TOTAL NUMBER OF DOMESTIC VIOLENCE INCIDENT REPORTS	TOTAL NUMBER OF INCIDENTS IN WHICH A CHILD WAS PRESENT	% OF INCIDENTS WITH CHILDREN PRESENT
Barrington	56	16	29%
Bristol	167	56	34%
Burrillville	120	44	37%
Central Falls	165	65	39%
Charlestown	40	15	38%
Coventry	214	73	34%
Cranston	460	186	40%
Cumberland	84	33	39%
East Greenwich	42	13	31%
East Providence	267	98	37%
Exeter	NA	NA	NA
Foster	10	3	30%
Glocester	80	31	39%
Hopkinton	60	27	45%
Jamestown	22	11	50%
Johnston	397	124	31%
Lincoln	97	30	31%
Little Compton	20	6	30%
Middletown	140	38	27%
Narragansett	107	26	24%
New Shoreham	5	0	0%
Newport	392	99	25%
North Kingstown	293	100	34%
North Providence	296	88	30%
North Smithfield	69	18	26%
Pawtucket	915	292	32%
Portsmouth	139	34	24%
Providence	1,359	445	33%
Richmond	19	6	32%
Scituate	34	14	41%
Smithfield	152	35	23%
South Kingstown	144	56	39%
Tiverton	218	77	35%
Warren	208	45	22%
Warwick	449	161	36%
Westerly	157	57	36%
West Greenwich	19	6	32%
West Warwick	171	55	32%
Woonsocket	533	203	38%
Rhode Island State Police	*111*	*42*	*38%*
Core Cities	*3,535*	*1,159*	*33%*
Remainder of State	*4,585*	*1,527*	*33%*
Rhode Island	*8,231*	*2,728*	*33%*

Source of Data for Table/Methodology

The number of domestic violence incident reports and the number of incidents in which children were present are based on the Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received by the Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit between January 1, 2002 and December 31, 2002.

Reports of domestic violence in Exeter are included in the Rhode Island State Police numbers.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1,3,5,6,9] *Domestic Violence and Its Impact on Children.* (Fall 2002). Washington, DC: Children's Defense Fund.

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[11] Pearlman, D. et al. (January-February 2003). Neighborhood Environment, Racial Position, and Risk of Police-Reported Domestic Violence: A Contextual Analysis. *Public Health Reports,* Vol. 118.

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Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total number of indicated investigations of child abuse and neglect per 1,000 children. Indicated investigation means that credible evidence exists that child abuse and/or neglect occurred following an investigation of an abuse report. An indicated investigation can involve more than one child and multiple allegations (claims) of different forms of abuse. Child abuse includes physical, sexual, and emotional abuse. Child neglect includes emotional, educational and medical neglect.

SIGNIFICANCE

Preventing child abuse and neglect is critical to helping children grow into strong, healthy, productive adults and good parents. Children are at increased risk for maltreatment if their parents or caregivers are overwhelmed by multiple problems such as inadequate income, lack of a job or a decent place to live, emotional stress, isolation from extended family or friends, drug and/or alcohol abuse, mental illness, or domestic violence.[1] Recent studies confirm that child abuse is linked to increases in poor school performance, juvenile delinquency, running away, substance abuse, suicide, criminal behavior, emotional and mental health problems, promiscuity, and teenage pregnancy.[2,3,4,5]

Many abusive parents lack essential parenting skills and are struggling with a combination of social and economic issues. Preventing child abuse and neglect requires help with housing, food, and child care as well as parenting education and counseling for substance abuse, domestic violence, and other problems. Families benefit from access to community-based, comprehensive services that are able to flexibly respond to their needs.[6,7]

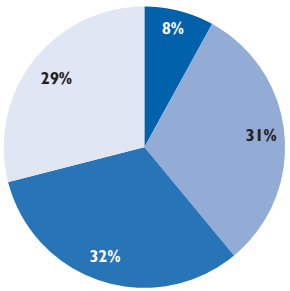
Responding to reports of child abuse and neglect and ensuring child safety in crisis situations are important functions of child protection systems. Maintaining the capacity to focus on prevention is equally critical and frequently more cost-effective. The absence of appropriate lower-cost placements and community-based family supports and early interventions contributes to a disproportionate share of the budget of the Department of Children, Youth and Families (DCYF) being spent on high-end costs such as psychiatric hospitalization, juvenile corrections, and residential treatment.[8,9,10]

In 2003 in Rhode Island, there were 2,126 indicated cases of child abuse and neglect involving 2,913 children, a rate of 7 cases per 1,000 children.[11]

Child Abuse and Neglect, Rhode Island, 2003

By Age of Victim

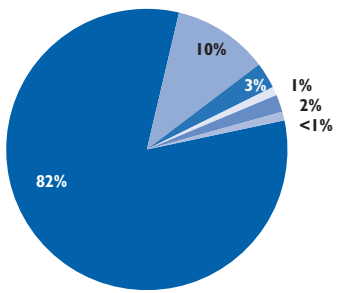
8%	Under Age 1
31%	Ages 1 to 5
32%	Ages 6 to 11
29%	Ages 12 and Older



*(n=2,913)**

By Relationship of Victim to Perpetrator

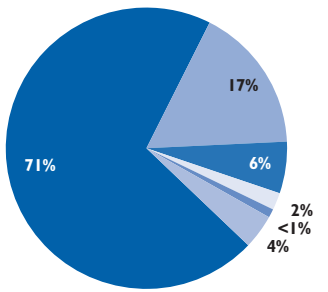
82%	Parents
10%	Relatives/Household Members
3%	Child Care Providers
1%	Foster Parents
2%	Residential Facility Staff
<1%	Other or Unknown



*(n=3,798)****

By Type of Abuse

71%	Neglect
17%	Physical Abuse
6%	Sexual Abuse
2%	Medical Neglect
<1%	Emotional Abuse
4%	Other



*(n=3,566)***

Notes on Pie Charts

All data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2003. Numbers may not add to 100 due to rounding.

** These data reflect an unduplicated count of child victims. The number of victims is higher than the number of indicated investigations. One indicated investigation can involve more than one child victim.*

***This number is greater than the unduplicated count of child victims because children often experience more than one maltreatment event and/or more than one type of abuse. Within each type of abuse, the number of child victims is unduplicated.*

****Perpetrators can abuse more than one child and can abuse a child more than once.*

DCYF (CANTS)* Hotline Calls for Reports of Abuse and/or Neglect, Investigations, and Indicated Cases, Rhode Island, 1995-2003

YEAR	TOTAL NUMBER UNDUPLICATED CHILD MALTREATMENT REPORTS	NUMBER OF COMPLETED INVESTIGATIONS**	NUMBER OF INDICATED CASES
1995	13,841	8,553	2,781
1996	13,098	8,398	2,541
1997	12,437	8,485	2,577
1998	12,674	8,463	2,459
1999	13,519	7,882	2,628
2000	13,580	7,635	2,234
2001	13,804	7,479	2,261
2002	14,545	7,254	2,209
2003	13,651	6,847	2,126

◆ Between 1995 and 2003 the number of child maltreatment reports remained steady but the number of completed investigations, and to a lesser extent, the number of indicated cases, declined.

◆ In 2003, 50% of reports resulted in completed investigations and one in three completed investigations resulted in a finding of an indicated case. An indicated case is one in which there is credible evidence that child abuse and/or neglect occured.

◆ During 2003, among the 13,651 maltreatment reports, 5,658 were classified as "early warnings," that is, instances where an essential criterion for investigation is not present, including that the victim is a minor, the alleged perpetrator is living in the home or responsible for the child's welfare, there is harm or risk of harm alleged and there is a specific incident or pattern of incidents suggesting that harm can be identified.

**One investigation can be generated by multiple hotline calls. Investigations can result in a finding of indicated, unfounded or unable to complete (as when essential party cannot be found).*

Source: All data are from the Rhode Island Department of Children, Youth and Families, 1995-2003.

Rhode Island Child Deaths Due to Child Abuse and/or Neglect*

YEAR	NUMBER OF DEATHS	YEAR	NUMBER OF DEATHS
1994	5	1999	3
1995	5	2000	3
1996	4	2001	5
1997	2	2002	1
1998	3	2003	4
Total 1994-1998	*19*	*Total 1999-2003*	*16*

**Based on R.I. Department of Children Youth and Families determination of death due to child abuse or neglect by a parent or caretaker.*

◆ Between 1994 and 2003, 35 children died as a result of injuries due to abuse by a parent or caretaker.

◆ During 2002, there were 46 children hospitalized with the diagnosis of child abuse or neglect, up from 29 in 2001 and 23 in 2000. The average over five years (1998-2002) was 30 hospitalizations.[12]

Preventing Child Abuse and Neglect

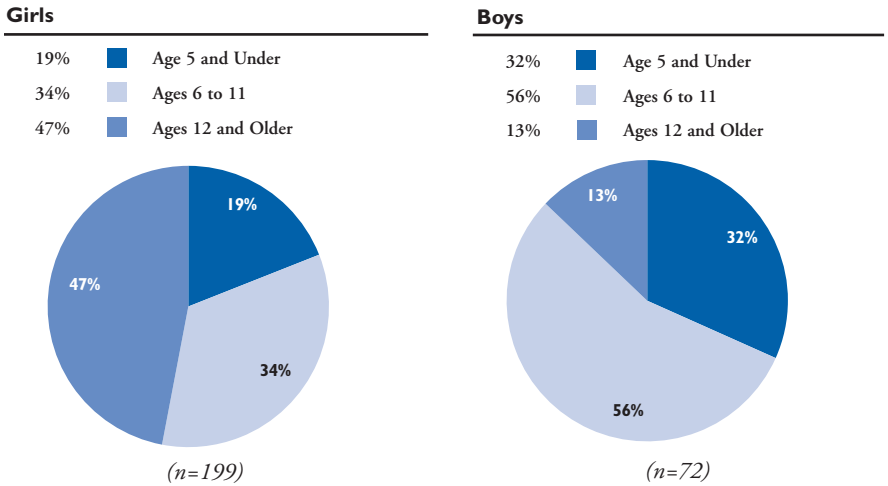
◆ In Rhode Island in 2003, almost three-quarters (71%) of all child abuse and neglect cases were the result of neglect.[13]

◆ Families overwhelmed by multiple personal, social, or economic problems may lack the resources to meet their children's needs and require a variety of readily accessible services and interventions.[14]

◆ Connecting families with economic supports, decreasing isolation, and providing easy access to substance abuse and mental health treatment are especially critical.[15]

Child Abuse and Neglect

Child Sexual Abuse, by Gender and Age of Victim, Rhode Island, 2003



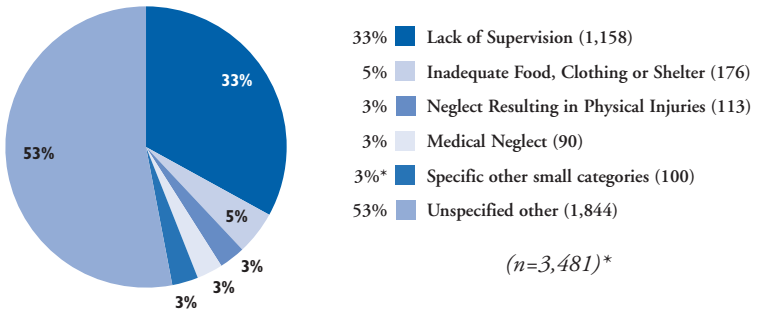
(n=199) *(n=72)*

◆ In Rhode Island in 2003, there were 271 indicated allegations (confirmed claims) of sexual abuse. Some children were victims of sexual abuse more than once. Multiple allegations (or claims) may be involved in each indicated investigation. An indicated allegation of abuse is defined as one in which credible evidence was found indicating sexual abuse.

◆ In 73% (199) of the 271 indicated allegations of sexual abuse the victim was a female. Sixty-two percent of the victims (53% of girls and 88% of boys) were under age 12.

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2003.

Child Neglect, by Nature of Neglect, Rhode Island, 2003



*(n=3,481)**

** The total refers to indicated allegations of neglect. Some children were victims of neglect more than once. Multiple allegations may be involved in each indicated investigation.*

◆ In Rhode Island in 2003, of the 3,481 indicated allegations (confirmed claims) of neglect, 33% involved lack of supervision.

◆ The single largest category of neglect (53%) falls under other. These are instances of neglect that do not fit into any of the other specified categories.

◆ The specific small categories of less than 1% each include: drug and alcohol abuse (28), failure to thrive (23), abandonment (21), educational neglect (9), tying and confinement (6), poisoning (5), emotional neglect (5), excessive/inappropriate discipline (3).

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2003.

Table 23.

Indicated Cases of Child Abuse and Neglect, Rhode Island, 2003

CITY/TOWN	TOTAL POPULATION OF CHILDREN UNDER AGE 21	NUMBER OF INDICATED CASES OF CHILD ABUSE/NEGLECT	2003 RATE OF CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Barrington	5,211	2	0.4
Bristol	6,294	21	3.3
Burrillville	4,646	25	5.4
Central Falls	6,443	80	12.4
Charlestown	1,952	20	10.2
Coventry	9,438	50	5.3
Cranston	19,854	85	4.3
Cumberland	8,595	25	2.9
East Greenwich	3,861	7	1.8
East Providence	12,060	79	6.6
Exeter	1,790	5	2.8
Foster	1,234	2	1.6
Glocester	2,998	12	4.0
Hopkinton	2,255	10	4.4
Jamestown	1,354	5	3.7
Johnston	6,729	25	3.7
Lincoln	5,720	30	5.2
Little Compton	874	6	6.9
Middletown	4,757	18	3.8
Narragansett	3,897	21	5.4
New Shoreham	203	0	0.0
Newport	7,046	75	10.6
North Kingstown	7,561	39	5.2
North Providence	6,854	47	6.9
North Smithfield	2,674	18	6.7
Pawtucket	20,870	233	11.2
Portsmouth	4,726	8	1.7
Providence	62,125	591	9.5
Richmond	2,221	11	5.0
Scituate	2,944	6	2.0
Smithfield	6,112	19	3.1
South Kingstown	10,393	20	1.9
Tiverton	3,806	10	2.6
Warren	2,809	24	8.5
Warwick	21,330	133	6.2
West Greenwich	1,606	9	5.6
West Warwick	7,746	82	10.6
Westerly	6,094	52	8.5
Woonsocket	12,792	179	14.0
Out of State/Unknown	*NA*	*15*	*NA*
Core Cities	*117,022*	*1,240*	*10.6*
Remainder of State	*182,852*	*845*	*4.6*
Rhode Island	*299,874*	*2,100*	*7.0*

Source of Data for Table/Methodology

Data are from the State of RI Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), number of reports (indicated investigations) for the period January 1, 2003 to December 31, 2003.

An indicated investigation is an investigated report of child abuse and neglect for which credible evidence exists that child abuse and/or neglect occurred. An indicated investigation can involve more than one child and multiple allegations. City/town reports of indicated investigations omit certain investigations, particularly those where there are data entry errors affecting location. For this reason, the city/town table of indicated investigations reports fewer indicated investigations than does the chart with reports/investigations and indicated cases.

The denominator is the number of children under the age of 21 according to the 2000 U.S. Census of Population.

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Children in Out-of-Home Placement

DEFINITION

Children in out-of-home placement is the number of children who have been removed from their families and are in the care of the Rhode Island Department of Children, Youth and Families while awaiting permanent placement. Out-of-home placements include foster homes, placement with a relative or friend, group home, shelter care, residential treatment, and medical facility. Permanent placement includes reunification with the family, adoption or guardianship.

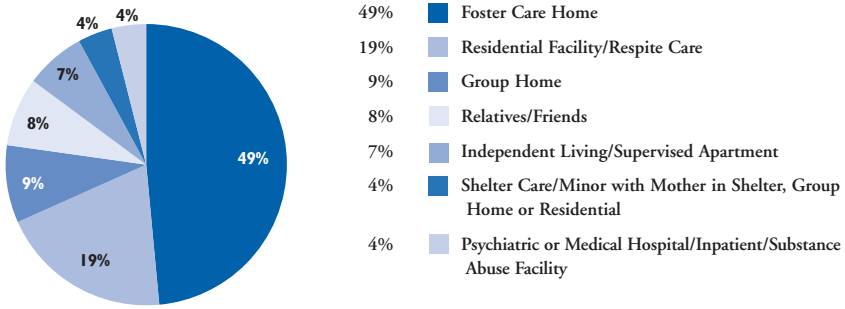
SIGNIFICANCE

Children need stability, permanency and safety in order to develop and flourish. Removal from the home may be necessary for the child's safety and well-being; however, it is disruptive and can be traumatic for both the child and the family.[1] Children who have been abused or neglected are particularly vulnerable and in need of a safe, stable and permanent environment which provides for their well-being. Yet children in out-of-home care frequently remain in temporary placements for extended periods of time, experience multiple placements, lose contact with family members, friends and neighborhoods, and may experience recurrence of abuse.[2] Older children may linger in care until adulthood.

Long-term stays in temporary out-of-home placement can negatively affect children, causing emotional, behavioral or educational problems that adversely affect their future well-being and self-sufficiency.[3] Children in out-of-home care suffer more frequent and more serious medical, developmental, and mental health problems than nearly any other group of children. Effective strategies to promote the optimal development of children in out-of-home placement include: assessment on system entry; a comprehensive system of care to address identified health (physical, mental, emotional, behavioral) and educational needs immediately; family involvement; training for caregivers; coordinated services and funding strategies; and a managed care model that addresses the complex needs of children in the child welfare system.[4,5,6]

National research indicates that youth in state custody have high aspirations, including a college education, but experience serious educational difficulties. Adequate remedial and special education services are needed to ensure that these youth maximize their potential and are prepared for the employment market.[7]

Children in Out-of Home Placement, December 2003



n = 2,512

◆ As of December 31, 2003, there were 2,512 children under age 21 in the care of DCYF who were in out-of-home placement.

◆ The total caseload of DCYF on December 31, 2003 was 8,245 including: 2,932 children living in their home (with a parent, guardian or step-parent) under DCYF supervision; 2,457 children in adoption placements, most receiving subsidized adoption supports; 190 children/youth in detention at the Training School or in prison; 24 children in out-of-state placement/placement with another agency; and 10 children in Job Corps or other placement.

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2003.

Night-to-Night Placements

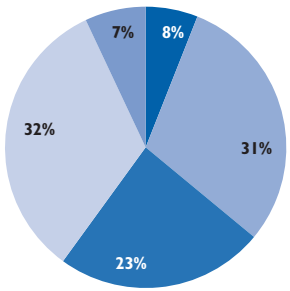
◆ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting longer-term placements. Night-to-night placements are the subject of ongoing litigation between the Department of Children, Youth and Families and the Office of the Child Advocate, which seeks to minimize such placements.

◆ In 2003, an average of 13 children per week were placed in night-to-night placements for a total of 1,547 bed nights i.e., instances when a night-to-night bed is occupied by a child and paid for by DCYF. In 2002, an average of 18 children per week were placed in night-to-night placements for a total of 2,322 bed nights.[8]

Children in Foster Care Homes, Rhode Island, 2004

By Age

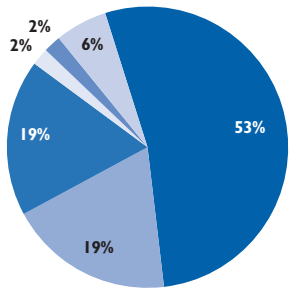
8%	Under Age 1
31%	Ages 1 to 5
23%	Ages 6 to 11
32%	Ages 12 to 17
7%	Over Age 18



n = 1,246

By Race and Ethnicity

53%	White
19%	Black
19%	Hispanic
2%	Asian
2%	American Indian/Alaskan/ Pacific Islander
6%	Unknown/Multiracial/Other



◆ As of January 2, 2004, there were 1,246 children in foster care homes. Of these, 531 (43%) were in non-relative foster homes, 575 (41%) were in relative foster homes, 132 (11%) were in the care of private agencies and eleven (1%) were in respite care. In Rhode Island and nationally there is an ongoing shortage of foster parents.[9,10]

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), January 2004.

Safety, Permanency and Well-Being

◆ The Adoption and Safe Families Act of 1997 (ASFA) recognizes that the broad goals of child protection systems are child safety, permanency and well-being. Preventing the recurrence of abuse or neglect, ensuring the safety of children in out-of-home placement, and maximizing stability of placements are the paramount concerns which the Act seeks to address.

◆ Of the 1,532 Rhode Island children who were victims of abuse or neglect during the first six months of federal fiscal year 2002 (whether or not they were removed from the home), 10.2% (156) experienced one or more recurrences of abuse or neglect within 6 months, down from 12.6% in 1998.[11]

◆ In FY 2002, 18% of the 1,797 children who had been in out-of-home care for less than one year had experienced 3 or more placements, down from 27% in FY 1998. Three or more placements were experienced by 40% of children who had been in care between 12 and 23 months, down from 47% in 1998; 53% of children who had been in care for 24-35 months experienced three or more placements (compared with 54% in 1998).[12]

◆ Research shows disparate treatment of children of color as they enter the foster care system and while they are in the system. Black and Hispanic families are more likely than non-Hispanic White families under similar circumstances to be reported for child abuse and neglect and to have their child removed and placed in foster care. Once in foster care, children of color are more likely than non-Hispanic White children to remain there for longer periods of time, to receive fewer familial visits, fewer contacts with caseworkers, fewer written case plans, and fewer developmental assessments.[13]

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Adoption and Permanency

DEFINITION

Adoption and permanency is the percentage of children in out-of-home care who transition to a permanent placement through adoption, reunification or guardianship. Data are for all children who were in out-of-home placement during federal fiscal year 2002.

SIGNIFICANCE

The uncertainty of multiple, prolonged or unstable out-of-home placements has negative effects on children's emotional well-being, identity formation, and sense of belonging, impacting behavior, academic achievement and long term self-sufficiency.[1, 2] Youth who age out of care without finding a permanent placement or who spend significant parts of their adolescence in foster care suffer disproportionately from poverty, unemployment, academic failure, incarceration and premature parenting.[3]

One of the goals of the federal Adoption and Safe Families Act of 1997 (ASFA) is to ensure that children exit out-of-home placement to permanent placement, i.e. reunification, adoption or guardianship, as quickly as possible without jeopardizing the child's safety. Effectiveness in achieving permanency must include the interrelated measures of how quickly permanency is achieved, the proportion of children for whom it is achieved, and the lasting success of the permanent placements.[4] In addition, increasing attention is being paid to the long-term personal, social, academic and economic outcomes achieved for children who leave the child welfare system.[5,6,7]

National experience indicates that particular attention must be paid to populations of children for whom permanency may be more difficult to achieve. This includes older children, children with disabilities and minority children.[8, 9,10] Planning for permanency requires a mix of family-centered and legal strategies designed to ensure that children and youth have safe, caring, stable and lifelong families in which to grow up.[11]

Percentage of Children in Out-of-Home Care Exiting Care to a Permanent Placement, Rhode Island, FY 2002*

	All Exits	With Disability	Over Age 12 at Entry
Adoption	14%	10%	<1%
Guardianship	2%	1%	2%
Reunification	70%	66%	73%
Other	13%	22%	23%
Missing	1%	1%	2%
Total Number	*1,378*	*232*	*662*

◆ In FY 2002 there were 3,742 children in out-of-home placement. Of these, 1,378 children exited care. Of the children who exited care, 86% exited to a permanent placement such as adoption, guardianship or reunification. Children exiting to a permanent placement account for 32% of all children in out-of-home placement.[12]

Source: *Safety, Permanency, and Well-Being in Rhode Island: Child Welfare Outcomes Annual Report for 2002.* (AFCARS Annual Foster Care Database, FY 2002) The Consultation Center, Yale University School of Medicine, for the U.S. Department of Health and Human Services.

Children Aging Out of Foster Care*

◆ Children who do not exit care promptly may eventually age out, never having found a permanent placement. In FY 2002, 62 Rhode Island children exited out-of-home placement to emancipation. Of these, 82% were older than age 12 at entry into care.[13]

◆ Youth who age out of foster care experience high rates of poverty, homelessness, unemployment, incarceration and poor health. Youth who receive more training and services, have real work experience and have positive support systems prior to exiting foster care experience better outcomes after exiting foster care. Research indicates that specialized mental health services and transition systems that extend beyond the age of discharge are crucial for the success of these youth.[14]

*Foster care refers to all out-of home placements, consistent with language used in federal reports. *Throughout this indicator, fiscal year refers to federal fiscal year, Oct. 1-Sept. 30. Permanent placement indicates adoption, reunification or guardianship.

Length of Time to Adoption or Reunification, Rhode Island, FY 1998-2002

	Adoption		Reunification	
	1998	2002	1998	2002
Less than 24 months	28%	45%	75%	84%
More than 24 months	63%	53%	6%	14%
Missing data	9%	2%	19%	3%

◆ The percentage of children in the Rhode Island child welfare system who were adopted in less than 24 months increased from 28% in FY 1998 to 45% in FY 2002.

◆ The percentage of children who were reunified with their family of origin in less than 24 months increased from 75% in FY 1998 to 84% of children in FY 2002.

Source: The Consultation Center, Yale University School of Medicine, for the U.S. Department of Health and Human Services. *Safety, Permanency, and Well-Being in Rhode Island: Child Welfare Outcomes Annual Report for 2002.* (AFCARS Annual Foster Care Database, FY 1998 and 2002)

Children Re-Entering Foster Care after Prior Episode, FY 1998-2002

◆ Success in reducing the duration in temporary placement must be measured in conjunction with rates of re-entry into the system (i.e., the failure rate of the permanent placement). In FY 2002, 31% of children in Rhode Island who entered out-of-home placement were re-entering after a prior episode, up from 27% in 1998.[15]

◆ The majority of child maltreatment cases involve neglect. The greatest contributors to neglect are poverty, parental substance abuse and/or mental illness. Achieving timely and successful reunification requires access to substance abuse and mental health treatment.

◆ Parents striving for reunification with their children may also require in-home services, parenting skills training, assistance in meeting basic needs (food, housing, income), child care, and specific strategies to decrease isolation and strengthen community supports.[16]

Adoptions of Children in DCYF Care, 2003

◆ In calendar year 2003, 256 children in the care of DCYF were adopted in Rhode Island. Of these children, 52% were White, 17% were Black, 16% were Hispanic and 15% were other racial/ethnic groups or unknown.

◆ Of the children adopted, 59% were under age 6, 24% were between age 6 and 11 and 17% were age 12 or older.
As of December 31, 2003, 210 children in the care of DCYF were awaiting adoption. Of these children, 44% were White, 29% were Black, 22% were Hispanic and 6% were other racial/ethnic groups or unknown race or ethnicity.

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2003.

References for Indicator

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Education

Fiesta

A fiesta in the mountains was a rare treat.
The other campesinos would invite us. They worked as gardeners like my father or housekeepers like my mother.

We would gather under a large carpa as big as a circus tent huddled up against a mountain slope. I remember stove fires, guitars and my father's harmonica, and sweet tortillas the size of my hand that tasted like licorice candy.

The men would lift me up in their arms and offer me churros con canela y azucar – Mexican donuts with cinnamon and sugar.

It was a home-made city of brown faces with smiles and music.

By Juan Felipe Herrera

Infant and Pre-School Child Care

DEFINITION

Infant and pre-school child care is the number of regulated child care slots per 100 children under age 6. Regulated child care slots include full-time licensed child care center slots and certified family child care home slots.

SIGNIFICANCE

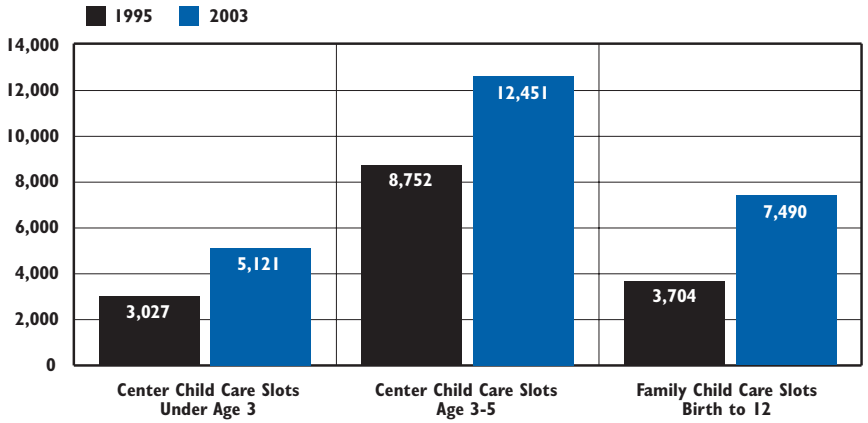
Child care has become a fundamental need for Rhode Island families over the past two decades. In Rhode Island in 2000, 62% (45,820) of children under age 6 had all parents in the workforce, higher than the U.S. average of 59%.[1]

High-quality child care provides a safe and nurturing learning environment for infants and young children. Recent brain research indicates that early care and education has long-lasting effects on how children learn and develop, cope with stress, and handle their emotions.[2,3,4] High-quality child care programs are linked to school readiness. Children from all backgrounds who have received high-quality child care score higher on tests of both cognitive and social skills in their early school years than children in poor quality care.[5,6] High quality child care can generate a four to one return on investment in increased lifetime earnings of both the child and the mother and in decreased public expenditures on special education, remedial education and medical costs.[7]

Low-income children, who receive high quality early education score significantly higher on tests of reading and math from the early grades through middle adolescence and are less likely to repeat a grade. They are more interested in learning, and are stronger in reading, math, problem solving, and working with others.[8,9] Low-income children are less likely to be in high quality care arrangements because of the high cost of such care, and because nonstandard work hours (weekends, night shifts, and irregular hours) may make it difficult to find such care.[10,11,12,13]

In 2003 in Rhode Island, there were 25,062 slots in licensed child care centers or certified family child care homes, as compared with 15,483 slots in 1995. In 2003 in Rhode Island, 28 of the 444 licensed child care centers in Rhode Island were accredited by the National Association for the Education of Young Children and 25 of these were serving children under age 6. The National Association for Family Child Care accredited 6 of the 1,164 certified family child care homes.[14]

Infant and Pre-School Licensed Child Care Capacity, Rhode Island, 1995 and 2003



Source: Options for Working Parents, 1995 and 2002.

Caring for Infants and Toddlers

◆ Child care for infants and toddlers is more expensive to provide than for older children due to the need for more intensive supervision and interaction.[15] National research indicates that the quality of infant care is often very low.[16]

◆ Recent research points to several strategies that are effective in promoting the availability of higher quality child care for infants and toddlers. These include combining multiple funding streams to cover the higher costs associated with caring for young children and developing collaborative relationships with programs such as Early Head Start. Financial incentives are important to promote training, accreditation and to improve the quality of the physical environment.[17,18]

◆ The quality of child care is strongly related to the wages, education, and retention of teachers. Compensation initiatives can improve child care workforce education and retention, particularly when professional development and education are linked to pay increases.[19]

Table 24.

Child Care for Children Under Age 6, Rhode Island, 2003

CITY/TOWN	# CHILD CARE CENTER SLOTS < AGE 3	# CHILD CARE CENTER SLOTS AGES 3-5	# CERTIFIED FAMILY CHILD CARE HOME SLOTS*	TOTAL REGULATED CHILD CARE SLOTS FOR CHILDREN < AGE 6	POTENTIAL CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE	SLOTS PER 100 CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE
Barrington	45	144	40	229	386	59
Bristol	33	108	61	202	447	45
Burrillville	16	78	35	129	408	32
Central Falls	56	218	222	496	520	95
Charlestown	23	35	19	77	170	45
Coventry	118	203	124	445	962	46
Cranston	370	932	491	1,793	1,799	100
Cumberland	75	125	178	378	912	41
East Greenwich	303	513	39	855	277	309
East Providence	222	654	182	1,058	1,168	91
Exeter	8	45	6	59	189	31
Foster	31	35	0	66	107	62
Glocester	16	68	35	119	264	45
Hopkinton	0	0	21	21	283	7
Jamestown	31	33	8	72	83	87
Johnston	132	394	135	661	702	94
Lincoln	208	331	44	583	565	103
Little Compton	0	0	0	0	53	0
Middletown	208	367	16	591	463	128
Narragansett	41	90	0	131	228	57
New Shoreham	6	30	0	36	27	133
Newport	146	268	48	462	615	75
North Kingstown	114	323	58	495	805	61
North Providence	54	166	168	388	662	59
North Smithfield	0	0	183	183	285	64
Pawtucket	292	914	559	1,765	2,103	84
Portsmouth	67	200	28	295	411	72
Providence	859	2,053	3,942	6,854	4,002	171
Richmond	14	19	77	110	255	43
Scituate	27	85	11	123	288	43
Smithfield	143	246	36	425	400	106
South Kingstown	119	307	82	508	590	86
Tiverton	25	145	64	234	358	65
Warren	43	130	44	217	325	67
Warwick	743	1,601	228	2,572	2,119	121
West Greenwich	133	174	0	307	173	177
West Warwick	158	423	110	691	737	94
Westerly	72	411	11	494	644	77
Woonsocket	170	583	185	938	1,100	85
Core Cities	*1,681*	*4,459*	*5,066*	*11,206*	*9,077*	*123*
Remainder of State	*3,440*	*7,992*	*2,424*	*13,856*	*16,808*	*82*
Rhode Island	*5,121*	*12,451*	*7,490*	*25,062*	*25,885*	*97*

Source of Data for Table/Methodology

The denominator is the number of children under age 6 with both parents in the workforce, multiplied by 56.5% (the percentage of mothers using non-relative care, according to the Census Bureau's Survey of Income and Program Participation, Spring 1999). The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots, as of December, 2003 (data provided by Options for Working Parents).

* Family child care slots are for children birth to 12 years old.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

See Methodology, page 133.

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continued on page 136

Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the percentage of eligible 3 and 4 year old children enrolled in the Head Start preschool program as of October 2003.

SIGNIFICANCE

Head Start is a comprehensive early childhood program for low-income preschool children and their families.[1] Children are eligible for Head Start if their family's income is below 100% of the federal poverty line; the family receives Supplemental Security Income (SSI) or is enrolled in the Family Independence Program (FIP); or the family is using supportive services that are federal Temporary Assistance for Needy Families (TANF) benefits, such as transportation vouchers, subsidized child care, or job training. Children in foster care are also Head Start eligible. Up to 10% of the children served by Head Start can be in families that do not meet these eligibility guidelines, especially if the child has a special need.[2,3]

The Head Start program is designed to provide low-income children with the socialization and school-readiness skills they need to enter public schools on an equal footing with more economically advantaged children. Head Start performance standards require that programs deliver a high-quality early childhood education program; involve parents in program policy and planning; provide at least one nutritional meal per day; identify children's individual nutritional needs; ensure that each child has an ongoing source of health care; perform or obtain health, developmental and behavioral screenings; and make arrangements for mental health professionals to be available to identify mental health concerns and help locate needed treatment.[4]

Children in poor families are at greater risk for developmental delays and learning disabilities; have a greater prevalence of health and nutrition problems; and are more likely to have serious accidents, require special education, perform below grade level at school, drop out of school and earn less as adults.[5] The Head Start program succeeds in narrowing the gap between disadvantaged children and other children in vocabulary, writing, math skills and social skills, with the greatest gains among the most disadvantaged children.[6] Long-term improvements include reduced rates of grade retention and need for special education services and increased rates of high school graduation.[7]

Children Enrolled in Head Start, Rhode Island, 1995-2003

◆ As of 2003, Head Start served 53% of the estimated 4,989 children ages 3 and 4 in Rhode Island.

◆ Between 1997 and 2000, there was a steady increase in the number of children who participated in Head Start. In Rhode Island in 2003, the Head Start Program experienced it's highest enrollment to date with 2,646 children, an increase of 267 children since 1995.[8]

◆ Because Head Start is available to only half of Rhode Island's lowest-income children, resources were appropriated under Starting Right (Rhode Island's 1998 child care law) to create Comprehensive Child Care Networks which provide developmentally appropriate education and support services to children and families in underserved communities.[9]

◆ As of January 2004, the Comprehensive Child Care Networks were providing services to 320 children. Children in the lowest-income families are prioritized for services to ensure that the most disadvantaged children receive the services they need to start school ready to learn.[10]

Early Head Start

◆ Early Head Start is a national program developed in 1995 to promote healthy prenatal outcomes for pregnant women, support the early care and education of infants and toddlers ages birth to three, foster healthy family relationships and build community resources.[11]

◆ Rhode Island's six Early Head Start programs are located in Warwick, Warren, Providence, Cranston, Johnston and Middletown. During 2003, 369 families and 402 infants and toddlers received Early Head Start services.[12]

Table 25. **Percent of Eligible Children Ages 3 and 4 Enrolled in Head Start, Rhode Island, 2003**

CITY/TOWN	ESTIMATED ELIGIBLE CHILDREN AGED 3&4*	NUMBER OF CHILDREN ENROLLED IN HEAD START	% OF ELIGIBLE 3&4 YEAR OLDS ENROLLED
Barrington	10	1	10%
Bristol	50	20	40%
Burrillville	36	23	64%
Central Falls	280	90	32%
Charlestown	6	10	100%*
Coventry	51	37	73%
Cranston	147	228	100%*
Cumberland	34	9	26%
East Greenwich	28	4	14%
East Providence	139	92	66%
Exeter	25	2	8%
Foster	0	0	NA
Glocester	15	6	40%
Hopkinton	15	2	13%
Jamestown	0	1	100%*
Johnston	55	44	80%
Lincoln	24	4	17%
Little Compton	3	1	33%
Middletown	30	23	77%
Narragansett	17	8	47%
New Shoreham	1	0	0%
Newport	218	138	63%
North Kingstown	87	30	34%
North Providence	63	43	68%
North Smithfield	16	3	19%
Pawtucket	598	193	32%
Portsmouth	24	5	21%
Providence	2,075	917	44%
Richmond	7	3	43%
Scituate	9	3	33%
Smithfield	5	7	100%*
South Kingstown	31	33	100%*
Tiverton	15	33	100%*
Warren	15	22	100%*
Warwick	133	173	100%*
West Greenwich	7	2	29%
West Warwick	209	125	60%
Westerly	56	69	100%*
Woonsocket	455	242	53%
Core Cities	*3,835*	*1,705*	*44%*
Remainder of State	*1,154*	*941*	*82%*
Rhode Island	*4,989*	*2,646*	*53%*

**Estimated Number Eligible is based on Census 2000 and may not refelect increases in eligible population.*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled as of October 2003.

The denominator is the estimated number of eligible children based on the number of three and four-year-old children in each community multiplied by the poverty rate for children under 5 in that community, according to Census 2000. This is an estimate of the eligible population and does not take into account any increases or decreases in the number of eligible children enrolled in Head Start since 2000.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

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School-Age Child Care

DEFINITION

School-age child care is the number of licensed child care programs and slots for children ages 6 to 12. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 6 to 12 that do not require licensing by the state.

SIGNIFICANCE

Many children are without adult supervision during the hours before and after school.[1] Many parents need care for their school-age children during work hours. Children spend only 20% of their waking hours in school. The gap between parents' work schedules and students' school schedules can amount to 20 or more hours per week.[2]

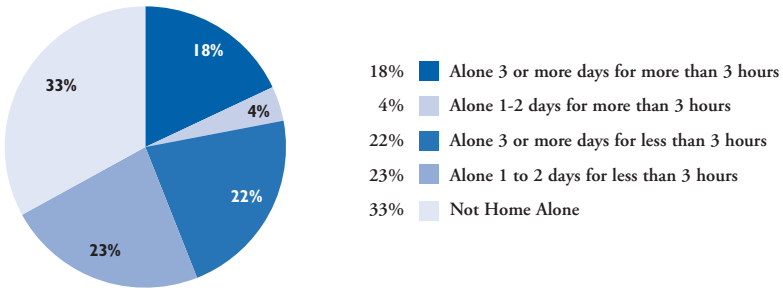
Children who are without adult supervision when school is out are at significantly greater risk of truancy from school, emotional stress, receiving poor grades, substance use, sexual activity, and crime.[3,4] Low-income children, children in urban or high-crime neighborhoods are most at risk when they spend time caring for themselves and are most likely to benefit from high quality after-school programming.[5]

When school is out, children and young adolescents need a safe environment that does not simply duplicate the school day. They need access to a wide variety of enriching and challenging activities – homework and reading help, sports, music, theater, art – and the opportunity to build meaningful relationships with their peers and caring adults.[6,7] Programs for older youth can be particularly successful if they engage youth as a resource and provide opportunities to contribute to the community.[8]

Children in high quality, well-designed after-school programs and extracurricular activities have better peer relations, emotional adjustment, social skills, schoolwork habits, grades, and conduct in school than children who do not. They are less likely to use drugs or become teen parents or become involved in criminal activities. Their parents are more likely to be involved in school activities.[9,10,11,12,13] Yet, many programs are poor in quality due to a lack of resources, staff turnover, and inappropriate physical space. Resources are particularly scarce in low-income communities where they are needed most.[14]

In 2003 there were 14,236 licensed child care slots for children ages 6 to 12 in Rhode Island, up from 12,117 in 2002 and nearly two and a half times as many as in 1995 (5,750).[15]

Rhode Island Middle School Children (Grades 5-8)
At Home After School without Adult Supervision, 2002-2003



Source: Felner, R. PhD. (2003). *SALT Survey Reports, School Year 2002-2003.* Providence, RI: University of Rhode Island, National Center on Public Education and Policy.

◆ Children in grades 5 through 8 left home alone for three hours or more report more negative perceptions of school climate, lack of family involvement in their educational activities, depression, low self-esteem, behavior problems, and poor academic performance than children who were not left home alone for that length of time.[16]

◆ One in five (18%) Rhode Island school children in grades 5 to 8 are home after school without adult supervision for more than three hours on at least three days per week. An additional 4% are home alone one to two days per week for more than three hours. Being home alone for three hours or more on even one day places children at higher risk than children who are home alone more frequently but for fewer than three hours.[17]

◆ Rhode Island students in grades 5 through 8 from low-income families are less likely than students from higher-income families to participate in extracurricular activities and programs. In 2002-2003, 59% of low-income students in grades 5 through 8 participated in at least one extracurricular activity compared to 80% of higher-income students.[18]

Table 26.

Licensed School-Age Child Care for Children Ages 6 to 12, Rhode Island, 2003

CITY/TOWN	PROGRAMS	SLOTS
Barrington	9	396
Bristol	4	126
Burrillville	4	242
Central Falls	6	325
Charlestown	1	26
Coventry	14	612
Cranston	22	701
Cumberland	3	115
East Greenwich	6	225
East Providence	15	813
Exeter	4	130
Foster	2	68
Glocester	0	0
Hopkinton	1	40
Jamestown	1	50
Johnston	6	133
Lincoln	9	367
Little Compton	1	26
Middletown	7	248
Narragansett	1	60
Newport	9	413
New Shoreham	0	0
North Kingstown	11	530
North Providence	2	150
North Smithfield	1	100
Pawtucket	17	1,328
Portsmouth	2	91
Providence	42	3,058
Richmond	3	90
Scituate	2	64
Smithfield	3	112
South Kingstown	8	370
Tiverton	2	95
Warren	5	202
Warwick	32	1,581
West Greenwich	2	36
West Warwick	7	390
Westerly	14	488
Woonsocket	11	435
Core Cities	*92*	*5,949*
Remainder of State	*197*	*8,287*
Rhode Island	*289*	*14,236*

Source of Data for Table/Methodology

All data are from Options for Working Parents, Greater Providence Chamber of Commerce, December 2003.

Number of licensed school-age child care programs and slots for children ages 6 to 12 as of December 2003. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 6 to 12 that do not require licensing by the state. Licensed school-age child care programs also provide services to 5 year old children who are enrolled in Kindergarten.

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Children Receiving Child Care Subsidies

DEFINITION

Children receiving child care subsidies is the number of children receiving child care that is either fully or partially paid for with a child care subsidy from the Rhode Island Department of Human Services. Child care subsidies can be used for care by a child care center, family child care home, a relative, or an in-home caregiver.

SIGNIFICANCE

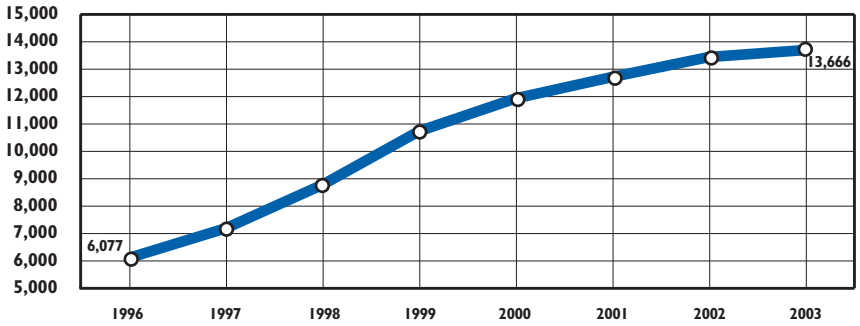
Families rely on child care to enable them to work and to provide the early education experiences needed to prepare their children for school.[1] Yet the high cost of child care puts quality care out of reach for many families, particularly low-income families.[2] National studies have shown that child care subsidies increase the likelihood that low-income parents, particularly current or former welfare recipients, will be able to work and to remain employed.[3,4]

Families with earnings below the federal poverty level who pay for child care spend 18% of their earnings, low-income families spend 14% of their earnings and higher-income families spend 7% of their earnings for child care. Families with younger children spend a higher share of income on child care than families with older children.[5] Low-skilled single mothers who pay for child care pay the highest proportion of their income on child care.[6]

The availability of high quality and affordable child care is critical to both child development and to a parent's ability to work.[7] Parents of children who receive child care subsidies are more likely to remain employed longer, increasing the likelihood of advancement, promotion, real wage growth and economic security.[8]

Nationally, only one out of seven children who are federally eligible for child care assistance receives it.[9] Rhode Island is the only state that has a legal entitlement to a child care subsidy for income-eligible families. Working families with incomes up to 225% of the federal poverty line ($41,400 for a family of four) are entitled to a child care subsidy for their children through age 16. Co-payments are required for families with income over the federal poverty guidelines. Reimbursement rates for child care providers who accept subsidies are set at the 75th percentile of the child care market rate in order to provide low-income families with access to a large proportion of the child care that exists, including higher quality care.[10,11] A recent study estimates that 18,302 Rhode Island families qualify for child care subsidies.[12] In 2003 in Rhode Island, there were 13,666 children receiving child care subsidies.[13]

Child Care Subsidies, Rhode Island, 1996-2003



Source: Rhode Island Department of Human Services, December 1996-December 2003.

◆ The number of children receiving child care subsidies has increased from 6,077 in December of 1996 to 13,666 in December of 2003. In 2003, 67% of Rhode Island children receiving child care subsidies were in licensed child care centers and 27% were in certified family child care homes for their child care arrangements.[14]

◆ The high cost of child care disproportionately affects the lowest-income families. Low-income families that pay for child care spend an average of $1 in every $7 of earnings to purchase that care. Child care subsidies broaden a family's employment options, broaden the child care options available to families (including improving access to higher quality care), and alleviate the financial burden of child care.[15]

◆ In December 2003, 72% of all child care subsidies in Rhode Island were being used by low-income working families not receiving cash assistance and 22% by families receiving cash assistance through the Family Independence Program (FIP) and engaged in education, training or employment.[16]

Children Receiving Child Care Subsidies

Table 27.

Child Care Subsidies, Rhode Island, 2003

CITY/TOWN	COMMUNITY CONTEXT: # OF CHILDREN UNDER AGE 16 IN WORKING FAMILIES < 185% POVERTY	COMMUNITY CONTEXT: # OF CHILDREN UNDER AGE 16 ENROLLED IN FIP	NUMBER OF CHILD CARE SUBSIDIES: UNDER AGE 3	AGES 3-5	AGES 6-11	AGES 12-16	TOTAL CHILD CARE SUBSIDIES
Barrington	189	25	7	17	40	0	64
Bristol	586	115	8	26	19	1	54
Burrillville	389	104	2	17	26	0	45
Central Falls	1,773	1,442	65	124	165	18	372
Charlestown	231	67	2	8	3	0	13
Coventry	793	214	43	74	57	0	174
Cranston	2,336	862	222	273	307	21	823
Cumberland	632	148	27	49	12	0	88
East Greenwich	137	39	52	46	14	0	112
East Providence	1,895	619	120	202	205	13	540
Exeter	171	38	4	4	1	0	9
Foster	129	19	1	6	14	0	21
Glocester	263	26	9	10	1	0	20
Hopkinton	267	45	4	4	2	0	10
Jamestown	81	16	7	4	3	0	14
Johnston	856	274	52	65	66	2	185
Lincoln	459	130	77	92	104	4	277
Little Compton	38	5	0	0	0	0	0
Middletown	657	94	54	46	41	2	143
Narragansett	322	68	14	17	29	6	66
New Shoreham	19	0	0	0	0	0	0
Newport	1,372	763	109	155	86	5	355
North Kingstown	833	216	45	102	68	8	223
North Providence	823	349	37	74	80	2	193
North Smithfield	132	36	0	6	10	0	16
Pawtucket	5,059	2,617	325	478	583	53	1,439
Portsmouth	329	51	8	15	21	0	44
Providence	13,712	11,866	1,394	1,725	2,136	350	5,605
Richmond	170	22	2	7	2	0	11
Scituate	175	66	1	15	16	3	35
Smithfield	330	52	39	50	30	0	119
South Kingstown	423	175	42	72	44	8	166
Tiverton	248	99	6	17	20	0	43
Warren	412	128	39	61	57	6	163
Warwick	2,136	682	250	378	352	23	1,003
West Greenwich	121	17	20	28	17	0	65
West Warwick	1,568	486	82	157	165	2	406
Westerly	875	179	23	36	53	1	113
Woonsocket	2,926	1,993	126	211	165	15	517
Out-of-State	*NA*	*0*	*35*	*52*	*29*	*4*	*120*
Core Cities	*26,410*	*19,167*	*2,101*	*2,850*	*3,300*	*443*	*8,694*
Remainder of State	*17,457*	*4,980*	*1,217*	*1,821*	*1,714*	*100*	*4,852*
Rhode Island	*43,867*	*24,147*	*3,353*	*4,723*	*5,043*	*547**	*13,666*

FIP is the Family Independence Program

Notes to Table

*Of these, 29 subsidies were used by youth ages 15 and 16. This small number of subsidies for youth is due in part to the fact that many out-of-school time programs serving older youth do not require certification as child care providers.

Source of Data for Table/Methodology

The Rhode Island Department of Human Services, INRHODES Database, December 1, 2003. All data are reported by location of the child care program not the residence of the child. Data in this table does not include retroactive payments made in December and may therefore differ slightly from data reported on previous page. Also see Methodology on page 133.

References for Indicator

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Full-Day Kindergarten

DEFINITION

Full-day kindergarten is the percentage of public school kindergarten children enrolled in a full-day kindergarten program as of October 2003. Full-day kindergarten is defined as a kindergarten program that operates for at least six hours per day. The numbers do not include children enrolled in private kindergarten programs or in half-day kindergarten programs that offer after-school child care.

SIGNIFICANCE

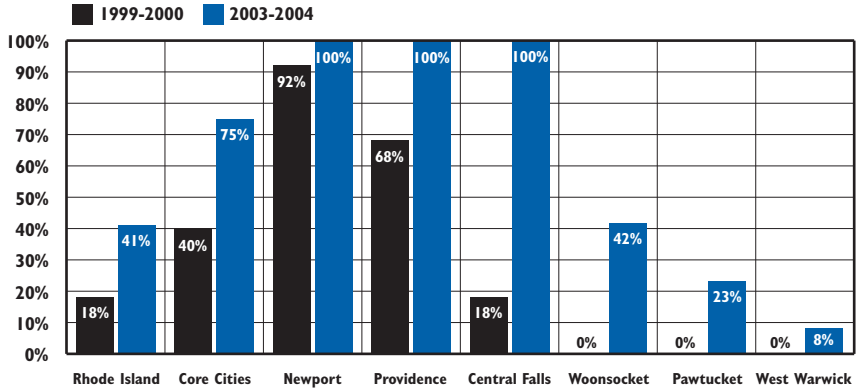
Research shows that many children benefit academically from participation in full-day kindergarten and are more likely to be ready for first grade than children in half-day kindergarten programs.[1,2] Full-day kindergarten programs are especially beneficial to children from low-income and educationally disadvantaged backgrounds.[3]

The increase in single parent families, the increase in the number of families with both parents working and the fact that most children have experience with full-day preschool or child care programs have increased the demand for full-day kindergarten. Studies show that parents favor a full-day program that reduces the number of transitions that their kindergarten child must make each day.[4]

Teachers and parents report that children who participate in full-day kindergarten have more time to discover at a relaxed pace, more opportunities to choose activities and develop their own interests and more time for creative activities.[5] The longer school day allows children and teachers time to explore topics in depth and provides an environment that supports a child-centered, developmentally-appropriate approach. Full-day kindergarteners exhibit more positive behaviors than half-day kindergartners, including: independent learning, classroom involvement, and productivity in work with peers.[6,7] Children in full-day programs are more likely to understand a broader range of letter-sound relationships, recognize words by sight, learn more in reading and math and understand words in context.[8,9]

In a full-day program, teachers and school staff have more opportunities to recognize a child's learning style, assess progress and identify problems or behavioral issues. This allows for more timely intervention and the potential to reduce costs associated with remedial education and special education costs in later school years.[10,11]

Children in Full-Day Public Kindergarten Programs, Core Cities and Rhode Island, 1999-2000 and 2003-2004



Source: Rhode Island Department of Elementary and Secondary Education, 1999-2000 and 2003-2004 school years.

◆ In Rhode Island in 2003-2004, 41% of children who attended kindergarten were in a full-day kindergarten program. Seventy-five percent of full-day kindergarteners live in the core cities. Of Rhode Island's thirty-six school districts, eight offer universal access to full-day kindergarten programs in 2003-2004.[12]

Kindergarten Entry Age

◆ On January 1, 2004, Rhode Island's new kindergarten entry age policy went into effect. Children must now be 5 years old by September 1, rather than December 31 to enter kindergarten.[13] Rhode Island is one of 35 states that have changed their kindergarten cut-off date.[14]

◆ A child's school readiness is based upon his or her maturity and the skills they have mastered. Regardless of the age at school entry, it is critical that a child's education address all domains of child development including: physical well-being and motor development, social and emotional development, and cognition and language development.[15]

Table 28. **Children Enrolled in Full-Day Kindergarten Programs, Rhode Island, 1999-2000 and 2003-2004**

SCHOOL DISTRICT	1999-2000 SCHOOL YEAR			2003-2004 SCHOOL YEAR		
	TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL-DAY K	% OF CHILDREN IN FULL-DAY K	TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL DAY K	% CHILDREN IN FULL DAY K
Barrington	214	0	0%	189	0	0%
Bristol-Warren	255	0	0%	234	75	32%
Burrillville	164	0	0%	160	76	48%
Central Falls	250	44	18%	305	305	100%
Chariho	292	0	0%	264	40	15%
Coventry	381	0	0%	306	0	0%
Cranston	737	0	0%	690	0	0%
Cumberland	373	0	0%	373	0	0%
East Greenwich	165	0	0%	144	9	6%
East Providence	443	0	0%	404	55	14%
Exeter-W. Greenwich	129	0	0%	110	0	0%
Foster	55	0	0%	49	0	0%
Foster-Glocester	0	0	0%	0	0	0%
Glocester	124	0	0%	116	0	0%
Jamestown	59	0	0%	48	48	100%
Johnston	241	0	0%	253	61	24%
Lincoln	232	0	0%	246	1	<1%
Little Compton	38	0	0%	30	0	0%
Middletown	258	211	82%	209	209	100%
Narragansett	125	0	0%	87	87	100%
New Shoreham	8	8	100%	13	13	100%
Newport	225	206	92%	244	244	100%
North Kingstown	313	0	0%	289	51	18%
North Providence	211	0	0%	198	0	0%
North Smithfield	122	55	45%	137	137	100%
Pawtucket	788	0	0%	631	144	23%
Portsmouth	214	0	0%	193	0	0%
Providence	2,117	1,431	68%	2,140	2,140	100%
Scituate	107	0	0%	134	16	12%
Smithfield	177	0	0%	158	0	0%
South Kingstown	278	0	0%	235	0	0%
Tiverton	144	0	0%	148	0	0%
Warwick	766	29	4%	750	42	6%
West Warwick	260	0	0%	274	22	8%
Westerly	282	10	4%	284	252	89%
Woonsocket	522	0	0%	543	230	42%
State Run Schools	*NA*	*NA*	*NA*	*3*	*2*	*67%*
Charter Schools	*NA*	*NA*	*NA*	*133*	*133*	*100%*
Core Cities	*4,162*	*1,681*	*40%*	*4,137*	*3,085*	*75%*
Remainder of State	*6,907*	*313*	*5%*	*6,451*	*1,172*	*18%*
Rhode Island	*11,069*	*1,994*	*18%*	*10,724*	*4,392*	*41%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education. Data are as of October for the 1999-2000 and 2003-2004 school years.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

Charter schools reported for this indicator are CVS Highlander Charter Elementary School, The Compass Charter School, International Charter, Kingston Hill Academy and the Paul Cuffee Charter School. The state-run school is the Rhode Island School for the Deaf.

References for Indicator

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[7,9] Early Education for All. *Full-Day Kindergarten.* Boston, MA: Strategies for Children. www.earlyeducationforall.org.

[8] *Narrowing the Gap in Early Literacy: Evidence from Minneapolis Public Schools Kindergarten Assessments.* (November 2002). Minneapolis, MN: Minneapolis Public Schools.

[10] West, J. et al. (2000). *The Kindergarten Year: Findings from the Early Childhood Longitudinal Study, Kindergarten Class of 1998-99.*

[13] State of Rhode Island General Assembly, Title 16 Education, Chapter 16-2 School Committees and Superintendents, section 16-2-27.

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[15] *School Readiness: Helping Communities Get Children Ready for School and Schools Ready for Children.* (October 2001). Research Brief. Washington, DC: Child Trends.

English Language Learners

DEFINITION

English language learners is the percentage of all public school children (pre-Kindergarten through grade 12) who are receiving English as a Second Language services or Bilingual Education services in Rhode Island public elementary and secondary schools. The term "Limited English Proficient students" has been replaced by the term "English language learners" in the education community.

SIGNIFICANCE

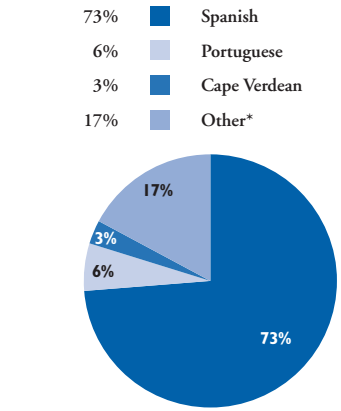
Children of recent immigrants are at very high risk for difficulties at school. They face multiple risk factors including poverty, low educational level of parents, and discrimination based on race, ethnic background, culture, or language.[1] Children who speak languages other than English at home and who also have difficulty speaking English face greater challenges progressing in school and face barriers in the workforce as adults.[2]

Adults who report that they have some difficulty with English are twelve times as likely to have completed less than five years of schooling and half as likely to have graduated from high school. Children who live in these households are 50% more likely to live in poverty.[3] These children are also most likely to be concentrated in under-resourced schools in high poverty communities.[4]

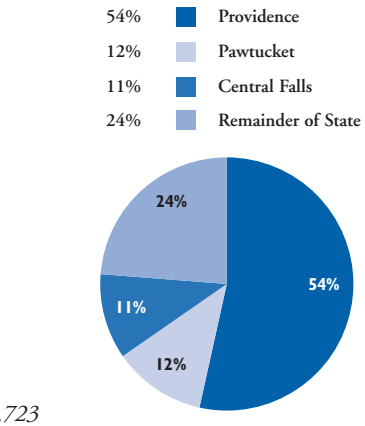
Immigrant students may enter school after extended absences from formal education and with difficulty in basic language and literacy skills. Schools play a critical role in helping children to transition to the culture of the United States and in providing an education that supports academic success for children with a primary language other than English.[5] Rhode Island schools are legally mandated to provide programs to English language learners that are comparable in structure and content to instruction provided to their English proficient peers. Programs must focus on full English language literacy and all programs must have a process for evaluating the adequate yearly progress of each English language learner including those who have left the English as a Second Language (ESL) system.[6]

For Rhode Island as a whole, the number of English language learners decreased from 10,677 students in 2001-2002 to 9,723 students in 2002-2003. In the core cities, there was a slight increase in the number of Bilingual and English as a Second Language students in Central Falls, Newport, West Warwick and Woonsocket.[7]

English Language Learners, by Language, Rhode Island, 2003



English Language Learners, by Community, Rhode Island, 2003



n = 9,723

** Includes Cambodian, Laotian, French, Chinese, Arabic, Hmong, Cantonese, Korean, Russian, Vietnamese, Haitian Creole and others.*

Source: Rhode Island Department of Elementary and Secondary Education, 2002-2003. All data are for public school students in Rhode Island.

◆ Research shows having the ability to speak English and obtaining education credentials is essential for achieving economic self-sufficiency. Without literacy in English and a higher education level, immigrant workers are often forced into low-wage jobs and poverty.[8]

◆ Spanish is the most commonly spoken language of Rhode Island's English language learners. This is consistent with the increase in the Latino child population in Rhode Island, from 16,000 in 1990 to 35,000 in 2000. In the last decade, the increase in the Latino population of Rhode Island accounted for all of the state's population increase.[9]

◆ Providence serves the largest percentage of the English Language Learners student population in Rhode Island at 54%. One in five students in Providence is an English Language Learner.[10]

Table 29.

English Language Learners, Rhode Island, 2002-2003

SCHOOL DISTRICT	TOTAL NUMBER OF STUDENTS	NUMBER OF ENGLISH LANGUAGE LEARNERS (ELL)					% OF TOTAL DISTRICT
		PRE K AND K	ELEMENTARY GRADES 1-5	MIDDLE GRADES 6-8	HIGH GRADES 9-12	TOTAL ELL	
Barrington	3,241	0	13	1	2	16	<1%
Bristol-Warren	3,658	25	86	10	15	136	4%
Burrillville	2,557	1	0	1	1	3	<1%
Central Falls	3,596	120	498	234	221	1,073	30%
Chariho	3,688	3	4	1	8	16	<1%
Coventry	5,663	1	7	1	2	11	<1%
Cranston	10,798	25	235	108	62	430	4%
Cumberland	5,220	10	78	24	11	123	2%
East Greenwich	2,363	5	10	3	5	23	1%
East Providence	6,200	70	156	39	36	301	5%
Exeter-W. Greenwich	2,111	0	4	1	1	6	<1%
Foster	364	0	0	0	0	0	0%
Foster-Glocester	1,687	0	0	0	0	0	0%
Glocester	722	0	0	0	0	0	0%
Jamestown	552	5	6	0	0	11	2%
Johnston	3,194	0	16	15	7	38	1%
Lincoln	3,576	14	10	6	5	35	1%
Little Compton	324	0	0	0	0	0	0%
Middletown	2,787	0	23	9	20	52	2%
Narragansett	1,702	1	8	0	2	11	1%
New Shoreham	135	0	2	0	1	3	2%
Newport	2,886	23	69	14	9	115	4%
North Kingstown	4,476	7	35	9	10	61	1%
North Providence	3,347	8	29	17	25	79	2%
North Smithfield	1,837	0	0	0	0	0	0%
Pawtucket	9,480	101	448	285	284	1,118	12%
Portsmouth	2,902	0	5	0	2	7	<1%
Providence	27,481	623	3,063	826	692	5,204	19%
Scituate	1,728	0	0	0	0	0	0%
Smithfield	2,642	2	6	0	0	8	0%
South Kingstown	4,103	4	20	5	10	39	1%
Tiverton	2,160	0	0	0	0	0	<1%
Warwick	11,677	9	51	17	14	91	1%
West Warwick	3,701	22	35	14	16	87	2%
Westerly	3,659	18	31	9	6	64	2%
Woonsocket	6,569	68	227	58	44	397	6%
State Run Schools	*1,184*	*0*	*0*	*0*	*100*	*100*	*8%*
Charter Schools	*649*	*28*	*37*	*0*	*0*	*65*	*10%*
Core Cities	*53,713*	*957*	*4,340*	*1,431*	*1,266*	*7,994*	*15%*
Remainder of State	*99,073*	*208*	*835*	*276*	*245*	*1,564*	*2%*
Rhode Island	*154,619*	*1,193*	*5,212*	*1,707*	*1,611*	*9,723*	*6%*

Note to Table

Because of a change in methodology, the percentage of English Language Learners (ELL) by district can not be compared with previous factbooks. This year's percentage of ELL is based on the total number of ELL divided by the "average daily membership," as of June 2003. Past percentages were based on the total number of ELL divided by total enrollment as of October of the given year. This calculation did not account for the mobility of students throughout the academic year. Using "average daily membership" is a more accurate reflection of this mobility.

Sources of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2002-2003 school year. Total number of English language learners is the number of students in each district who were actively enrolled in English as a Second Language (ESL) or Bilingual Education Programs in the 2002-2003 school year. Students who are not yet fully English proficient but have exited the ESL or bilingual program to regular education are not included in these numbers.

The denominator (number of students) is the "average daily membership" as calculated by the Rhode Island Department of Elementary and Secondary Education.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

See Methodology page 134 for a list of state run and charter schools.

References

[1] *Information Works!* (2000). Providence RI: Rhode Island Department of Elementary and Secondary Education and University of Rhode Island, National Center on Public Education and Social Policy.

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[3] Crawford, James (1997). *Best Evidence: Research Foundations for the Bilingual Education.* Washington DC: National Clearinghouse for Bilingual Education.

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continued on page 136

Children Enrolled in Special Education

DEFINITION

Children enrolled in special education is the percentage of children ages 3 to 21 who are enrolled in special education in Rhode Island elementary and secondary schools.

SIGNIFICANCE

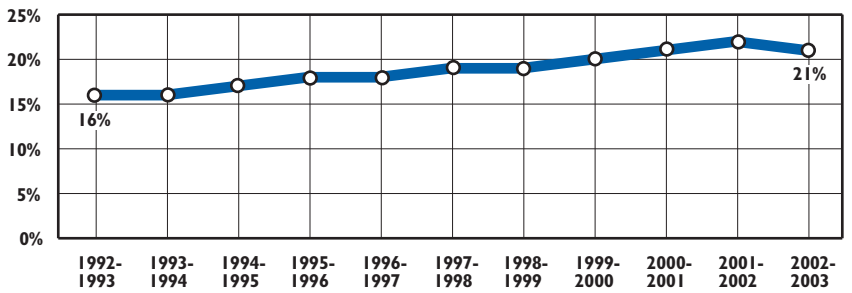
Special education services are an important resource for improving long-term outcomes for children with special needs, such as improving student achievement and graduation rates, increasing participation in post-secondary education, and increasing wages.[1,2] Revisions to federal educational statutes, signed into law early in 2002, now require states, districts and schools to demonstrate adequate yearly progress towards proficiency in reading and math by all students, including students with disabilities. This provision is intended to increase expectations and accountability so that more students with disabilities achieve grade-level standards.[3]

The federal Individuals with Disabilities Education Act (IDEA) mandates that local school districts identify and provide multidisciplinary evaluations for students ages 3 to 21 whom they have reason to believe are students with disabilities. Once found eligible for special education due to disability, a student must be provided with an Individualized Education Plan (IEP) laying out goals, outlining specific steps for achieving the goals, and providing services for the student based on their individual needs.[4]

Services described in the IEP must be provided in the least restrictive environment, i.e. to the extent appropriate, the child should receive special services in a setting that is integrated with other children with and without disabilities. This is sometimes referred to as inclusion and is meant to raise expectations for student performance, improve opportunities to learn alongside nondisabled peers and improve coordination between regular and special educators.[5,6]

In Rhode Island, 48% of special education students spend less than 21% of the school day outside the regular classroom, in keeping with national averages (47%). Rhode Island lags behind national inclusion rates for children who may require more assistance: Only 19% of Rhode Island students (compared with 28% nationally) fall into the middle tier of inclusion, i.e. 21-60% of their time outside a regular classroom; 33% of Rhode Island special education students spend more than 60% of their time outside the general classroom or are in separate facilities, compared to 24% nationally.[7]

Special Education Enrollment as a Percentage of All Students, Rhode Island, 1992 to 1993 - 2002 to 2003



Source: Rhode Island Department of Elementary and Secondary Education, Office of Special Education, 1992-1993 to 2002-2003 school years.

◆ Between the 1992-1993 and 2002-2003 school years, special education enrollment increased from 16% of all students to 21% of all students.[8]

◆ Students with learning disabilities and students with speech/language impairments constituted the largest categories of students enrolled in special education throughout the decade, together accounting for more than two-thirds (68%) of special education enrollment in 2002-03.[9]

◆ Approximately two-thirds of the increase in special education enrollment in the last decade is accounted for by combined increases in lower incidence disabilities, including health impairments, emotional disturbance, and autism.[10]

◆ Speech/language impairments accounted for about one-quarter of of the increase in special education enrollment over the past decade. Learning disabilities increased slightly over the decade and declined as a proportion of special education enrollment.[11]

Table 30.

Children and Youth in Special Education, by Primary Disability, Ages 3-21, Rhode Island, 2002-2003

SCHOOL DISTRICT	TOTAL # OF STUDENTS	EMOTIONAL DISTURBANCE	MENTALLY RETARDED	AUTISM	HEALTH IMPAIRED	LEARNING DISABLED	SPEECH DISORDER	DEVELOP-MENTALLY DELAYED	OTHER	TOTAL STUDENTS WITH DISABILITIES	% STUDENTS IN SPECIAL EDUCATION
Barrington	3,272	65	10	20	68	254	147	21	28	613	19%
Bristol-Warren	3,719	60	53	12	24	436	180	38	25	828	22%
Burrillville	2,587	65	17	19	108	176	124	20	14	543	21%
Central Falls	3,695	111	42	6	75	509	121	48	22	934	25%
Chariho	3,680	51	12	16	41	328	232	34	26	740	20%
Coventry	5,645	77	41	6	73	795	146	47	21	1,206	21%
Cranston	10,818	169	45	30	251	1,395	376	93	48	2,407	22%
Cumberland	5,262	137	28	30	307	361	320	43	37	1,263	24%
East Greenwich	2,385	31	6	26	92	121	139	22	11	448	19%
East Providence	6,231	159	57	31	330	514	308	21	41	1,461	23%
Exeter-W. Greenwich	2,132	47	14	13	101	89	138	8	8	418	20%
Foster	365	1	1	0	2	11	41	3	2	61	17%
Foster-Glocester	1,706	14	13	5	13	133	47	0	5	230	13%
Glocester	728	0	7	4	13	44	81	7	7	163	22%
Jamestown	741	6	2	11	35	49	29	5	2	139	19%
Johnston	3,254	74	26	19	171	309	222	31	20	872	27%
Lincoln	3,618	47	25	24	164	286	167	29	20	762	21%
Little Compton	443	3	2	1	6	42	25	1	3	83	19%
Middletown	2,733	47	5	18	84	272	171	3	11	611	22%
Narragansett	1,718	27	3	10	47	155	137	21	10	410	24%
New Shoreham	136	0	1	0	0	9	9	0	0	19	14%
Newport	2,895	84	7	24	28	466	131	27	30	797	28%
North Kingstown	4,342	63	17	10	42	403	195	26	18	774	18%
North Providence	3,381	67	18	13	135	259	148	17	22	679	20%
North Smithfield	1,841	21	8	4	45	161	90	14	13	356	19%
Pawtucket	9,628	242	134	58	175	970	509	146	40	2,274	24%
Portsmouth	2,868	42	7	20	74	181	218	2	15	559	19%
Providence	28,046	523	346	24	200	3,205	958	76	41	5,373	19%
Scituate	1,758	7	3	10	32	99	159	5	5	320	18%
Smithfield	2,670	11	9	14	85	192	175	23	12	521	20%
South Kingstown	4,163	78	20	26	127	376	263	25	28	943	23%
Tiverton	2,184	31	3	8	41	243	157	5	12	500	23%
Warwick	11,800	149	77	45	443	1,183	423	165	82	2,567	22%
West Warwick	3,927	117	24	8	23	441	220	25	26	884	23%
Westerly	3,688	87	10	22	79	245	212	41	16	712	19%
Woonsocket	6,668	215	148	16	365	509	262	84	52	1,651	25%
State Run Schools	*1,159*	*12*	*0*	*0*	*25*	*111*	*12*	*0*	*82*	*242*	*21%*
Charter Schools	*649*	*4*	*0*	*2*	*5*	*31*	*33*	*0*	*5*	*80*	*12%*
*DCYF**	*NA*	*158*	*1*	*0*	*4*	*24*	*0*	*0*	*2*	*189*	*NA*
Core Cities	*54,859*	*1,292*	*701*	*136*	*866*	*6,100*	*2,201*	*406*	*211*	*11,913*	*22%*
Remainder of State	*99,868*	*1,636*	*540*	*467*	*3,033*	*9,121*	*5,079*	*770*	*562*	*21,208*	*21%*
Rhode Island	*156,535*	*3,102*	*1,242*	*605*	*3,933*	*15,387*	*7,325*	*1,176*	*862*	*33,632*	*21%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2002-2003 school year. Office of Special Education, June 30, 2003.

The denominator (number of students) is the "resident average daily membership" as calculated by the RI Department of Elementary and Secondary Education.

"Other" includes deaf and blind, visually impaired or blind, hearing impaired, multi-handicapped, orthopedically impaired, and traumatic brain injury. Prior to 2002-2003, the category "emotional disturbance" was called "behaviorally disordered."

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

"State-Run Schools" includes Davies Career and Vocational Technical School, Metropolitan Career Technical Center and Rhode Island School for the Deaf. The Training School is not included. Charter Schools include Blackstone Academy, CVS Highlander, Compass Charter School, International Charter School, Kingston Hill Academy, and Paul Cuffee Charter School.

* "DCYF" refers to children in the care and custody of the Department of Children, Youth and Families, specifically those who are at the Training School or who are in out-of-home placement in residential facilities. They do not include children in foster care.

Children attending schools out-of-district (e.g.when no appropriate placement exists in the district) are listed under the enrolling district, not the sending district.

References

[1] *Twenty-five Years of Educating Children with Disabilities.* (2001). Washington, DC: American Youth Policy Forum and Center on Education Policy.

[2] *Children with Disabilities Study: Special Education in the Context of School Reform.* (2002). Providence, RI: Commissioned by the Rhode Island General Assembly in July 1999.

[3] *No State Left Behind: The Challenges and Opportunities of ESEA 2001.* (March 2002). Denver, CO: Education Commission of the States.

[4] Martin, E.W. et al. (Spring 1996). *The Legislative and Litigation History of Special Education. Special Education for Students with Disabilities.* Los Altos, CA: Center for the Future of Children, David and Lucille Packard Foundation.

continued on page 136

Student Mobility

DEFINITION

Student mobility is the number of students who either enrolled in or withdrew from Rhode Island public schools during the school year divided by the number of students in the fall school enrollment.[1]

SIGNIFICANCE

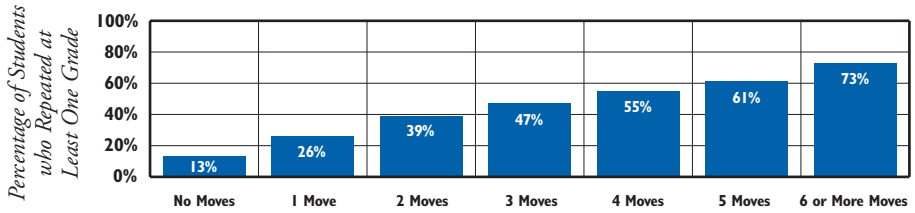
Families move for a variety of reasons that may include changes in household structure, parental employment status, an inability to pay the rent, dissatisfaction with neighborhood conditions or a desire to improve overall quality of family life.[2,3]

One in six third-grade students in the U.S. has attended at least three schools since the beginning of the first grade.[4] Student mobility affects both the student and the classrooms they attend. Changing schools causes a disruption in a child's learning experience and may accentuate learning difficulties if the child enters a classroom at a different point in the curriculum than in their previous school.[5]

Research shows that frequent moves can have a negative effect on school performance, behavior and may affect other areas of child well-being.[6,7] Teachers in schools with highly mobile students are more likely to have problems accurately assessing the needs of new children, determining their past educational experiences and being able to build on the student's knowledge and skills.[8]

Nationally, children under age five, children of color, children living in low-income households or renter households and immigrants have the highest rates of mobility.[9] Children who are English Language Learners (ELL) are more than twice as likely to change schools frequently as are non-ELL students.[10] Mobility also has a strong relationships to child well-being. Frequent moves are correlated with negative outcomes such as dropping out of school, delinquency, depression, anti-social behavior, and teen births.[11,12]

Students Who Repeated at Least One Grade by Number of Residential Moves, Providence, 1987 - 2001



Source: *Development and Use of Neighborhood Health Analyisis: Residential Mobility in Context* (October 30, 2002). Providence, RI: The Providence Plan. Data represent the 57,641 children who were enrolled in Providence Schools between 1987 and 2001.

◆ Students in Providence who move often are more likely to repeat a grade. As the number of moves increases, the likelihood of repeating a grade increases. Almost half (47%) of Providence students who moved 3 times had repeated a grade at least once. Almost three-quarters (73%) of children who moved 6 times had repeated a grade at least once.[13]

Mobility and Education Outcomes in Rhode Island

◆ In Rhode Island, students who move are absent more often than students that do not move. Thirty-one percent of students that did not move missed 16 or more days of school, compared to 42% of students that moved at least once during the same period.[14]

◆ Children that move perform worse on standardized tests than children that have not experienced mobility. The more frequent the number of moves the worse the performance. Based on a 2002 study by the Providence Plan, 66% of children who have not moved met the 4th Grade Reading Standards, as opposed to 59% of students who moved once, 56% of students who moved twice, and 48% of students who moved three or more times.[15]

Residential Mobility Among Children Ages Birth to Five Years, Core Cities and Rhode Island 1997-2001

Place of Birth	All Births	No Moves	1 Move	2 Moves	3+ Moves
Central Falls	1,692	48%	28%	14%	11%
Newport	1,655	57%	27%	10%	5%
Pawtucket	4,778	59%	25%	10%	6%
Providence	13,182	51%	27%	13%	9%
West Warwick	1,967	63%	24%	9%	4%
Woonsocket	2,683	52%	28%	12%	9%
Core Cities	13,877	53%	27%	12%	8%
Remainder of State	24,590	74%	20%	4%	2%
Rhode Island	38,467	65%	23%	8%	4%

Source: *Development and Use of Neighborhood Health Analysis: Residential Mobility in Context.* (October 2002). Providence, RI: The Providence Plan.

◆ Between 1997 and 2001 in Rhode Island, 53% of children ages birth to five in the core cities did not experience residential moves, as compared to 74% of children ages birth to five in the remainder of the state and 65% of children in Rhode Island as a whole.[16]

◆ Central Falls (25%), Providence (22%), and Woonsocket (21%) have the highest percentage of children under six years of age who have moved more than once.[17]

◆ Of all young children in Rhode Island, those born to teen mothers, single mothers or mothers with less than a high school diploma are most likely to experience residential mobility.[18]

Mobility and Health Outcomes

◆ A study of Rhode Island children under age 6 found that residentially-mobile children have fewer office visits and less contact with any physician than other young children. As the number of moves increases, the likelihood that a child will not have a consistent primary care provider also increases.[19]

◆ Increased mobility can affect the emotional and behavioral well-being of children. Children who move frequently find it difficult to maintain relationships with old friends and may develop feelings of loneliness, abandonment, helplessness, and a fear of the unknown.[20]

◆ One study found that conduct disorders, emotional disorders, and hyperactivity were more prevalent among children ages four to sixteen who moved two or more times in a two-year period than among children moving once or not at all. More longitudinal data are required to explore the relationship between mobility and mental health disorders.[21]

References for Indicator

[1] Data on student mobility in Rhode Island for elementary school, middle school, and high school are not available for the 2002-2003 school year, but will be reported in future years.

[2] *Why People Move: Exploring the March 2000 Current Population Survey: March 1999 to March 2000.* (May 2001). Washington, DC: U.S. Bureau of the Census.

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[7,12] Scanlon, E. and Devine, K. (March 2001). Residential Mobility and Youth Well-Being: Research, Policy and Practice Issues. *Journal of Sociology and Social Welfare,* Vol. XXVIII, Number 1.

[9] *Geographical Mobility - Population Characteristics: March 1999 to March 2000.* (May 2001). Washington, DC: U.S. Bureau of the Census.

[11] *Trends in the Well-Being of America's Children and Youth.* (2002). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[13,14,15,16,17,18,19] *Development and Use of Neighborhood Health Analysis: Residential Mobility in Context.* (October 30, 2002). Providence, RI: The Providence Plan. Data represents the Providence Plan's analysis of data from the Providence School Department student enrollment databases, the Rhode Island Department of Elementary and Secondary Education standardized test scores and the Rhode Island Department of Health Kidsnet databases.

[20,21] *Mobility.* (December 1999). "Keeping Score" on Kids in Hamilton-Wentworth. Canada: Canadian Centre for Studies of Children at Risk.

Fourth-Grade Reading Skills

DEFINITION

Fourth-grade reading skills is the percentage of fourth-grade students who scored at or above the proficiency level for reading in the *New Standards English Language Arts Reference Exam* in 2003. The exam is made up of two parts: *Basic Understanding* focuses on the student's ability to comprehend and understand text, and *Interpretation and Analysis* focuses on the student's ability to correctly interpret and analyze text.

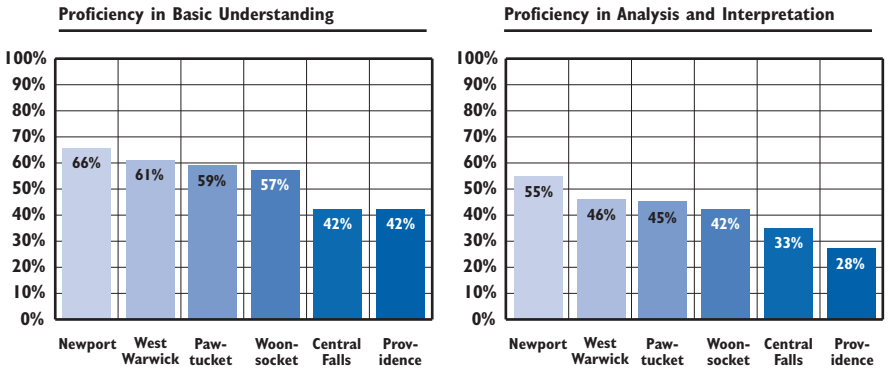
SIGNIFICANCE

Reading skills are critical to a student's success in school and in the workforce. Students who cannot read are more likely to be absent from school, exhibit behavior problems, have low levels of self-confidence, and perform poorly in school. Parent education, language proficiency, family structure, and the community's socioeconomic status are strong predictors of student achievement in reading.[1,2] Across the U.S., schools with high poverty rates have achieved high performance by emphasizing best practices such as standards for curriculum design and accountability; parent involvement; extra teaching time for the basics of reading and math; and immediate and intensive support for low-achieving students.[3]

Literacy begins long before children encounter formal school instruction in writing and reading. Reading to young children at home, allowing the child to read out loud, and encouraging conversation, correlates with advanced literacy development and reading achievement.[4,5,6] Participation in high-quality pre-schools can also boost language and literacy skills by helping children learn, think, and talk about new areas of knowledge; by integrating reading, letters, sounds, and storytelling into everyday activities; and by offering opportunities to play in ways that build awareness of the sounds and structure of language.[7]

Out-of-school activities are important predictors of reading achievement. Children who report that they regularly read for fun on their own time, visit the library and have parents who are involved in school activities tend to have higher reading proficiency.[8]

Rhode Island Public School 4th Grade Reading Proficiency, Core Cities, 2002-2003



Source: RI Department of Elementary and Secondary Education, New Standards English Language Arts Reference Exam at Grade 4, 2002-2003 school year.

◆ In 2003, 70% of Rhode Island fourth graders scored at or above proficiency in *Basic Understanding* and 57% scored at or above proficiency in *Analysis and Interpretation.* All of Rhode Island's core cities had reading proficiency levels below the state rates.[9]

◆ Between 2001-2002 and 2002-2003, *Basic Understanding* proficiency scores declined in all of the core cities. The *Analysis and Interpretation* proficiency scores declined or remained steady in four of the core cities but improved in Newport and Central Falls (53% to 55% and 28% to 33% respectively).[10]

Promoting Reading Achievement

◆ The Reading First Initiative is a new federal program aimed at ensuring that all students are reading at or above grade level by third grade. The initiative, part of the federal *No Child Left Behind Act of 2001*, helps states and districts implement reading programs for children and provides professional development for teachers regarding scientifically-based instruction and in the identification of children at risk of reading disabilities.

◆ Reading First targets services to districts with the highest numbers of students in kindergarten through third grade reading below grade level as well as schools with the highest number of low-income children.[11,12]

Table 31.

Fourth-Grade Reading Proficiency, Rhode Island, 2003

SCHOOL DISTRICT	COMMUNITY CONTEXT				% OF 4TH GRADE STUDENTS MEETING OR EXCEEDING STANDARDS FOR BASIC UNDERSTANDING	% OF 4TH GRADE STUDENTS MEETING OR EXCEEDING STANDARDS FOR ANALYSIS & INTERPRETATION
	% ADULTS COMPLETING HIGH SCHOOL	% CHILDREN IN POVERTY	% LIMITED ENGLISH PROFICIENCY	NUMBER OF 4TH GRADE TEST TAKERS		
Barrington	92%	4%	<1%	295	91%	84%
Bistol-Warren	NA	12%	4%	267	72%	62%
Burrillville	80%	5%	<1%	193	70%	59%
Central Falls	49%	37%	30%	320	42%	33%
Chariho	NA	6%	<1%	289	89%	79%
Coventry	83%	8%	<1%	426	82%	68%
Cranston	79%	8%	4%	872	80%	70%
Cumberland	81%	3%	2%	396	86%	72%
East Greenwich	93%	5%	1%	203	91%	84%
East Providence	71%	9%	5%	474	70%	55%
Exeter-W. Greenwich	NA	5%	<1%	166	80%	66%
Foster	88%	6%	0%	70	93%	87%
Foster-Glocester	NA	4%	0%	NA*	NA	NA
Glocester	87%	8%	0%	136	91%	75%
Jamestown	93%	3%	2%	70	91%	80%
Johnston	78%	9%	1%	270	76%	56%
Lincoln	82%	6%	1%	284	80%	66%
Little Compton	91%	1%	0%	31	94%	77%
Middletown	91%	9%	2%	236	78%	68%
Narragansett	91%	10%	1%	124	75%	74%
New Shoreham	95%	11%	2%	NA*	NA	NA
Newport	87%	24%	4%	253	66%	55%
North Kingstown	92%	11%	1%	392	89%	79%
North Providence	77%	9%	2%	257	79%	63%
North Smithfield	82%	2%	0%	146	82%	71%
Pawtucket	66%	21%	12%	842	59%	45%
Portsmouth	91%	3%	<1%	212	91%	83%
Providence	66%	37%	19%	2,336	42%	28%
Scituate	87%	4%	0%	158	85%	78%
Smithfield	85%	4%	<1%	201	84%	76%
South Kingstown	91%	6%	1%	317	86%	77%
Tiverton	80%	3%	0%	146	73%	65%
Warwick	85%	8%	1%	868	82%	68%
West Warwick	76%	18%	2%	297	61%	46%
Westerly	82%	11%	2%	282	83%	71%
Woonsocket	64%	27%	6%	529	57%	42%
Charter Schools	*NA*	*NA*	*10%*	*54*	*52%*	*48%*
State Run Schools	*NA*	*NA*	*8%*	*5*	*0%*	*0%*
Core Cities	*NA*	*30%*	*15%*	*4,577*	*NA*	*NA*
Remainder of State	*NA*	*7%*	*2%*	*7,781*	*82%*	*70%*
Rhode Island	*78%*	*15%*	*6%*	*12,417*	*70%*	*57%*

Source of Data for Table/Methodology

% children in poverty is from the U.S. Bureau of the Census, Small Area Income and Population Estimates, Children Ages 5-17, 1999. % of adults completing high school or higher is from Census 2000. All other data are from the Rhode Island Department of Elementary and Secondary Education, 2002-2003 school year.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

NA*: Community has a regional school.

See Methodology, pg 133.

References for Indicator

[1,4,12] *America's Children: Key National Indicators of Well-Being.* (2003). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2,6] *The Condition of Education 2003.* (July 2003). Washington, DC: National Center for Education Statistics.

[3] Jerald, C. (2001). *Dispelling the Myth Revisited: Preliminary Findings From a Nationwide Analysis of "High-Flying" Schools.* Washington, DC: The Education Trust.

[5] *The Condition of Education 2003.* (2003). Washington, DC: U.S. Department of Education, National Center for Education Statistics.

[7] Dickinson, D. and Tabors, P. (2001). *Beginning Literacy With Language: Young Children Learning at Home and School.* Baltimore, MD: Paul H. Brookes Publishing Company.

[8] *Trends in the Well-Being of America's Children and Youth: 2002.* (2003) Washington, DC: U.S. Child Trends Inc., Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[9,10] Rhode Island Department of Elementary and Secondary Education, 2001-2002 and 2002-2003 school years.

[11] *Guidance for the Early Reading First Program.* (March 2003). Washington, DC: United States Department of Education.

[12] Kauerz, K. (April 2002). *No Child Left Behind Policy Brief: Literacy.* Denver, CO: Education Commission of the States.

High Performing Schools

DEFINITION

High performing schools is the percentage of schools in Rhode Island that are classified as high performing, based on new guidelines that meet the provisions of the No Child Left Behind Act of 2001, the federal education law. As required by federal law, the Rhode Island Department of Elementary and Secondary Education established 21 annual targets for each school level, out to the year 2014. A school is classified as high performing if the school as a whole has already met the targets for the year 2011.[1]

SIGNIFICANCE

Appropriate accountability systems that regularly measure student performance can improve instruction and student learning. Accountability standards make intended learning goals explicit and provide periodic feedback to parents, students, teachers, policymakers and the public.[2] It is important that performance assessments are consistent with the schools' content standards specifying what teachers are supposed to teach and what students are expected to learn.[3,4]

Reading and mathematical skills as well as the ability to reason and communicate effectively are factors that affect a student's ability to succeed in the labor market. On average, students with higher test scores will earn more and be unemployed less often than students with lower test scores. Mathematics and reading achievement test scores are important measures of student skills in these subject areas as well as good indicators of overall achievement in school.[5]

National research indicates that schools serving low-income and educationally disadvantaged students can achieve high standards for student performance. High poverty schools that exceed expectations for school performance have a common set of core practices in place. These schools use standards to inform curriculum design; evaluate both students and teachers based on state standards; spend more time on the basics of reading and math; invest in professional development; closely monitor individual student performance and provide additional supports when students are struggling; and involve parents.[6]

In 2003, 29% of schools in Rhode Island were categorized as high performing. In the core cities only 2% of schools were high performing and 79% were schools in need of improvement.[7] Schools which are considered in need of improvement are classified as making progress or insufficient progress.[8] In 2003, of 123 schools in need of improvement, only 21 were making progress. Seven of these were in the core cities.[9]

Annual School Performance Targets

◆ Rhode Island has in place an accountability program which classifies schools as "high performing", "moderately performing" or "in need of improvement" based on 21 annual targets as required by federal law, including:

- Targets for the performance of the school as a whole in English Language Arts and Mathematics on New Standards Reference Examinations.
- Targets for the performance of 8 subgroups of students in English Language Arts and Mathematics, including Asian, Black, Hispanic, Native American, White, students in poverty, students with disabilities, and English-language learners.
- Targets for participation rates on state tests.
- Targets for attendance (for elementary schools and middle schools) or graduation rates (for high schools).[10]

Source: Rhode Island Department of Elementary and Secondary Education.

School Performance Classifications, Rhode Island 2003

◆ Schools are considered to be high performing if the school as a whole has already met the English Language Arts and Mathematics targets for the year 2011 and no subgroup of students has fallen below current year targets. A total of 92 schools (29%) across Rhode Island were classified as high performing.[11]

◆ Schools are moderately performing if they have met all of their current year targets. There were 106 schools (33%) classified as moderately performing.[12]

◆ Schools are in need of improvement if they missed any of the 21 targets, for the school as a whole or for any of the 8 subgroups of students. Across Rhode Island, 123 schools (38%) were classified as in need of improvement. Of these, 21 schools (7% of all schools) were classified as in need of improvement / making progress and 102 schools (32% of all schools) are in need of improvement / insufficient progress.[13]

School Performance, Rhode Island 2003

Table 32.

DISTRICT	TOTAL # OF SCHOOLS	HIGH PERFORMING SCHOOLS	MODERATELY PERFORMING SCHOOLS	SCHOOLS IN NEED OF IMPROVEMENT		% HIGH PERFORMING SCHOOLS	% SCHOOLS IN NEED OF IMPROVEMENT
				MAKING PROGRESS	INSUFFICIENT PROGRESS		
Barrington	6	3	3	0	0	50%	0%
Bristol-Warren	9	1	4	1	3	11%	44%
Burrillville	5	0	2	2	1	0%	60%
Central Falls	7	0	1	0	6	0%	86%
Chariho	6	5	0	1	0	83%	17%
Coventry	8	3	3	0	2	38%	25%
Cranston	24	11	11	1	1	46%	8%
Cumberland	8	2	4	0	2	25%	25%
East Greenwich	6	4	2	0	0	67%	0%
East Providence	11	1	6	2	2	9%	36%
Exeter-W. Greenwich	5	1	3	0	1	20%	20%
Foster	1	1	0	0	0	100%	0%
Foster-Glocester	2	1	1	0	0	50%	0%
Glocester	2	2	0	0	0	100%	0%
Jamestown	2	2	0	0	0	100%	0%
Johnston	9	2	4	1	2	22%	33%
Lincoln	7	2	1	0	4	29%	57%
Little Compton	2	2	0	0	0	100%	0%
Middletown	5	2	3	0	0	40%	0%
Narragansett	3	3	0	0	0	100%	0%
New Shoreham	3	3	0	0	0	100%	0%
Newport	8	1	4	1	2	13%	38%
North Kingstown	9	4	3	0	2	44%	22%
North Providence	9	0	7	0	2	0%	22%
North Smithfield	3	2	1	0	0	67%	0%
Pawtucket	15	0	3	3	9	0%	80%
Portsmouth	5	3	2	0	0	60%	0%
Providence	44	1	3	2	38	2%	91%
Scituate	5	5	0	0	0	100%	0%
Smithfield	6	3	3	0	0	50%	0%
South Kingstown	11	5	1	0	5	45%	45%
Tiverton	5	3	2	0	0	60%	0%
Warwick	26	9	11	3	3	35%	23%
West Warwick	5	0	2	0	3	0%	60%
Westerly	7	3	4	0	0	43%	0%
Woonsocket	12	0	4	1	7	0%	67%
Charter Schools	*13*	*2*	*7*	*3*	*1*	*15%*	*31%*
State Run Schools	*5*	*0*	*1*	*0*	*4*	*0%*	*80%*
Rhode Island Training School	*1*	*0*	*0*	*0*	*1*	*0%*	*100%*
Urban Collaborative Accelerated Program	*1*	*0*	*0*	*0*	*1*	*0%*	*100%*
Core Cities	*91*	*2*	*17*	*7*	*65*	*2%*	*79%*
Remainder of State	*210*	*88*	*81*	*11*	*30*	*42%*	*20%*
Rhode Island	*321*	*92*	*106*	*21*	*102*	*29%*	*38%*

Note to Table

Rhode Island school performance classifications for 2003 are not comparable to those for previous years due to change in performance criteria necessitated by compliance with the federal No Child Left Behind Act of 2001.

Source of Data for Table/Methodology

All data are from the Rhode Island Department of Elementary and Secondary Education. (March 2004). School performance data are based on the past three years of assessment data (2001-2003), except that the current single year of assessment data is used where it improves a school's classification from school in need of improvement to moderately performing. See Methodology on p.134

The denominator is the total number of categorized schools in each school district. In several communities and charter schools one school building may house elementary, middle and/or high school grades. For purposes of this table they are reported as separate schools.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References for Indicator

[1] *School and District Performance and Accountability System, Technical Assistance Bulletin* (Incorporating the NCLB Accountability System). (August 2003). Providence, RI: Rhode Island Department of Elementary and Secondary Education.

[2,3] Linn, R. (April 2001). *The Design and Evaluation of Educational Assessment and Accountability Systems* (CSE Technical Report 539). Los Angeles, CA: Center for the Study of Evaluation, National Center for Research on Evaluation, Standards, and Student Testing, University of California, Los Angeles.

[4] Briars, D. (August 2000). *Standards, Assessments—and What Else? The Essential Elements of Standards-Based School Improvement.* CSE Technical Report 528. Los Angeles, CA: Center for the Study of Evaluation, National Center for Research on Evaluation, Standards, and Student Testing, University of California, Los Angeles.

[5] *America's Children: Key National Indicators of Well-Being, 2003.* (2003).Washington, DC: Federal Interagency Forum on Child and Family Statistics, Government Printing Office.

continued on page 136

School Attendance

DEFINITION

School attendance is the average daily attendance of public school students in each school district in Rhode Island for elementary school (grades 1-5), middle school (grades 6-8), and high school (grades 9-12). Public school students in pre-school, kindergarten, and ungraded classrooms are not included.

SIGNIFICANCE

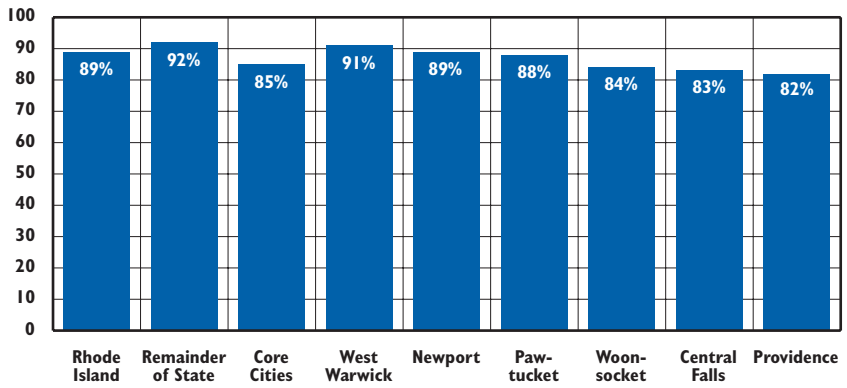
An important aspect of students' access to education is the amount of time actually spent in the classroom. When students are absent from school they forgo opportunities to learn.[1] Lower attendance rates are linked to lower reading scores and are an important factor in variation in states' mathematics scores.[2,3] Additionally, students who think of dropping out begin by skipping school.[4] Truancy among teens is a powerful predictor of juvenile delinquency and may be connected with substance abuse.[5,6] Nationally, the tendency to miss school increases notably by grade level. Over the past two decades, twelfth graders have reported a declining interest in school.[7]

Student absenteeism places individual children at risk for school failure. Truancy is rarely a reflection of the child alone and is often an early indication that the family needs help.[8] Teens who live in more affluent families and those who live with both parents have higher education aspirations and expectations, are more engaged in school, do better academically, and are more likely to continue their schooling than their peers in less well-off families and those in single-parent families.[9]

Problems with student attendance create a climate of instability in schools. In schools where truancy rates are low, there is less disruption and violence. Teachers are more committed to students and are more likely to interact and engage with the entire class. Students are less likely to miss school when they are engaged and have a sense of belonging due to established relationships with both their teachers and classmates.[10]

Students are very aware of whether their teachers have high or low expectations for them and often their achievement levels are strongly linked to what those expectations are. The relationships between students and their teachers are critical in shaping the school climate of the school. All students, regardless of age, will do better when relationships are respectful, behavior is not disruptive, and teachers are invested in the student's success.[11]

High School Attendance in the Core Cities and Rhode Island, 2002-2003



Source: Rhode Island Department of Elementary and Secondary Education

◆ Attendance rates in the core cities overall are lower than in the remainder of Rhode Island at each school level. The largest difference is in high school, when the attendance rate is 85% in the core cities and 92% in the remainder of the state.[12]

◆ With 11,894 high school students in the core cities, improving the core cities' attendance rate from 85% to 92% would mean that 832 more students would be attending high school in the core cities each day of the school year.[13]

Programs to Increase School Attendance

◆ Research shows that youth who participate in mentoring programs have fewer unexcused absences and better attitudes toward school than youth who do not participate.[14]

◆ Effective truancy reduction strategies include clear, consistently enforced school policies; school reorganization to support students' engagement in learning and attachment to school; effective communication between the school and the parent; family counseling programs; and collaboration between the school and community partners.[15]

Table 33.

School Attendance Rates, Rhode Island, 2002-2003

SCHOOL DISTRICT	ELEMENTARY SCHOOL AVERAGE DAILY ATTENDANCE	ELEMENTARY SCHOOL TOTAL # OF STUDENTS	ELEMENTARY SCHOOL ATTENDANCE RATE	MIDDLE SCHOOL AVERAGE DAILY ATTENDANCE	MIDDLE SCHOOL TOTAL # OF STUDENTS	MIDDLE SCHOOL ATTENDANCE RATE	HIGH SCHOOL AVERAGE DAILY ATTENDANCE	HIGH SCHOOL TOTAL # OF STUDENTS	HIGH SCHOOL ATTENDANCE RATE
Barrington	1,259	1,311	96%	772	807	96%	970	1,015	96%
Bristol-Warren	1,310	1,387	94%	861	923	93%	1,061	1,194	89%
Burrillville	879	926	95%	616	652	94%	797	842	95%
Central Falls	1,428	1,518	94%	788	868	91%	739	886	83%
Chariho	1,337	1,406	95%	863	914	94%	1,105	1,174	94%
Coventry	2,090	2,186	96%	1,339	1,415	95%	1,639	1,861	88%
Cranston	4,141	4,342	95%	2,613	2,766	94%	2,984	3,305	90%
Cumberland	2,053	2,134	96%	1,262	1,319	96%	1,383	1,516	91%
East Greenwich	946	984	96%	623	635	98%	636	671	95%
East Providence	2,253	2,361	95%	1,495	1,599	93%	1,718	1,993	86%
Exeter-W. Greenwich	754	786	96%	540	564	96%	641	685	94%
Foster	321	339	95%	NA	NA	NA	NA	NA	NA
Foster-Glocester	NA	NA	NA	714	758	94%	851	929	92%
Glocester	638	667	96%	NA	NA	NA	NA	NA	NA
Jamestown	286	299	96%	184	193	95%	NA	NA	NA
Johnston	1,262	1,330	95%	817	886	92%	755	851	89%
Lincoln	1,312	1,366	96%	921	969	95%	1,007	1,088	93%
Little Compton	162	171	95%	129	138	93%	NA	NA	NA
Middletown	1,091	1,142	96%	591	622	95%	711	778	91%
Narragansett	611	640	95%	405	425	95%	480	513	94%
New Shoreham	51	55	93%	30	33	91%	28	30	93%
Newport	1,074	1,148	94%	576	631	91%	719	811	89%
North Kingstown	1,732	1,802	96%	1,034	1,080	96%	1,311	1,398	94%
North Providence	1,184	1,255	94%	877	933	94%	980	1,058	93%
North Smithfield	672	701	96%	427	444	96%	497	526	94%
Pawtucket	3,848	4,054	95%	2,481	2,651	94%	2,054	2,339	88%
Portsmouth	1,115	1,167	96%	673	708	95%	881	929	95%
Providence	10,486	11,334	93%	6,137	6,926	89%	5,819	7,060	82%
Scituate	664	698	95%	438	460	95%	458	494	93%
Smithfield	993	1,033	96%	671	704	95%	769	833	92%
South Kingstown	1,467	1,531	96%	1,063	1,118	95%	1,224	1,306	94%
Tiverton	765	804	95%	555	598	93%	636	695	92%
Warwick	4,215	4,418	95%	2,818	2,978	95%	3,513	3,834	92%
West Warwick	1,492	1,574	95%	831	887	94%	977	1,078	91%
Westerly	1,311	1,374	95%	870	916	95%	1,024	1,094	94%
Woonsocket	2,548	2,723	94%	1,399	1,522	92%	1,586	1,884	84%
Core Cities	*20,876*	*22,351*	*93%*	*12,212*	*13,485*	*91%*	*11,894*	*14,058*	*85%*
Remainder of State	*36,874*	*38,615*	*95%*	*24,201*	*25,557*	*95%*	*28,059*	*30,612*	*92%*
Rhode Island	*57,750*	*60,966*	*95%*	*36,413*	*39,042*	*93%*	*39,953*	*44,670*	*89%*

Note to Table

Because of a change in methodology, School Attendance Rates cannot be compared with previous Factbooks. This year's attendance rates were based on the "average daily attendance" divided by the "average daily membership," as of June 2003. Past attendance rates were based on the "average daily attendance" divided by total enrollment as of October of the given year. This calculation did not account for the mobility of students throughout the course of the academic year. Using "average daily membership" in the denominator is a more accurate reflection of this mobility.

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2002-2003 school year.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The denominator (number of students) is the "average daily membership" by school district, as calculated by the Rhode Island Department of Elementary and Secondary Education.

References for Indicator

[1,15] Student Truancy, *ERIC Digest,* Number 125 (1999). Eugene, OR: ERIC Clearinghouse on Educational Management

[2] Indicator 42: Student Absenteeism and Tardiness (1996). *The Condition of Education.* Washington, DC: National Center for Education Statistics.

[3] *A Report from the Kids Mobility Project.* (March 1998). Minneapolis: The Kids Mobility Project.

[4] Student Life: School, Home and Community. *The MetLife Survey of the American Teacher.* (2002). New York, NY: MetLife, Inc.

[5] *Manual to Combat Truancy: The Problem of Truancy in America's Communities.* (July 1996). Washington, DC: U.S. Department of Education and U.S. Department of Justice.

[6,8] *Truancy, Literacy and the Courts, A User's Manual for Setting Up a Truancy Intervention Program.* (2001). Washington, DC: The American Bar Association.

[7] *The Condition of Education.* (2002). Washington, DC: Office of Educational Research and Improvement, U.S. Department of Education.

[9] *Educating America's Youth: What Makes a Difference.* Research Brief. (2002). Washington, DC: Child Trends.

continued on page 136

Suspensions

DEFINITION

Suspensions is the rate of infractions and disciplinary actions per 100 students in kindergarten through twelfth grade in Rhode Island public schools. Disciplinary actions include in-school suspensions, out-of-school suspensions, and alternative program placements. Data are for the 2002-2003 school year.

SIGNIFICANCE

Effective school disciplinary practices ensure the safety and dignity of students and educators, preserve the integrity of the learning environment, and address the causes of a student's misbehavior in order to encourage positive behavior and improve long-term outcomes.[1] Out-of-school suspension is the most widely used disciplinary technique, both nationally and in Rhode Island. Suspension may be used for relatively minor offenses, such as attendance infractions and disrespect, as well as for the most serious and dangerous offenses, such as drug-related offenses, weapon possession, and assault.[2,3]

Research has called into question the effectiveness and long-term outcomes of excluding students from school. Suspension often does not deter students from repeating negative behaviors. Studies show that up to 40% of school suspensions are due to repeat offenders and that, for at-risk students, suspension is a predictor of further suspension.[4] Suspended students are also more likely to have poor academic performance and to drop out of school.[5,6] The psychological and behavioral consequences of exclusion from school include the student's further disempowerment and alienation from peers and teachers, anti-social behavior and feelings of resentment in the student, and accelerated delinquency associated with the student's greater likelihood of socializing with deviant peers.[7,8]

Low-income and minority students are at increased risk for school suspension and for disproportionately severe disciplinary action in response to relatively minor offenses.[9,10] In 2002, the Rhode Island Task Force on Racial Bias and School Discipline concluded that as many as one-third of Rhode Island school districts show an over-representation of minorities in suspension data.[11]

During the 2002-2003 school year in Rhode Island, 44,474 suspensions were attributed to 17,398 students at a rate of 2.6 suspensions per student.[12] Of these suspensions, 14,444 (33%) were due to attendance infractions. Drug offenses and weapon possession accounted for 817 (2%) disciplinary actions.[13]

Disciplinary Actions, Rhode Island Public Schools, 2002-2003

By Type of Infraction	Number	Percent
Attendance Offenses	8,274	19%
Cut/Skipped Detention/Tardy	6,170	14%
Insubordination/Disrespect	5,995	13%
Disorderly Conduct	6,217	14%
Other Offenses*	5,087	11%
Fighting	3,284	7%
Assault	2,506	6%
Obscene /Abusive Language	2,396	5%
Tobacco/Alcohol Offenses	1,039	2%
Threat/Intimidation	983	2%
Larceny/Theft/Vandalism/Arson	990	2%
Harassment	716	2%
Drug Offenses	549	1%
Weapon Possession	268	<1%
Total	*44,474*	*100%*

*Examples of other offenses include forgery, trespassing and communication/electronic devices.

Source: Rhode Island Department of Elementary and Secondary Education, 2002-2003 school year.

◆ During the 2002-2003 school year, 58% of suspensions were to high school students (grades 9-12), 36% were to middle school students (grades 6-8), and 6% were to elementary students (grades k-5).[14]

◆ Of the 44,474 suspensions to Rhode Island public school students of all grades, 62% were out-of-school suspensions, 36% were in-school suspensions and 2% were alternate program placements.[15]

◆ During the 2002-2003 school year, 31% of the disciplinary actions in Rhode Island public schools were attributed to students enrolled in special education.[16]

◆ Students who are suspended are more likely to have a history of poor behavior, academic achievement below grade level, grade repetition, mobility between schools, and attendance at schools with high rates of suspension.[17]

Table 34.

Disciplinary Actions, Rhode Island School Districts, 2002-2003

SCHOOL DISTRICT	# OF STUDENTS ENROLLED	TYPE OF DISCIPLINARY ACTION: SUSPENDED OUT-OF-SCHOOL	SUSPENDED IN-SCHOOL	ALTERNATE PROGRAM PLACEMENT	MISSING	TOTAL DISCIPLINARY ACTIONS	RATE PER 100 STUDENTS
Barrington	3,241	121	29	0	0	150	5
Bristol Warren	3,658	734	1,000	0	4	1,738	48
Burrillville	2,557	282	661	11	1	955	37
Central Falls	3,596	851	794	1	0	1,646	46
Chariho	3,688	706	0	2	0	708	19
Coventry	5,663	758	36	609	0	1,403	25
Cranston	10,798	1,965	0	0	0	1,965	18
Cumberland	5,220	699	5	0	0	704	13
East Greenwich	2,363	140	244	0	0	384	16
East Providence	6,200	609	0	0	0	609	10
Exeter-West Greenwich	2,111	1	0	1	0	2	0
Foster	364	0	0	0	0	0	0
Foster-Glocester	1,687	376	0	0	0	376	22
Glocester	722	0	0	0	0	0	0
Jamestown	552	2	0	0	0	2	0
Johnston	3,194	808	1,057	4	0	1,869	59
Lincoln	3,576	640	177	55	0	872	24
Little Compton	324	6	0	0	0	6	2
Middletown	2,787	220	1,639	2	0	1,861	67
Narragansett	1,702	165	195	3	0	363	21
New Shoreham	135	4	2	0	0	6	4
Newport	2,886	1,016	8	1	0	1,025	36
North Kingstown	4,476	239	62	0	0	301	7
North Providence	3,347	508	643	0	0	1,151	34
North Smithfield	1,837	300	0	0	0	300	16
Pawtucket	9,480	1,836	3	0	0	1,839	19
Portsmouth	2,902	148	925	7	0	1,080	37
Providence	27,481	7,440	2,769	6	0	10,215	37
Scituate	1,728	50	174	0	0	224	13
Smithfield	2,642	297	2	0	0	299	11
South Kingstown	4,103	777	33	1	0	811	20
Tiverton	2,160	243	533	90	0	866	40
Warwick	11,677	2,000	2,037	2	0	4,039	35
West Warwick	3,701	707	677	0	1	1,385	37
Westerly	3,659	252	8	1	0	261	7
Woonsocket	6,569	2,377	2,393	1	0	4,771	73
State-Operated	*1,184*	*215*	*6*	*0*	*0*	*221*	*19*
Charter Schools	*421*	*39*	*28*	*0*	*0*	*67*	*16*
Core Cities	*53,713*	*14,227*	*6,644*	*9*	*1*	*20,881*	*39*
Remainder of State	*99,073*	*13,050*	*9,462*	*788*	*5*	*23,305*	*24*
Rhode Island	*154,391*	*27,531*	*16,140*	*797*	*6*	*44,474*	*29*

Notes to Table

Because of a change in methodology, Suspensions cannot be compared with previous Factbooks. This year's suspension rate per 100 students is based on the total disciplinary actions for the school district at all grade levels divided by the "average daily membership," as of June 2003. Past suspension rates were based on the total disciplinary actions for the school district at all grade levels divided by total enrollment as of October of the given year. This calculation did not account for the mobility of students throughout the course of the academic year. Using "average daily membership" in the denominator is a more accurate reflection of this mobility.

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2002-2003 school year.

The denominator (number of students in kindergarten through 12th grade) is the "average daily membership" as calculated by the RI Department of Elementary and Secondary Education.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket.

See Methodology, page 134

References for Indicator

[1] *Fair and Effective Discipline Factsheet.* (2002). Bethesda, MD: National Association of School Psychologists.

[2,4,6,8,10] Skiba, R. (August 2000). *Zero Tolerance, Zero Evidence: An Analysis of School Disciplinary Practice.* Policy Research Report #SRS2. Bloomington, IN: Indiana Education Policy Center.

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[12,14,15,16] Rhode Island Department of Elementary and Secondary Education, 2002-2003 school year.

[5,7] Breunlin, D., et al. (July/August 2002). Conflict Resolution Training as an Alternative to Suspension for Violent Behavior. *Journal of Educational Research,* 95:6, 349-357.

[9] Skiba, R., et al. (June 2000). *The Color of Discipline: Sources of Racial and Gender Disproportionality in School Punishment.* Policy Research Report #SRS1. Bloomington, IN: Indiana Education Policy Center.

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High School Graduation Rate

DEFINITION

High school graduation rate is the number of 2003 graduates divided by the estimated size of the twelfth grade class had no one dropped out.

SIGNIFICANCE

High school graduation is the minimum requisite for college and most employment. The path to high school graduation begins early; research indicates that children who attend quality preschool programs are more likely to graduate from high school.[1]

Several factors contribute to a student's decision to leave school. Repeating one or more grades, ongoing patterns of absenteeism, suspensions, poor grades, and poor achievement on tests are linked to dropping out. Youth who move are more likely to drop out than those with stable housing.[2] Student achievement and graduation rates can be improved when schools have high expectations for all students; effective and up-to-date curricula and teaching methods; prepared and sufficiently supported teachers; strong home/school linkages; adequate accountability systems; and effective and equitable allocation of resources.[3]

Students can benefit from access to a broad range of community supports that address academic issues, health problems, inadequate nutrition, neighborhood and family violence, and other factors that can disrupt school performance.[4] Nationally, low-income students are three times more likely to drop out than middle-income students.[5]

Youth who drop out of school are more likely to rely on public assistance as adults.[6] In 2001, over half of the people over 25 who did not have a high school diploma or GED reported no earnings during that year.[7] Also in 2001, adults without a high school diploma who found employment earned a median income of $11,864 compared to $19,900 for people with a high school degree or equivalent.[8]

Female dropouts are much more likely than male dropouts of the same racial or ethnic group to live in poverty.[9] Young women who drop out of school are more likely to have children at younger ages and more likely to be single parents than high school graduates.[10]

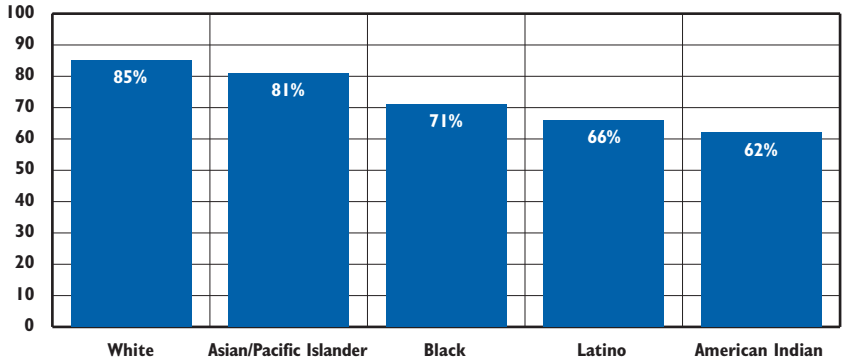
Percent of Teens Who are High School Dropouts, Ages 16-19

	1990	2000
RI	11%	10%
US	10%	9%
National Rank*		*30th*
New England Rank**		*6th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *KIDS COUNT DATA BOOK: State Profiles of Child Well-Being 2003.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

High School Graduation Rates, by Race and Ethnicity, Rhode Island 2003



Source: Rhode Island Department of Elementary and Secondary Education.

◆ In 2003 in Rhode Island, 85% of White students, 81% of Asian/Pacific Islander students, 71% of Black students, 66% of Latino students and 62% of American Indian students graduated from high school.[11]

◆ In Rhode Island and nationwide, Hispanic students have a lower high school graduation rate than non-Hispanic White students and non-Hispanic Black students.[12]

High School Graduation Rates for Children with Disabilities

◆ In Rhode Island, the high school dropout rate in 2002-2003 for students with disabilities was 26%.[13]

◆ Nationwide, more than 50% of students with emotional disturbances dropped out of school in 2000-2001, while 25% or less of students with other types of disabilities dropped out.[14]

◆ Nationwide, 11% of students with disabilities who graduated from high school received an alternative credential.[15]

Table 35.

High School Graduation Rate, Rhode Island, 2003

SCHOOL DISTRICT	COMMUNITY CONTEXT						2003 GRADUATION RATE
	% CHILDREN IN POVERTY	% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT	% OF STUDENTS TAKING THE SAT	
Barrington	4%	92%	3,356	<1%	4%	90%	93%
Bistol-Warren	12%	NA	3,824	4%	4%	62%	76%
Burrillville	5%	80%	2,682	<1%	2%	60%	87%
Central Falls	37%	49%	3,651	29%	78%	37%	67%
Chariho	6%	NA	3,861	<1%	3%	61%	89%
Coventry	8%	83%	5,850	<1%	4%	48%	90%
Cranston	8%	79%	11,269	4%	17%	57%	84%
Cumberland	3%	81%	5,411	2%	7%	58%	93%
East Greenwich	5%	93%	2,444	1%	5%	90%	94%
East Providence	9%	71%	6,442	5%	19%	52%	70%
Exeter-W. Greenwich	5%	NA	2,183	<1%	4%	60%	90%
Foster	6%	88%	385	0%	4%	NA	NA
Foster-Glocester	4%	NA	1,693	0%	1%	63%	91%
Glocester	8%	87%	771	0%	3%	NA	NA
Jamestown	3%	93%	568	2%	4%	NA	NA
Johnston	9%	78%	3,311	1%	6%	55%	82%
Lincoln	6%	82%	3,706	1%	7%	68%	94%
Little Compton	1%	91%	343	0%	0%	NA	NA
Middletown	9%	91%	2,838	2%	14%	68%	96%
Narragansett	10%	91%	1,736	1%	6%	73%	94%
New Shoreham	11%	95%	140	2%	7%	100%	86%
Newport	24%	87%	2,915	4%	40%	67%	80%
North Kingstown	11%	92%	4,647	1%	5%	67%	91%
North Providence	9%	77%	3,445	2%	16%	52%	86%
North Smithfield	2%	82%	1,875	0%	3%	77%	93%
Pawtucket	21%	66%	9,888	11%	49%	43%	67%
Portsmouth	3%	91%	2,995	<1%	4%	72%	94%
Providence	37%	66%	27,711	19%	85%	69%	66%
Scituate	4%	87%	1,782	0%	3%	72%	98%
Smithfield	4%	85%	2,703	<1%	2%	69%	88%
South Kingstown	6%	91%	4,238	1%	12%	79%	86%
Tiverton	3%	80%	2,231	0%	2%	84%	84%
Warwick	8%	85%	12,085	1%	6%	60%	88%
West Warwick	18%	76%	3,822	2%	12%	56%	74%
Westerly	11%	82%	3,692	2%	8%	53%	88%
Woonsocket	27%	64%	6,839	6%	38%	48%	70%
Core Cities	*30%*	*NA*	*54,826*	*15%*	*65%*	*58%*	*68%*
Remainder of State	*7%*	*NA*	*102,506*	*2%*	*8%*	*63%*	*87%*
Rhode Island	*15%*	*78%*	*157,332*	*6%*	*28%*	*62%*	*81%*

Note to Table

Because of a change in methodology, High School Graduation rates in this Factbook cannot be compared with previous Factbooks. The Rhode Island Department of Elementary and Secondary Education has changed its method for calculating graduation rates to conform with the National Center for Education Statistics definition.

Source of Data for Table/Methodology

% children in poverty is from the U.S. Bureau of the Census, Small Area Income and Population Estimates, Children Ages 5-17, 1999. % of adults completing high school or higher is from Census 2000. All other data are from the Rhode Island Department of Elementary and Secondary Education, 2002-2003 school year.

The denominator for the indicator is the sum of 2003 graduates plus the number of grade 9 dropouts in 1999-00 plus the number of grade 10 dropouts in 2000-01 plus grade 11 dropouts in 2001-02 plus grade 12 dropouts in 2002-03.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

See Methodology page 133.

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[1,2,4] Shore, R. (July 2003). *Reducing the High School Dropout Rate.* Baltimore, MD: The Annie E. Casey Foundation.

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[13] *Improving Outcomes for Children with Special Needs.* (November 2003). Providence, RI: Rhode Island KIDS COUNT.

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Teens Not in School and Not Working

DEFINITION

Teens not in school and not working is the percentage of teens ages 16 to 19 who are not enrolled in school, not in the Armed Forces, and not employed. This indicator includes recent high school graduates who are unemployed and teens who have dropped out of high school and are jobless.

SIGNIFICANCE

Improving educational and employment opportunities is especially important for urban, disadvantaged and minority youth.[1] Many school and community programs do not adequately address the needs of students on the verge of dropping out of school and out-of-school youth.[2] Caring parent-child interactions, positive peer influences, and support from siblings, teachers and mentors can greatly influence a teen's choices and attitudes.[3,4] Mentoring can have a particularly beneficial impact on an adolescent's development. Mentored youth are likely to have fewer absences from school, better attitudes towards school, less drug and alcohol use, and improved relationships with their parents.[5,6] Employment programs also show potential for exposing youth to supportive relationships and reducing criminal behavior.[7]

Dropping out of school and not becoming part of the workforce places teens at a significant disadvantage as they transition from adolescence to adulthood.[8] These adolescents have a difficult time getting connected to the job market as young adults and have a less stable employment history than their peers who stayed in school or secured jobs.[9,10] They are also at an especially high risk for teen parenting, crime and risk behaviors.[11] In addition, they are at an increased risk of needing public assistance.[12,13]

In 2000, 7% of Rhode Island teens ages 16 to 19 (4,477) were neither enrolled in school nor working. In 2000, 17% of Hispanic youth, 16% of Black youth and 7% of Asian youth were not in school and not employed as compared to 5% of White youth.[14]

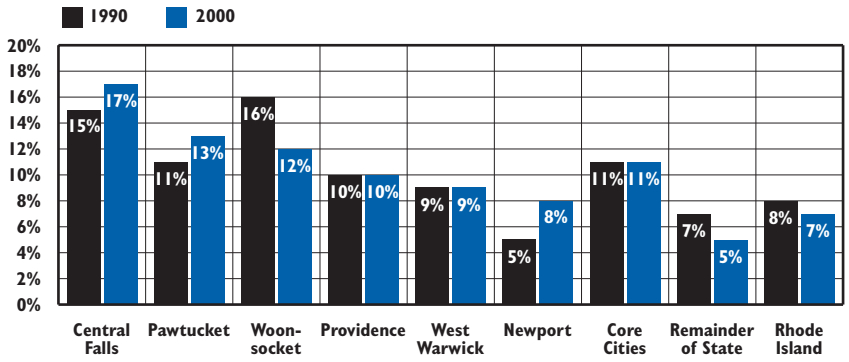
Teens Not in School and Not Working 1990 and 2000

	1990	2000
RI	9%	8%
US	10%	8%
National Rank*		*21st*
New England Rank**		*5th*

**1st is best; 50th is worst*
***1st is best; 6th is worst*

Source: *KIDS COUNT Databook: State Profiles of Child Well-Being.* (2003). Baltimore, MD: The Annie E. Casey Foundation.

Teens Not in School and Not Working, Ages 16 to 19, Core Cities and Rhode Island, 1990 and 2000



Source: U.S. Bureau of the Census, 1990 Census of the Population and Census 2000.

Disengagement from School Starts Early

◆ The process of engaging children in school and learning begins in early childhood. According to the Carnegie Task Force on Learning in the Primary Grades, the process of disengagement from school may begin as early as kindergarten.

◆ Children must have experiences that make them feel that school is fun and exciting, as well as a place to learn. Teachers and parents need to help children stay involved in the entire school day and after-school activities, address weak academic and social skills, and reward students' effort.

◆ Schools are more likely to engage students when they emphasize real-world experiences, problem-solving, and skill-building that includes the ability to listen and speak to people, negotiate a variety of new situations, manage time, money and materials, use computers, work as a member of a team, deal with cultural diversity, and develop a basic grasp of how organizations and system work.

Source: Shore, R. (2003). *Reducing the Number of Disconnected Youth.* Baltimore, MD: The Annie E. Casey Foundation.

Table 36. **Teens Not in School and Not Working, Ages 16-19, Rhode Island, 2000**

CITY/TOWN	TOTAL NUMBER OF TEENS AGES 16-19	JOBLESS HIGH SCHOOL GRADUATES	JOBLESS NON-HIGH SCHOOL GRADUATES	TOTAL NUMBER OF JOBLESS TEENS	% OF TEENS WHO ARE JOBLESS
Barrington	816	7	11	18	2.2%
Bristol	1,701	0	23	23	1.4%
Burrillville	980	3	14	17	1.7%
Central Falls	1,082	66	112	178	16.5%
Charlestown	320	0	0	0	0.0%
Coventry	1,632	9	50	59	3.6%
Cranston	4,233	304	329	633	15.0%
Cumberland	1,449	67	28	95	6.6%
East Greenwich	636	0	0	0	0.0%
East Providence	2,068	75	55	130	6.3%
Exeter	251	5	0	5	2.0%
Foster	232	0	0	0	0.0%
Glocester	551	5	10	15	2.7%
Hopkinton	402	4	16	20	5.0%
Jamestown	267	0	5	5	1.9%
Johnston	1,080	33	17	50	4.6%
Lincoln	974	0	26	26	2.7%
Little Compton	175	0	16	16	9.1%
Middletown	713	37	18	55	7.7%
Narragansett	739	9	12	21	2.8%
New Shoreham	26	0	0	0	0.0%
Newport	1,740	31	100	131	7.5%
North Kingstown	1,159	13	0	13	1.1%
North Providence	1,262	22	38	60	4.8%
North Smithfield	494	0	0	0	0.0%
Pawtucket	3,684	203	292	495	13.4%
Portsmouth	736	0	12	12	1.6%
Providence	15,673	420	1,138	1,558	9.9%
Richmond	326	16	0	16	4.9%
Scituate	604	44	17	61	10.1%
Smithfield	1,904	11	11	22	1.2%
South Kingstown	3,532	8	11	19	0.5%
Tiverton	769	23	22	45	5.9%
Warren	507	33	33	66	13.0%
Warwick	3,843	60	130	190	4.9%
West Greenwich	300	0	0	0	0.0%
West Warwick	1,341	47	73	120	8.9%
Westerly	1,029	24	23	47	4.6%
Woonsocket	2,179	75	181	256	11.7%
Core Cities	*25,699*	*842*	*1,896*	*2,738*	*10.7%*
Remainder of State	*35,710*	*812*	*927*	*1,739*	*4.9%*
Rhode Island	*61,409*	*1,654*	*2,823*	*4,477*	*7.3%*

Sources of Data for Table/Methodology

U.S. Bureau of the Census, Census 2000.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The denominator is the number of teens ages 16 to 19 according to Census 2000.

References for Indicator

[1,6,9] Shore, R. (2003). *Reducing the Number of Disconnected Youth.* Baltimore, MD: The Annie E. Casey Foundation.

[2] Hughes, K. L., Bailey, T. R., and Mechur, M. J. (2001). *School-to-Work: Making a Difference in Education.* New York, NY: Institute on Education and the Economy, Teachers College, Columbia University.

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Methodology and
Acknowledgements

Methodology

The *2004 Rhode Island KIDS COUNT Factbook* examines 54 indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. The information on each indicator is organized as follows:

- ***Definition:*** A description of the indicator and what it measures.
- ***Significance:*** The relationship of the indicator to child and family well-being.
- ***Sidebars:*** Current state and national data and information related to the indicator.
- ***National Rank and New England Rank:*** For those indicators that are included in the Annie E. Casey Foundation's KIDS COUNT publications, the Factbook highlights Rhode Island's rank among the 50 states, as well as trends since 1990. New this year, the New England Rank highlights Rhode Island's rank among the 6 New England states, including Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Data are from the national *2003 KIDS COUNT Data Book, State Profiles of Child Well-Being,* unless otherwise noted. Data from this publication comes from different data sources depending on the indicator. 2000 data used for National Rank and New England Rank come from the Population Reference Bureau, tabulation of data from the U.S. Census Bureau, or the Census 2000 Supplementary Survey (C2SS).
- ***City/Town Tables:*** Data for each indicator presented for each of Rhode Island's cities and towns, the state as a whole and the core cities.
- ***Core Cities Data:*** Six core cities are identified based on high child poverty rates: Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket. These are the only Rhode Island communities in which more than 15% of the children live below the poverty level, according to the 2000 Census.
- ***Most Recent Available Data:*** The 2004 Factbook uses the most current, reliable data available for each indicator.
- ***New Indicators:*** Two new indicators have been added to the 52 indicators included in the *2003 Rhode Island KIDS COUNT Factbook:* "Grandparents Caring for Grandchildren" and "Gun Violence". *The 2004 Rhode Island KIDS COUNT Factbook* presents the data for each indicator using numbers, rates and/or percentages.

Numbers

The most direct measure of the scope of a problem is the count of the number of events of concern during a specified time period - e.g., the number of child deaths between 1997 and 2001. Numbers are important in assessing the scope of the problem and in estimating the resources required to address a problem. Numbers are not useful to compare the severity of the problem from one geographic area to another or to compare the extent of the problem in your state with national standards. For example, a state with more children might have more low birthweight infants due to the larger number of total births, not due to an increased likelihood of being born low birthweight.

Rates and Percentages

A rate is a measure of the probability of an event - e.g., out of every 1,000 live births, how many infants will die before their first birthday. A percentage is another measure of the probability of an event - e.g., out of every 100 births, how many will be born low birthweight. Rates and percentages take into account the total population of children eligible for an event. They are useful in comparing the severity of the problem from one geographic area to another, to compare with state or national standards, or to look at trends over time.

Sources of Data and Methodology for Calculating Rates and Percentages

For each indicator, the source of information for the actual number of events of interest (the "numerator") are identified within the Source of Data/Methodology section next to the table for that indicator. For each indicator that uses a rate or a percent, the methodology used to estimate the total number of children eligible for the indicator of interest (i.e., the "denominator") is also noted within the Source of Data/Methodology section. Rates and percentages were not calculated for cities and towns with small denominators (less than 500 for delayed prenatal care, low birthweight infants, and infant mortality rates and less than 100 for births to teens). Rates and percentages for small denominators are statistically unreliable. "NA" is noted in the indicator table when this occurs. In the indicator for child deaths and teen deaths, the indicator events are rare; in these instances, city and town rates are not calculated, as small numbers make these rates statistically unreliable.

Use of Census 2000 Data

Wherever possible, data from Census 2000 was included in the 2004 Factbook. When Census 2000 data have been substituted in denominators, this

was noted in the note to the table. Caution should be taken when comparing new rates with past years as the population numbers used in the denominator have changed for all cities and towns. Otherwise, when Census 2000 data were not yet available, three-year averages were used from the Current Population Survey. Because of improved accuracy of the Current Population Survey, three-year averages replaced five year averages in previous Factbooks.

Methodology for Children Receiving Child Support Indicator

Estimated Number of Children in the Child Support Enforcement System: Beginning in the 2002 Factbook, this number is higher than in previous years because it includes Rhode Island children for whom the Child Support Enforcement Office collects and disburses child support payments, regardless of whether or not the Child Support Enforcement Office is providing the family with services related to paternity establishment or child support enforcement.

Methodology for Infant and Preschool Child Care Indicator

Estimated Number of Children in Need of Regulated Care is computed by multiplying the Census 2000 number of children under age 6 with both or only parent in the workforce by 56.5% (the percent of mothers who used center based care or other non-relative care as their child care arrangement as reported by the U.S. Census Bureau's Survey of Income and Program Participation data from Spring 1999). The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots, as of December 2003.

Methodology for Children Receiving Child Care Subsidies

The Number of Children Receiving Child Care Subsidies in a licensed child care center or a certified family child care home is the total number of children for whom the Rhode Island Department of Human Services paid a full or part-time subsidy as of December 2003. All data are based on the location of the child care program where the child receives services, not the residence of the child.

The number of children under age 16 in working families under 185% of the Federal Poverty Level (FPL) is computed by: multiplying the number of children under age 16 living in households with income below 185% of the federal poverty threshold as reported in Census 2000 by the percent of children under age 18 living in families with only or both parents in the workforce as reported in Census 2000.

Parents who are working and are enrolled in the Family Independence Program (FIP) can claim a "child care disregard". When DHS calculates cash benefits levels based on monthly income, the child care disregard allows families to not count or "disregard" and designate for child care expenses up to $200 of their monthly income for children under 2 and up to $175 for children two and older. The child care disregard is a form of subsidy not included in this table. In 2003, families of 199 children used child care disregards.

Methodology for Fourth Grade Reading Skills

As of 2000, the manner in which reading scores are calculated changed. In the past, a student was counted as a test taker only if they actually took the test and completed enough of it for a score to be calculated. As of 1999-2000, however, all students eligible to take the test are counted, whether or not they take the test or score. As a result, overall proficiency rates, as reported here, are lower than they were under the previous system of scoring. For instance, in 1999, under the previous system of scoring, 84% of fourth graders were proficient in basic understanding and 69% in interpretation and analysis.

Charter schools reported for this indicator are CVS Highlander Charter Elementary School, The Compass Charter School and the Paul Cuffee Charter School. The state-run school is the Rhode Isalnd School for the Deaf.

Methodology for High School Graduation

Because of a change in methodology, High School Graduation Rates in this Factbook cannot be compared with previous Factbooks. The Rhode Island Department of Elementary and Secondary Education has changed its method for calculating graduation rates to conform with the National Center for Education Statistics definition. Whereas in past years the denominator for the indicator was the number of children enrolled in the 9th, 10th, 11th, and 12th grades in the fall of the given school year, the denominator for the this year's indicator is the sum of 2003 graduates plus the number of grade 9 dropouts in 1999-00 plus the number of grade 10 dropouts in 2000-01 plus grade 11 dropouts in 2001-02 plus grade 12 dropouts in 2002-03.

Methodology for English Language Learners

Because of a change in methodology for the 2004 Factbook, English Language Learners (ELL) cannot be compared with previous Factbooks. This year's percentage of ELL is based on the total number of public school children receiving English as a Second Language or Bilingual Education services divided

continued, next page

Methodology

by the "average daily membership," as of June 2003. Past ELL percentages were based on total number public school children receiving English as a Second Language or Bilingual Education services divided by total enrollment as of October of the given year. This calculation did not account for the mobility of students throughout the course of the academic year. Using "average daily membership" in the denominator is a more accurate reflection of this mobility.

Charter schools reported for this indicator are International Charter and the Paul Cuffee Charter School. The state-run schools are Davies Career Technical School and the Metropolitan Career Technical Center.

Methodology for High Performing Schools

The target scores (annual measurable objectives) that schools must achieve to be classified as high performing or moderately performing increase gradually until 2014 when 100% of students are expected to achieve proficiency in both math and language arts and when attendance and graduation rate targets will be 95%.

Student achievement is disaggregated by race/ethnicity, special needs (IEP), limited English proficiency (LEP), and economic disadvantage (school lunch status). A school's performance classification is based on student scores by student subgroups in each of 18 categories (all students plus 8 disaggregated subgroups, for each of the two exams, English Language Arts and Math). Each student's performance is assigned a score from 0 to 100 based on how closely the student comes to achieving the standard. Aggregated scores for all students and for each subgroup are then compared with target objectives (which increase each year) to determine the school's performance category. Other factors which influence school classification include test participation rate (target: 95%) and compliance with either target attendance or (for high schools) graduation rates.

Schools that, as a whole, have met target goals for the year 2011 and have met current year objectives for each subgroup are classified as high performing. Schools that achieve annual targets for each subgroup and the school as a whole are classified as moderately performing. Schools that fail to achieve annual objectives, or in which any subcategory of students does not achieve them, are classified as in need of improvement.

Schools are also classified as sustaining or improving (for high or moderately performing) or making progress/insufficient progress (for schools in need of improvement). These classifications are based on progress relative to previous years.

State-run schools are Rhode Island School for the Deaf, William M. Davies Career and Technical High School and the Metropolitan Career & Technical Center. Charter schools are Blackstone Academy, The Compass Charter School, CVS Highlander Charter Elementary School, The International Charter School, Kingston Hill Academy, Paul Cuffee Charter School, Textron/Chamber of Commerce Academy, and Times 2 Academy. The Urban Collaborative Accelerated Program is listed separately. RITS is the Rhode Island Training School for Youth, Rhode Island's state owned and operated juvenile correctional facility.

Methodology for School Attendance

Because of a change in methodology, School Attendance Rates cannot be compared with previous Factbooks. This year's attendance rates were based on the "average daily attendance" divided by the "average daily membership," as of June 2003. Past attendance rates were based on the "average daily attendance" divided by total enrollment as of October of the given year. This calculation did not account for the mobility of students throughout the course of the academic year. Using "average daily membership" in the denominator is a more accurate reflection of this mobility.

Methodology for Suspensions

Because of a change in methodology, Suspensions cannot be compared with previous Factbooks. This year's suspension rate per 100 students is based on the total disciplinary actions for the school district at all grade levels divided by the "average daily membership," as of June 2003. Past suspension rates were based on the total disciplinary actions for the school district at all grade levels divided by total enrollment as of October of the given year. This calculation did not account for the mobility of students throughout the course of the academic year. Using "average daily membership" in the denominator is a more accurate reflection of this mobility.

Total disciplinary actions is the number of incidents resulting in suspension - either in-school or out-of-school, or placement of the student in an alternate program. It does not reflect the total number of students disciplined because each student can receive more than one disciplinary action during the school year.

Suspension policies vary by district. The type of infraction resulting in disciplinary action varies according to school district policy. The type of disciplinary action used for each type of infraction also varies according to school district policy.

State-Operated/Charter schools includes data for the Rhode Island School for the Deaf, Davies Career Technical School, and Metropolitan Career Technical Center, Black Stone Academy, International Charter, and the Paul Cuffee Charter School.

Limitations of the Data

In any data collection process there are always concerns about the accuracy and completeness of the data being collected. All data used in the 54 indicators were collected through the U.S. Bureau of the Census and through routine data collection systems operated by different agencies of the state of Rhode Island. We do not have estimates of the completeness of reporting to these systems. In all cases, we used the most reliable data currently available. For census-based indicators, statewide numbers have been updated to 2002 using the Current Population Survey, 2001 - 2003 average. The Current Population Survey does not provide data at the level of city and town. City/town tables, therefore, use information from the 2000 Census when available.

Family Income Levels Based on the Federal Poverty Measures

The poverty thresholds are the original version of the federal poverty measure. They are updated each year by the Census Bureau. The thresholds are used mainly for statistical purposes — for instance, estimating the number of children in Rhode Island living in poor families. The poverty threshold is adjusted upward based on family size and whether or not household members are children, adults or 65 years and over. The 2003 federal poverty threshold for a family of three with two children is $14,824 and $18,660 for a family of four with two children.

The poverty guidelines are the other version of the federal poverty measure. They are issued each year in the Federal Register by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds used for administrative purposes — for instance, determining financial eligibility for certain federal programs. Often, government assistance programs, including many of those administered by the state of Rhode Island use the federal poverty guidelines to determine income eligibility. The figures are adjusted upward for larger family sizes.

Family Income Levels Based on the Federal Poverty Guidelines

2004 Federal Poverty Guidelines	Annual Income Family of Three	Annual Income Family of Four
50%	$7,835	$9,425
100%	$15,670	$18,850
130%	$20,371	$24,505
185%	$28,990	$34,873
200%	$31,340	$37,700
225%	$35,258	$42,413
250%	$39,175	$47,125

Source: 2004 Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services

Methodology

(continued from page 35)

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Poetry Credits

"Give Me Your Name!" by Judith Nicholls, reprinted from *A Child's Treasury of Poems* (1986). Edited by Mark Daniel. New York, NY: Dial Books for Young Readers.

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"Give Me The Splendid Silent Sun" by Walt Whitman, reprinted from *Favorite Poems Old and New* (1957). Garden City, NJ: Doubleday and Company, Inc.

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