2005 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, The Robert Wood Johnson Foundation, The David and Lucile Packard 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 *2005 Rhode Island KIDS COUNT Factbook* are available for $15.00 per copy. Reduced rates are available for bulk orders. To receive copies of the *2005 Factbook*, please contact:

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Factbook design by Greenwood Associates.
Illustrations by Chil Mott and Gail Greenwood.

2005 Rhode Island KIDS COUNT Factbook

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**New Indicator*

Overview

Block City

What are you able to build with your blocks?

Castles and palaces, temples and docks.

Rain may keep raining, and others go roam,

But I can be happy and building at home.

Let the sofa be mountains, the carpet be sea,

There I'll establish a city for me:

A kirk and a mill and a palace beside,

And a harbor as well where my vessels may ride.

Great is the palace with pillar and wall,

A sort of a tower on the top of it all,

And steps coming down in an orderly way

To where my toy vessels lie safe in the bay.

This one is sailing and that one is moored:

Hark to the song of the sailors on board!

And see on the steps of my palace, the kings

Coming and going with presents and things!

Now I have done with it, down let it go!

All in a moment the town is laid low.

Block upon block lying scattered and free,

What is there left of my town by the sea?

Yet as I saw it, I see it again,

The kirk and the palace, the ships and the men,

And as long as I live and where'er I may be,

I'll always remember my town by the sea.

By Robert Louis Stevenson

Overview

The *2005 Rhode Island KIDS COUNT Factbook* is the eleventh 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 *2005 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 six core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

The Factbook provides community-level information on indicators 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 *2005 Rhode Island KIDS COUNT Factbook* examines fifty-nine indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety and Education. All areas of child well-being are interrelated and critical throughout a child's development. A child's safety in his or her family and community affects school performance; a child's economic security affects his or her health and education. The *2005 Rhode Island KIDS COUNT Factbook* reflects these interrelationships and builds a framework to guide policy, programs and individual service on behalf of children. Five new indicators are included in this edition of the Factbook.

Family Economic Security

Children most at risk of not achieving their full potential are children in poverty. Child poverty is related to every indicator in the 2005 Rhode Island KIDS COUNT Factbook. According to the 2000 Census, the child poverty rate in Rhode Island was 17%. Nearly half of Rhode Island's 41,162 poor children live in extreme poverty — with a family income less than $9,579 (half of the federal poverty threshold of $19,157 for a family of four with two children). Even those with incomes above the official poverty threshold 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 improve school readiness and enhance learning opportunities. The path to academic success begins long before children enter kindergarten. Children who participate in high-quality preschool programs are more likely to read at grade level by fourth grade and are more likely to complete high school. Student achievement can be improved when families, communities and schools support children's physical, academic, and emotional growth. Young people who complete high school are more likely to be capable, self-sufficient 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

Folding Sheets

They must be clean.
There ought to be two of you
to talk as you work, your
eyes and hands meeting.
They can be crisp, a little rough
and fragrant from the line;
or hot from the dryer
as from the oven. A silver
grey kitten with amber
eyes to dart among
the sheets and wrestle and leap out
helps. But mostly pleasure
lies in the clean linen
slapping into shape.
Whenever I fold a fitted sheet
making the moves that are like
closing doors, I feel my mother.
The smell of clean laundry is hers.

By Marge Piercey

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, representing almost a third (31%) of all Rhode Island households. According to Census 2000, there were 1,048,319 Rhode Island residents. Of these, 24% or 247,822 were children under age 18.[1]

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. By 2002, the number of children in the United States had risen further to 72.9 million, but represented 25% percent of the population, down from a peak of 36% at the end of the baby boom.[3] By contrast, the child population of Rhode Island has fallen slightly in recent years. In 2003, the population of children under 18 years of age was 244,049 and represented 23% of the state's total population.[4,5]

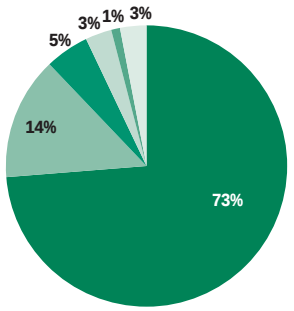
Children in Rhode Island at the start of the 21st century are older and more ethnically diverse than those children living in the state in the previous decade. The largest increase in any age category between 1990 and 2000 was in the number of children in early adolescence (ages 10 to 14). The number of Rhode Island children between the ages of 10 and 14 increased by 20% during the decade, from 59,406 to 71,370.[6,7] In 2003, the number of adolescents had risen to 73,644, up 3% from the 2000 population.[8] In contrast, the number of children under age 5 living in Rhode Island dropped from 66,969 in 1990 to 63,896 in 2000.[9,10] In 2003, 61,511 children under the age of 5 lived in Rhode Island, a 4% decrease from the 2000 population.[11]

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.[12] In Rhode Island, the number of White, non-Hispanic children declined over the 1990s by nearly 9,000 children. Between 1990 and 2000, the number of minority children increased by 31,000 to nearly 68,000.[13]

Rhode Island's Children, 2000

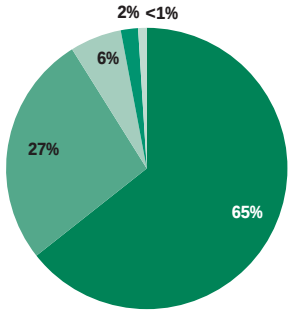
By Race/Ethnicity

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



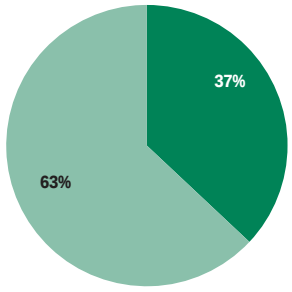
By Family Structure

65%	Married Couple Families**
27%	Single Parent 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 threshold. 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, Summary File 1.

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

[1,7,10] U.S. Bureau of the Census, Census 2000, Summary File 1.

[2,12,13] O'Hare, W. (2001). *The child population: First data from the 2000 Census.* Baltimore, MD: The Annie E. Casey Foundation and The Population Reference Bureau.

[3] Federal Interagency Forum on Child and Family Statistics. (2004). *America's children in brief: Key national indicators of well-being, 2004*. Washington, DC: U.S. Government Printing Office.

[4] "Annual Estimates of the Population for the United States and States and for Puerto Rico: April 1, 2000 to July 1, 2004," Populations Division, U.S. Census Bureau.

[5,8,11] "State by Age, Race, Sex and Hispanic Origin," Populations Division, U.S. Census Bureau, Census 2000.

[6,9] U.S. Bureau of the Census, 1990 Census of Population, Summary File 1.

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 2003 in Rhode Island, 35% of single-parent families with children under age 18 were living below the poverty threshold compared to only 5% of two-parent families.[1] Of the 74,716 Rhode Island children who lived in single-parent families in 2003, 87% lived in households headed by a female.[2] Children in single-parent families are at an increased risk for low academic achievement, dropping out of high school and increased levels of depression, stress, anxiety and aggression.[3]

According to Census 2000, 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%).[4]

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.[5]

According to the U.S. Census 2000, of all Rhode Island children living with at least one biological or adoptive parent, 70% lived in married-couple families and the remaining 30% lived in single-parent families.[6] White children and Asian children are far more likely to live in married-couple families than are Black, Hispanic and Native American children.[7] The core cities, those with child poverty rates higher than 15%, continue to have the highest rates of children living in single-parent families.[8]

Single-Parent Families

	1996	2001
RI	28%	29%
US	27%	28%
National Rank*		*29th*
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 2004*. (2004). Baltimore, MD: The Annie E. Casey Foundation.

Effects of Welfare Reform on Single-Parent Families

◆ Since the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform), U.S. children in single-parent families living below the poverty threshold have received less cash assistance than under the previous system. Cash assistance receipts fell by nearly one third for children in single-parent families with incomes between 50% and 100% of the federal poverty threshold. These children were also less likely to receive Medicaid and food stamps in 2000 than in 1996.[9]

◆ Nationally in 2000, four years after welfare reform, poor children living in single-parent families were at greater risk of going without health care coverage than in the pre-reform period. Children living below 50% of the federal poverty threshold are at the greatest risk of being uninsured.[10]

◆ While welfare reform has resulted in increased work participation for single parents, more than three fourths of these parents are concentrated in low-wage occupations. There has been no significant increase in receipt of health insurance through employment. Lack of health insurance significantly decreases job stability and retention rates among low-income workers.[11,12]

◆ With a "work first" emphasis in federal welfare reform, the access to higher education for low-income single parents can be jeopardized. Nationally, the percentage of single-parent welfare recipients with some college education fell from 24% before welfare reform to 17% after reform.[13]

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, Summary Tape File 1 and Summary File 1.

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

References for Indicator

[1,2] U.S. Bureau of the Census, Current Population Survey, 2002 to 2004, three year average.

[3] *KIDS COUNT DATA BOOK: State profiles of child well-being 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

[4,5,6,8] U.S. Bureau of the Census, Census 2000, Summary File 1.

[7] Census Data Online. Baltimore, MD: The Annie E. Casey Foundation KIDS COUNT. Access: http://www.aecf.org/kidscount/ census.

[9,10] Lyter, D., Sills, M., & Oh, G. (2002). *Children in single-parent families living in poverty have fewer supports after welfare reform.* Washington, DC: Institute for Women's Policy Research.

[11,13] *Before and after welfare reform: The work and well-being of low-income single parent families.* (2003). Washington, DC: Institute for Women's Policy Research.

[12] Lee, S. (2004). *Women's work supports, job retention, and job mobility: Child care and employer-provided health insurance helps women stay on jobs.* Washington, DC: Institute for Women's Policy Research.

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, child 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]

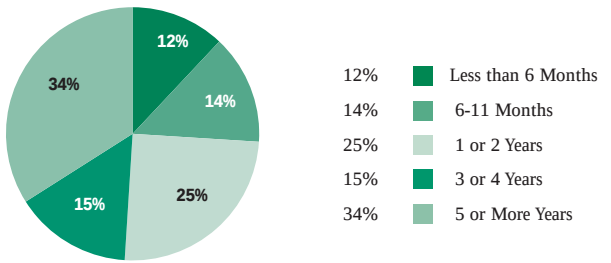
Grandparent caregivers are at risk of living in poverty since many have fixed incomes.[2] In fact, grandparent caregivers are more likely to live in poverty than other grandparents.[3]

In the U.S. the majority of children in relative care (77%) are in private care, meaning that they have not been involved with a child welfare agency.[4] For this reason, most relative caregivers receive less training, information, and supervision than licensed, non-relative foster parents.[5] Studies indicate that relative caregivers are more likely to be poor, single, older and have less education than non-kin foster parents.[6] As a result, relative caregivers may require more services than non-relative 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.[7]

Often, grandparent caregivers do not receive the support or services that they need and for which they are eligible. This may be because grandparents lack information and understanding about programs, such as cash assistance and Medicaid, or because grandparents feel that there is a stigma attached to receiving this assistance.[8,9] Nearly all grandparent caregivers are eligible for either foster care payments or child-only Temporary Assistance for Needy Families (TANF) payments regardless of their household income levels, but few receive this assistance. In 2002 in the U.S., only 1 out of 5 children in private, relative care received a TANF child-only payment, compared to nearly 1 out of 2 children in relative care who have been involved with a child welfare agency.[10]

Grandparent caregivers are at risk for poor physical and mental health.[11] They may face legal barriers when enrolling children in school, or when seeking health insurance or medical care for the children.[12] Grandparents make up the largest percentage of relative caregivers, but other relative caregivers, including aunts, uncles, cousins and siblings, may face similar obstacles.[13]

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



n = 5,060

Source: U.S. Census Bureau, Census 2000, Summary File 3.

◆ Nearly half (49%) of the 5,060 Rhode Island grandparents who are financially responsible for their grandchildren have been responsible for the children for three or more years.[14]

◆ In 2003, there were 10,134 children in Rhode Island living in households headed by grandparents, though not all grandparents were financially responsible for their grandchildren. This accounts for 4% of all children living in Rhode Island.[15]

◆ Demographic trends show an increase in grandparent-headed families across all socioeconomic and ethnic groups in the U.S.[16] Though poverty rates are consistently higher for all grandparent-headed families, African American and Native Americans have the highest poverty rates among this group and are four times as likely to be responsible for their grandchildren as White Americans.[17]

◆ Rhode Island regulations state that the Department of Children, Youth and Families (DCYF) must give priority to relatives when placing a child in out-of-home care. As of December 2004 in Rhode Island, there were 674 children in DCYF care who were in out-of-home placements with a grandparent or other relative. These children make up 9% of all children in the care of DCYF in Rhode Island.[18]

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. Summary File 3.

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

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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 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 U.S. in 2001, a person without a high school diploma earned only two thirds of the earnings of a high school graduate and only a little more than 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] As of Census 2000, there were 153,086 adults 25 years and older in Rhode Island with less than a high school diploma.[8] Educational attainment levels vary widely across cities and towns in Rhode Island.

Of the 9,226 Rhode Island children born to mothers with less than a high school diploma between 1999 and 2003, 84 were to teen mothers under the age of 15 and 1,592 were to mothers from 15 to 17 years old.[9] Teen mothers reduce their academic attainment by close to three years.[10]

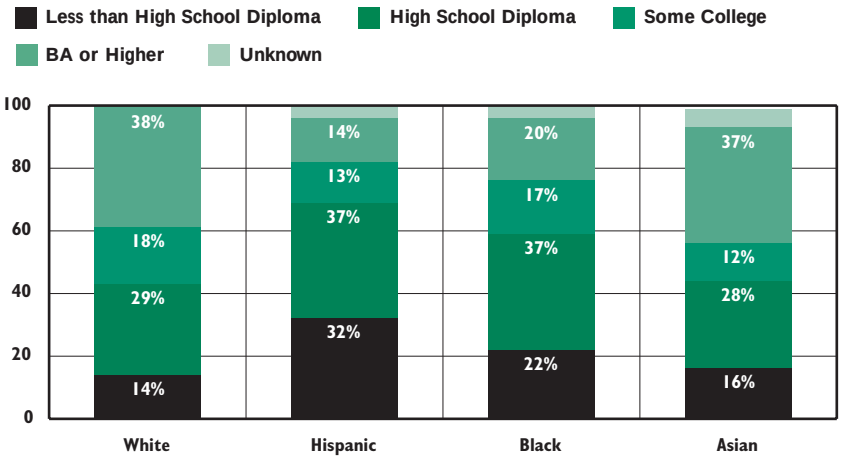
Percent of Total Births to Mothers with Less than 12 Years of Education

	1990	2002
RI	19%	15%
US	24%	22%
National Rank*		*18th*
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.* (2005). Baltimore, MD: The Annie E. Casey Foundation.

Educational Attainment at Childbirth by Mother's Race, Rhode Island, 1999-2003



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1999-2003 average. Data for 2002-2003 are provisional. Due to rounding, totals may not equal 100%.

◆ Among Rhode Island women giving birth between 1999 and 2003, White women (38%) and Asian women (37%) were more likely than Black women (20%) or Hispanic women (14%) to have a Bachelor's degree or higher.[11]

Educational Attainment and Income

◆ Higher education is one of the most effective ways that parents can raise their families' incomes.[12] Nationally in 2001, White women with a Bachelor's degree earned a median weekly income of $744, Black women earned $692 and Hispanic women earned $676. Of all working women with only a high school diploma, White women earned $453, Black women earned $395, and Hispanic women earned a median weekly income of $406.[13]

◆ Between 1999 and 2003, of the births to Rhode Island women with a Bachelor's degree or higher, 77% were to mothers with high-income to middle-income. Of the births to women with less than a high school diploma, 26% were to mothers in the high-income to middle-income bracket.[14]

Births by Education Level of Mother, Rhode Island, 1999-2003

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	839	660	79%	100	12%	64	8%	7	1%
Bristol	1,034	489	47%	202	20%	270	26%	65	6%
Burrillville	803	293	36%	174	22%	246	31%	59	7%
Central Falls	1,862	166	9%	230	12%	686	37%	712	38%
Charlestown	459	196	43%	110	24%	110	24%	35	8%
Coventry	2,003	887	44%	389	19%	590	29%	125	6%
Cranston	4,305	1,929	45%	825	19%	1,134	26%	358	8%
Cumberland	1,763	961	55%	337	19%	353	20%	79	4%
East Greenwich	569	401	70%	79	14%	68	12%	16	3%
East Providence	2,478	884	36%	491	20%	806	33%	258	10%
Exeter	343	168	49%	53	15%	92	27%	27	8%
Foster	196	95	48%	43	22%	46	23%	9	5%
Glocester	429	200	47%	107	25%	94	22%	24	6%
Hopkinton	453	183	40%	91	20%	152	34%	22	5%
Jamestown	206	157	76%	21	10%	21	10%	4	2%
Johnston	1,470	609	41%	296	20%	428	29%	119	8%
Lincoln	988	506	51%	189	19%	207	21%	56	6%
Little Compton	170	111	65%	28	16%	26	NA	3	2%
Middletown	1,075	487	45%	249	23%	289	27%	44	4%
Narragansett	631	378	60%	108	17%	104	16%	26	4%
New Shoreham	54	28	52%	16	30%	9	NA	1	2%
Newport	1,576	577	37%	270	17%	419	27%	295	19%
North Kingstown	1,503	918	61%	217	14%	276	18%	64	4%
North Providence	1,614	631	39%	339	21%	485	30%	130	8%
North Smithfield	521	271	52%	87	17%	120	NA	23	4%
Pawtucket	5,219	1,070	21%	932	18%	1,916	37%	1,150	22%
Portsmouth	869	511	59%	160	18%	164	19%	25	3%
Providence	14,306	3,036	21%	1,876	13%	4,941	35%	3,785	26%
Richmond	500	255	51%	96	19%	121	24%	24	5%
Scituate	472	248	53%	91	19%	108	NA	20	4%
Smithfield	769	437	57%	147	19%	152	20%	17	2%
South Kingstown	1,293	796	62%	185	14%	211	16%	70	5%
Tiverton	655	290	44%	178	27%	150	23%	36	5%
Warren	559	233	42%	132	24%	139	25%	50	9%
Warwick	4,416	1,948	44%	886	20%	1,253	28%	282	6%
West Greenwich	305	179	59%	50	16%	62	NA	11	4%
West Warwick	2,035	564	28%	384	19%	761	37%	306	15%
Westerly	1,308	449	34%	298	23%	410	31%	135	10%
Woonsocket	3,092	413	13%	481	16%	1,201	39%	751	24%
Unknown	*15*	*7*	*47%*	*1*	*7%*	*3*	*20%*	*3*	*20%*
Core Cities	*28,090*	*5,826*	*21%*	*4,173*	*15%*	*9,924*	*35%*	*6,999*	*25%*
Remainder of State	*35,052*	*16,788*	*48%*	*6,774*	*19%*	*8,760*	*25%*	*2,224*	*6%*
Rhode Island	*63,157*	*22,621*	*36%*	*10,948*	*17%*	*18,687*	*30%*	*9,226*	*15%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1999-2003. Data for 2002-2003 are provisional. Data are self-reported and reported by the mother's place of residence, not the place of the infant's birth. Data does not include births to Rhode Island residents that occurred out of state.

Note that for 1,675 births between 1999 and 2003, the education level of the mother was unknown and for 15 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

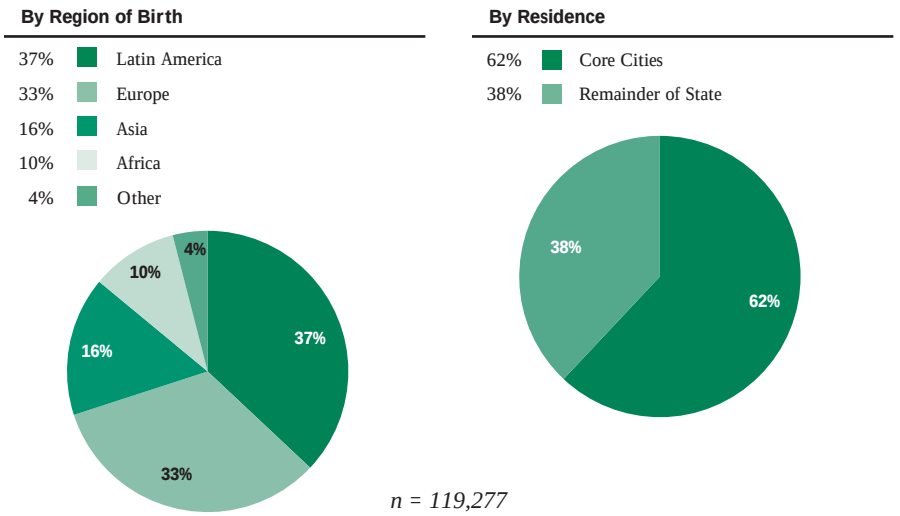
Racial and ethnic diversity has increased significantly in the United States over the last several decades. Diversity is projected to continue to rise in the future.[1] Nationally, minority children (all those except White, non-Hispanic children) accounted for 98% of the growth in the child population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

In 2003, there were 30,002 Rhode Island households headed by immigrants with children under age 18.[9] Compared to children in families that are not new to the U.S., children in immigrant families are more likely to live in two-parent households but also 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 and mental health services 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]

Foreign-Born Individuals, Rhode Island, 2000



n = 119,277

Source: U.S. Census Bureau, Census 2000, Summary File 3.

◆ Between 1990 and 2000, the immigrant population in Rhode Island grew by 31%, increasing from 91,061 in 1990 to 119,277 in 2000. Just under half (47%) of these Rhode Islanders were naturalized citizens.[12] There is not a single country of birth that predominates among Rhode Island immigrants.[13]

◆ Settlement patterns of immigrants within Rhode Island vary by country of birth. Portuguese immigrants have settled primarily in Pawtucket and Bristol. Latin American immigrants have settled primarily in Providence and Pawtucket. By contrast, African and Asian immigrants are more evenly distributed between the cities and suburbs.[14]

◆ Nationally, children of immigrants are twice as likely as children of native-born parents to lack health insurance and more than four times as likely to live in crowded housing.[15] In Rhode Island in 2000, 6% of all immigrants lived in neighborhoods with crowded housing compared with 3% of all state residents.[16]

Table 5.

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

	UNDER AGE 18 BY RACE AND ETHNICITY								
CITY/TOWN	HISPANIC OR LATINO	WHITE	BLACK	AMERICAN INDIAN AND ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	SOME OTHER RACE	TWO OR MORE RACES	2000 POPULATION UNDER AGE 18
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.

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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 account for 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

◆ In 2003, there were 37,201 Latino children living in Rhode Island up from 35,102 in 2000. Between 2000 and 2003 the Hispanic child population grew by 6% whereas the total child population in Rhode Island decreased by 1%.[11]

◆ Three-quarters of the Latino children in Rhode Island live in Central Falls, Pawtucket, and Providence.[12] Providence has the largest population of Latinos. Latinos are most densely concentrated in Central Falls.[13]

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%. Rhode Island Latinos have the lowest median family income of all Latinos in the United States.[14]

◆ Latinos have a higher level of unemployment than any other racial or ethnic group in the state. In 2000, the Latino unemployment rate was more than twice that of non-Latino Whites. Thirty-three percent of Latino households with children in Rhode Island are headed by a single adult and thus have only one potential wage earner.[15]

Health

◆ In Rhode Island, 12% percent of Latino women who give birth received delayed prenatal care between 1999-2003, compared to 9% of all races. Latino female teens were more than three times as likely to give birth between the ages 15 and 17 as non-Hispanic White female teens (61.9 per 1,000 teens compared to 17.7 per 1,000).[16]

Education

◆ Latinos in Rhode Island have lower educational attainment levels than the population overall. In 2004, the high school graduation rate for Latino youth was 66%, much lower that the high school graduation rate of 83% for 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	13%	45%	41%	22%	NA	15%
% of Births to Mothers with Education < 12 years	14%	32%	22%	17%	34%	15%
% of Children with All Parents in the Workforce	65%	49%	63%	54%	50%	62%
Median Household Income for Households with Children Under 18	$61,886	$26,107	$29,540	$40,700	$32,472	$57,717
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, 1999-2003 and Children in Poverty and Median Household Income from U.S. Bureau of the Census, Current Population Survey, 2002-2004. All Census data refers to only those individuals who selected one race. Data on children in poverty, maternal education levels, median household income and homeownership includes in the White, Black, Asian and Native American categories those who also identify as Hispanic. In one category, data for the Native American population is left out due to a sample size the Census Bureau deemed too small to report.

◆ In 2000, there were 41,162 poor children in Rhode Island, the majority of whom are children of color. Rhode Island's child poverty rates for Hispanic and Asian children are notably 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. Black and Hispanic children in Rhode Island are about twice as likely to live in single-parent families as their White counterparts. In 2003 in Rhode Island, 74% of Black children, 55% of Hispanic children and 28% of White children lived in single-parent families. Over the last five years, the percentage of White and Hispanic children living in single-parent families has fallen while the percentage of Black children in single-parent families has risen from 59% in 1998 to 74% in 2003.[20]

Health Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Women with Delayed Prenatal Care	7.8%	12.3%	15.4%	15.3%	17.1%	8.9%
Births to Teens Ages 15 – 17 (per 1,000 teens)	17.7	61.9	39.1	34.5	89.7	20.4
Infants Born Low Birthweight	7.1%	7.6%	11.9%	9.4%	11.3%	7.7%

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database 1999-2003. Information based on self-reported race and ethnicity. For teen birth rate, total population numbers come from the U.S. Bureau of the Census estimates.

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

◆ In 2003 in the United States, 11% of White children under 18 years of age were not covered by health insurance, as compared with 21% of Hispanic children, 14% of Black children, 12% of Asian children, and 18% 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)	1.2	4.6	10.1	0.8	2.4	2.3
Children of Incarcerated Parents (per 1,000)	9.7	23.9	87.5	NA	NA	15.5
Children in Out of Home Placement (per 1,000)	2.9	5.3	11.8	2.3	11.0	4.0

Source: *Juveniles in the Training School:* Rhode Island KIDS COUNT analysis of data from the Rhode Island Training School, based on adjudicated residents as of 12/31/04, children ages 13-21. *Children of Incarcerated Parents:* Rhode Island KIDS COUNT analysis of data from the Rhode Island Department of Justice, 2004, children ages birth to 17. *Children in Out-of-Home Placement:* Rhode Island KIDS COUNT analysis of data from the Rhode Island Department of Children, Youth and Families RICHIST Database from January 2003, January 2004, and January 2005, children ages birth to 21. Out-of-Home Placement includes licensed and pending-license non-relative foster homes, licensed and pending-license relative foster homes, and licensed and pending-license private agency foster care.

◆ 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] Nationally, Black youth are disproportionately overrepresented in the juvenile justice system more than any other minority group, but the proportion of Hispanic youth in the juvenile justice population is growing faster than that of any other racial or ethnic group.[24]

◆ Children of color account for 33% of the child population in the United States and more than 55% of children in foster care. This disproportion most affects Black children, who account for 15% of the child population and 38% of children in foster care. Higher poverty rates among families of color contribute to this trend.[25] 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.[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	9%	22%	19%	15%	13%	12%
Attending Schools Making Insufficient Progress	10%	48%	40%	29%	21%	19%
4th Grade Children Meeting the Standard for Reading						
Basic Understanding	81%	50%	57%	68%	51%	73%
Analysis and Interpretation	71%	37%	44%	52%	50%	62%
High School Graduation Rate	87%	66%	72%	79%	70%	83%
% of Adults Over Age 25 with a Bachelor's Degree or Higher	27%	9%	17%	36%	14%	26%

Source: *Percentage Attending School in Need of Improvement:* Rhode Island KIDS COUNT analysis of Rhode Island Department of Elementary and Secondary Education, 2004 School Performance Classification. Denominator is school enrollment by race 2003 – 2004 school year. *4th Grade Reading Scores:* Rhode Island State Assessment Program, Report of Student Performance by Demographic Characteristics, State Report Grade 4, Spring 2004 Data. *High School Graduation Rate:* Rhode Island Department of Elementary and Secondary Education, 2004. *Adult Educational Attainment:* Census 2000.

◆ In Rhode Island, children of color are far more likely to attend schools in need of improvement than are White children. Rhode Island's Hispanic and Black children are twice as likely as White children in the state to attend schools in need of improvement.[27]

◆ For the 2002-2003 school year, Black, Hispanic and Asian students were under represented in special education placement.[28] Within the population of Rhode Island students, Black and Hispanic children are disproportionately likely to be identified as mentally retarded and disproportionately unlikely to be identified as speech or hearing impaired, autistic, blind, deaf, developmentally delayed or as having a traumatic brain injury.[29]

Immigrant Children

◆ In 2003, Rhode Island was home to 11,136 children under age 18 who were born outside the United States, 5% of all children in the state.[30] This represents an increase since 2000, when 7,346 immigrant children constituted 3% of Rhode Island's child population.[31] These numbers are likely to be underestimates because immigrant children are among the most likely to be undercounted by population estimates.

◆ In 2000 in Rhode Island, 21% of all children in the state lived in immigrant families; Rhode Island has the ninth highest percentage of children in immigrant families of all states.[32] In 2003, 30,002 Rhode Island households with children under age 18 were headed by immigrants.[33] Children of immigrants are the fastest growing segment of the United States population under age 18.[34]

◆ Immigrant families are generally poorer than native families. While immigrant families are more likely than native families to include two parents and just as likely to include full-time workers, immigrants tend to earn lower wages than U.S. natives, leading to lower household incomes.[35] Immigrants are 50% more likely than natives to earn less than the minimum wage.[36]

◆ Nationally in 2000, nearly half of all children of immigrants lived in families with incomes below 200% of the federal poverty threshold, compared with 34% of native children.[37] In Rhode Island, the poverty rate for children of immigrants is 26% compared with a rate of 15% for children in U.S.-born families. Rhode Island has the sixth highest poverty rate for immigrant children of all states.[38]

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Economic Well-Being

Juke Box Love Song

i could take the Harlem night

and wrap around you,

Take the neon lights and make a crown,

Take the Lenox Avenue busses,

Taxis, subways,

And for your love song tone their rumble down.

Take Harlem's heartbeat,

Make a drumbeat,

Put it on a record, let it whirl,

And while we listen to it play,

Dance with you till day--

Dance with you, my sweet brown Harlem girl.

By Langston Hughes

Median Household Income

DEFINITION

Median household income is the dollar amount which divides all Rhode Island households' income distributions 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, the median household income of all Rhode Island families with children under age 18 was $50,557.[1]

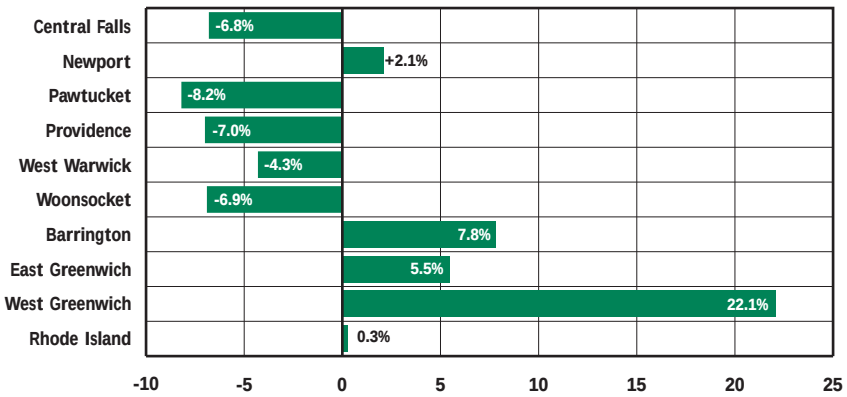
In Rhode Island in 2002, the median household income for all households, including those without children, was $53,789. The median household income for households with children was $57,717.[2] Rhode Island saw a significant decrease of 3.1% in median household income between the periods of 2001-2002 and 2002-2003. Rhode Island was one of 10 states nationally and one of three states in the Northeast to experience this decrease in median income.[3] In 2002, the Rhode Island median household income decreased for Black and Asian households, but increased for White and American Indian households. In 2002 Hispanic households with children had a median income of $26,107, whereas the median income for non-Hispanic households with children was $63,465.[4]

According to the Census, income inequality was greater in 2003 than it was in 1995, although individual annual changes have not been statistically significant.[5]

Communities with above average income inequality have higher mortality rates than communities with comparable incomes but lower inequality.[6] Increased income disparities lead to geographic segregation as wealthier families move to the suburbs. This can result in unequal school funding from property taxes.[7]

Through the 1980s and 1990s, income inequality between the top and bottom of the income distribution continued to grow in Rhode Island.[8] In 2002, 18% of Rhode Island households with children had incomes less than $25,000 and 10% had incomes between $25,000 and $35,000.[9] By contrast, 22% of families with children had household incomes of $100,000 or more.[10]

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 increases in median household income between 1989 and 1999 while the lowest income communities had real declines in income.[11]

◆ The share of Rhode Island jobs paying poverty-level wages grew over the 1990s. In 1999, 24% of jobs in Rhode Island paid below the wage necessary to put a family of four above the poverty threshold with full-time, year round work.[12]

◆ According to the Poverty Institute's 2003 Rhode Island Standard of Need, a two-parent family with two children in which both parents are working needs an income of $48,096 to pay basic living expenses, including housing, food, clothing, health insurance, child care and transportation.[13]

◆ Income supports including RIte Care, child care subsidies, Food Stamps and the Earned Income Tax Credit are critical in helping low-income and moderate-income working families make ends meet.

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 with 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. Nationally, the percentage of families with a cost burden, crowding, and/or physically inadequate housing 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]

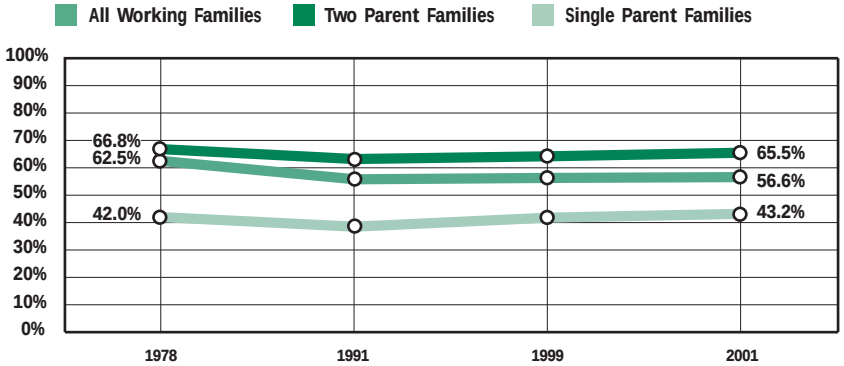
Severe financial strain can hinder effective parenting, heighten conflict and contribute to the break-up of families.[2] Severe cost burdens disproportionately fall on minority and single-parent households, with nearly one in three spending more than 50% of their income on housing.[3]

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.[4] In 2003, 41% percent of Rhode Island renters and 28% of homeowners spent 30% or more of their household income on housing.[5]

Nationally and in Rhode Island, the cost of housing has outpaced the income growth of many working families.[6,7] The increasing housing costs not only negatively impacts Rhode Island's families, but the state's business communities as well. Housing represents a significant share of a household's expenditures, limiting disposable income and putting upward pressure on wages.[8,9,10]

The current housing stock, combined with the limited construction of affordable housing has made it difficult for low-income and moderate-income families to compete in the housing market, resulting in rising rents for often substandard housing.[11,12] Research shows that there are strong links between substandard housing and educational disadvantages.[13,14] In 2003 in Rhode Island, 2,312 units had severe physical defects, which may include roach and rodent infestation, lead exposure, faulty wiring or plumbing problems. An additional 14,059 units had moderate physical problems and/or lacked central heat.[15]

Homeownership Rates for Working Families, United States, 1978-2001



Source: *Working families with children: A closer look at homeownership trends.* (2004). Washington, DC: Center for Housing Policy.

◆ Overall in the United States, all working families with children experienced a 9% decline in homeownership rates between 1978 and 2001. Two parent working families experienced a 2% decline, while single parent families experienced an increase of 3%.[16]

◆ In Rhode Island, a very low-income household (earning $30,350, 50% of the Area Median Income of $60,700) can afford monthly rent of no more than $759, while the average rent for a two bedroom apartment was $1,032 in 2003.[17,18]

◆ To be able to afford the average rent in 2003 in Rhode Island, a worker would have to earn $19.85 per hour for forty hours per week. This is nearly three times the state's minimum wage of $6.75 per hour.[19]

◆ High energy costs put affordable housing even further out of reach for low-income families. Rhode Island state law prohibits utility shut offs for protected customers — such as the elderly, seriously ill or low-income — during the moratorium period (November 1 through April 15). In 2004, 3,367 residential customers who used electric or gas to heat their homes entered the moratorium period with their utility shut off due to nonpayment. This number does not include those that heat with oil and consequently underestimates the number of individuals who went into the heating season without adequate resources to heat their homes.[20]

Table 7. **Cost of Rental Housing for Low-Income Families, Rhode Island, 2003**

CITY/TOWN	2003 AVERAGE RENT 2-BEDROOM	2003 POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT, POVERTY LEVEL FAMILY OF THREE	2003 VERY LOW INCOME FAMILY	% INCOME NEEDED FOR RENT, VERY LOW INCOME FAMILY
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. 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. The 2004 Rent Survey from Rhode Island Housing and Mortgage Finance Corporation was not available this year.

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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(continued on page 145)

Secure Parental Employment

DEFINITION

Secure 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 2003 the Rhode Island annual unemployment rate was 5.3%, lower than the national rate of 6.0%. Both the Rhode Island and U.S. unemployment rates have risen over the past five years, with the national unemployment rate rising slightly faster than that for Rhode Island.[3] Unemployment rates vary significantly across cities and towns in the state, from highs of 9.1% in New Shoreham and 8.2% in Central Falls to lows of 2.7% in Richmond and 3.0% in Barrington and Narragansett.[4]

Nationally in 2002, 78% of children had at least one parent with full-time, year-round employment, a rate not statistically distinguishable from the 2001 rate, but below the peak of 80% in 2000.[5] In Rhode Island in 2000, there were 52,043 children with no parent working full-time, year-round, representing slightly less than one quarter of all children in the state.[6]

Even when families include adults with secure parental employment, low wages cause many to remain below the federal poverty threshold. 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.[7] 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%.[8]

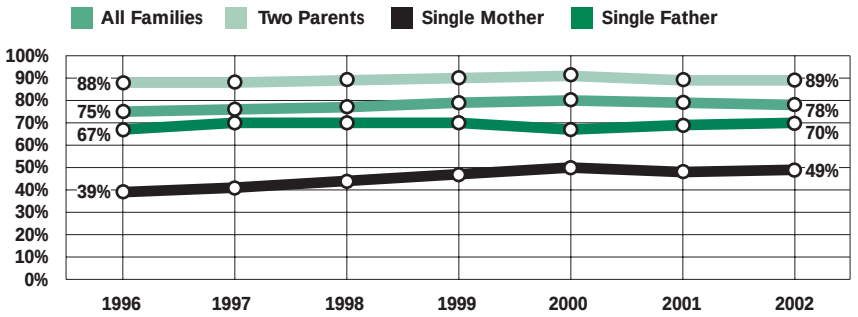
% of Children Living in Families Where Parent Has Full-Time, Year-Round Employment

	1996	2001
RI	70%	75%
US	72%	75%
National Rank*		*26th*
New England Rank**		*4th*

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

Source: *KIDS COUNT data book: State profiles of child well-being 2004*. (2004). Baltimore, MD: The Annie E. Casey Foundation.

Secure Parental Employment by Family Structure, United States, 1996-2002



Source: Federal Interagency Forum on Child and Family Statistics. (1997-2004). *America's children: Key national indicators of well-being.* Washington, DC: U.S. Government Printing Office. Secure parental employment is at least one parent working full-time, year-round.

◆ Much of the increase in secure parental employment during the 1990s was due to the increase in the percentage of children living with single mothers employed full-time, year-round, which increased from 39% in 1996 to 49% in 2002. Single mothers saw a rise in unemployment during the 2001 recession despite consistently high levels of labor force participation, indicating the group's strong desire to find work.[9]

◆ Single mothers consistently average both lower earnings and wages than single fathers. The differences in monthly earnings and hourly wages between men and women leaves a large number of families headed by working single mothers without adequate resources.[10]

◆ In Rhode Island in 2003, there were 2,705 families with incomes below the federal poverty threshold that had at least one adult with full-time, year-round employment. Fifty-six percent of these families were headed by married-couples, 32% were headed by single women and 12% were headed by single men.[11]

◆ In Rhode Island, the percentage of children living in families in which no parent has full-time, year-round employment decreased from 30% in 1996 to 23% in 2000, but rose in 2001 to 25%.[12]

Secure Employment and Child Care

◆ Research shows a strong link between child care availability and sustained labor force participation by mothers. Nationally child care availability is particularly problematic for parents working nonstandard hours, as only between 12% and 35% of providers accept children beyond the nine-to-five work day.[13]

◆ Nationally, estimates show that providing full child care subsidies to mothers currently faced with paying child care expenses would increase the probability of work among poor mothers from 29% to 44% and among near-poor mothers from 43% to 57%.[14]

◆ Low-income parents are less likely to use paid child care, but when they do, they spend five times more of their income than higher-income parents. Child care is generally the second or third greatest expense for low-income, working families.[15]

◆ In Rhode Island, eligibility expansions for child care subsidies and welfare reform more than tripled the probability that a single mother currently or formerly on welfare would work 20 or more hours a week, from 7% in 1996 to 22% in 2000.[16]

References for Indicator

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[3] Rhode Island Department of Labor and Training, Labor Market Information Division. Local Area Unemployment Statistics: New England Labor Force Statistics, Not Seasonally Adjusted 1978-Present. Retrieved February 4, 2005 at www.dlt.state.ri.gov/lm.

[4] Rhode Island Department of Labor and Training, Labor Market Information Division. Local Area Unemployment Statistics: Rhode Island City/Town 2003 Labor Force Statistics. Retrieved February 4, 2005 at www.dlt.state.ri.gov/lmi.

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[6] *KIDS COUNT data book: State profiles of child well-being 2003*. (2003). Baltimore, MD: The Annie E. Casey Foundation. Calculations done by Rhode Island KIDS COUNT.

[8] *Children at risk: State trends 1990 – 2000* (2002). Baltimore, MD: The Annie E. Casey Foundation.

[9] Sherman, A., Fremstad, S., & Parrott, S. (2004). *Employment rates for single mothers fell substantially during recent period of labor market weakness.* Washington, DC: Center on Budget and Policy Priorities.

[10] *Before and after welfare reform: The work and well-being of low-income single parent families.* (2003). Washington, DC: Institute for Women's Policy Research.

[11] U.S. Bureau of the Census, 2003 American Community Survey, Summary Tables. "Poverty Status in the Past 12 Months of Families by Family Type by Work Experience of Householder and Spouse."

[12] *KIDS COUNT data book: State profiles of child well-being 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

Rhode Island Earned Income Tax Credit

◆ Welfare reform focuses on transitioning welfare recipients to work, yet when these individuals enter the workforce they earn low-wages, typically from $8,000 to $12,000 per year. Income at this level is well below the poverty threshold for a family of three. Supplementing this income with funds from the federal and state EITCs can close the poverty gap for low-income and moderate-income working families.[17]

◆ Currently, Rhode Island offers a state EITC equal to 25% of the federal EITC, with 1.5% being refundable. Of the 18 states offering state EITCs, 13 offer credits that are fully refundable, meaning taxpayers receive back the entire tax credit even if it exceeds their income tax liability; Rhode Island is one of 5 states that does not offer a fully-refundable credit. Non-refundable credits, such as Rhode Island's, generally assist fewer working-poor families with children than refundable credits.[18]

◆ In all of the other states offering fully-refundable EITCs, taxpayers get back at least 5% and as much as 50% of the amount assigned to them through the federal EITC.[19] Increasing the EITC refundable amount from the current 1.5% to 5% of the federal EITC refund would provide a maximum benefit of $210 to very low-income Rhode Islanders as opposed to the current maximum of $50.[20]

◆ In 2004, 61,911 Rhode Island working families and individuals received tax credits from EITC up from 60,880 in 2003, for a 1.7% increase. The aggregate dollar amount Rhode Island families and individuals received through the EITC in 2004 was over $100 million. While this represents a 2.3% increase from 2003, the increase was outpaced by inflation.[21]

[13,14] Henry, C., Werschkul, M., & Rao, M. C. (2003). *Child care subsidies promote mothers' employment and children's development.* Washington, DC: Institute for Women's Policy Research.

[15] Children fare better in low-income families with work supports, *The Forum*, 6(4), 1-2.

[16] Witte, A. D., & Queralt, M. (2003). *Impacts of eligibility and provider reimbursement rate increases on child care subsidy take-up rates, welfare use and work.* Cambridge, MA: National Bureau of Economic Research Working Paper 9693.

[17,18,19] Llobrera, J. & Zahradnik, B. (2004). *A HAND UP: How state earned income tax credits help working families escape poverty in 2004.* Washington, DC: Center on Budget and Policy Priorities.

[20] *One Rhode Island Platform.* (2004). Providence, RI: Rhode Island College School of Social Work, The Poverty Institute.

[21] *Facts about the earned income credit: Tax time can pay working families.* (2005). Washington, DC: Center on Budget and Policy Priorities.

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 in which the non-custodial parent is not under a court order because he/she cannot be located. Court orders for child support require establishment of paternity.

SIGNIFICANCE

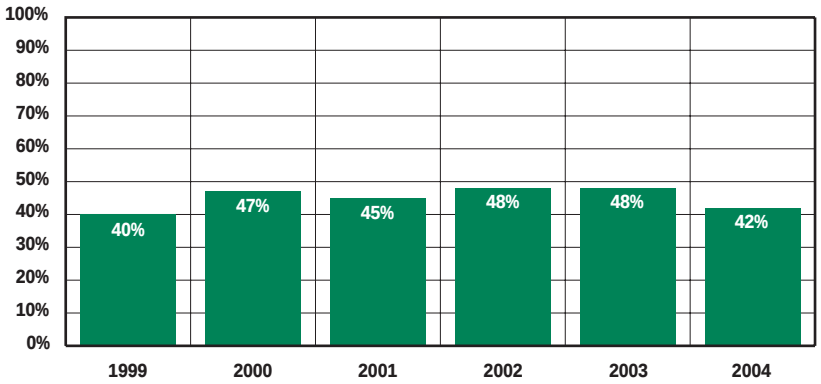
The receipt of child support payments can significantly improve the economic status of a child growing up in a family with a non-resident parent. Child support is an essential source of financial support for low-income families, often making up a significant portion of their incomes.[1] Nationally, approximately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

The goal of the child support system is not only to collect money from non-custodial parents so that their children can have adequate financial security as they grow up, but also provide support and services to custodial parents in locating the non-custodial parent or establishing paternity and to help non-custodial parents connect to education and training.[3] To collect child support on behalf of a child, the non-custodial parent must be identified, located, provided with due process, paternity must be established and a support order must be filed with the court.[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 a child support order is in place, payments can be unreliable.[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 making it difficult to fullfill their child support obligations.[8] Research shows that providing education and job training that increase non-custodial parents' ability to pay child support also increases their contact with their children.[9]

Non-custodial Parents with Court Orders Who Pay Child Support On Time and In Full, Rhode Island 1999 – 2004



Source: Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, 1999 - 2004.

◆ In 2004 in Rhode Island, 42% of non-custodial parents under court order paid child support on time and in full, a decrease of 13% since 2003.[10]

◆ As of December 2004, there were 94,514 Rhode Island children in the state's Child Support Enforcement System.[11] Of these, 15,454 (16%) had not yet had paternity established and therefore were not yet eligible for a child support order.[12]

◆ In Rhode Island in 2004, 56% of the children in the state's Child Support Enforcement System resided in one of the six core cities, those cities with 15% or more of children in poverty.[13] Nationally, the poverty rate for custodial-parent families was about four times higher in 2001 than the rate for married-couple families with children.[14]

◆ As of December 1, 2004, the cumulative principle amount of past due court-ordered child support in Rhode Island totaled over $178 million.[15]

◆ In Rhode Island in 2001, an estimated 67,653 children lived in a household headed by a single parent.[16] Of the Rhode Island families headed by a single female, 41% received child support or alimony payments in 2001, compared to 35% nationally.[17]

Medical Child Support

◆ Rhode Island General Laws, Title 15, Chapter 29, requires that any child support order issued by the family court must 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 parents' place of employment at reasonable cost.[18]

◆ Rhode Island defines reasonable cost for health coverage as 5% of the gross monthly income of the individual providing the coverage. If the cost of health coverage is 5% or lower, the non-custodial parent is ordered to obtain and maintain the coverage.[19]

◆ 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 child receives private insurance through the custodial parent, the weekly cash medical order is sent to the custodial parent.[20]

◆ As of September 2004, there were 21,795 court orders for non-custodial parents to maintain or obtain medical insurance. Of these, only 4,700 (22%) non-custodial parents provided coverage through private insurance and 1,555 (7%) non-custodial parents provided a cash medical order toward the cost of RIte Care. The remaining 15,540 (71%) of orders either have children covered through the custodial parent's insurance or through RIte Care.[21]

◆ For Federal Fiscal Year 2004, a total of $513,029 was retained by the state to offset the cost of RIte Care, while $134,544 was disbursed directly to families to offset the cost of private coverage or other medical expenses.[22]

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[2,5,6,14,16] Grall, T. (2003). *Custodial mothers and fathers and their child support: 2001.* (2001). Washington DC: U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau.

[3,4] U.S. Department of Health and Human Services. (2002). *Fact sheets: Child support enforcement program.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

[7] Frank, A. (2004). *Where the funds are: Potential uses of child support funds for transitional jobs programs* (Brief). Washington, DC: Center for Law and Social Policy.

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.[23]

◆ In Rhode Island as of December 2004, all 23,917 children enrolled in the Family Independence Program were in the Child Support Enforcement System. Of these 14,857 (62%) of these children had paternity established.[24,25]

◆ In 2004, the average child support obligation to children enrolled in FIP was $245 per month, compared to an average child support obligation of $317 per month for children in non-FIP families.[26] It is expected that the child support obligation for children enrolled in FIP would be lower as calculations for the payments are based upon the income of both parents.

◆ Recent research finds that more generous child support "pass through" programs and disregard policies increase the number of fathers making payments, increase the average payments received by mothers and have positive effects on paternity establishment.[27] 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. An average of 2,700 Rhode Island families on FIP over a nine month period received the $50 child support pass-through in 2004.[28]

[10,11,12,13,15,20,22,25,26] Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, December 1999-2004.

[16] U.S. Bureau of the Census, Current Population Survey, 2001-2003.

[17] *KIDS COUNT Data Book: State profiles of child well-being, 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

[18,21] Rhode Island Law, Title 15, Chapter 29, Section 1, 15-5-16.2 (2).

[19] Rhode Island Family Court, Administrative Order.

[24] Rhode Island Department of Human Services, InRhodes Database, December 2004.

[27] Miller, C. Farrell, M., Cancian, M. & Meyer, D. (2005). *The interaction of child support and TANF: Evidence from samples of current and former welfare recipients.* Washington, DC: U.S. Department of Health and Human Services.

[28] Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, December 2004. Note: Due to a change in policy the $50 pass through was terminated as of April 1, 2004 until June 30, 2004 when the General Assembly restored the payment to families.

Children in Poverty

DEFINITION

Children in poverty is the percentage of related and unrelated children under age 18 living in a household below the federal poverty threshold, as defined by the U.S. Office of Management and Budget. Poverty is determined based on income received during the year prior to the Census.

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 after school and on the weekends, such as sports and recreation 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 2004 federal poverty threshold for a family of three with two children is $15,219 while the poverty threshold for a family of four with two children is $19,157.[7] Historically, the poverty threshold fails to provide a complete scope of how the cost of basic goods such as food and housing, taxes, work related expenses, medical expenses and child care affect people's economic well-being. The poverty threshold also fails to account for increased expenses that occur as family size increases. According to the 2003 Rhode Island Standard of Need developed by the Poverty Institute, a family of three needs to make $23,000 a year with the use of child care subsidies and RIte Care to make ends meet. Likewise, a family of four with two children needs to make $28,080 a year with the use of child care subsidies and RIte Care to meet their basic needs.[8]

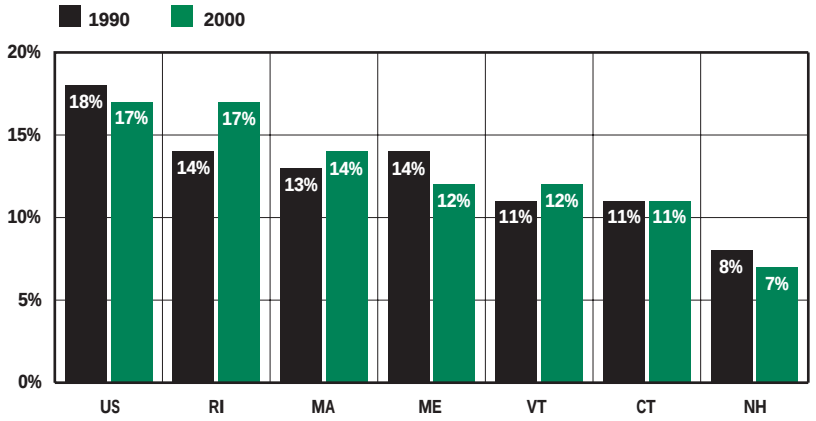
Children in Poverty

	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 in poverty 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 poverty threshold, while Connecticut remained constant. The percentage of children below the poverty threshold in Rhode Island increased from 14% in 1990 to 17% in 2000.[9]

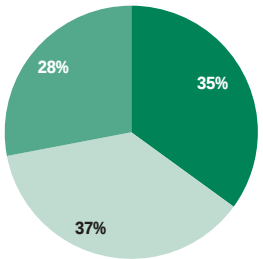
◆ Rhode Island has the largest percentage of Latino children living below the federal poverty threshold (47%), compared to the national rate (28%).[10] Rhode Island has the highest percentage of African American children living below the federal poverty threshold (38%) in New England.[11]

◆ Family structure continues to be strongly related to whether or not children grow up in poor households. Children in single-parent families are five times more likely than children in two-parent families to be living below the poverty threshold.[12] According to the 2000 Census, compared to the rest of New England, Rhode Island has the highest percentage of families with children headed by a single parent (32%).[13]

Rhode Island's Poor Children, 2000

By Age

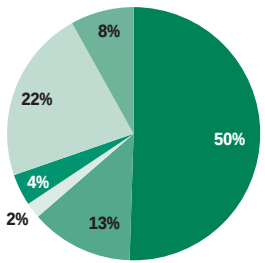
35%	Ages 5 and younger
37%	Ages 6 to 11
28%	Ages 12 to 17



n = 41,162

By Race*

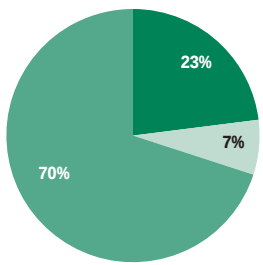
50%	White
13%	Black
2%	American Indian
4%	Asian
22%	Some Other Race
8%	Two or More Races



n = 41,162

By Family Structure**

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

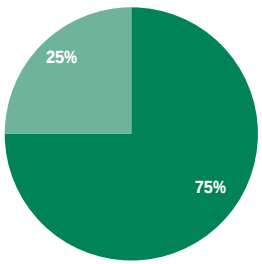


n = 40,117

*** Only includes related children living in households.*

By Residence

75%	Core Cities
25%	Remainder of State



n = 41,162

**Hispanic children may be included in any race category. Of Rhode Island's 41,162 poor children, 16,013 (39%) are Hispanic.*

Source: U.S. Bureau of the Census, Census 2000, Summary File 3. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

Children Living in Extreme Poverty

◆ Families with income below 50% of the federal threshold are considered to be living in extreme poverty.[14] The extreme poverty threshold in 2004 was family income below $7,610 for a family of three with two children and $9,579 for a family of four with two children.[15]

◆ In 2000, of the 41,162 children living below the poverty threshold in Rhode Island, nearly half (48%) lived in extreme poverty. In total, 8% (19,773) of all children in Rhode Island lived in extreme poverty.[16]

◆ Children who live in deep, long-term poverty experience poor 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 obstruct 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 below the poverty threshold, compared to 18% nationally.[19] Of these children, 7,230 (10%) were extremely poor.[20]

◆ In Newport (22.6%), Providence (22.5%), Central Falls (20.6%) and Woonsocket (19.9%), one in five children under age 6 lived in extreme poverty.[21]

◆ As of December 1, 2004 there were 5,468 children under age 3 and 4,470 children ages 3 to 5 in families receiving cash assistance from the Family Independence Program. Of all children under 18 in the Family Independence Program, 47% are age 6 or under.[22]

Children in Poverty

Building Blocks of Economic Security

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.[23]

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.[24]

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.[25] 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.[26]

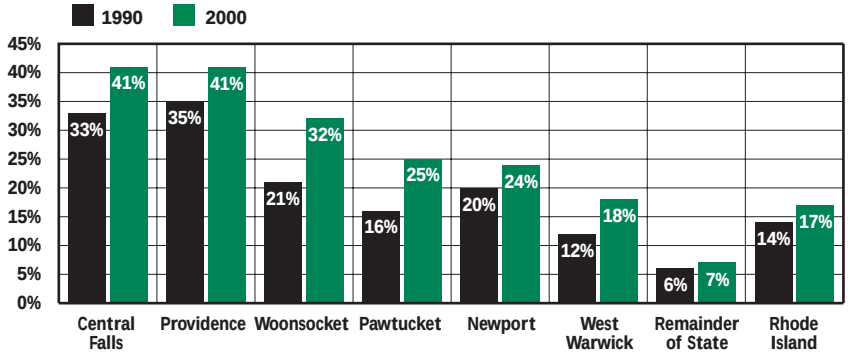
Affordable Housing

◆ Stable housing is a critical requirement for job retention and performance.[27] In 2003, the average rent for a two bedroom apartment in Rhode Island was $1,032 more than double the amount that is considered affordable for a poor family of three.[28] The high cost of utilities can make finding and keeping affordable housing more difficult.

Educational Attainment

◆ Low-income workers are nearly three times more likely not to have finished high school.[29] Individuals with higher education generally have more job opportunities, higher wages and greater job security than those with lower levels of education.[30]

Child Poverty Rates, 1990 and 2000, Core Cities, Remainder of State and Rhode Island



Source: U.S. Census Bureau, Census 1990 and 2000, Summary File 3.

◆ Rhode Island's child poverty rate 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. [31]

◆ 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.[32]

◆ Because of increases in child poverty between 1990 and 2000, West Warwick is now a core city, with 18% of children living in poverty.[33] Providence now has the third highest child poverty rate (41%) in the U.S. among cities with a population of 100,000 or more.[34]

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

Table 8.

	CHILDREN UNDER 6 LIVING IN EXTREME POVERTY		CHILDREN UNDER 6 LIVING BELOW POVERTY		CHILDREN UNDER 18 LIVING IN EXTREME POVERTY		CHILDREN UNDER 18 LIVING BELOW POVERTY	
CITY/TOWN	N	%	N	%	N	%	N	%
Barrington	0	0	23	1.9%	41	1%	127	2.7%
Bristol	66	4.8%	157	11.4%	184	4.2%	436	10.0%
Burrillville	54	5.3%	80	7.9%	139	3.5%	236	6.0%
Central Falls	357	20.6%	740	42.7%	1,146	21.2%	2,210	40.9%
Charlestown	2	<1%	18	3.7%	10	1%	78	4.7%
Coventry	32	1.4%	149	6.4%	146	1.8%	481	5.9%
Cranston	161	3.2%	437	8.6%	605	3.7%	1,496	9.1%
Cumberland	41	1.6%	89	3.6%	65	1%	237	3.1%
East Greenwich	39	4.2%	57	6.1%	76	2.1%	147	4.1%
East Providence	214	6.9%	452	14.5%	557	5.4%	1,126	10.8%
Exeter	50	11.8%	69	16.3%	93	6.2%	112	7.5%
Foster	0	0	0	NA	0	NA	32	2.9%
Glocester	17	2.6%	37	5.7%	112	4.2%	178	6.7%
Hopkinton	0	0	55	8.9%	8	<1%	115	5.9%
Jamestown	0	0	0	NA	17	1.4%	17	1.4%
Johnston	69	3.6%	183	9.5%	191	3.3%	527	9.0%
Lincoln	39	2.9%	76	5.6%	142	2.8%	329	6.5%
Little Compton	8	3.5%	8	3.5%	8	1.0%	8	1.0%
Middletown	16	1.1%	70	5.0%	128	3.0%	264	6.2%
Narragansett	25	3.3%	50	6.5%	59	2.2%	235	8.6%
New Shoreham	1	1.6%	3	4.8%	12	6.4%	19	10.2%
Newport	413	22.6%	628	34.3%	773	14.9%	1,267	24.4%
North Kingstown	153	7.1%	239	11.1%	375	5.5%	663	9.7%
North Providence	85	4.8%	212	12.0%	271	4.7%	579	10.1%
North Smithfield	45	6.3%	45	6.3%	58	2.5%	72	3.0%
Pawtucket	824	14.1%	1,711	29.2%	2,195	12.2%	4,542	25.3%
Portsmouth	34	2.7%	63	5.0%	49	1.2%	118	2.8%
Providence	3,252	22.5%	6,137	42.5%	8,846	19.9%	18,045	40.5%
Richmond	17	2.4%	17	2.4%	60	3.0%	82	4.2%
Scituate	8	1.1%	30	4.2%	18	1%	113	4.3%
Smithfield	11	1.0%	11	1.0%	47	1.2%	153	3.9%
South Kingstown	5	<1%	82	4.6%	120	2.0%	324	5.3%
Tiverton	14	1.6%	48	5.4%	48	1.4%	92	2.8%
Warren	41	5.2%	60	7.6%	136	5.6%	205	8.4%
Warwick	126	2.2%	386	6.8%	410	2.2%	1,243	6.7%
West Greenwich	0	0	18	3.7%	0	NA	40	2.7%
West Warwick	239	10.6%	606	26.8%	462	7.0%	1,186	18.1%
Westerly	0	0	141	8.0%	105	2.0%	534	10.0%
Woonsocket	772	19.9%	1,361	35.0%	2,061	18.8%	3,494	31.8%
Core Cities	*5,857*	*19.5%*	*11,183*	*37.3%*	*15,483*	*17.1%*	*30,744*	*33.9%*
Remainder of State	*1,373*	*3.0%*	*3,365*	*7.3%*	*4,290*	*2.8%*	*10,418*	*6.8%*
Rhode Island	*7,230*	*9.5%*	*14,548*	*19.2%*	*19,773*	*8.1%*	*41,162*	*16.9%*

Source of Data for Table/Methodology

Data are from the U.S. Bureau of the Census, Census 2000, Summary File 3, P.87 and PCT.50. The data include the poverty rate for all children for whom poverty was determined, including related children and unrelated children living in the household. In the past this table has reflected the poverty rate for only related children under 18 from Census 2000, Summary File 3, PCT.52.

Children under 18 living in extreme poverty are those living in households with income below 50% of the federal poverty threshold.

References for Indicator

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(continued on page 145)

Children in the Family Independence Program

DEFINITION

Children enrolled in the Family Independence Program is the percentage of children under age 18 who were living in families receiving cash assistance through the Family Independence Program (FIP) on December 1, 2004. 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 participated in the program at other points in the year but were not enrolled on December 1, 2004.

SIGNIFICANCE

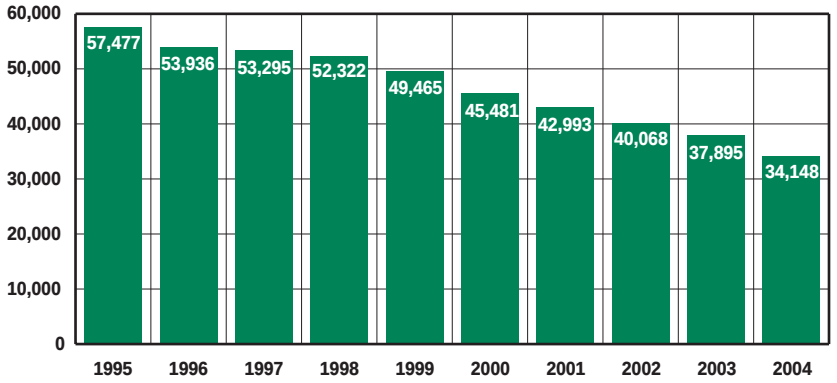
Rhode Island's Family Independence Program (FIP) helps families make successful transitions to work by providing the cash assistance and work supports, including health insurance and subsidized child care, that parents need to obtain and keep a job. As of December 1, 2004 in Rhode Island, 9,694 (96%) adults had FIP work plans in place; of these adults, 1,879 (19%) were employed.[1] In 2004, employed adult FIP recipients earned an average wage of $9.02 per hour.[2]

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 needs to earn $11.00 per hour with child care and medical subsidies to make ends meet, compared to nearly $21.50 per hour without these programs.[3] 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.[4]

In addition to helping low-income working families meet their basic needs, FIP also provides an economic safety net for children living in families with adults that are unable to work. As of December 1, 2004 there were 749 families enrolled in FIP who were unable to work due to illness or advanced age, 164 families exempt because of an illness to a spouse or child and 2,229 exempt from work because they were in their third trimester of pregnancy or had children under age one.[5]

If a family has no earned income, the maximum monthly FIP benefit for a Rhode Island family of three is $554 per month.[6] With an additional $393 per month in Food Stamps, this amount is 71% of the federal poverty guidelines and well below the amount of income families need to pay basic living expenses.[7] The FIP monthly payment has not increased in 15 years.[8]

Adults and Children Enrolled in AFDC/Family Independence Program, 1995 to 2004



Source: Rhode Island Department of Human Services, INRHODES Database, 1995 to 2004.

Note: Prior to May 1, 1997 the Family Independence Program was called Aid to Families with Dependent Children.

◆ In Rhode Island in December 2004, there were 23,917 children under the age of 18, 10,098 adults and 133 eighteen year olds (included in a parent's case) who were enrolled in the Family Independence Program. This is a 41% decline in cash assistance recipients since 1995.[9]

◆ Nearly three quarters (70%) of all FIP beneficiaries are children under the age of 18.[10] Three out of four children enrolled in FIP are age 12 and under, and almost half are under age 6.[11]

◆ In 2004, in Rhode Island, 79% of children enrolled in FIP cash assistance lived in the six core cities (those cities with 15% or more of children living in poverty). Nearly half (48%) of all children enrolled in FIP lived in Providence.[12]

Changes to the Family Independence Program

Full Family Sanctions

◆ Beginning in September 2004, families who have been sanctioned for a total of twenty-four months for failing to enter into an employment plan or comply with the employment plan without good cause have had their entire cash benefit terminated (full family sanction).[13]

◆ Full family sanction replaced a system of graduated penalties applied to only the parent's portion of the benefit. Under full family sanction, a graduated system will still apply prior to the twenty-fourth month.[14]

◆ As of December 31, 2004, 159 cases had been closed as a result of the full family sanction. To have cash benefits reinstated, the adult must reapply for benefits, sign an employment plan and be in compliance with that plan for two weeks. Of the cases in full family sanction as of December, 69 reapplied for benefits.[15]

Alternative Cash Assistance

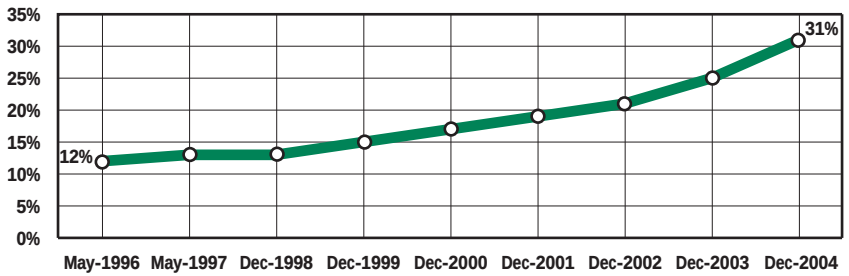
◆ As of January 2005, a family applying for benefits may choose an alternative cash assistance (ACA) payment in a lump sum equal to three times the monthly amount of cash assistance to which the family would otherwise be entitled. An ACA payment is only an option when the payment would allow the parent to remain employed or to accept a verifiable job offer. To receive the payment, the family must waive cash assistance for the six month period beginning with receipt of ACA.[16]

Simplified Reporting

◆ In December 2004, Rhode Island implemented a simplified reporting policy for most Food Stamp households. Simplified reporting households receive a consistent amount of Food Stamps for a six month period and are only required to report to the Department of Human Services if its income exceeds the gross income limit.[17]

◆ Families receiving both Food Stamps and FIP are required to report changes of more than $100 (earned) and $50 (unearned) income which will result in an adjustment of both their cash assistance and Food Stamps. All FIP families that receive Food Stamps will be required to recertify for the FIP program at those 6 month intervals – instead of the 12 month intervals previously in place.[18]

Child-Only Cases as a Percentage of Total AFDC/Family Independence Program Cases, Rhode Island, 1996-2004



Source: Rhode Island Department of Human Services, INRHODES Database, 1998 to 2004, and Witte, A. & Queralt, M. (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.

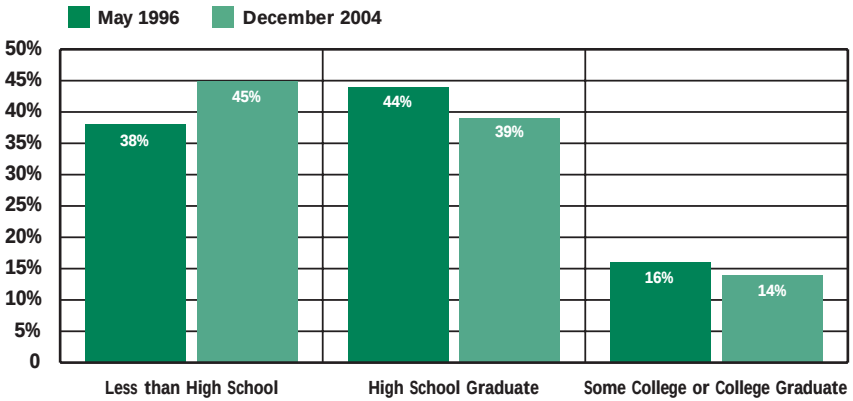
Note: Prior to May 1, 1997, The Family Independence Program was called Aid to Families with Dependent Children (AFDC).

◆ As of December 2004 there were 4,034 child-only cases in the Family Independence Program.[19] 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 an eligible immigrant or refugee.

◆ Child-only cases have increased from 12% of all FIP cases in May 1996 to 31% of all FIP cases in December 2004.[20,21] The percentage of all cases that are child-only cases will continue to increase as adults reach five-year time limits. As of December 2004, 2,176 adults had reached their time limits.[22]

Children in the Family Independence Program

Education Level, Families Enrolled in the Family Independence Program, 1996 and 2004



Source: Rhode Island Department of Human Services, INRHODES Database, May 1996 and December 2004. Percentages do not add to 100 due to cases in which education level is not reported.

◆ In Rhode Island, almost half (45%) of FIP heads of households, excluding child only cases, had less than a high school education in 2004.[23]

◆ Compared to 1996, adults enrolled in FIP in 2004 were less likely to have graduated from high school or have at least some college education.[24]

◆ A growing number of jobs in today's labor market require a certain level of skill and/or credentials. Research finds 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.[25]

◆ 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 post secondary education as part of the FIP plan were more likely to be employed and have a higher average hourly wage than those who did not participate ($11.37 compared to $8.66).[26,27]

Welfare and Housing Policy

◆ In order to align housing policy with welfare-to-work efforts, the Quality Housing and Work Responsibility Act (QHWRA), enacted in 1998, devolved authority over many areas of housing policy from the federal level to state and local Public Housing Authorities (PHAs). As a result, important decisions regarding eligibility and targeting requirements, rent regulations, Section 8 payment standards, support programs and community work requirements are now made at the state and local level.[28]

◆ QHWRA permanently repealed the federal rule that gave preference for admission to housing assistance programs to the neediest families. PHAs are, however, still required to provide at least 40% of newly available public housing and Section 8 units to families with incomes below 30% of the area median income ($18,350 to $18,800 in Rhode Island in 2004 depending on geographic location).[29,30]

◆ With the high cost of housing, low-income families are likely to experience difficulty finding and keeping stable housing.[31] Research shows that housing assistance in conjunction with cash assistance can have a positive effect on work efforts and family well-being.[32]

◆ In December 2004, 4,053 of the 13,158 families enrolled in FIP in Rhode Island received housing assistance.[33]

Table 9.

Children Enrolled in the Family Independence Program (FIP), Rhode Island, December 1, 2004

CITY/TOWN	All Children Under 18	Number Receiving FIP Cash Assistance: Families	Number Receiving FIP Cash Assistance: Children	FIP Children as % of All Children Under 18
Barrington	4,745	19	27	1%
Bristol	4,399	71	106	2%
Burrillville	4,043	68	119	3%
Central Falls	5,531	772	1,529	28%
Charlestown	1,712	32	61	4%
Coventry	8,389	136	201	2%
Cranston	17,098	547	874	5%
Cumberland	7,690	109	179	2%
East Greenwich	3,564	31	47	1%
East Providence	10,546	406	648	6%
Exeter	1,589	27	48	3%
Foster	1,105	19	26	2%
Glocester	2,664	18	32	1%
Hopkinton	2,011	28	56	3%
Jamestown	1,238	8	10	1%
Johnston	5,906	198	294	5%
Lincoln	5,157	84	136	3%
Little Compton	780	5	6	1%
Middletown	4,328	71	101	2%
Narragansett	2,833	37	49	2%
New Shoreham	185	0	0	0%
Newport	5,199	355	689	13%
North Kingstown	6,848	121	200	3%
North Providence	5,936	201	319	5%
North Smithfield	2,379	31	45	2%
Pawtucket	18,151	1,618	2,880	16%
Portsmouth	4,329	40	51	1%
Providence	45,277	5,949	11,599	26%
Richmond	2,014	19	29	1%
Scituate	2,635	34	45	2%
Smithfield	4,019	37	54	1%
South Kingstown	6,284	90	189	3%
Tiverton	3,367	69	110	3%
Warren	2,454	75	143	6%
Warwick	18,780	419	658	4%
West Greenwich	1,444	12	15	1%
West Warwick	6,632	269	448	7%
Westerly	5,406	122	197	4%
Woonsocket	11,155	1,011	1,697	15%
Core Cities	*91,945*	*9,974*	*18,842*	*21%*
Remainder of State	*155,877*	*3,184*	*5,075*	*3%*
Rhode Island	*247,822*	*13,158*	*23,917*	*10%*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, INRHODES Database, December 2004. 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.

References for Indicator

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[7] Rhode Island Department of Human Services, INRHODES Database, December, 2004. Calculations by Rhode Island KIDS COUNT.

[13,14] Rhode Island Department of Human Services Manual, Family Independence Program, Work Policies and Procedures, Section 0812.35.

[15] Rhode Island Department of Human Services, INRHODES Database, September, 2004.

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[30] 2004 *Income limits, state of Rhode Island.* (n.d.) Retrieved February 2005 from the U.S. Department of Housing and Urban Development at www.hud.gov.

[31,32] Khadduri, J., Shroder, M. & Steffen, B. (2003). Can housing assistance support welfare reform? In B. Sard & A. Bogdon (Eds.), *A place to live, a means to work: How housing assistance can strengthen welfare policy* (pp. 23-62). Washington, DC: Fannie Mae Foundation.

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]

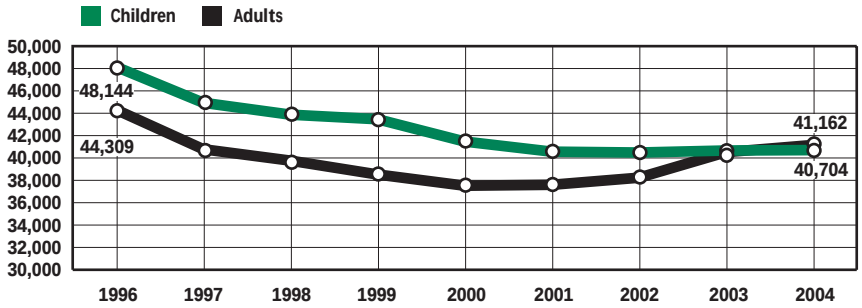
The Food Stamp Program is an entitlement, meaning that federal funding is provided to all applicants who meet the eligibility requirements. Participation in the Food Stamp Program is not time-limited and can be used as long as the person maintains his or her certification (with the exception of able-bodied adults without dependent children who live in communities not given a waiver).[3] The program is structured to respond to changes in need brought on by economic cycles or natural emergencies and plays an important role in helping low-income families purchase adequate and nutritious foods.[4] The benefit level for each eligible household is adjusted according to income, and the monthly benefit level decreases as household income increases.[5]

To qualify for food stamps, a household must have a gross income less than 130% of the federal poverty guidelines for that family size and must meet requirements that limit the value of liquid assets.[6] For example, in 2004 a family of three with a gross annual income of less than $20,376 (monthly income less than $1,698) will qualify for Food Stamps if they meet the assets guidelines.[7]

Most non-participation in the Food Stamp Program does not result from a lack of awareness about the program, but rather is a result of individuals or families being unaware of their eligibility. A recent national study on eligible non-participants in the Food Stamp Program found that more than half (57%) of people surveyed did not believe they were eligible.[8]

The maximum monthly food stamp benefit for a Rhode Island family of three is $393. This is $22 higher than last year's maximum. The average monthly benefit for a family of three in the state is $249.67, an increase of $17.67 from last year, but a decrease from the 1997 monthly average of $270.[9] In October, 2004 there were 40,704 children in Rhode Island who received benefits from the Food Stamp Program.[10]

Food Stamp Participation, Children under Age 18 and Adults, Rhode Island, 1996-2004



Source: Rhode Island Department of Human Services, InRhodes Database, 1996 – 2004. Data represents children and adults who participated in the Food Stamp program for the month of October.

◆ The number of children participating in the Food Stamp Program declined from 48,144 in 1996 to 40,704 in 2004, a 15% decrease. During the same time period, the number of adults on the Food Stamp program decreased from 44,309 to 41,162, a 7% decrease.[11]

◆ According to the USDA, Rhode Island is one of twelve states nationally in which the participation rate – like the national rate – for working poor people was significantly lower than the rate for all eligible people.[12] In Rhode Island in 2001 it is estimated that between 61% and 73% of all people who were eligible for the Food Stamp Program participated, compared to between 49% and 69% for working poor people.[13,14]

◆ Effective August 2004, Rhode Island repealed the ban of Food Stamp and Family Independence Program (FIP) participation for persons with drug-related felony convictions. Prior to this change those that had been convicted of sale or distribution of drugs were not eligible for food stamp or FIP assistance.[15]

◆ In December 2004, Rhode Island implemented a simplified reporting policy for most food stamp households. Households in this category receive a constant amount of food stamps for a six month period and are only required to report to the Department of Human Services if income exceeds the gross income limit.[16] Previously, food stamp households needed to report changes in monthly unearned income of $50 or more, changes in monthly earned income of $100 or more, changes in household size, residence, shelter costs and resources.[17]

Table 10. **Children Under Age 18 Receiving Food Stamps, Rhode Island, October 1, 2004**

CITY/TOWN	ESTIMATED NUMBER INCOME-ELIGIBLE	NUMBER PARTICIPATING	% OF INCOME-ELIGIBLE PARTICIPATING
Barrington	155	28	18%
Bristol	607	174	29%
Burrillville	356	240	67%
Central Falls	2,840	2,242	79%
Charlestown	173	76	44%
Coventry	654	459	70%
Cranston	2,057	1,632	79%
Cumberland	485	326	67%
East Greenwich	242	98	40%
East Providence	1,687	1,107	66%
Exeter	169	77	46%
Foster	66	21	32%
Glocester	225	66	29%
Hopkinton	228	97	43%
Jamestown	36	13	36%
Johnston	733	481	66%
Lincoln	404	207	51%
Little Compton	21	10	48%
Middletown	404	103	25%
Narragansett	310	115	37%
New Shoreham	19	1	5%
Newport	1,731	822	47%
North Kingstown	818	388	47%
North Providence	802	459	57%
North Smithfield	92	54	59%
Pawtucket	5,948	4,432	75%
Portsmouth	187	42	22%
Providence	22,395	17,961	80%
Richmond	118	74	63%
Scituate	157	62	39%
Smithfield	239	84	35%
South Kingstown	485	284	59%
Tiverton	150	102	68%
Warren	333	202	61%
Warwick	1,712	1,381	81%
West Greenwich	81	36	44%
West Warwick	1,610	920	57%
Westerly	843	435	52%
Woonsocket	4,125	2,905	70%
Core Cities	*38,649*	*29,282*	*76%*
Remainder of State	*15,048*	*8,934*	*59%*
Rhode Island	*53,697*	*38,216*	*71%*

Note to Table

Because of a change in methodology, Food Stamp participation rates in this Factbook can not be compared with Factbooks before 2003.

Source of Data for Table/Methodology

Estimated number income-eligible is based on the total number of children ages birth to 18 living in families with incomes below 130% of poverty from the Census 2000 Summary File 3. Food Stamp Program data are from the Rhode Island Department of Human Services, INRHODES Database, October 1, 2004.

Note: The data in the city/town table may differ from the data on the previous page as this table uses point-in-time data for October, rather than data based on participation for the entire month.

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

References for Indicator

[1] Food Assistance and Nutrition Research Program. *The food assistance landscape.* (2004). Washington, DC: Economic Research Service, U.S. Department of Agriculture.

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[12,14] Castner, L. & Schirm, A. (2004). *State food stamp participation rates for the working poor in 2001.* Washington, DC: U.S. Department of Agriculture and Mathematica Policy Research, Inc.

[13] Schirm, A. & Castner, L. (2004). *Reaching those in need: State food stamp participation rates in 2001.* Washington, DC: U.S. Department of Agriculture and Mathematica Policy Research, Inc.

[15] Rhode Island Department of Human Services Manual, Section 0806.40.25 and 1002.25. (2004).

[16] Households that are not included in semi-annual reporting are: Households without earnings in which all members are elderly or disabled; Households in which all members are homeless; Households in which all members are migrants; Households in which there is an able bodied childless adult who is working less than 20 hours/week; and Households which pay legally obligated child support. These households are still required to report changes during the certification period.

[17] The Poverty Institute. *Department of Human Services proposes changes to the Food Stamp Program and Family Independence Program to implement semi-annual reporting.* Retrieved January 10, 2005 from www.povertyinsitute.org.

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

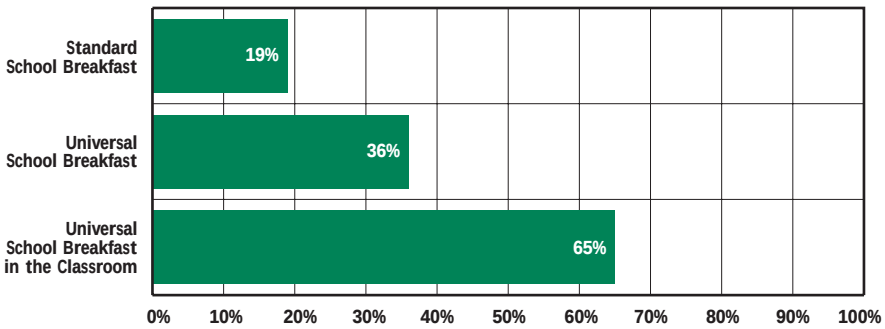
Children who suffer from under-nutrition have poorer overall health status than well-nourished children, miss more days of school and are less ready to learn when they do attend.[1] Students who eat breakfast have significantly higher math and reading scores, fewer absences, improved attentiveness and 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 in 2000, one in three households with children did not have enough food to meet basic needs at all times.[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 arrive and concentrate in class.[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 2004, an average of 19,743 breakfasts was served daily in schools across Rhode Island. Of these, 80% (15,728) were to low-income children eligible for free or reduced-price meals.[11]

U.S. 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.* (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]

◆ Currently, Central Falls, Cranston, Pawtucket and Providence all offer universal free school breakfast.[13]

◆ Rhode Island increased participation in the school breakfast program by students receiving free or reduced price meals by 18% between the 2002-2003 and the 2003-2004 school years, making it one of five states to increase participation by more than 10%.[14]

◆ Rhode Island ranks 35th in the country for participation in school breakfast. During the 2003-2004 school year, 38 low-income students participated in the breakfast program for every 100 that participated in the lunch program.[15] Were Rhode Island to increase this ratio from 38 to 55 low-income students participating in the school breakfast program, the state could garner an additional $1.7 million of federal funds that can support the program and flow into the state's economy.[16]

Table 11. **Children Participating in School Breakfast, Rhode Island, Fall 2004**

SCHOOL DISTRICT	2004 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	3,302	16	<1%	89	3	3%
Bristol Warren	3,543	234	7%	810	172	21%
Burrillville	2,517	112	4%	492	67	14%
Central Falls	3,540	933	26%	2,804	772	28%
Chariho	3,706	94	3%	512	59	12%
Coventry	5,548	356	6%	814	187	23%
Cranston	10,775	1,242	12%	2,528	673	27%
Cumberland	5,104	255	5%	661	264	40%
East Greenwich	2,404	78	3%	131	66	50%
East Providence	5,925	481	8%	1,975	419	21%
Exeter-West Greenwich	2,076	43	2%	235	26	11%
Foster	315	29	9%	54	13	24%
Foster-Glocester	1,683	68	4%	157	27	17%
Glocester	711	46	6%	101	36	36%
Jamestown	474	6	1%	40	4	10%
Johnston	3,254	167	5%	778	128	16%
Lincoln	3,568	154	4%	385	134	35%
Little Compton	304	2	1%	23	0	0%
Middletown	NA	NA	NA	NA	NA	NA
Narragansett	1,624	26	2%	168	21	13%
New Shoreham	140	19	14%	11	8	73%
Newport	2,554	499	20%	1,205	489	41%
North Kingstown	4,514	212	5%	543	159	29%
North Providence	3,379	257	8%	827	208	25%
North Smithfield	1,836	43	2%	169	19	11%
Pawtucket	9,126	2,163	24%	6,245	1,751	28%
Portsmouth	2,947	90	3%	186	44	24%
Providence	26,386	9,287	35%	21,252	7,953	37%
Scituate	1,765	25	1%	128	16	13%
Smithfield	2,556	75	3%	182	32	18%
South Kingstown	3,955	138	3%	424	121	29%
Tiverton	2,102	124	6%	316	65	21%
Warwick	11,325	754	7%	2,462	528	21%
West Warwick	3,599	375	10%	1,150	309	27%
Westerly	3,595	388	11%	807	250	31%
Woonsocket	6,658	1,408	21%	3,957	1,198	30%
Core Cities	*51,863*	*14,665*	*28%*	*36,613*	*12,472*	*34%*
Remainder of State	*94,947*	*5,534*	*6%*	*16,009*	*3,749*	*23%*
Rhode Island	*146,810*	*20,199*	*14%*	*52,622*	*16,221*	*31%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, October 2004. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

Fall enrollment is the public school enrollment as of October 1, 2004. Average daily participation in breakfast is the number of students eating breakfast in school on average in the month of October 2004. 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 2004. 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 2004. Half-day kindergarten, 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

Rock 'N' Roll Band

if we were a rock 'n' roll band,
We'd travel all over the land.
We'd play and we'd sing and wear
spangly things,
if we were a rock 'n' roll band.

if we were a rock 'n' roll band,
And we were up there on the stand,
The people would hear us and love us
and cheer us,
Hurray for that rock 'n' roll band.

if we were a rock 'n' roll band,
Then we'd have a million fans.
We'd giggle and laugh and sign
autographs,
if we were a rock 'n' roll band.

if we were a rock 'n' roll band,
The people would all kiss our hands.
We'd be millionaires and have
extra long hair,
if we were a rock 'n' roll band.

But we ain't no rock 'n' roll band,
We're just seven kids in the sand
With homemade guitars and pails
and jars
And drums of potato chip cans.

Just seven kids in the sand,
Talkin' and wavin' our hands,
And dreamin' and thinkin' oh
wouldn't it be grand,
if we were a rock 'n' roll band.

By Shel Silverstein

Children's Health Insurance

DEFINITION

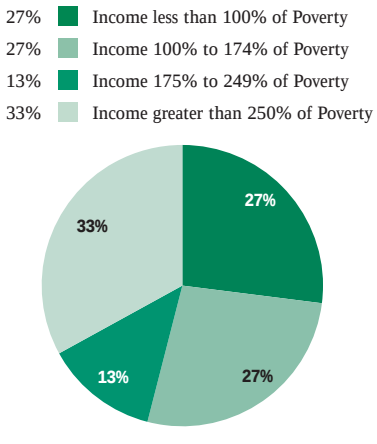
Children's health insurance is the percentage of children below age 19 who were covered by any kind of public or private health insurance, including Medicaid, during the previous calendar year.

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, 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] Children without health insurance often have poorer school attendance and lower school achievement.[4] Children are more likely to use health care when their parents are insured and have access to health care.[5]

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, 2004, two-thirds (80,953) of the RIte Care members who qualified based on family income were children under age 19.[6] There were 44,199 low-income parents enrolled in RIte Care as of December 31, 2004.[7] Of these parents, 10,098 (23%) received RIte Care because they were enrolled in the Family Independence Program (FIP).[8]

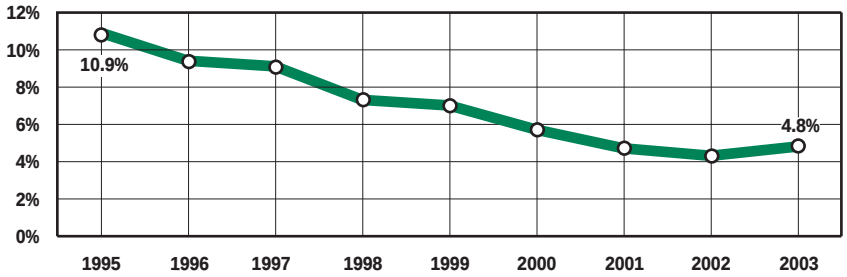
Children Under Age 19 Without Health Insurance, by Poverty Level, Rhode Island, 2003



n = 15,000

Source: U.S. Bureau of Census, Current Population Survey, 2002-2004, three-year average. Compiled by The Annie E. Casey Foundation. These data reflect only those who were uninsured throughout the entire year and do not include those who were insured for only part of the year.

Children Without Health Insurance, Rhode Island, 1995 - 2003



Source: U.S. Census Bureau, Current Population Survey, 1994-2004, three-year averages, compiled by Rhode Island KIDS COUNT. Data are for children under 18 years of age.

◆ As of 2003, 4.8% of Rhode Island's children under age 18 were uninsured, compared to 11.6% of children nationally.[9] The rate of uninsured children in Rhode Island has been reduced by 56% over the past nine years.[10]

◆ Like many other states, Rhode Island also provides health insurance to children up to their 19th birthday. In Rhode Island, 5.8% of children under age 19 were uninsured, compared to 12.0% nationally.[11]

◆ As of 2003, there were 15,000 uninsured children under age 19 in Rhode Island. Of these, an estimated 10,000 Rhode Island children were eligible for RIte Care but uninsured.[12] Two thirds of Rhode Island's uninsured children live in working families.[13]

◆ During 2004, 2,142 adults and 3,734 children participated in RIte Share.[14] 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 and receive wrap-around benefits such as co-pays for doctor visits and prescriptions through Medical Assistance.[15]

Table 12.

Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 2004

CITY/TOWN	RIte Care FIP	RIte Care Non-FIP	SSI	Katie Becket Provision	Adoption Subsidy	Foster Care	Total
Barrington	43	191	15	40	11	6	306
Bristol	154	547	34	15	18	17	785
Burrillville	155	529	38	23	57	43	845
Central Falls	1,876	2,720	256	4	12	13	4,881
Charlestown	74	215	12	10	12	6	329
Coventry	245	1142	74	57	89	42	1,649
Cranston	1,065	3,370	224	134	84	49	4,926
Cumberland	230	788	62	76	54	20	1,230
East Greenwich	55	209	14	52	12	5	347
East Providence	853	1,983	144	61	61	51	3,153
Exeter	50	122	5	7	19	16	219
Foster	27	106	3	8	21	4	169
Glocester	45	239	19	13	39	31	386
Hopkinton	69	297	9	6	8	2	391
Jamestown	13	74	6	9	12	2	116
Johnston	362	1,050	70	28	20	19	1,549
Lincoln	171	602	37	44	28	16	898
Little Compton	6	65	3	3	1	2	80
Middletown	121	451	39	28	13	22	674
Narragansett	72	316	18	17	12	40	475
New Shoreham	0	17	2	0	0	0	19
Newport	806	1,053	110	20	19	31	2,039
North Kingstown	248	769	51	65	19	4	1,156
North Providence	387	1034	80	30	38	59	1,628
North Smithfield	55	209	11	22	15	34	346
Pawtucket	3,582	5,588	546	46	76	116	9,954
Portsmouth	69	332	12	41	12	14	480
Providence	13,382	17,272	2,011	72	1,130	1,125	34,992
Richmond	40	170	15	9	10	24	268
Scituate	64	292	13	28	25	11	433
Smithfield	61	321	16	31	22	10	461
South Kingstown	221	597	51	47	43	15	974
Tiverton	119	429	28	20	12	11	619
Warren	182	367	18	18	19	11	615
Warwick	831	2,969	227	147	129	101	4,404
West Greenwich	17	124	4	12	15	8	180
West Warwick	508	1,649	107	18	57	21	2,360
Westerly	243	919	67	33	12	16	1,290
Woonsocket	2,228	3,085	407	36	88	115	5,959
Out of State/Unknown	*10*	*2*	*39*	*0*	*0*	*2*	*53*
Core Cities	*22,382*	*31,367*	*3,437*	*196*	*1,382*	*1,421*	*60,185*
Remainder of State	*6,347*	*20,845*	*1,421*	*1,134*	*942*	*711*	*31,400*
Rhode Island	*28,739*	*52,214*	*4,897*	*1,330*	*2,324*	*2,134*	*91,638*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, MMIS Database, December 31, 2004.

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

From September 2003 through March 2004, children with special health care needs were voluntarily transitioned from fee-for-service Medical Assistance to managed care RIte Care. Children who were transitioned into RIte Care included those who qualify for Medical Assistance because they receive SSI, adoption subsidy or qualify for the Katie Beckett provision. Certain groups of children, including those with commercial health insurance, were not included in the transition to RIte Care. The columns SSI, Katie Beckett and Adoption Subsidy include children in fee-for-service Medicaid and (managed care) RIte Care as of December 31, 2004.

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 145)

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.

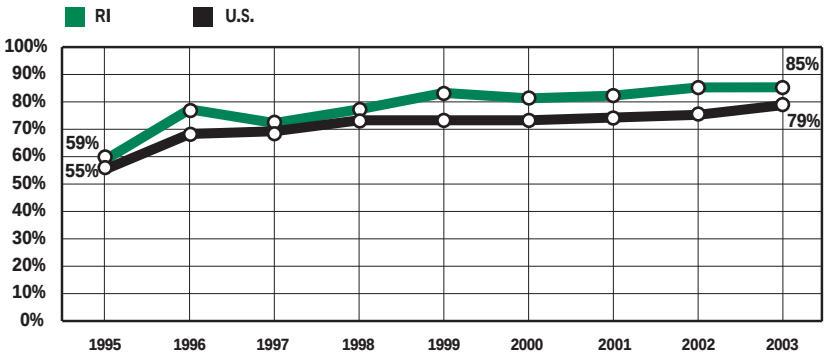
SIGNIFICANCE

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, 1995-2003



Source: Centers for Disease Control and Prevention, National Immunization Survey, 1996-2003.

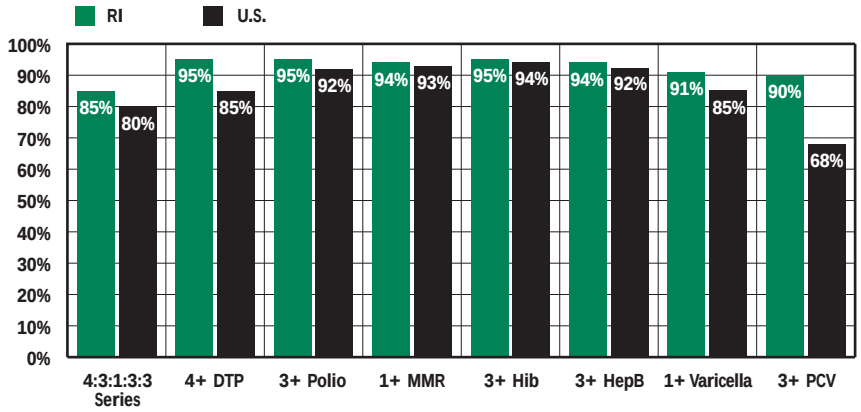
◆ In 2003, 85% of Rhode Island children ages 19-35 months were fully immunized with the 4:3:1:3:3 Series, compared to 79% nationally.[10]

◆ Despite the improvement of vaccination rates overall, racial, ethnic and income disparities persist. In the United States during 2003, 83% of White children were fully immunized, compared to 79% of Asian children, 77% of Hispanic children and 73% of Black children. Nationally in 2003, children at or above the poverty level had an 81% vaccination rate while children below the poverty level had a 75% vaccination rate.[11]

◆ Strategies to reduce the racial, ethnic and income disparities in vaccination coverage include:

- Ensure that all children have early access to health care.
- Make connections and improve coordination with WIC and school-based health centers.
- Educate parents to track their children's immunization status.
- Collect site-specific immunization statistics so that providers can identify children who need additional vaccinations.[12]

Vaccination Coverage Among Children Ages 19 Months - 35 Months, United States and Rhode Island, 2003



Source: Centers for Disease Control and Prevention, National Immunization Survey, 2003.

◆ In 2003, Rhode Island ranked among the top 5 states on vaccination rates for four childhood vaccines and in the top 20 for the remaining three 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] Between 2002 and 2003, Rhode Island increased the percentage of 19 to 35 month olds vaccinated with PCV from 67% to 90%, the second highest rate in the nation.[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 2003-2004 Rhode Island School Immunization Survey included 46,506 children over the age of 19 months across 762 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]

◆ During 2003, 107 children in Rhode Island obtained exemptions from receiving one or more vaccines for medical or religious reasons. Of these, 52 (49%) were exempted from receiving all vaccines.[17]

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).[18]

◆ 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.[19]

◆ During the 2003-2004 school year, 53 schools participated in the program. Of the 1,534 students who enrolled in the program, 95% received immunizations and 85% completed all the immunizations for which they were enrolled.[20]

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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, 2004 and had received dental services at any point during the previous federal fiscal year (October 1, 2003 - September 30, 2004).

SIGNIFICANCE

Dental caries (tooth decay) is the most common chronic 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 reduced school performance, poor self-image and absenteeism.[3]

Children in families with incomes below the poverty threshold 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, primarily those from low-income families.[4] Children from families without dental insurance are three times more likely to have dental needs than children with either public or private insurance.[5] National estimates indicate that for every child without medical insurance there are 2.6 children without dental insurance.[6] In Rhode Island the percentage of children with dental insurance increased from 62% in 1990 to 73% in 2001.[7] Minority families, low-income families and families with low education levels are the most likely to be uninsured for dental care.[8]

For children in low-income families, the efficacy of public dental insurance is a critical factor in access to dental prevention and treatment.[9] Children eligible for Medicaid services experience twice the ratio of untreated dental disease as more affluent children.[10] 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.[11] Obtaining services from dental specialists is especially difficult for children covered through public health insurance programs.[12] Children with disabilities or special health care needs may also have problems accessing providers who are equipped to address their special needs.[13]

Access to Dental Care

◆ Twenty-three percent (23%) of all children between the ages of 2-17 in the U.S. had untreated dental caries in 1999-2000. Among very young children (ages 2-5), 45% of children living in families below 100% of the federal poverty threshold had untreated dental caries, compared with 17% of those whose families were at 100-199% of the poverty threshold.[14]

◆ 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.[15]

◆ Forty-three percent (43%) of children who were enrolled in RIte Care, RIte Share or Medicaid fee-for-service on September 30, 2004 received any dental service during federal fiscal year 2004.[16]

Reimbursement Rates

◆ The Rhode Island Department of Human Services spent $9.5 million in state and federal funds on dental services for children and adolescents under age 21 enrolled in Medical Assistance programs (RIte Care and Medicaid fee-for-service) in state fiscal year 2003. This is less than 0.63% of the total state Medicaid expenditures for that year.[17]

◆ 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. State efforts to attract more dentists to Medicaid by paying higher fees and streamlining administrative requirements can result in increased access to dental care services.[18]

◆ Rhode Island's Medicaid dental reimbursement rates were last increased in 1992. When comparing Rhode Island's 2004 Medicaid reimbursement rates and average fees charged by dentists in the state, 14 out of 15 rank below the 1st percentile. This means that fewer than 1% of dentists in Rhode Island would consider the Medicaid rate to be equal to or greater than their current charge.[19]

Early Detection and Prevention of Dental Disease

◆ Nearly one half of children in the U.S. do not receive dental care in accordance with the American Academy of Pediatric Dentistry's recommendations of two visits per year beginning at age one. The youngest children are the least likely to receive dental care.[20]

◆ Although figures for Rhode Island are not available, a study of young children enrolled in Medicaid in North Carolina found that those who see a dentist by age one are more likely to have subsequent preventive visits than children who had their first preventive visit at age two or three. Those children who had their first visit later were more likely to have subsequent preventive, restorative and emergency visits, which are more costly.[21]

◆ The Healthy People 2010 target is for 50% of children to have dental sealants, which are plastic coatings applied to the chewing surfaces of back teeth to prevent decay.[22] In 2001, 42% of children between 6 and 17 years of age in Rhode Island had at least one dental sealant. Thirty percent of children enrolled in RIte Care had sealants, compared with 46% of those with private insurance.[23]

Emergency Room Care and Hospitalizations for Untreated Dental Disease

◆ In Rhode Island, an average of 541 children under age 21 were treated each year for a dental related condition in Lifespan Emergency Departments (Rhode Island Hospital, Hasbro Children's Hospital, The Miriam Hospital, and Newport Hospital) during fiscal years 2001, 2002 and 2003.[24]

◆ Between 1998 and 2004 in Rhode Island, an average of 46 children under 18 years of age were hospitalized each year with a diagnosis that included an oral health condition. For an average of 13 of those children, an oral health condition was the main reason for the hospitalization.[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 suffers significant functional impairments at home, at school and with peers as a result of his or her 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 parents with mental health or substance abuse disorders; 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 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]

Hospitals

◆ Butler Hospital provides a wide range of psychiatric services for children and adolescents. In 2004, Butler Hospital treated 853 children age 18 and under; of these, 692 were admitted to the hospital and the remaining 161 were in partial hospital or outpatient programs. Youth between the ages of 13 and 18 accounted for 80% of services provided.[14]

◆ Rhode Island Hospital provided 6,546 child psychiatry outpatient visits in 2004. This was down from 9,786 in 2003 due to a decrease in the number of psychiatrists on staff.[15]

◆ Bradley Hospital, Rhode Island's largest psychiatric center for children, had 892 child and adolescent admissions and 75 Developmental Disabilities Program admissions in 2004. An average of 190 students per day were served at Bradley's three schools for children with mental illness and developmental disabilities in 2004.[16]

Children Under 18 Served at Bradley Hospital, 2004

	General Psychiatric Services	Developmental Disabilities Program
Inpatient	659	53
Residential	67	18
Partial Hospitalization	288	12
Home Based	0	60
Outpatient	1,229	231

Source: Lifespan, 2005. Data contain duplicated counts.

Rhode Island's Community Mental Health Centers

◆ The eight Community Mental Health Centers (CMHCs) in Rhode Island are the primary source of public mental health treatment services available in the state. During 2004, 7,533 children were treated at mental health centers and 3,424 children were receiving services as of December 31, 2004.[17]

◆ Of the children who received services through mental health centers in 2004, 21% presented with a primary diagnosis of attention deficit disorder, 19% with depressive disorders, 15% with conduct disorder and 10% with anxiety disorders. Forty-eight percent had diagnoses of serious mental illness.[18]

Children's Intensive Services

◆ Children and youth at the highest risk for out-of-home placement can remain at home in their community while receiving intensive, home-based psychotherapeutic and case management services offered by the Children's Intensive Services (CIS) program at the Rhode Island Department of Children, Youth and Families (DCYF). DCYF authorizes care at one of four levels of varying intensity and service duration based on the acuity and needs of the child and family.[19]

◆ Of the 1,244 children who were served by CIS during July, August and September 2004, 54% were between the ages of 12-18, 35% were ages 5-11, and 10% were ages 3-5. Over 60% had a behavior diagnosis (including attention deficit disorder, post traumatic stress disorder and conduct disorder); 30% had a mood disorder; and 20% had an adjustment disorder. (Children may have more than one disorder so the total percentage is greater than 100%.) Forty-nine children (12% of new admissions) received CIS services after an inpatient psychiatric hospitalization. Approximately 30% of the children were in the care of DCYF.[20]

Home-Based Therapeutic Services

◆ The Home-Based Therapeutic Services (HBTS) Program run by the Rhode Island Department of Human Services provides intensive home and community services to children up to age 21 with severe behavioral health, developmental or physical disabilities. These services are provided by trained paraprofessionals following a prescribed treatment plan and under the supervision of licensed clinicians.[21]

◆ As of December 31, 2004, there were 412 children receiving HBTS services. Ten percent were under the age of five, 33% were between five and nine years of age, 39% were between 10 and 14, and 18% were between 15 and 21.[22]

◆ There were 280 children on waiting lists for the HBTS program as of December 31, 2004.[23]

Access to Mental Health Services

◆ There are waiting lists for many mental health services for children and families throughout Rhode Island. As of December 2004, the wait time for general outpatient services at Bradley Hospital was 8-12 weeks, the wait for residential services was 3-4 months, and the Developmental Disabilities Program's Medication Management Clinic had been closed to outside referrals for over one year.[24]

◆ In 2004, approximately 356 children between the ages of 4 and 17 with a psychiatric diagnosis were "boarded" in emergency departments and/or medical floors at hospitals throughout Rhode Island due to the unavailability of an inpatient child psychiatric beds in the state.[25] While awaiting placement, children who are "boarded" must wait for appropriate treatment and may require constant monitoring by staff so that they do not injure themselves or others.

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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 (when the child is eligible due to special health care needs) in 2004.

SIGNIFICANCE

As many as 18% of children nationwide have a chronic physical, developmental, behavioral or emotional condition that requires 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 lives.[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]

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.[12]

◆ In 2004, the seven certified Early Intervention providers in Rhode Island served 2,870 children ages birth to three.[13]

◆ In 2004, 58% of children in Early Intervention programs had significant developmental delays, i.e. physical, cognitive, behavioral and/or emotional delays of unknown medical origin, 25% had a single established condition affecting development, such as cerebral palsy and 6% had multiple established conditions.[14]

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 2003-2004 school year, there were 32,925 public school children enrolled in special education, 21% of the public school student population. Forty-three percent of children in special education in Rhode Island have a learning disability.[15]

◆ Early Intervention programs are required to provide transition services for children who may be eligible for Special Education at age 3. In 2004, 594 (73%) of the 812 children who reached age 3 while in Early Intervention were referred to Special Education.[16] During the 2003-2004 school year, there were 2,963 children ages 3 to 5 who were not yet in kindergarten receiving Special Education services in Rhode Island public schools.[17]

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.[18] As of December 31, 2004, there were 5,382 Rhode Island children under the age of 21 receiving Medical Assistance benefits because of their enrollment in SSI.[19]

◆ In Rhode Island, the Katie Beckett eligibility provision provides Medical Assistance coverage to certain children who have serious disabling conditions, in order to enable them to be cared for at home instead of in an institution. As of December 31, 2004, there were 1,462 Rhode Island children under the age of 21 enrolled in Medical Assistance because of eligibility through the Katie Beckett provision.[20]

◆ It is estimated that 14% of Rhode Island children ages 0 to 17 have special health care needs. Twenty-three percent of all households in Rhode Island include a child with at least one special health care need. The prevalence increases with age: 8% of children under the age of 5, 16% of children ages 6 to 11 years, and 18% of children 12 to 17 have special health care needs.[21]

◆ A higher percentage of children in low-income families in Rhode Island have special health care needs compared to those in the U.S., with 17% of Rhode Island children in families with incomes less than 200% of the federal poverty threshold reporting special health care needs, compared with 14% nationally.[22]

Children in the Child Welfare System

United States

◆ Forty-seven percent of U.S. children ages 6 to 11 who are in foster care and 40% of those ages 12 to 14 have a clinical level of behavior and emotional problems. The rate of emotional and behavioral problems among children between the ages of 6 and 14 who live in foster care is approximately four times that of other children.[23]

◆ 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 rates of developmental delay found among children in the general population.[24]

◆ Twenty-four percent of U.S. children under age 15 who live in foster care have chronic health problems, including 30% of those under age 6. Nearly one third (30%) under the age of 15 have a disability.[25]

Rhode Island

◆ 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, 2004, 2,554 children were receiving Medical Assistance because of special needs adoptions. In addition, 2,284 children in foster care were enrolled in Medical Assistance due to their foster care status.[26]

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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]

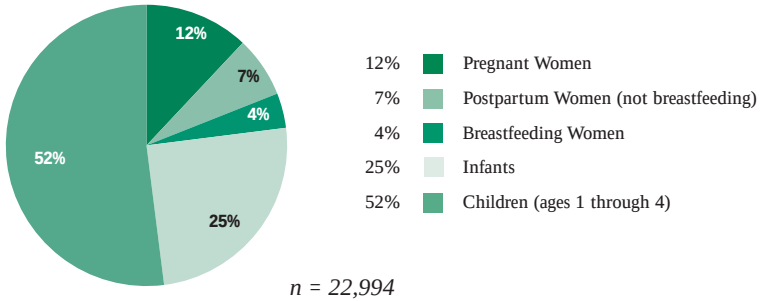
WIC is not an entitlement program and is not funded at a level that is sufficient to serve all eligible women, infants and children.[4] Rhode Island received $14.3 million dollars in federal funding during fiscal year 2004 and served an average of 22,994 people per month.[5,6]

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 coupon vouchers.[7,8] Through the WIC program participants also receive education on the value of proper nutrition, healthy eating practices and positive food related behaviors, as well as receive referrals to health care and social services.[9,10] WIC promotes breastfeeding as the optimal method of infant feeding and program eligibility for breastfeeding mothers is extended for up to one year.[11] In Rhode Island, the percentage of WIC infants who were breastfed in 2004 was 16%.[12]

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 2004, 17 farmer's markets authorized by WIC provided fresh produce to 21,116 recipients.[13]

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.[14]

Women, Infants and Children Served by WIC, Rhode Island, 2004



n = 22,994

Source: Rhode Island Department of Health, Division of Family Health, WIC Program, 2004. Data represent the monthly average for fiscal year 2004.

◆ In August 2004, pregnant women accounted for 12% of the population being served by WIC. Infants (25%) and children ages one through four (52%) comprised the majority of the population being served.[15]

◆ During fiscal year 2004, 42% percent of WIC participants were White, 35% were Hispanic and 11% were Black.[16]

Access to WIC in Rhode Island

◆ Four of the six core cities with the highest child poverty rates – Central Falls, Pawtucket, Providence and Woonsocket – have WIC participation rates that exceed the statewide average participation rate of 63%.[17]

◆ In fiscal year 2004, Rhode Island was selected as one of eight states to receive an Electronic Benefit Transfer (EBT) grant award. This grant will allow the current process of issuing benefit checks to participants to be changed to issuing benefits onto a debit card. WIC clients will be able to shop without the stigma of handling WIC checks and the likelihood of theft or fraud will be reduced. The two pilot sites in Rhode Island are located in Newport and Middletown.[18,19,20]

Table 13. **Women, Infants and Children Receiving WIC, Rhode Island, August 2004**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	87	33	38%
Bristol	291	158	54%
Burrillville	306	203	66%
Central Falls	2,104	1,567	74%
Charlestown	145	62	43%
Coventry	607	323	53%
Cranston	1,772	1,002	57%
Cumberland	435	240	55%
East Greenwich	101	35	35%
East Providence	1,217	803	66%
Exeter	93	36	39%
Foster	37	26	70%
Glocester	89	28	31%
Hopkinton	129	84	65%
Jamestown	41	14	34%
Johnston	550	308	56%
Lincoln	285	160	56%
Little Compton	29	9	31%
Middletown	255	214	84%
Narragansett	166	59	36%
New Shoreham	7	1	14%
Newport	910	513	56%
North Kingstown	436	216	50%
North Providence	583	321	55%
North Smithfield	107	42	39%
Pawtucket	4,006	2,736	68%
Portsmouth	190	90	47%
Providence	13,689	8,980	66%
Richmond	115	65	57%
Scituate	150	69	46%
Smithfield	144	92	64%
South Kingstown	394	189	48%
Tiverton	219	133	61%
Warren	229	114	50%
Warwick	1,579	892	56%
West Greenwich	52	17	33%
West Warwick	1,004	588	59%
Westerly	510	303	59%
Woonsocket	2,386	1,640	69%
Unknown Residence	*NA*	*10*	*NA*
Core Cities	*24,099*	*16,024*	*66%*
Remainder of State	*11,350*	*6,341*	*56%*
Rhode Island	*35,449*	*22,375*	*63%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, WIC Program, August 2004.

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 poverty according to the 2000 Census of Population as estimated by the United States Department of Agriculture.

Note: The "estimated number eligible" is now based on data from Census 2000. Factbooks prior to 2005 were based on the 1990 Census estimates.

Race and ethnicity data are for all active cases as of August 2004. As such, percentages include some cases for which services were not provided during August 2004, but were provided during the previous two months.

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Breastfeeding

DEFINITION

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

SIGNIFICANCE

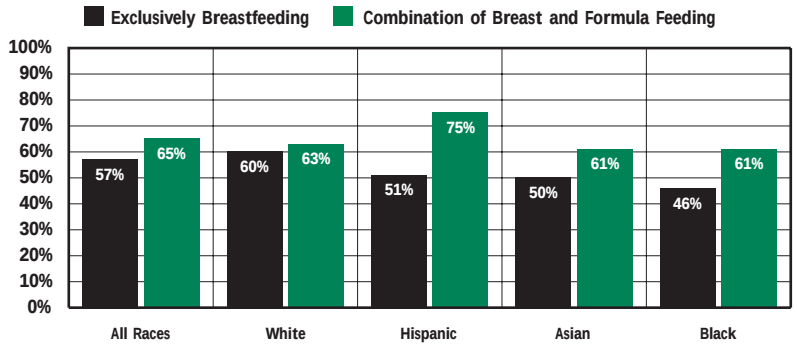
The American Academy of Pediatrics (AAP) identifies breastfeeding as the ideal method of feeding and nurturing infants and recognizes breastfeeding as a critical component in achieving optimal infant and child health, growth and development. The AAP recommends exclusive breastfeeding for approximately 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 in children; 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]

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 and exclusive breastfeeding and provide ongoing lactation consultation, timely postpartum follow-up care and home health visits, and links to lactation support networks and resources.[8]

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.[9]

Breastfeeding Rates by Race and Ethnicity, Rhode Island, 1999-2003



Source: Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program, 1999-2003.

◆ Race is a strong predictor of breastfeeding even after controlling for socio-economic background.[10] In Rhode Island, the exclusive breastfeeding rates for Asian, Black and Hispanic infants are lower than the rates for White infants and the average for all races.[11]

◆ Racial disparities that appear in exclusive breastfeeding rates do not appear in a comparison across races for the percentage of mothers using a combination of formula and breast feeding. While the consensus of the scientific community remains that exclusive breastfeeding for the first six months is best for the majority of infants, several of the same positive health outcomes are associated with partial breastfeeding but to a lesser extent.[12,13]

◆ Between 1999-2003, over half (57%) of all women who gave birth in Rhode Island chose to exclusively breastfeed their children, rather than formula feed (32%).[14]

Table 14.

Breastfeeding Rates, Rhode Island, 1999-2003

CITY/TOWN	NUMBER OF BIRTHS SCREENED	NUMBER EXCLUSIVELY BREASTFEEDING	PERCENT EXCLUSIVELY BREASTFEEDING	NUMBER BREAST AND FORMULA FEEDING	PERCENT WITH ANY BREASTFEEDING
Barrington	813	670	82%	688	85%
Bristol	995	596	60%	620	62%
Burrillville	761	422	55%	449	59%
Central Falls	1,788	888	50%	1,190	67%
Charlestown	491	349	71%	356	73%
Coventry	1,928	1,134	59%	1,164	60%
Cranston	3,859	2,107	55%	2,318	60%
Cumberland	1,627	1,102	68%	1,160	71%
East Greenwich	743	550	74%	571	77%
East Providence	2,414	1,337	55%	1,429	59%
Exeter	320	217	68%	221	69%
Foster	217	162	75%	166	76%
Glocester	339	216	64%	222	65%
Hopkinton	614	414	67%	439	71%
Jamestown	198	171	86%	177	89%
Johnston	1,432	734	51%	797	56%
Lincoln	861	562	65%	592	69%
Little Compton	112	95	85%	98	88%
Middletown	1,044	785	75%	810	78%
Narragansett	541	390	72%	402	74%
New Shoreham	51	46	90%	46	90%
Newport	1,578	1,073	68%	1,115	71%
North Kingstown	1,585	1,154	73%	1,188	75%
North Providence	2,194	1,085	49%	1,249	57%
North Smithfield	468	310	66%	320	68%
Pawtucket	4,980	2,612	52%	3,145	63%
Portsmouth	789	595	75%	613	78%
Providence	13,926	6,963	50%	9,362	67%
Richmond	243	159	65%	167	69%
Scituate	551	389	71%	400	73%
Smithfield	704	465	66%	481	68%
South Kingstown	1,414	1,053	74%	1,080	76%
Tiverton	360	241	67%	253	70%
Warren	525	308	59%	326	62%
Warwick	4,161	2,421	58%	2,520	61%
West Greenwich	301	213	71%	218	72%
West Warwick	2,015	1,039	52%	1,109	55%
Westerly	1,116	745	67%	776	70%
Woonsocket	2,830	1,227	43%	1,400	49%
Unknown	*550*	*77*	*14%*	*96*	*17%*
Core Cities	*27,117*	*13,802*	*51%*	*17,321*	*64%*
Remainder of State	*33,771*	*21,197*	*63%*	*22,316*	*66%*
Rhode Island	*61,438*	*35,076*	*57%*	*39,733*	*65%*

Sources of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program Database and Maternal and Child Health Database, 1999-2003. Data reflect intended feeding method at hospital discharge. Births to Rhode Island women that occurred outside Rhode Island and births that did not occur in the hospital are not included.

References for Indicator

[1,7] Breastfeeding and the use of human milk. *Pediatrics,* 100(6), 1035-1039.

[2,3,9] Office of Disease Prevention and Health Promotion. *Healthy people 2010, conference edition, Vol. 2.* (2000). Washington, DC: U.S. Department of Health and Human Services.

[4] *A woman's guide to breastfeeding.* (n.d.) Retrieved December 2004 from the American Academy of Pediatrics at www.aap.org.

[5] Wright, N. (2000). State and regional partnerships improve breastfeeding promotion and support. *Breastfeeding: Best for baby and mother,* 2(1), 1-3.

[6,8] Office on Women's Health. *HHS blueprint for action on breastfeeding.* (2000). Washington, DC: U.S. Department of Health and Human Services.

[10] Forste, R., Weiss, J. & Lippincott, E. (2001). The decision to breastfeed in the United States: Does race matter? *Pediatrics,* 108(2), 291-296.

[11,12,14] Rhode Island Department of Health, Division of Family Health, Newborn Developmental Risk Screening Program and Maternal and Child Health Database, 1999-2003.

[13] American Dietetic Association. (2001). Position of the American Dietetic Association: Breaking the barriers to breastfeeding. *Journal of the American Dietetic Association,* 101(10), 1213-1220.

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]

In Rhode Island between 1999 and 2003, 8.9% of Rhode Island women received delayed prenatal care. The rate for women in the core cities (12.4%) was more than twice that for women in the remainder of the state (6.1%).[5]

Late or No Prenatal Care

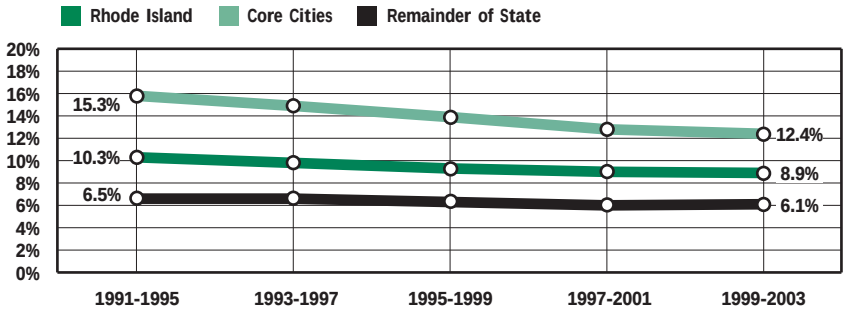
	1990	2002
RI	2.0%	1.5%
US	6.1%	3.6%
National Rank*		*2nd*
New England Rank**		*2nd*

**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: City and state trends.* (2005). Baltimore, MD: The Annie E. Casey Foundation.

Delayed Prenatal Care,
Rhode Island, Core Cities and the Remainder of the State, 1991-2003



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-2003. Data for 2002-2003 are provisional.

◆ Over the past decade, the rate of delayed prenatal care decreased across Rhode Island. However, women in the core cities remain twice as likely to receive delayed prenatal care as women in the remainder of the state.[6]

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 system's barriers resulted in the improvement of adequate prenatal care utilization by women in the program.[7]

◆ Between 1993 and 2002, the percentage of women using Medicaid who began prenatal care in the first trimester increased from 77% to 82%.[8]

◆ 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 2002, the percentage of women receiving high-quality care increased from 56% to 72%.[9]

Table 15.

Delayed Prenatal Care, Rhode Island, 1999-2003

City/Town	# Births	# Delayed Care	% Delayed Care
Barrington	839	20	2.4%
Bristol	1,034	76	7.4%
Burrillville	803	56	7.0%
Central Falls	1,862	304	16.3%
Charlestown	459	40	NA
Coventry	2,003	100	5.0%
Cranston	4,305	229	5.3%
Cumberland	1,763	100	5.7%
East Greenwich	569	21	3.7%
East Providence	2,478	176	7.1%
Exeter	343	22	NA
Foster	196	8	NA
Glocester	429	31	NA
Hopkinton	453	50	NA
Jamestown	206	10	NA
Johnston	1,470	67	4.6%
Lincoln	988	57	5.8%
Little Compton	170	16	NA
Middletown	1,075	67	6.2%
Narragansett	631	32	5.1%
New Shoreham	54	11	NA
Newport	1,576	203	12.9%
North Kingstown	1,503	75	5.0%
North Providence	1,614	97	6.0%
North Smithfield	521	28	5.4%
Pawtucket	5,219	675	12.9%
Portsmouth	869	43	4.9%
Providence	14,306	1,615	11.3%
Richmond	500	29	5.8%
Scituate	472	21	NA
Smithfield	769	26	3.4%
South Kingstown	1,293	78	6.0%
Tiverton	655	60	9.2%
Warren	559	42	7.5%
Warwick	4,416	222	5.0%
West Greenwich	305	10	NA
West Warwick	2,035	154	7.6%
Westerly	1,308	205	15.7%
Woonsocket	3,092	530	17.1%
Unknown	*15*	*1*	*NA*
Core Cities	*28,090*	*3,481*	*12.4%*
Remainder of State	*35,052*	*2,125*	*6.1%*
Rhode Island	*63,157*	*5,607*	*8.9%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1999-2003. Data for 2002-2003 are provisional.

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

NA: Percentages were not calculated for cities and towns with fewer 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 1999-2003.

References for Indicator

[1] Office of the Assistant Secretary for Planning and Evaluation. (2004). *Trends in the well-being of America's children and youth 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. (2001). The prenatal visit. *Pediatrics,* 107(6), 1456-1458.

[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.

[5,6] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-2003.

[7] Silow-Carroll, S. (2003). *Building quality into RIte Care: How Rhode Island is improving health care for its low-income populations.* Washington, DC: The Commonwealth Fund.

[8,9] Griffin, J. (2004). *The impact of RIte Care on adequacy of prenatal care and the health of newborns: Ten year profiles and trends of births by insurance status, 1993-2002.* Cranston, RI: Rhode Island Medicaid Research and Evaluation Project.

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 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 1999 and 2003, the percentage of low birthweight among Black infants (12%) was nearly double the percentage among White infants (7%) and was higher than all other racial/ethnic groups.[11]

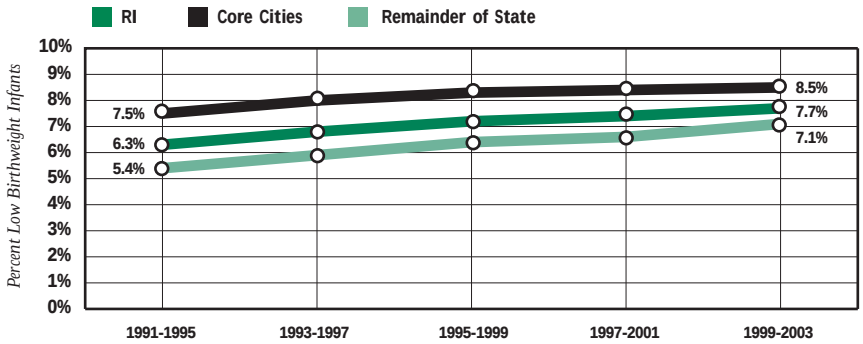
Low Birthweight Infants

	1990	2002
RI	6.2%	7.9%
US	7.0%	7.8%
National Rank*		*24th*
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.* (2005). Baltimore, MD: The Annie E. Casey Foundation.

Low Birthweight Infants, Rhode Island, Core Cities and the Remainder of the State, 1991-2003



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-2003. Data for 2002-2003 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 babies 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 1999 through 2003, 6% of singletons were born low birthweight, compared to 53% of twin births and 95% 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, 1999-2003**

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	839	33	3.9%
Bristol	1,034	72	7.0%
Burrillville	803	71	8.8%
Central Falls	1,862	142	7.6%
Charlestown	459	24	NA
Coventry	2,003	168	8.4%
Cranston	4,305	286	6.6%
Cumberland	1,763	148	8.4%
East Greenwich	569	32	5.6%
East Providence	2,478	176	7.1%
Exeter	343	18	NA
Foster	196	23	NA
Glocester	429	22	NA
Hopkinton	453	38	NA
Jamestown	206	10	NA
Johnston	1,470	132	9.0%
Lincoln	988	65	6.6%
Little Compton	170	21	NA
Middletown	1,075	60	5.6%
Narragansett	631	47	7.4%
New Shoreham	54	2	NA
Newport	1,576	92	5.8%
North Kingstown	1,503	86	5.7%
North Providence	1,614	131	8.1%
North Smithfield	521	40	7.7%
Pawtucket	5,219	433	8.3%
Portsmouth	869	54	6.2%
Providence	14,306	1,311	9.2%
Richmond	500	30	6.0%
Scituate	472	33	NA
Smithfield	769	53	6.9%
South Kingstown	1,293	73	5.6%
Tiverton	655	37	5.6%
Warren	559	52	9.3%
Warwick	4,416	352	8.0%
West Greenwich	305	13	NA
West Warwick	2,035	143	7.0%
Westerly	1,308	75	5.7%
Woonsocket	3,092	258	8.3%
Unknown	*15*	*6*	*NA*
Core Cities	*28,090*	*2,379*	*8.5%*
Remainder of State	*35,052*	*2,477*	*7.1%*
Rhode Island	*63,157*	*4,862*	*7.7%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1999-2003. Data for 2002-2003 are provisional.

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

NA: Percentages were not calculated for cities and towns with fewer 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 1999-2003.

References for Indicator

[1,6] *KIDS COUNT data book: State profiles of child well-being 2004.* (2004). 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] Federal Interagency Forum on Child and Family Statistics. (2003). *America's children: Key national indicators of well-being, 2003.* Washington, DC: U.S. Government Printing Office.

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

[7] Fewell, R. & Deutscher, B. (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, 1991-2003. Data for 2002-2003 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]

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.[3,4]

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.[5]

During the past decade, the proportion of infant deaths in Rhode Island attributed to maternal health increased from 50% to 63%.[6] Maternal health includes preconceptional health, perinatal care and health behaviors.

Infant mortality has two components: neonatal mortality or deaths of infants younger than 28 days and postneonatal mortality or deaths between 28 days and one year old.[7] From 1999 to 2003, 413 infants died before their first birthday in Rhode Island. Of these, 313 (76%) were neonatal deaths and 100 (24%) were postneonatal deaths.[8] The overall infant mortality rate for Rhode Island for 1999-2003 was 6.5 deaths per 1,000 births.[9]

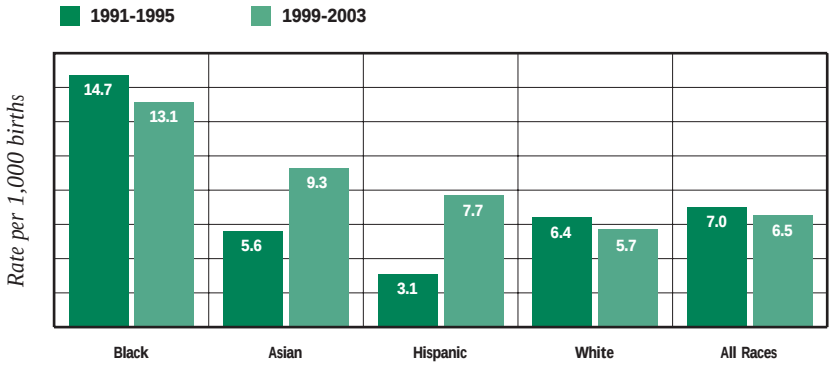
Infant Mortality Rate
(rate per 1,000 live births)

	1996	2001
RI	5.2	6.8
US	7.3	6.8
National Rank*		*23rd*
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 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

Infant Mortality Rates by Race/Ethnicity, Rhode Island, 1991-1995 and 1999-2003



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-2003. Data for 2002-2003 are provisional.

◆ Over the past decade, Rhode Island's infant mortality rate declined for White and Black infants, but increased for Asian and Hispanic infants. However, the Black infant mortality rate, 13.1 deaths per 1,000 births, is more than twice the rate for White infants (5.7) and higher than that of any other racial or ethnic group.[10]

◆ 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 birthweight infant.[11]

◆ The overall decrease in Rhode Island's infant mortality rate over the past decade 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.[12]

Table 17. **Number of Infant Deaths, Rhode Island, 1999-2003**

CITY/TOWN	# BIRTHS	# INFANT DEATHS	RATE/1000 BIRTHS
Barrington	839	1	1.2
Bristol	1,034	7	6.8
Burrillville	803	1	1.2
Central Falls	1,862	12	6.4
Charlestown	459	2	NA
Coventry	2,003	10	5.0
Cranston	4,305	19	4.4
Cumberland	1,763	13	7.4
East Greenwich	569	2	3.5
East Providence	2,478	14	5.6
Exeter	343	0	NA
Foster	196	5	NA
Glocester	429	5	NA
Hopkinton	453	3	NA
Jamestown	206	1	NA
Johnston	1,470	9	6.1
Lincoln	988	11	11.1
Little Compton	170	2	NA
Middletown	1,075	3	2.8
Narragansett	631	5	7.9
New Shoreham	54	0	NA
Newport	1,576	8	5.1
North Kingstown	1,503	7	4.7
North Providence	1,614	9	5.6
North Smithfield	521	1	1.9
Pawtucket	5,219	42	8.0
Portsmouth	869	5	5.8
Providence	14,306	135	9.4
Richmond	500	0	0.0
Scituate	472	1	NA
Smithfield	769	2	2.6
South Kingstown	1,293	2	1.5
Tiverton	655	3	4.6
Warren	559	4	7.2
Warwick	4,416	19	4.3
West Greenwich	305	1	NA
West Warwick	2,035	15	7.4
Westerly	1,308	10	7.6
Woonsocket	3,092	24	7.8
Unknown	*15*	*0*	*NA*
Core Cities	*28,090*	*236*	*8.4*
Remainder of State	*35,052*	*177*	*5.1*
Rhode Island	*63,157*	*413*	*6.5*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1999- 2003. Data for 2002-2003 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 1999-2003.

References for Indicator

[1] Federal Interagency Forum on Child and Family Statistics. (2003). *America's children: Key national indicators of well-being 2003.* Washington, DC: U.S. Government Printing Office.

[2] *KIDS COUNT data book: State profiles in child well-being 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

[3] U.S. Department of Health and Human Services. (2002). *HHS fact sheet: Preventing infant mortality.* Washington, DC: U.S. Department of Health and Human Services.

[4] Matthews, T., Menacker, F., MacDorman, M. (2003). Infant mortality statistics from the 2001 period linked birth/infant death data set. *National vital statistics reports,* 52(2).

[5] *Perinatal profiles: statistics for monitoring maternal and infant health.* (2003). Washington, DC: March of Dimes.

[6] Viner-Brown, S. Kini, H. & Hollinshead, W. (2003). Infant mortality in Rhode Island: A time trend analysis. *Medicine & health Rhode Island,* 86(1), 24-26.

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

[8,9,10] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1991-2003. Data for 2002-2003 are provisional.

[11] Shore, R. (2002). *KIDS COUNT indicator brief: Preventing low birthweight.* Baltimore, MD: The Annie E. Casey Foundation.

[12] Center for Child and Family Health. (2002). *RI Medicaid research and evaluation reports, issue brief #3: Rhode Island's infant mortality rate drops significantly in 1990s.* Cranston, RI: Rhode Island Department of Human Services.

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, 2004.[1] These data are for children eligible to enter kindergarten in the Fall of 2006 (i.e. born between September 1, 2000 and August 31, 2001).

SIGNIFICANCE

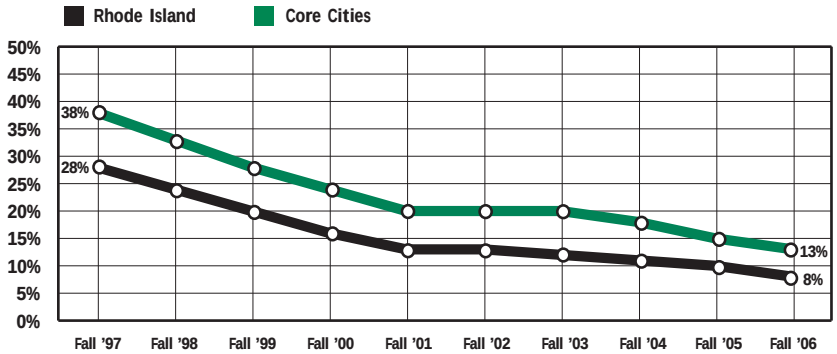
Childhood lead poisoning is one of the most common pediatric health problems, yet it is entirely preventable.[2] Infants, toddlers and preschool age children are most susceptible to the toxic effects of lead and absorb lead more readily than adults.[3] Lead exposure can cause irreversible damage including loss of intelligence, learning disabilities and behavioral problems including aggression. The most acute poisoning can result in severe illness and death.[4,5,6] 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.[7,8]

Children living in homes built before 1978 (when lead paint was banned from interior use in the U.S.) are at risk for lead poisoning.[9] Low-income and minority children are particularly likely to be affected.[10] Children in older homes undergoing renovation are also at risk.[11] 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.[12] Inadequate nutrition, which is more common in low-income children, further increases susceptibility to lead poisoning.[13]

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.[14,15,16] 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.[17]

Rhode Island children have higher lead poisoning rates than children in the rest of the country. Between 1999 and 2000, the most recent time period for which national data is available, the national rate of lead poisoning for children under age 6 was 2.2%, compared to 9.8% for Rhode Island.[18,19] The Rhode Island rate has since decreased for children under age 6 to 5.1% in 2004.[20]

Children Entering Kindergarten with History of Lead Poisoning, Rhode Island and Core Cities, 1997- 2006



Source: Rhode Island Department of Health, Division of Family Health and Division of Environmental Health, Childhood Lead Poisoning Prevention Program, 1996-2004.

◆ Despite declines in lead poisoning rates, kindergarten children living in core cities are nearly three times as likely to have a history of elevated blood lead levels (13%) as those in the remainder of the state (5%).[21] Of the 7 children hospitalized for severe lead poisoning during 2004, 5 resided in Providence, 1 in West Warwick and 1 in Cumberland.[22]

◆ In Rhode Island, when a child is significantly lead poisoned, an inspection of the child's home is offered.[23] 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 2004, 168 inspections were offered; of these 119 were performed.[24]

◆ 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 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.[25]

Table 18.

Lead Poisoning in Children Entering Kindergarten in the Fall of 2006

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	# SCREENED POSITIVE >=10 UG/DL	% CHILDREN >=10 UG/DL
Barrington	211	10	4.7%
Bristol	224	20	8.9%
Burrillville	192	17	8.9%
Central Falls	464	80	17.2%
Charlestown	124	7	5.6%
Coventry	444	20	4.5%
Cranston	947	54	5.7%
Cumberland	419	11	2.6%
East Greenwich	185	6	3.2%
East Providence	552	35	6.3%
Exeter	63	1	1.6%
Foster	57	2	3.5%
Glocester	70	5	7.1%
Hopkinton	115	5	4.3%
Jamestown	43	2	4.7%
Johnston	331	14	4.2%
Lincoln	258	6	2.3%
Little Compton	39	2	5.1%
Middletown	213	8	3.8%
Narragansett	147	7	4.8%
New Shoreham	11	2	18.2%
Newport	345	45	13.0%
North Kingstown	395	13	3.3%
North Providence	318	8	2.5%
North Smithfield	109	0	0.0%
Pawtucket	1,167	116	9.9%
Portsmouth	197	6	3.0%
Providence	3,223	503	15.6%
Richmond	92	9	9.8%
Scituate	138	2	1.4%
Smithfield	198	3	1.5%
South Kingstown	351	20	5.7%
Tiverton	167	14	8.4%
Warren	128	11	8.6%
Warwick	932	35	3.8%
West Greenwich	73	1	1.4%
West Warwick	457	26	5.7%
Westerly	279	16	5.7%
Woonsocket	753	74	9.8%
Unknown Residence	*104*	*2*	*1.9%*
Core Cities	*6,409*	*844*	*13.2%*
Remainder of State	*8,022*	*372*	*4.6%*
Rhode Island	*14,535*	*1,218*	*8.4%*

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 2006 reflect the number of Rhode Island children eligible to enter school in the Fall of 2006 (i.e. born between 9/1/00 and 8/31/01) who screened positive for lead poisoning at any time in their lives prior to the end of December 2004. Data are based on the highest lead test result through December 2004. Data include both venous and capillary tests. The denominator is the number of children entering school in the Fall of 2006 who were screened for lead poisoning.

References for Indicator

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[23] 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.

[25] Lead Hazard Mitigation Act, Rhode Island General Laws 42-128.1.

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 2002, 9 million children under age 18 (12%) had previously been diagnosed with asthma and 4 million children (6%) had an asthma attack in the past year.[5]

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.[6] 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.[7,8]

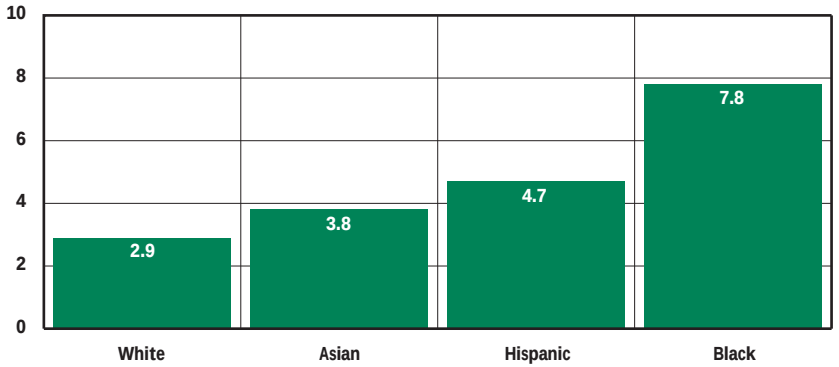
Proper asthma management requires a long-term, multifaceted approach, including patient education, behavior modification, avoidance of asthma triggers, medication to minimize and prevent symptoms, and frequent medical follow-up.[9] Uninsured children are 72% more likely not to receive care for asthma than children who have health insurance.[10] 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.[11]

Childhood Asthma Hospitalization Rates, Core Cities and Rhode Island, 1999-2003

City/Town	Number of Children Hospitalized	Rate per 1,000 Children
Central Falls	155	5.6
Newport	89	3.4
Pawtucket	378	4.2
Providence	1,417	6.3
West Warwick	153	4.6
Woonsocket	239	4.3
Rhode Island	4,472	3.6

Source: Rhode Island Department of Health, Hospital Discharge Database, 1999-2003.

Asthma Hospitalizations by Race/Ethnicity, Per 1,000 Children Under Age 18, Rhode Island, 1999-2003



Source: Rhode Island Department of Health, Hospital Discharge Database, 1999-2003. Race/ethnicity was unknown for 142 children.

◆ In Rhode Island between 1999 and 2003, the rate of hospitalizations for Black children (7.8) was more than twice the rate for White children (2.9).[12]

◆ Nationally, although asthma is only slightly more prevalent in minority children than in White children, it accounts for three times the number of deaths.[13]

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. 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 1999-2003, over half (54%) 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, 1999-2003**

CITY/TOWN	ESTIMATED NUMBER OF CHILDREN UNDER 18	NUMBER OF ASTHMA HOSPITALIZATIONS	RATE/1000 CHILDREN
Barrington	23,725	41	1.7
Bristol	21,995	47	2.1
Burrillville	20,215	50	2.5
Central Falls	27,655	155	5.6
Charlestown	8,560	35	4.1
Coventry	41,945	114	2.7
Cranston	85,490	262	3.1
Cumberland	38,450	74	1.9
East Greenwich	17,820	35	2.0
East Providence	52,730	173	3.3
Exeter	7,945	12	1.5
Foster	5,525	15	2.7
Glocester	13,320	19	1.4
Hopkinton	10,055	21	2.1
Jamestown	6,190	7	1.1
Johnston	29,530	73	2.5
Lincoln	25,785	56	2.2
Little Compton	3,900	5	1.3
Middletown	21,640	74	3.4
Narragansett	14,165	28	2.0
New Shoreham	925	1	1.1
Newport	25,995	89	3.4
North Kingstown	34,240	83	2.4
North Providence	29,680	96	3.2
North Smithfield	11,895	20	1.7
Pawtucket	90,755	378	4.2
Portsmouth	21,645	50	2.3
Providence	226,385	1,417	6.3
Richmond	10,070	19	1.9
Scituate	13,175	28	2.1
Smithfield	20,095	39	1.9
South Kingstown	31,420	70	2.2
Tiverton	16,835	27	1.6
Warren	12,270	37	3.0
Warwick	93,900	284	3.0
West Greenwich	7,220	16	2.2
West Warwick	33,160	153	4.6
Westerly	27,030	81	3.0
Woonsocket	55,775	239	4.3
Unknown Residence	*NA*	*49*	*NA*
Core Cities	*459,725*	*2,431*	*5.3*
Remainder of State	*779,385*	*1,992*	*2.6*
Rhode Island	*1,239,110*	*4,472*	*3.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Hospital Discharge Database, 1999-2003.

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.

See Methodology page 143.

References for Indicator

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Overweight Children and Youth

DEFINITION

Overweight children and youth is the percentage of children ages 6-19 with weight above the 95th percentile for their height, age and gender. Children between the 85th and 95th percentiles are considered "at risk" for overweight.[1]

SIGNIFICANCE

Weight gain occurs when more calories are consumed than are expended.[2] 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.[3] Less than 10% of overweight in children is caused by genetic or hormonal problems.[4] Instead, most children become overweight through sedentary activity, especially television viewing, in combination with consumption of large portions of energy-dense foods.[5]

Overweight causes hypertension, heart disease, stroke, asthma, sleep apnea, type II diabetes and orthopedic problems.[6,7] Overweight children are susceptible to psychosocial problems that include depression, low self-esteem and negative self-image.[8] Overweight adolescents have a 70% chance of becoming overweight or obese adults.[9]

Overweight in children ages 6-19 quadrupled between the 1960s and 1999-2002, with most of the increase occurring during the last two decades.[10] In the U.S., 16% of children ages 6-19 were overweight during 1999-2002.[11] Another 15% were at risk for being overweight.[12] Among Rhode Island children ages 6-19, 20% were overweight in 2001.[13] In Rhode Island, 10% of high school students were overweight in 2003.[14]

Increases in overweight and obesity over the last four decades cut across all racial, ethnic and economic groups, but some groups are at higher risk.[15] The prevalence of overweight is highest in Hispanic, Black and Native American children.[16] Among adolescents, Mexican boys are one and a half times more likely and Black girls are twice as likely as their White counterparts to be overweight.[17] Non-Hispanic White adolescents from lower income families experience a greater prevalence of overweight than those from higher income families.[18]

Causes of Increased Overweight Among Children and Youth

◆ The increase in overweight children over the past four decades is the result of the complex interaction between numerous social and environmental factors that influence physical activity and eating, including:[19]

- Urban and suburban community designs that discourage physical activity, including walking.
- Frequent consumption of unhealthy convenience foods as a result of pressures on families to minimize food cost and preparation time.
- Reduced affordability and access to fruits, vegetables and other nutritious foods in some communities.
- Less physical activity at, after and to/from school.
- Leisure time spent on sedentary activities, including TV watching, computer use, and video games, rather than physical activities.

Nutrition and Physical Activity Among Public School Students, Rhode Island, 2003-2004

	ELEMENTARY	MIDDLE	HIGH
Ate 5 or more servings of vegetables*	12%	10%	7%
Played computer/video games at home for less than 2 hours**	74%	75%	80%
Watched TV at home for less than 2 hours**	53%	48%	53%
Attended after school/weekend intramural or interscholastic sports through school***	33%	34%	38%
Attended youth sports or recreation programs in the community***	53%	44%	22%

refers to the day prior ** refers to the average school day * refers to the past year*
Elementary School includes students in grades 4-6. Middle School includes students in grades 5-8. High School includes students in grades 9-12.

Source: Felner, R. (2004). *Rhode Island SALT Survey Reports, Student Reports of Health Care, Nutrition, Sleep, Computer Use, TV Viewing, and Extracurricular Activities by Grade Level.* Rockland, IL: National Center on Public Education and Policy.

Preventing Overweight in Children and Youth: A Multi-System Approach

The likelihood that overweight will persist into adulthood increases with the child's age and severity.[20] Reducing the number of Rhode Island children who are overweight will require a comprehensive, multi-system approach shared among families, communities, health care providers and schools.

Families

◆ Family involvement is critical to preventing and reducing overweight in children. Parents who encourage healthy eating and regular physical activity, provide and promote healthy food choices, limit television viewing and other recreation screen time to less than two hours a day, and discuss weight status with their child's health care provider can significantly improve their children's health.[21]

Health Care Providers

◆ Pediatricians and other health care providers play a key role in early detection and intervention with overweight children. Health care professionals should regularly track height and weight for age and offer relevant counseling and guidance.[22] Physician-supervised treatment plans should include a weight goal, attention to dietary management, an increase in physical activity and long-term follow up.[23]

Communities

◆ Local governments, public health agencies and community groups can expand opportunities for physical activities and design their communities to promote physical activities with recreational facilities, sidewalks and bike paths.[24] Communities can also foster the development of local farmers' markets, which increase access to fresh, nutritious foods.[25]

Schools

◆ Schools can get involved in preventing overweight by integrating behavior-focused nutrition education and high quality physical education into their curriculum, serving a variety of healthy foods in the school meal program and in additional food options, and increasing opportunities for physical activity with fitness programs, enhanced playgrounds and extracurricular activities.[26,27] Schools can also conduct assessments of students' weight, height and body mass index on an annual basis and communicate the findings to parents.[28]

Perceptions of Weight and Weight Loss Behaviors Among High School Students, Rhode Island, 2003

	ALL	MALE	FEMALE
Students who were overweight	10%	14%	6%
Students who described themselves as overweight	30%	26%	35%
Students who were trying to lose weight	44%	28%	61%
"To Lose or Keep from Gaining Weight":			
Students who ate less food, fewer calories, or low-fat foods*	40%	27%	54%
Students who went without eating for 24 hours or more*	11%	7%	15%
Students who took diet pills, powders, or liquids*	6%	5%	7%
Students who vomited or took laxatives*	4%	3%	5%

Source: Rhode Island Department of Health, Center for Health Information and Communication, Rhode Island Youth Risk Behavior Survey, 2003. **During the past 30 days*

◆ Although 10% of Rhode Island high school students were overweight in 2003, 30% considered themselves overweight and many attempted to lose weight by changing their eating and exercising behaviors.[29] These behaviors can threaten their growth and development. Many adolescents who do not meet the strict diagnostic criteria for eating disorders can have disordered eating patterns which have a significant adverse impact on their health.[30]

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(continued on page 145)

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.[3,4] Teen mothers 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]

Of all births to teens ages 15 to 17 in Rhode Island from 1999-2003, 74% occurred in the core cities. Between 1999 and 2003 in Rhode Island, 60% of pregnancies in girls ages 15 to 19 resulted in live births, 37% resulted in abortion, and 3% resulted in miscarriage.[11]

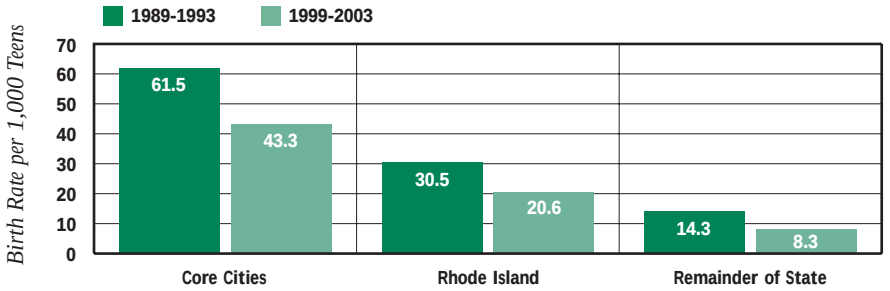
Teen Birth Rate
(births per 1,000 teens ages 15-17)

	1996	2001
RI	25	22
US	33	25
National Rank*		*26th*
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 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

Births to Teens Ages 15-17, Core Cities, Rhode Island and Remainder of State, 1989-1993 and 1999-2003



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1989-1993 and 1999-2003. Data for 2002-2003 are provisional.

◆ Over the past decade, teen birth rates for Rhode Island girls ages 15 to 17 declined in all geographic areas. The rate decreased by 32% for the state as a whole and the core cities compared to a 44% decrease in the remainder of the state. Despite the decreases, teen girls in the core cities become pregnant and give birth at five times the rate of girls of the same age in the remainder of the state.[12]

Repeat Births to Teens, Ages 12 to 19, Rhode Island, 1999-2003

Age	Total Number of Births	Number of Repeat Births	Percent
12-14	97	0	0%
15-17	2,028	185	9%
18-19	3,942	1,038	26%
Total	*6,067*	*1,223*	*20%*

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1999-2003. Data for 2002-2003 are provisional.

◆ Between 1999 and 2003 in Rhode Island, one in five teen births (20%) was to a teen who was already a mother. For girls ages 15-17, 9% of births were repeat births and for girls ages 18-19, more than one in four (26%) were repeat births.[13] Repeat births can further impede a teen mother's ability to finish school and keep a job.[14]

Table 20.

Births to Teens, Ages 15-17, Rhode Island, 1999-2003

CITY/TOWN	# OF TEEN GIRLS AGES 15-17	# OF BIRTHS TO TEENS AGES 15-17	1999-2003 RATE PER 1,000 TEENS
Barrington	2,130	2	0.9
Bristol	1,860	15	8.1
Burrillville	1,785	11	6.2
Central Falls	1,875	122	65.1
Charlestown	670	10	14.9
Coventry	3,210	43	13.4
Cranston	6,890	93	13.5
Cumberland	3,125	27	8.6
East Greenwich	1,415	5	3.5
East Providence	4,565	46	10.1
Exeter	725	7	9.7
Foster	445	1	NA
Glocester	1,145	5	4.4
Hopkinton	870	8	9.2
Jamestown	565	3	5.3
Johnston	2,295	22	9.6
Lincoln	2,190	11	5.0
Little Compton	295	0	NA
Middletown	1,370	6	4.4
Narragansett	1,265	4	3.2
New Shoreham	80	0	NA
Newport	1,990	54	27.1
North Kingstown	2,660	11	4.1
North Providence	2,470	32	13.0
North Smithfield	1,015	4	3.9
Pawtucket	6,820	217	31.8
Portsmouth	1,680	8	4.8
Providence	17,055	860	50.4
Richmond	815	6	7.4
Scituate	1,215	6	4.9
Smithfield	1,750	9	5.1
South Kingstown	2,750	22	8.0
Tiverton	1,345	10	7.4
Warren	1,000	4	4.0
Warwick	7,910	77	9.7
West Greenwich	540	2	3.7
West Warwick	2,455	47	19.1
Westerly	2,170	23	10.6
Woonsocket	4,240	195	46.0
Core Cities	*34,435*	*1,495*	*43.4*
Remainder of State	*64,215*	*533*	*8.3*
Rhode Island	*98,650*	*2,028*	*20.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1999-2003. Data for 2002–2003 are provisional.

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

NA: Rates were not calculated for cities and towns with fewer 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 Census 2000, multiplied by five to compute a rate over five years, 1999-2003.

References for Indicator

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Alcohol, Drug and Cigarette Use by Teens

DEFINITION

Alcohol, drug and cigarette use by teens is the percentage of middle school students and high school students who report having used alcohol, cigarettes or illegal drugs (such as marijuana, uppers, or downers) at least once in the 30 days prior to taking the School Accountability for Learning and Teaching (SALT) Student Survey during the 2003-2004 school year.

SIGNIFICANCE

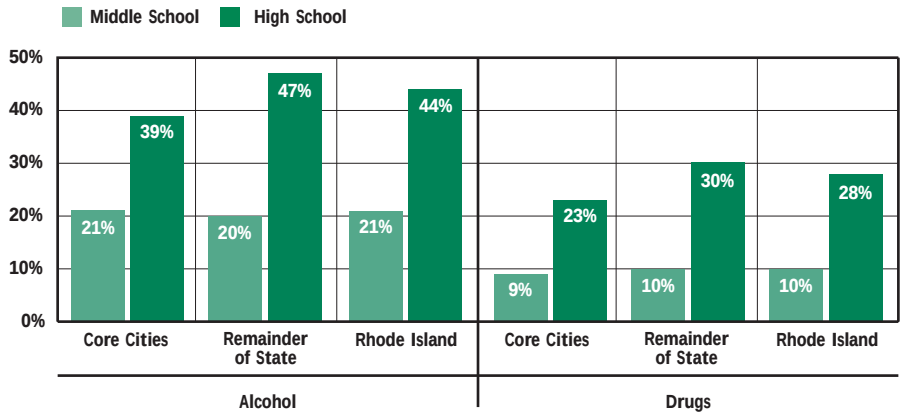
The use of substances threatens the health and safety of children, families and communities. For nearly a decade, the number of adolescents using tobacco and illegal drugs has been slowly decreasing both in Rhode Island and nationwide, while the age at first use has increased.[1,2,3,4] The age when young people first start using alcohol, tobacco and illicit drugs is a predictor of later alcohol and drug problems, especially if use begins before the age of 15.[5]

Research shows that the key risk periods for alcohol, cigarette and other drug 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.[6]

The risk for becoming a substance user 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.[7]

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 to prevent substance abuse as early as pre-school by addressing risk factors such as aggressive behavior, poor social skills, and academic difficulties.[8]

Reported Use of Alcohol and Drugs, Core Cities, Remainder of State and Rhode Island, 2003-2004 School Year



Source: Felner, R. (2004). *Rhode Island SALT Survey Reports, Student Reports of Health Risk Practices by Grade Level.* Rockland, IL: National Center on Public Education and Policy. Retrieved from Information Works at www.infoworks.ride.uri.edu. Data are for students who reported substance use in the past 30 days.

◆ Students in the core cities generally reported lower rates of alcohol and drug use than all students statewide at both the middle school and high school levels.

◆ Twenty-one percent of middle school students and 44% of high school students in Rhode Island reported using alcohol in the previous month.[9]

◆ One in ten (10%) middle school students and more than one in four (28%) high school students in Rhode Island reported using illegal drugs such as marijuana, uppers, or downers.[10]

Cigarette Use

◆ Students in the core cities generally reported lower rates of cigarette use than all students statewide. Nine percent of middle school students and 23% of high school students in Rhode Island reported using cigarettes in the previous month.[11]

Table 21.

Student Reports of Alcohol, Drug and Cigarette Use by Student Grade Level, Rhode Island, 2003-2004

SCHOOL DISTRICT	ALCOHOL USE		DRUG USE		CIGARETTE USE	
	MIDDLE SCHOOL	HIGH SCHOOL	MIDDLE SCHOOL	HIGH SCHOOL	MIDDLE SCHOOL	HIGH SCHOOL
Barrington	19%	50%	10%	31%	8%	26%
Bristol-Warren	23%	42%	8%	24%	10%	21%
Burrillville	27%	47%	13%	28%	14%	29%
Central Falls	21%	36%	9%	18%	8%	15%
Chariho	20%	51%	13%	37%	13%	29%
Coventry	14%	45%	7%	34%	8%	28%
Cranston	21%	45%	10%	25%	10%	21%
Cumberland	16%	45%	9%	29%	10%	22%
East Greenwich	10%	44%	3%	27%	3%	19%
East Providence	30%	52%	11%	37%	13%	31%
Exeter-West Greenwich	18%	40%	9%	28%	7%	22%
Foster-Glocester	31%	48%	19%	39%	16%	34%
Jamestown	27%	NA	15%	NA	11%	NA
Johnston	26%	47%	11%	29%	9%	23%
Lincoln	25%	41%	18%	27%	19%	21%
Little Compton	19%	NA	5%	NA	6%	NA
Middletown	16%	49%	4%	34%	5%	27%
Narragansett	12%	47%	7%	32%	7%	24%
New Shoreham	NA	50%	NA	33%	NA	16%
Newport	17%	45%	8%	35%	7%	29%
North Kingstown	20%	49%	11%	35%	12%	26%
North Providence	23%	45%	8%	28%	8%	22%
North Smithfield	16%	43%	12%	33%	13%	28%
Pawtucket	22%	38%	9%	23%	8%	19%
Portsmouth	13%	50%	7%	30%	6%	24%
Providence	22%	39%	10%	22%	8%	18%
Scituate	15%	42%	8%	24%	8%	25%
Smithfield	18%	46%	8%	26%	9%	26%
South Kingstown	15%	46%	7%	32%	6%	22%
Tiverton	20%	50%	7%	32%	7%	24%
Warwick	24%	46%	10%	28%	10%	24%
West Warwick	16%	35%	7%	22%	8%	22%
Westerly	19%	51%	9%	31%	10%	26%
Woonsocket	22%	39%	11%	26%	10%	19%
Core Cities	*21%*	*39%*	*9%*	*23%*	*8%*	*19%*
Remainder of State	*20%*	*47%*	*10%*	*30%*	*10%*	*25%*
Rhode Island	*21%*	*44%*	*10%*	*28%*	*9%*	*23%*

NA = Community has no middle school or no high school

Data are for students reporting use in the 30 days prior to the date the SALT Survey was administered.

Sources of Data for Table/Methodology

Rhode Island SALT Survey Reports, School Year 2003-2004. Retrieved from Information Works at www.infoworks.ride.uri.edu.

The School Accountability for Learning and Teaching (SALT) Student Survey is administered during one 60-minute class period each school year. All students in grades 4-12 in Rhode Island complete the survey, with the exceptions of students who have been excused by their parents and students with Individual Education Plans (IEPs) who are unable to take the survey. Grades included in middle and high school vary by district. For the Rhode Island percentage, middle school includes grades 5-8 and high school includes grades 9-12. Results are available at www.infoworks.ride.uri/edu.

Response rates for each of these questions, for all districts and at all grade levels, ranged from 82% to 99%. Nationally, a response rate of 60% or greater is considered acceptable.

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Additional Children's Health Issues

Developmental Assets In Young People

◆ Children and adolescents in Rhode Island can reach their full potential through a combination of thriving (e.g., succeeding in school), being resilient (i.e., rebounding in the face of adversity) and avoiding the initiation of behaviors that might compromise their physical and/or mental health.[1]

◆ Adolescent risk behaviors such as substance use, violence toward themselves or others, eating disorders, gambling, and problems in school such as school failure and dropping out, can be lessened or prevented by protective factors, sometimes referred to as "developmental assets."[2]

◆ The developmental assets framework created by the Search Institute is one of many models that identify different types of relationships, opportunities, skills, character traits and other strengths that promote healthy development among young children and teens.[3]

◆ The 40 assets in the Search Institute Framework are organized in eight categories and are divided evenly between external assets (those in a young person's family, school and community) and internal assets (the values, competencies and skills youth have within themselves).[4]

◆ The average young person in the U.S. reports having 19 of the 40 assets.[5] Youth of all races and ethnicities benefit similarly from these assets, regardless of their socioeconomic status, although the importance of particular categories varies by race and ethnicity.[6] Assets promote positive development regardless of risk context; they are important to high-risk and to low-risk youth.[7]

◆ The development of opportunities in schools and communities that build assets can result in improvements to the overall health of young people in Rhode Island.

Framework of Developmental Assets

External Assets	Internal Assets
SUPPORT	**COMMITMENT TO LEARNING**
1. Family support	21. Achievement motivation
2. Positive family communication	22. School engagement
3. Other adult relationships	23. Homework
4. Caring neighborhood	24. Bonding to school
5. Caring school climate	25. Reading for pleasure
6. Parent involvement in schooling	
POSITIVE VALUES	**EMPOWERMENT**
7. Community values youth	26. Caring
8. Youth as resources	27. Equality and social justice
9. Service to others	28. Integrity
10. Safety	29. Honesty
	30. Responsibility
	31. Restraint
BOUNDARIES AND EXPECTATIONS	**SOCIAL COMPETENCIES**
11. Family boundaries	32. Planning and Decision Making
12. School boundaries	33. Interpersonal competence
13. Neighborhood boundaries	34. Cultural competence
14. Adult role models	35. Resistance skills
15. Positive peer influence	36. Peaceful conflict resolution
16. High expectations	
CONSTRUCTIVE USE OF TIME	**POSITIVE IDENTITY**
17. Creative activities	37. Personal power
18. Youth programs	38. Self-esteem
19. Religious community	39. Sense of purpose
20. Time at home	40. Positive view of personal future

Source: *40 Developmental Assets.* (2004). Minneapolis, MN: Search Institute.

Protective Factors Among Rhode Island High School Students, 2003-2004

◆ There were several questions on the 2003-2004 School Accountability for Learning and Teaching (SALT) Student Survey that assessed protective factors among Rhode Island's high school students.

◆ The level of protective factors experienced by Rhode Island students vary by gender, ethnicity, grade level and economic status.[8]

Caring School Climate	
Feels they can talk to a teacher or other staff member at school about academic issues most of the time or always	46%
Feels they can talk to a teacher or other staff member at school about personal or family problems most of the time or always	18%
After School Supervision	
Take care of themselves after school for more than 3 hours 3+ days per week without an adult present	35%
Academic Expectations	
Thinks they will graduate from high school	85%
Thinks they will go to college	78%
Constructive Use of Time	
Participated in at least one extracurricular activity or program not including paid work in past year	59%
Homework	
Spend at least one hour per week night doing homework	40%
Parents often make sure that students do their homework assignments	31%
Reading for Pleasure	
Spend more than one hour per day reading	10%
Have read 1-2 books in the past 3 months that weren't required by school	36%

Source: *Rhode Island SALT Survey Reports, School Year 2003-2004.* Rock Island, IL: National Center on Public Education and Policy.

The Role of Assets in Substance Abuse Prevention

◆ National research has shown that the more developmental assets young people have, the less likely they are to engage in the following eight types of substance use: using alcohol, smokeless tobacco, marijuana, inhalants or other illicit drugs, binge drinking, drinking and driving, and smoking cigarettes.[9]

◆ Youth with six or fewer assets are more likely to engage in three or more types of substance use, while those with 20 or more assets are likely to engage in less than one of these substance-related behaviors.[10]

◆ Students who report an increase in the number of assets between middle and high school show a significant decrease in substance use. Those who report a decrease in assets show an increase in substance use.[11]

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[1] Benson, P. (2001). *Building developmental assets: A new strategy for preventing high risk behavior.* Mounds View, MN: Central Center for the Application of Prevention Technologies.

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Safety

A Cradle Song

Golden slumbers kiss your eyes,

Smiles awake you when you rise.

Sleep, pretty wantons, do not cry,

And i will sing a lullaby:

Rock them, rock them, lullaby.

Care is heavy, therefore sleep you;

You are care, and care must keep you.

Sleep, pretty wantons, do not cry,

And i will sing a lullaby:

Rock them, rock them, lullaby.

By Thomas Dekker

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 healthof children, the dangers to which children are exposed in the community, access toand 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 1999 and 2003 there were 148 deaths of children ages 1 to 14. Of these deaths, 93 (63%) were due to disease, 41 (28%) were due to unintentional injuries, 8% were due to intentional injuries (10 homicides and 2 suicides) and 2 (1%) were unknown.[3] Between 1999 and 2003, Rhode Island had a child death rate of 15.5 per 100,000 children ages 1 to 14.[4,5]

Unintentional injuries are the leading cause of death for children ages 1 to 14 in Rhode Island, exceeding deaths from any single disease.[6] 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.[7,8]

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.[9]

Many of the injuries that do not result in death are extremely costly both financially and in terms of loss in quality of life. Injuries may leave children temporarily or permanently disabled, result in time lost from school, decrease children's abilities to participate in everyday activities and affect future

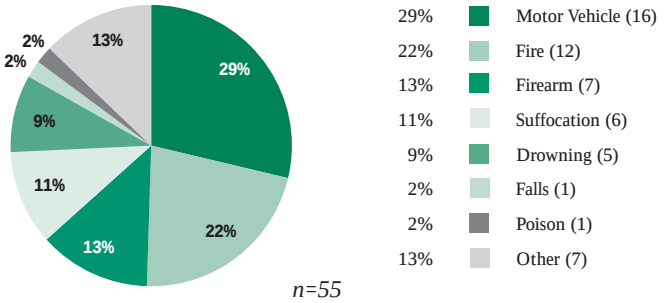
Child Death Rate
(per 100,000 Children Ages 1-14)

	1996	2001
RI	15	15
US	26	22
National Rank*		*3rd*
New England Rank**		*2nd*

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

Source: *KIDS COUNT data book: State profiles of child well-being 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

Child Deaths Due to Injury, By Cause, Rhode Island, 1999-2003



Source: Rhode Island Department of Health, Maternal and Child Health Database, 1999-2003. May not total 100% due to rounding.

◆ Between 1999 and 2003, 55 children died as a result of injury. Of these 78% (43) of deaths were caused by unintentional or undetermined injuries. Twenty-two percent of child deaths by injury were attributed to homicide or suicide.

◆ In Rhode Island, as well as nationally, motor vehicle accidents are the most common cause of injury deaths to children ages 1 to 14. Between 1999 and 2003 there were 16 motor vehicle accidents, causing 37% of the unintentional injuries that resulted in child deaths in Rhode Island.[11]

◆ Safety experts believe that as many as 90% of unintentional injuries are preventable. Effective safety products and safe environments can significantly reduce child injury and death. Child restraints in cars, adhering to traffic laws, wearing bicycle helmets and possessing smoke alarms and checking the battery monthly are a few precautions that can be taken to help prevent accidental childhood injury and death.[12]

References for Indicators

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[10] Miller, T. R., Romano, E. O., & Spicer, R. S. (2000). The cost of childhood injuries and the value of prevention. *The Future of Children,* 10(1), 137-163.

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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. Important factors which protect against risk behaviors are engagement in school and the presence of strong positive relationships with parents, family or other caring adults.[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% of students 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 1999 and 2003 there were 180 deaths of teens ages 15 to 19 in Rhode Island, a rate of 51.2 deaths per 100,000 teens.[4,5] Of these, 53 (29%) were due to disease, 48 (27%) were due to intentional injury, 68 (38%) were due to unintentional injuries (accidents) and 11 (6%) were undetermined. Of the intentional injuries, 30 were homicides and 18 were suicides. More than three-quarters of the unintentional deaths involved motor vehicles.[6]

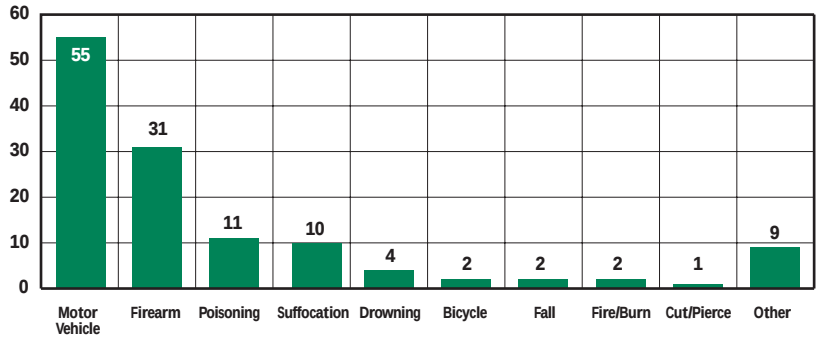
Teen Deaths by Accident, Homicide and Suicide
(deaths per 100,000 Children Ages 15-19)

	1996	2001
RI	24	31
US	60	50
National Rank*		*2nd*
New England Rank**		*1st*

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

Source: *KIDS COUNT Data Book: State Profiles in Child Well-Being 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

Injury Deaths by Cause, Teens Ages 15 to 19, 1999-2003



n=127

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1999-2003.

◆ Between 1999 and 2003 in Rhode Island, nearly two thirds (62%) of all teen deaths caused by injury were unintentional or undetermined. The majority of fatal accidents (81%) were automobile accidents.[7]

◆ Protective factors, those individual and environmental factors that can shield teens from the effects of risk behaviors, are important measures in reducing the teen death rate. Examples of protective factors are parental involvement in daily life and other support systems such as friends, religious groups and extracurricular activities. Expanding access to family mental health services is another protective factor that can help teens to manage their response to conflict and their ability to manage stress.[8,9]

References for Indicators

[1,8] *Youth violence fact sheet.* (n.d.) Atlanta, GA: Centers for Disease Control & Prevention. Retrieved January 14, 2005 from www.cdc.gov.

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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

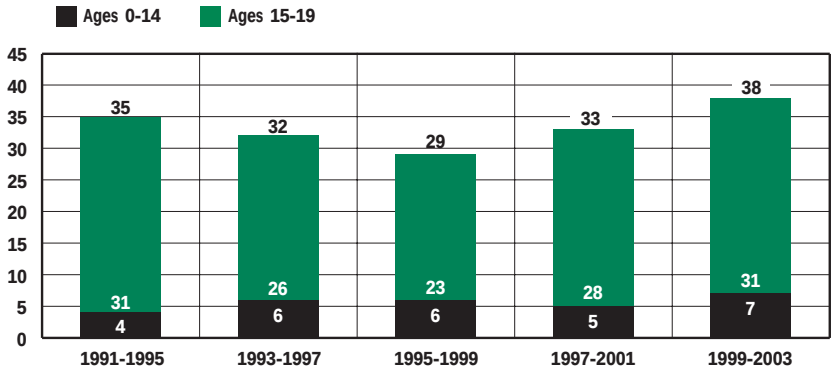
Gun violence affects all children and youth, not only those who are victims and perpetrators. Gun violence threatens the psychological, emotional, and social well-being of individuals and communities.[1]

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 1993 and 2001 in the U.S., the number of firearm-related crimes decreased by 63%, while the number of firearm-related murders dropped by 41%.[3] The gun death rate is still a cause for concern for children. The percentage of homicides victims killed with a gun increases up to age 17 and then declines.[4]

Nationally, in 2002, youth ages 15 to 24 were at highest risk for death by firearms with a death rate of 16.7 per 100,000 residents.[5] The likelihood of being a victim of gun violence is linked to gender and race. In the U.S., males 15 to 24-years-old are more than 8 times as likely as females 15 to 24-years-old to die as a result of a firearm.[6] Black (87.1), Hispanic (32.1) and Native American (30.0) males ages 15 to 24 had a disproportionately higher firearm-related death rate per 100,000, than their White (15.6) or Asian (11.7) male counterparts.[7]

Between 1995 and 1999 in the U.S., nearly one third (32%) of child handgun homicide victims were murdered by another child.[8] 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.[9]

Gun Deaths, Children Ages 0-14 and 15-19, Rhode Island, 1991-2003



Source: Centers for Disease Control and Prevention, Rhode Island Injury Mortality Statistics 1990-1996. Rhode Island Department of Health, Office of Health Statistics, 1995-2003.

◆ Rhode Island's trend in gun deaths among youth is disproportionately driven by gun death rates among teens ages 15 to 19. Between 1999 and 2003 in Rhode Island, 82% of youth gun deaths were to teens ages 15 to 19, and 18% were to children under the age of 15.[10]

Gun Hospitalizations

◆ There were 64 gun-related hospitalizations between 1999 and 2003 for children under age 20.[11] Of the 64 hospitalizations, five victims were younger than age 15 and 59 were between the ages of 15 to 19. Eighty percent (51) of the 64 hospitalized youths were victims of assault, 17% (11) were victims of unintentional injuries, 2% (1) were hospitalized for a self-inflicted firearm injury, and 2% (1) were undetermined.[12]

◆ Of the youth in Rhode Island hospitalized for gun-related injuries between 1999 and 2003, 80% were residents of the core cities (70% from Providence, 6% from Central Falls and 3% from Pawtucket).[13]

Preventing Youth Gun Violence

No single policy or effort will end youth gun violence. However, several strategies implemented simultaneously can mitigate the number of instances and the lethality of gun violence among children and youth:

◆ Reduce the exposure of children to guns in the home by educating parents to the risks that guns pose to their children and increasing awareness of safety measures. The best way to prevent firearm injuries among children is to remove guns from the home or store guns properly and separate from their ammunition.[14]

◆ Reduce children's exposure to guns in the media by increasing parental monitoring of programming and limiting the time children spend watching television, playing video games and accessing the computer.[15]

◆ Engage communities in antiviolence initiatives, community revitalization and public awareness campaigns to change youth attitudes towards guns. Important in the community approach is a partnership with law enforcement to communicate social norms against youth gun carrying and gun violence.[16]

◆ Some injury prevention experts believe that changing the design of guns and requiring product safety features could reduce unintentional injuries among children and youth.[17] A recent study found that incorporating three key safety devices on firearms (personalized devices, loaded changer indicator and magazine safeties) could have prevented 44% of deaths.[18]

Guns in the Home

◆ Research shows a strong correlation between firearm availability and firearm-related deaths and injuries among children and teens.[19] 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.[20]

◆ Research finds that in homes with guns keeping a gun locked and unloaded and storing ammunition locked and in a separate location reduces gun injuries to children and teenagers.[21]

◆ It was estimated that 35% of American households with children under 18 years old have at least one firearm and that 43% of those homes had at least one unlocked firearm.[22] 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.[23]

◆ Rhode Island is one of five states with the lowest levels of gun ownership. Children living in states with the highest levels of gun ownership are 16 times more likely to die from unintentional firearm injury, 7 times more likely to die from firearm suicide, and 3 times more likely to die from homicide than children living in the states with the lowest levels of gun ownership.[24]

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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, 2003 and June 30, 2004.

SIGNIFICANCE

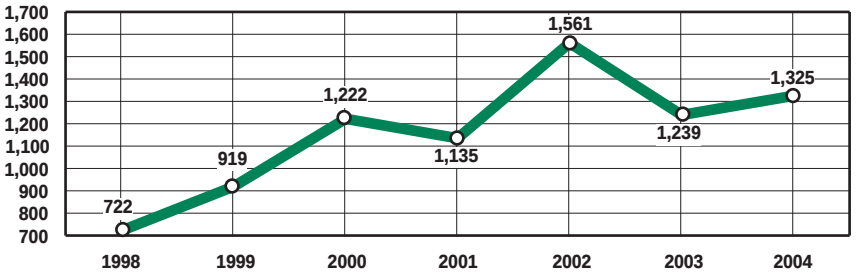
Poverty, low wages, unemployment, lack of affordable housing, mental illness or substance abuse, domestic violence and prisoner reentry are factors in family homelessness.[1,2] With a large percentage of family income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness.[3]

Compared to their peers, homeless children are more likely to get sick, develop mental health problems (such as anxiety and depression), have academic problems, have high rates of school mobility, have higher rates of learning disabilities diagnoses, be victims of violence, or exhibit delinquent and aggressive behavior.[4,5] Homeless children go hungry at twice the rate of other children and are more likely to experience illnesses such as stomach problems, ear infections and asthma.[6] Infants, toddlers and preschoolers who are homeless develop more slowly and may develop emotional problems serious enough to require professional care.[7]

Last year in the U.S., the average increase in requests for emergency shelter by homeless families with children was 7%.[8] On average, 32% of the shelter requests by homeless families in the U.S. are estimated to have gone unmet, largely because of inadequate resources.[9] Nationally, it is estimated that families with children comprise 40% of the homeless population, with 66% of these families being headed by a single parent.[10]

Between July 1, 2003 and June 30, 2004, 1,564 children under age 18 received shelter from Rhode Island's emergency shelter system, an increase of 8% from the year before.[11] Nearly half, 701 (45%) were age 5 or under, 624 (40%) were ages 6 to 12, and 239 (15%) were ages 13 to 17.[12] Youth between the ages of 13 and 17 are only admitted into the emergency shelter system with adult supervision.

Children Under Age 13 Living in Shelters, Rhode Island, 1998 – 2004



Source: Rhode Island Emergency Shelter Information Project 1998 – 2004. Providence RI: Emergency Food and Shelter Board.

◆ In Rhode Island, 1,325 children under age 13 received emergency housing in a homeless shelter or a domestic violence shelter in 2004.[13]

◆ Very young children under the age of 5 in Rhode Island are more likely to be homeless, with a rate of 9.3 per 1,000, compared to 5.8 per 1,000 for all Rhode Island residents.[14]

Supportive Housing

◆ Housing assistance alone does not always solve the housing problems for vulnerable families. Low wages, substance abuse and mental health issues can exacerbate a parent's inability to cope with pending homelessness or their ability to find and keep stable housing.[15] Supportive housing, a combination of affordable housing and on-site or visiting supportive services and employment services, helps people who suffer from long-term homelessness as a result of chronic physical and/or mental health conditions.[16]

◆ In Rhode Island, the Supportive Housing Program helps to prevent and end homelessness among those who experience long-term or episodic homelessness. Services provided include: assistance with budgeting and paying rent, access to employment, medication monitoring, daily living skills related to food, housekeeping and socialization, counseling and referrals to health and mental health programs.[17]

◆ In 2004, 131 families with children in Rhode Island were served in the Supportive Housing Program.[18]

DEFINITION

Homeless youth is the number of Rhode Island youth ages 13 to 17 who are homeless or at risk for homelessness, have run away from home or have been thrown out of their homes and are not allowed to return.

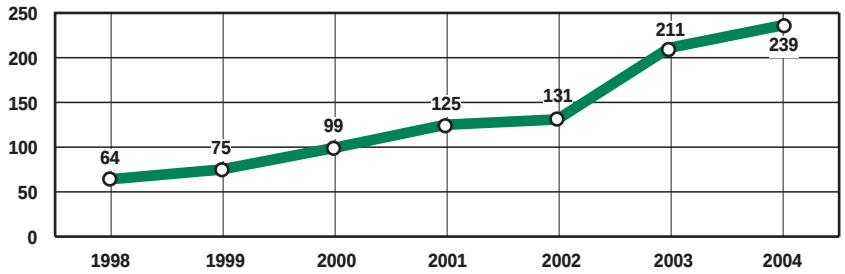
SIGNIFICANCE

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] Nationally, in 2004 46% of callers to the National Runaway Switchboard identified themselves as victims of problematic family dynamics or abuse.[2] Some runaway youth are considered to be throw-aways who were told or forced to leave a household, or were abandoned by their parents or guardians.[3]

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.[4]

Although estimates vary, it is projected that there are between 1 million and 1.3 million U.S. youth run away from home each year.[5]

Homeless Youth Ages 13 - 17, in Rhode Island's Emergency Shelter System, 1998-2004



Source: Rhode Island Emergency Shelter Information Project, Annual Reports 1998 – 2004.

◆ Between July 1, 2003 and June 30, 2004, 239 youth entered the Rhode Island Emergency Shelter system accompanied by a parent or another adult. This is an increase of 273% since 1998. 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 and does not have an overnight shelter for runaway youth.[6]

◆ During 2004, 169 Rhode Island youth ages 13 to 17 accessed crisis management services offered by Crossroads Rhode Island, and 1,073 calls were made to the Crossroads SAFELINE for runaway youth.[7] In 2004 the National Runaway Switchboard received 380 calls from Rhode Island and the Covenant House crisis hotline documented 1,648 crisis calls from Rhode Island.[8,9]

◆ As of December 31, 2004, there were 111 individuals under age 19 in the Department of Children, Youth and Families care who were classified as unauthorized absence/runaways.[10]

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[8] National Runaway Switchboard, Region 1 Statistics, 2004.

[9] Covenant House, Year End Nine-line Statistics, FY 2004.

[10] Rhode Island Department of Children, Youth and Families, December 2004.

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

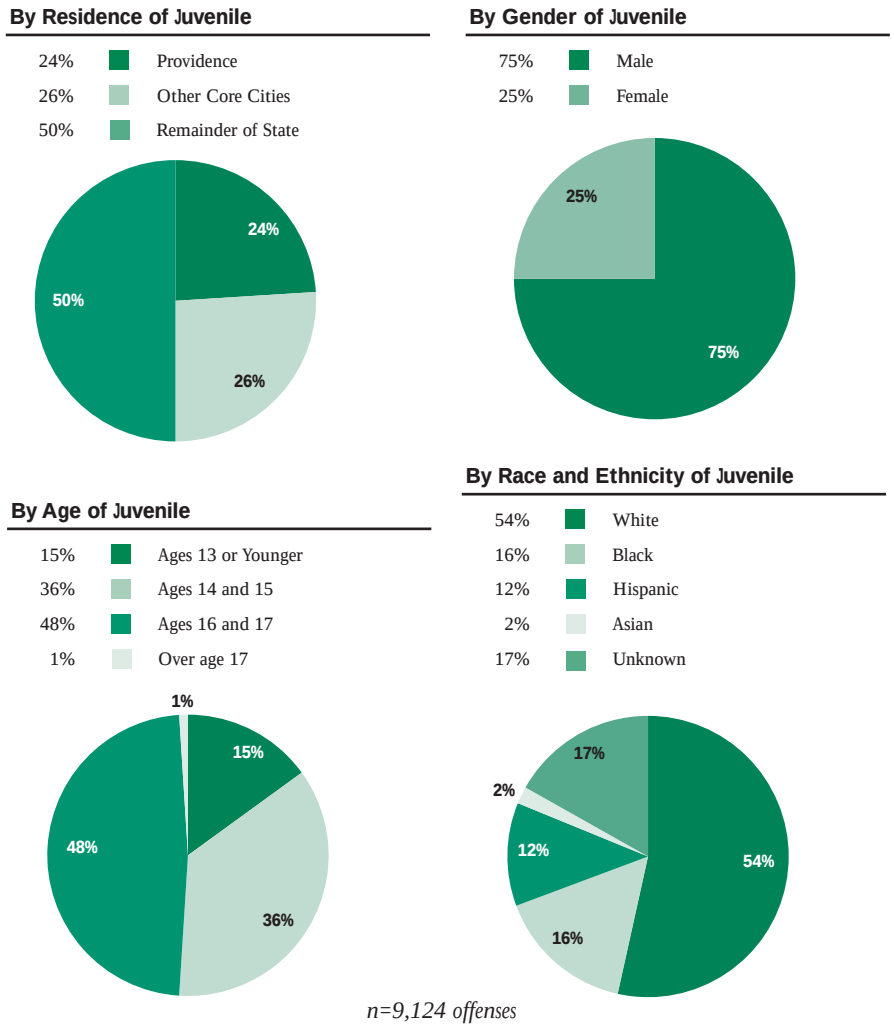
Youth risk factors for involvement in the juvenile justice system include poverty and diminished economic opportunity, family violence, parental and youth substance abuse, mental health problems, truancy, learning disabilities, poor school performance, aggression and association with other high-risk youth.[1,2] During 2004 in Rhode Island, 5,309 youth (5% of all youth between ages 10 and 17) were referred to Family Court for 9,124 wayward and delinquent offenses. Of these, 417 (5%) 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 29 Juvenile Hearing Boards serving 31 communities and permitting the diversion of juveniles accused of status offenses or misdemeanors.[6] Sanction options in this diversion process include community service, restitution, mental health or substance abuse counseling and/or a community-based program.[7]

Eight percent of juveniles referred to Family Court for wayward, delinquent and probation violations in 2004 had been referred to Family Court at least twice before.[8] Prevention, early intervention and positive youth development programs 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.[9,10]

Juvenile Wayward/Delinquent Offenses Referred to Family Court, Rhode Island, 2004



n=9,124 offenses

Source: Rhode Island Family Court, Juvenile Offense Report, 2004. Total may exceed 100% due to rounding.

Juvenile Wayward/Delinquent Offenses Referred to Family Court, by Type of Offense, Rhode Island, 2004

29%	Property Crimes	9%	Motor Vehicle Offenses
16%	Disorderly Conduct	5%	Violent Crimes
15%	Status Offenses*	3%	Weapons Offenses
11%	Simple Assault	5%	Other**
9%	Alcohol and Drugs		

n = 9,124

**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 2004. Total may exceed 100% due to rounding.

Mental Health and Substance Abuse Treatment Needs of Youth in the Juvenile Justice System

◆ Youth in the juvenile justice system experience substantially higher rates of mental health disorders than youth in the general population. Two-thirds of youths in juvenile justice custody in the U.S. meet the criteria for one or more mental disorders and at least one in five has mental health problems that are serious enough to interfere with their functioning.[11,12]

◆ Four of every five young people in the U.S. juvenile justice system are under the influence of alcohol or drugs when they committed their crime, test positive for drugs, are arrested for alcohol or drug offenses, admit having substance abuse and addiction problems, or share some combination of these characteristics. Only 3.6% receive any treatment after arrest.[13]

◆ On December 1, 2004, 21% of youth at the Training School were receiving psychiatric care and 18% were in the Residential Substance Abuse Treatment Program at the Training School.[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 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 2004, the Attorney General's Office filed 11 motions to waive jurisdiction to try juveniles as adults. One of these was a mandatory waiver. Seven motions were waived voluntarily and three were waived after a hearing. In January 2005, there was one such motion pending before the Family Court.[17]

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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 2004 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

The juvenile justice system has three primary obligations: to respond to the needs of the young people in its care; to protect youth from legal jeopardy; and to keep the public safe from youth who will harm others.[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]

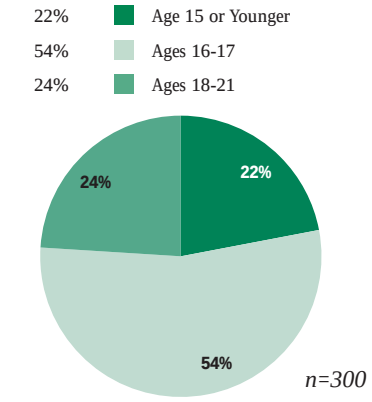
Nationwide only a fraction of incarcerated youth are violent and dangerous. Most are incarcerated for drug and property offenses that could be addressed through diversion programs. For all crimes, Black juveniles are arrested one and a half times more often than white juveniles and are incarcerated five times more often.[3,4]

Research indicates that alternatives to incarcerating youth are more successful in preventing recidivism, more cost-effective, and can lessen the disproportionate confinement of youth of color. Successful efforts are comprehensive, community-based and family-focused, with intensive counseling, treatment and transition services for reintegration into the community.[5,6] For some delinquent youth, community-based alternatives such as community service, restitution or diversion to drug court or substance abuse treatment are more effective at reducing re-offending rates than incarceration.[7,8,9]

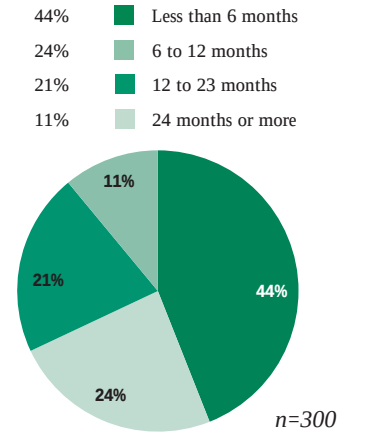
The Department of Children, Youth and Families operates the Rhode Island Training School for Youth, the state's residential detention facility for adjudicated youth and youth awaiting trial. There were a total of 1,069 youth in the care and custody of the Training School at some point during calendar year 2004. Of these, 16% were female.[10] As of December 31, 2004, there were 184 youth on the grounds at the Training School. Of these, 27 were un-adjudicated (i.e., awaiting trial). An additional 147 youth were within the care and custody of the Training School in temporary home or community placements. Twelve additional youth were classified as runaways.[11]

Juveniles in the Care and Custody of the Rhode Island Training School for Youth, 2004

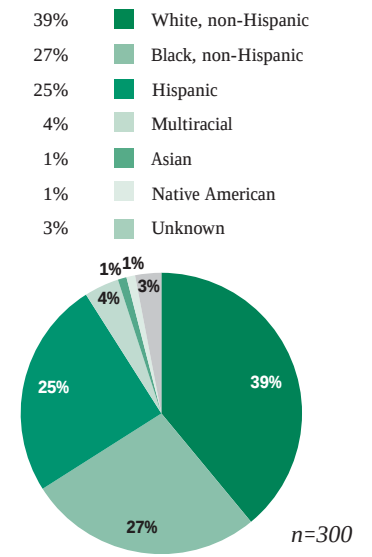
By Age



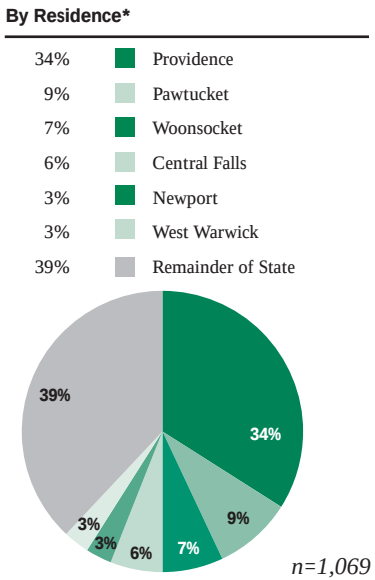
By Length of Time in Custody



By Race/Ethnicity



By Residence*



** Data by residence include all youth who passed through during calendar year 2004 and include those who were at the RITS more than once.*

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 31, 2004. Data are for 300 adjudicated residents except as noted.

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

School Failure

◆ A survey of educational records of adjudicated youth confirms significant academic difficulty prior to entry at the Training School. Based on a random review of 76 records of adjudicated students on December 1, 2004, 17 (22%) had passed all classes, 12 (16%) had failed all classes, and 21 (28%) had mixed grades (passing some, while failing others). One third of students (25) had no records available or no records indicative of grades for the past two years. One student entered with a GED.[12]

◆ During 2004, the average age of students at the Training School was 16. Their average self-reported grade placement was 9th grade, their average reading grade level as tested was 6th grade, and their average math grade level as tested was 7th grade.[13]

Need for Special Education, Mental Health and Substance Abuse Services

◆ Delinquent behavior may be directly related to a child's undetected and/or inadequately treated learning disabilities, substance abuse, and/or mental health disorders.[14] At the Rhode Island Training School on December 1, 2004, 53% 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 2004.[15,16] Most of the Training School students receiving special education services were receiving such services due to behavior disorders (64%) and learning disabilities (26%).[17]

◆ On December 1, 2004, 21% of students were receiving psychiatric care and 18% were in the Residential Substance Abuse Treatment Program at the Training School.[18]

History of Child Abuse and Neglect

◆ Forty-four percent (132) of the adjudicated youth within the care and custody of the Training School on December 31, 2004 had at some point in their childhood been victims of documented child abuse or neglect.[19]

Prevention of Recidivism Among Delinquent Youth

◆ Of the 1,069 youth who were at the Training School at some point during 2004, 24% had been admitted previously.[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 be returned 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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[16] Rhode Island Department of Elementary and Secondary Education, Office of Special Education, 2004.

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 poor academic achievement, substance abuse, impaired development, 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 children's 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]

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.[11,12] Seventy percent of imprisoned parents in the U.S. do not have a high school diploma and upon exiting prison, many face obstacles to furthering their education. Ex-offenders face barriers to earning a living, including limited significant work histories, the lack of skills and credentials and discrimination by potential employers.[13,14] Ex-offenders must also deal with pressures from previous peer groups, broken relationships and discrimination.[15]

Incarcerated Parents in Rhode Island

◆ Of the 2,667 inmates surveyed in Rhode Island who were serving a sentence or awaiting trial at the Rhode Island Department of Corrections as of December 31, 2004, 62% reported having children.

◆ Of the 89 women with children who were serving a sentence at the Rhode Island Department of Corrections on December 31, 2004, 53% were serving a sentence for a nonviolent offense and 20% for a drug offense. Another 24% had committed violent offenses and 3% were serving sentences for breaking and entering. Of the 1,183 sentenced men with children, 17% were serving sentences for nonviolent offenses, 17% for drug offenses, 41% for violent offenses and 25% for breaking and entering, sex offenses or other/unknown offenses.

◆ Of the 1,646 parents incarcerated as of December 31, 2004, including those awaiting trial in Rhode Island, 50% were White, 29% were Black and 20% were Hispanic.

Source: Rhode Island Department of Corrections, December 2004

Mentoring Children of Incarcerated Parents

◆ Research shows that children of incarcerated parents are nearly six times as likely to enter prison as children whose parents have not been incarcerated.[16] Children who lose their parents to the criminal justice system are more likely to express feelings of shame and loss and are at a higher risk for gang involvement, early pregnancy and drug abuse.[17]

◆ Mentoring is a promising approach to making a difference in the lives of children of incarcerated parents. Youth who are mentored have fewer unexcused absences from school than non-mentored youth, better attitudes and behaviors at school and less drug and alcohol use (especially among minority youth).[18]

Table 22.

Children of Incarcerated Parents, Rhode Island, 2004

CITY/TOWN	# OF INCARCERATED PARENTS	# OF CHILDREN REPORTED*	2000 TOTAL POPULATION UNDER AGE 18	RATE PER 1,000 CHILDREN
Barrington	2	3	4,745	0.6
Bristol	8	18	4,399	4.1
Burrillville	4	7	4,043	1.7
Central Falls	37	83	5,531	15.0
Charlestown	2	6	1,712	3.5
Coventry	14	35	8,389	4.2
Cranston	72	140	17,098	8.2
Cumberland	11	18	7,690	2.3
East Greenwich	5	15	3,564	4.2
East Providence	36	80	10,546	7.6
Exeter	2	5	1,589	3.1
Foster	3	4	1,105	3.6
Glocester	4	8	2,664	3.0
Hopkinton	3	7	2,011	3.5
Jamestown	2	3	1,238	2.4
Johnston	18	46	5,906	7.8
Lincoln	4	5	5,157	1.0
Little Compton	0	0	780	0.0
Middletown	4	7	4,328	1.6
Narragansett	7	27	2,833	9.5
New Shoreham	2	8	185	43.2
Newport	34	71	5,199	13.7
North Kingstown	12	23	6,848	3.4
North Providence	17	36	5,936	6.1
North Smithfield	2	6	2,379	2.5
Pawtucket	96	198	18,151	10.9
Portsmouth	5	12	4,329	2.8
Providence	419	926	45,277	20.5
Richmond	2	3	2,014	1.5
Scituate	3	4	2,635	1.5
Smithfield	3	7	4,019	1.7
South Kingstown	11	18	6,284	2.9
Tiverton	2	2	3,367	0.6
Warren	2	3	2,454	1.2
Warwick	65	141	18,780	7.5
West Greenwich	1	1	1,444	0.7
West Warwick	39	78	6,632	11.8
Westerly	6	12	5,406	2.2
Woonsocket	77	166	11,155	14.9
Unknown Residence	*165*	*357*	*NA*	*NA*
*Out of State Residence**	*71*	*146*	*NA*	*NA*
Core Cities	*702*	*1,522*	*91,945*	*16.6*
Remainder of State	*499*	*1,067*	*155,877*	*6.8*
Rhode Island	*1,201*	*2,589*	*247,822*	*10.4*

Source of Data for Table/Methodology

Rhode Island Department of Corrections, December 31, 2004.

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 report on those inmates from out of state, both those who are under jurisdiction of another state but serving time in Rhode Island and those who are under jurisdiction in Rhode Island, but report an out-of-state address.

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

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(continued on page 145)

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 2003. 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.

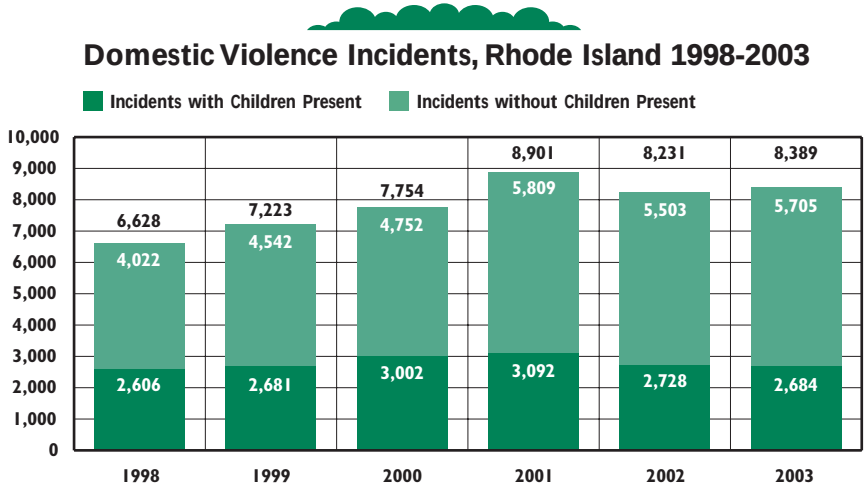
SIGNIFICANCE

National research indicates that millions of children are exposed to domestic violence each year.[1] In Rhode Island in 2003, police reports indicate that children were present in 32% 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 parent'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]



Source: Rhode Island Supreme Court Domestic Violence Training Unit, 1998-2003. 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 8,389 in 2003. The number of reported incidents with children present increased from 2,606 in 1998 to 3,092 in 2001 and then declined to 2,684 in 2003.

◆ 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 2004, 264 women and 315 children spent time in a domestic violence shelter. Rhode Island's domestic violence agencies provided services to 755 children including therapy, individual counseling, expressive arts therapy and child care. The shelters also provide school-based domestic violence prevention programs.[10]

◆ Early childhood programs such as child care, Head Start, educational home visiting, early intervention, pre-kindergarten and kindergarten programs can be an important avenue for intervention with children who have witnessed domestic violence.[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 2003, police officers reported that in 1,997 incidents the children saw their parent being abused and in 2,203 incidents the children heard (but did not see) their parent being abused.[13]

◆ Table 23 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 23 underestimates the total number of children who experienced domestic violence in their homes, because more than one child may be present at an incident.

Table 23.

Domestic Violence Incidents with Children Present, Rhode Island, 2003

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	48	12	25%
Bristol	173	47	27%
Burrillville	115	49	43%
Central Falls	211	64	30%
Charlestown	39	13	33%
Coventry	202	75	37%
Cranston	454	130	29%
Cumberland	137	41	30%
East Greenwich	32	8	25%
East Providence	269	97	36%
Exeter	NA	NA	NA
Foster	8	0	0%
Glocester	76	23	30%
Hopkinton	43	16	37%
Jamestown	15	4	27%
Johnston	384	128	33%
Lincoln	139	48	35%
Little Compton	17	1	6%
Middletown	141	42	30%
Narragansett	127	26	20%
New Shoreham	4	0	0%
Newport	452	116	26%
North Kingstown	240	81	34%
North Providence	284	78	27%
North Smithfield	75	26	35%
Pawtucket	792	270	34%
Portsmouth	123	32	26%
Providence	1,697	586	35%
Richmond	25	11	44%
Scituate	29	11	38%
Smithfield	152	38	25%
South Kingstown	146	48	33%
Tiverton	152	45	30%
Warren	125	27	22%
Warwick	435	152	35%
West Greenwich	23	6	26%
West Warwick	234	85	36%
Westerly	157	56	36%
Woonsocket	498	155	31%
Rhode Island State Police	*116*	*37*	*32%*
Core Cities	*3,884*	*1,276*	*33%*
Remainder of State	*4,389*	*1,371*	*31%*
Rhode Island	*8,389*	*2,684*	*32%*

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, 2003 and December 31, 2003.

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] Children's Defense Fund. (2002). *Domestic violence and its impact on children* (Fact Sheet). Washington, DC: Children's Defense Fund.

[2,13] Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit. Based on data from Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received from police departments between January 1, 2003 and December 31, 2003.

[4,7,8] Edleson, J. Mbilinyi, L. & Shetty, S. (2003). *Parenting in the context of domestic violence.* San Francisco, CA: Judicial Council of California, Administrative Office of the Courts.

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[12] Domestic Violence and Sexual Assault Reporting Form.

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.[1,2] Recent studies confirm that child abuse is linked to increases in low academic achievement, juvenile delinquency, substance abuse, suicide, behavioral, emotional and mental health problems, teenage pregnancy, adult criminality and increased likelihood of becoming an adult victim of physical or sexual abuse.[3,4,5,6]

Many abusive parents lack essential parenting skills and are struggling with a combination of social and economic issues. Preventing child abuse and neglect requires family support systems such as access to high quality child care as well as parenting education and counseling for substance abuse, domestic violence, and mental health problems. Families benefit from access to community-based, comprehensive services that are able to flexibly respond to their needs.[7,8]

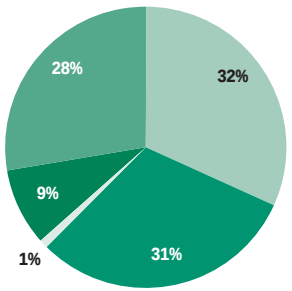
Responding to reports of child abuse and neglect and ensuring child safety in crisis situations are important functions of child protection systems. Maintaining the capacity to focus on prevention is equally critical and frequently more cost-effective. The absence of appropriate lower-cost placements 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.[9,10,11]

In 2004 in Rhode Island, there were 2,095 indicated investigations of child abuse and neglect involving 2,906 children.[12]

Child Abuse and Neglect, Rhode Island, 2004

By Age of Victim

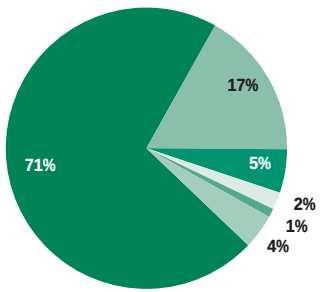
9%	Under Age 1
28%	Ages 1 to 5
32%	Ages 6 to 11
31%	Ages 12 and Older
1%	Unknown



*(n=2,906)**

By Type of Abuse

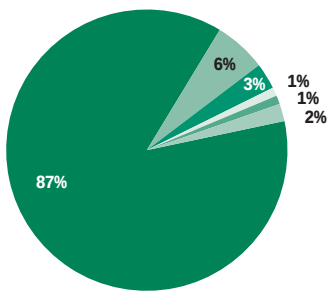
71%	Neglect
17%	Physical Abuse
5%	Sexual Abuse
2%	Medical Neglect
1%	Emotional Abuse
4%	Other



*(n=3,452)***

By Relationship of Perpetrator to Victims

87%	Parents
6%	Relatives/Household Members
3%	Child Care Providers
1%	Foster Parents
1%	Residential Facility Staff
2%	Other or Unknown



*(n=3,437)****

Notes on Pie Charts

All data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2004. 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. This number is a duplicated count of perpetrators based on their number of victims.*

DCYF (CANTS)* Hotline Calls for Reports of Abuse and/or Neglect, Investigations, and Indicated Cases, Rhode Island, 1995-2004

YEAR	TOTAL NUMBER UNDUPLICATED CHILD MALTREATMENT REPORTS	NUMBER OF COMPLETED INVESTIGATIONS	# OF INDICATED INVESTIGATIONS
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
2004	13,341	6,890	2,095

◆ Between 1995 and 2004 the percentage of child maltreatment reports for which there were completed investigations declined from 62% to 52% while the percent of investigations that were indicated remained fairly stable.

◆ In 2004, 52% of reports resulted in completed investigations and 30% of completed investigations were indicated. An indicated investigation is one in which there is credible evidence that child abuse and/or neglect occurred.

◆ During 2004, among the 13,341 maltreatment reports, 5,336 were classified as "early warnings", that is, instances where an essential criterion for investigation is not present. Criteria for investigation include 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, 1995-2004.

Rhode Island Child Deaths Due to Child Abuse and/or Neglect*

YEAR	NUMBER OF DEATHS	YEAR	NUMBER OF DEATHS
1995	5	2000	3
1996	4	2001	5
1997	2	2002	1
1998	3	2003	4
1999	3	2004	3
Total 1995-1999	*17*	*Total 2000-2004*	*16*

** Based on Rhode Island Department of Children, Youth and Families determination of death due to child abuse or neglect by parent or caretaker.*

◆ Between 1995 and 2004, 33 children died as a result of injuries due to abuse by a parent or caretaker.

◆ During 2004, there were 29 children hospitalized with the diagnosis of child abuse or neglect, down from 38 in 2002. The average over five years (1999-2003) was 30 hospitalizations annually.[13]

Child Abuse and Neglect in Rhode Island Communities

◆ In 2004, the rate of indicated investigations of child abuse and neglect per 1,000 indicated investigations was higher in each core city than for the state as a whole. The core cities represented six out of the seven cities or towns in Rhode with the highest rates of child abuse and neglect.

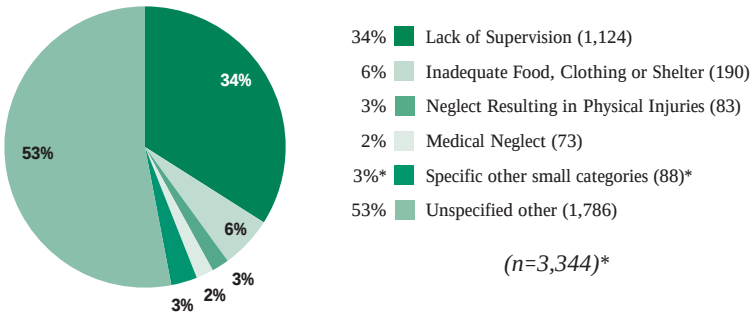
◆ In 2004, 56% of indicated investigations of child abuse and neglect occurred in core cities, which contain 39% of the state's population under age 21.

◆ Woonsocket has consistently had the highest rate of indicated investigations of child abuse and neglect of all of the core cities.

Source: Rhode Island Department of Children, Youth and Families, 2000-2004.

Child Abuse and Neglect

Child Neglect, by Nature of Neglect, Rhode Island, 2004



*(n=3,344)**

◆ In Rhode Island in 2004, of the 3,344 indicated allegations (confirmed claims) of neglect, 34% involved lack of supervision, highlighting the potential importance of adequate capacity, affordability and quality of child care, preschool and other early childhood and school-age programs.

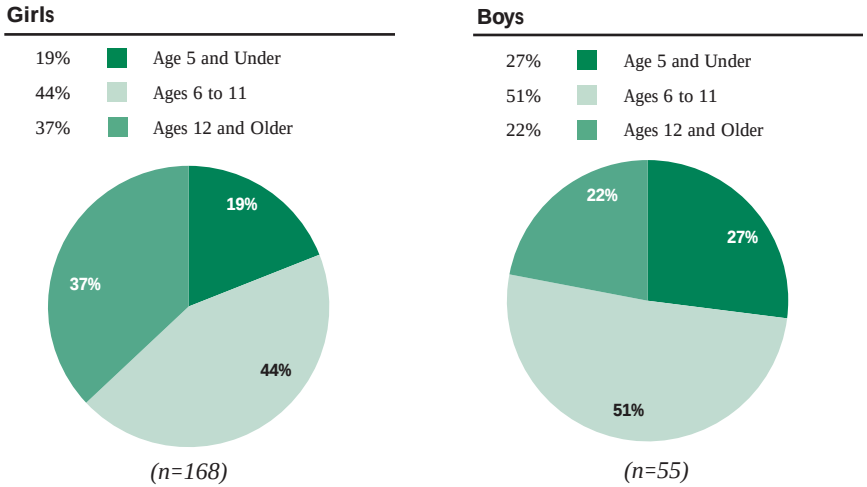
◆ The single largest category of neglect (53%) falls under other. These are instances of neglect that do not fit into any of the other specified categories.

◆ The specific small categories of less than 1% each include: drug/alcohol abuse (52), abandonment (12), tying and confinement (6), emotional neglect (6), excessive/ inappropriate discipline (6), educational neglect (4), poisoning (2).

** 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. Numbers do not include indicated allegations of institutional neglect.*

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2004.

Child Sexual Abuse, by Gender and Age of Victim, Rhode Island, 2004



(n=168) *(n=55)*

◆ In Rhode Island in 2004, there were 223 indicated allegations of sexual abuse. Some children were victims of sexual abuse more than once.[14]

◆ In 75% (168) of the 223 indicated allegations of sexual abuse the victim was a female. Sixty-seven percent of the victims (63% of girls and 78% of boys) were under age 12.[15]

Preventing Child Abuse and Neglect

◆ Families overwhelmed by personal, social or economic problems may lack resources to meet their children's needs and require a variety of readily accessible services and interventions.[16]

◆ Connecting families with economic supports, decreasing isolation and providing access to substance abuse and mental health treatment are especially critical.[17]

Table 24. **Indicated Investigations of Child Abuse and Neglect, Rhode Island, 2004**

CITY/TOWN	TOTAL POPULATION OF CHILDREN UNDER AGE 21	# OF INDICATED INVESTIGATIONS OF CHILD ABUSE/NEGLECT	RATE OF CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Barrington	5,211	13	2.5
Bristol	6,294	26	4.1
Burrillville	4,646	21	4.5
Central Falls	6,443	74	11.5
Charlestown	1,952	13	6.7
Coventry	9,438	61	6.5
Cranston	19,854	117	5.9
Cumberland	8,595	36	4.2
East Greenwich	3,861	5	1.3
East Providence	12,060	60	5.0
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	3	2.2
Johnston	6,729	29	4.3
Lincoln	5,720	27	4.7
Little Compton	874	1	1.1
Middletown	4,757	18	3.8
Narragansett	3,897	10	2.6
New Shoreham	203	3	14.8
Newport	7,046	70	9.9
North Kingstown	7,561	32	4.2
North Providence	6,854	56	8.2
North Smithfield	2,674	7	2.6
Pawtucket	20,870	227	10.9
Portsmouth	4,726	17	3.6
Providence	62,125	544	8.8
Richmond	2,221	3	1.4
Scituate	2,944	14	4.8
Smithfield	6,112	5	0.8
South Kingstown	10,393	33	3.2
Tiverton	3,806	22	5.8
Warren	2,809	23	8.2
Warwick	21,330	145	6.8
West Greenwich	1,606	3	1.9
West Warwick	7,746	98	12.7
Westerly	6,094	35	5.7
Woonsocket	12,792	168	13.1
Out of State/Unknown	*NA*	*47*	*NA*
Core Cities	*117,022*	*1,181*	*10.1*
Remainder of State	*182,852*	*867*	*4.7*
Rhode Island	*299,874*	*2,095*	*7.0*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), number of reports (indicated investigations) for the period January 1, 2004 to December 31, 2004.

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 U.S. Census 2000, Summary File 1.

References for Indicator

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[5] Office of Justice Programs. (2004). *Violence against women: Identifying risk factors*. Washington, DC: U.S. Department of Justice.

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[11] *Towards an organized system of care for Rhode Island's children, youth and families*. (2003). The Report of the Rhode Island System of Care Task Force.

[12,14,15] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2004.

[13] Rhode Island Department of Health, Hospital Discharge Database, 1999-2003.

16,17 Protecting children from child abuse and neglect. *The Future of Children*, 8(1).

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 (DCYF) while awaiting permanent placement. Out-of-home placements include foster homes, placements with relatives or friends, group homes, shelter care, residential treatment, and medical facilities. Permanent placement includes reunification with the family, adoption or guardianship.

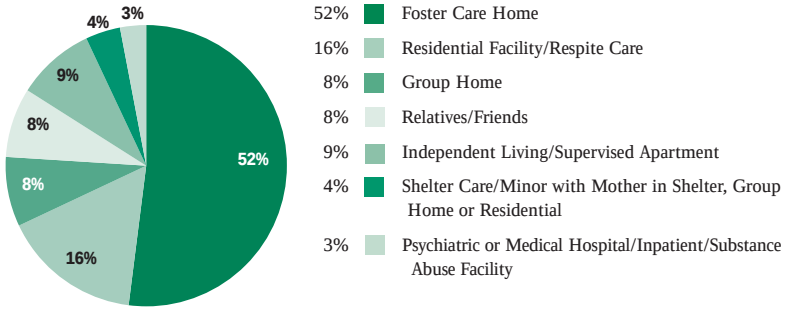
SIGNIFICANCE

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 compromises a child's developmental progress.[1] Children who have been abused or neglected are particularly in need of a safe, stable and permanent environment which provides for their well-being. Yet Rhode Island children in out-of-home care frequently experience multiple placements, lose contact with family members, and often have educational, physical, and mental health needs that are overlooked.[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 placements 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 college education, but experience serious educational difficulties. Adequate remedial and special education services are needed to ensure that each youth maximizes his or her potential and is prepared for the employment market.[7]

Children in Out-of Home Placement, December 2004



n = 2,435

◆ As of December 31, 2004, there were 2,435 children under age 21 in the care of DCYF who were in out-of-home placement.

◆ The total caseload of DCYF on December 31, 2004 was 7,985 including: 2,902 children living in their homes (with a parent, guardian or step-parent) under DCYF supervision; 2,315 children in adoption placements, most receiving subsidized adoption supports; 178 children/youth in detention at the Training School or in prison; 20 children in the care of another state agency; and 9 children in Job Corps or other placements. An additional 126 children and youth in the care of DCYF were classified as unauthorized absence/runaways.

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2004.

Night-to-Night Placements

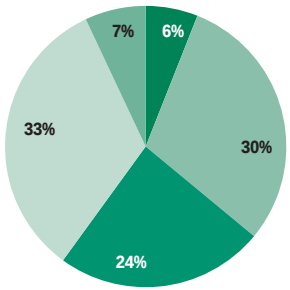
◆ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting longer-term placements. Night-to-night placements are the subject of prolonged litigation between DCYF and the Office of the Child Advocate, which succeeded in minimizing such placements.

◆ In 2004, there were 13 children placed in night-to-night placements for a total of 13 bed nights. This is a significant reduction in night-to-night placements since 2003, when an average of 13 children per week were placed in night-to-night placements for a total of 1,547 bed nights. There have been no night-to-night placements since June of 2004.[8]

Children in Foster Care Homes, Rhode Island, 2005

By Age

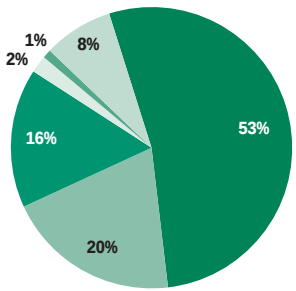
6% (82)	Under Age 1
30% (378)	Ages 1 to 5
24% (301)	Ages 6 to 11
33% (425)	Ages 12 to 17
7% (90)	Over Age 18



n = 1,276

By Race and Ethnicity

53% (677)	White
20% (251)	Black
16% (206)	Hispanic
2% (21)	Asian
1% (19)	American Indian/Alaskan/ Pacific Islander
8% (102)	Unknown/Multiracial/Other



◆ As of January 2, 2005, there were 1,276 children in foster care homes. Of these, 542 (42%) were in relative foster homes, 477 (37%) were in non-relative foster homes, 257 (20%) were at private agencies. 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 2005.

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 placements and maximizing the stability of placements are the paramount concerns which the Act seeks to address.

◆ Of the 1,599 Rhode Island children who were victims of abuse or neglect during the first six months of Federal Fiscal Year 2003 (whether or not they were removed from the home), 11.1% (177) experienced one or more recurrences of abuse or neglect within 6 months, down from 12.2% in 1999.[11]

◆ In Federal Fiscal Year 2003, 22% of the 1,751 children who had been in out-of-home care for less than one year had experienced 3 or more placements (compared with 23% in 1999). Three or more placements were experienced by 38% of children who had been in care between 12 and 23 months, the same level as in 1999; 59% of children who had been in care for 24-35 months experienced three or more placements (compared with 53% in 1999).[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 children 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]

References for Indicator

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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 2003.

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, have higher rates of special education needs, unemployment, academic failure, incarceration and premature parenting.[3,4]

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.[5] 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.[6,7,8]

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.[9,10,11] 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.[12,13]

In 2004, the U.S. Department of Health and Human Services conducted a Child and Family Services Review for the State of Rhode Island and determined that the Rhode Island Department of Children, Youth and Families needed to improve on 37 of a possible 45 items examined. Areas in which Rhode Island needed improvement included foster care placement stability, foster care reentry, and time to adoption, among others.[14]

Percentage of Children in Out-of-Home Care Exiting Care to a Permanent Placement, Rhode Island, FY 2003*

	ALL EXITS	WITH DISABILITY	OVER AGE 12 AT ENTRY
Adoption	17%	16%	1%
Guardianship	3%	3%	2%
Reunification	64%	59%	67%
Other	17%	23%	30%
Total Number	*1,347*	*351*	*648*

Source: The Consultation Center, Yale University School of Medicine, for the U.S. Department of Health and Human Services. (2004). *Safety, permanency, and well-being in Rhode Island: Child welfare outcomes Annual Report for 2003.* (AFCARS Annual Foster Care Database, FY 2003). May not total 100% due to rounding.

◆ In FY 2003 there were 3,649 children in out-of-home placement. Of these, 1,347 children exited care. Of the children who exited care, 83% exited to a permanent placement (adoption, guardianship or reunification). Children exiting to a permanent placement account for 31% of all children in out-of-home placement.[15]

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 2003, 85 Rhode Island children exited out-of-home placement to emancipation. Of these, 79% were older than age 12 at entry into care.[16]

◆ Youth who age out of foster care experience high rates of poverty, homelessness, unemployment, incarceration and poor health. 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.[17]

◆ 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.[18]

*Throughout this indicator, fiscal year refers to federal fiscal year, Oct. 1-Sept. 30. Permanent placement indicates adoption, reunification or guardianship.

** Foster care refers to all out-of-home placements, consistent with language used in federal reports.

Length of Time to Adoption or Reunification, Rhode Island, FY 1998 and 2003

	ADOPTION		REUNIFICATION	
	1998	2003	1998	2003
Less than 24 months	28%	50%	75%	86%
More than 24 months	63%	49%	6%	10%
Missing data	9%	1%	19%	4%

◆ The percentage of children in the Rhode Island child welfare system who are adopted in less than 24 months increased from 28% in FY 1998 to 50% in FY 2003.

◆ The percentage of children in the Rhode Island child welfare system who were reunified with their family of origin in less than 24 months increased from 75% in FY 1998 to 86% of children in FY 2003.

Source: The Consultation Center, Yale University School of Medicine, for the U.S. Department of Health and Human Services. (2004). *Safety, permanency, and well-being in Rhode Island: Child welfare outcomes Annual Report for 2003.* (AFCARS Annual Foster Care Database, FY 1998 and FY 2003).

Children Re-Entering Foster Care after Prior Episode, FY 1998 and 2003

◆ 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 2003, 33% of children in Rhode Island who entered out-of-home placement were re-entering after a prior episode, up from 27% in FY 1998.[19]

◆ 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 (e.g., food, housing, income), child care and specific strategies to decrease isolation and strengthen community supports.[20]

Adoptions of Children in DCYF Care, 2004

◆ In calendar year 2004, 244 children in the care of DCYF were adopted in Rhode Island. Of these children, 41% were White non-Hispanic, 18% were Black non-Hispanic, 20% were Hispanic and 22% were of another racial or ethnic group or of unknown race or ethnicity.

◆ Of the children adopted, 57% were under age 6, 30% were between age 6 and 11 and 13% were age 12 or older.

◆ As of December 31, 2004, 215 children in the care of DCYF were awaiting adoption. Of these children, 45% were White, 24% were Black, 19% were Hispanic and 12% were of another racial or ethnic group or of unknown race or ethnicity.

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2004.

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Education

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Children Enrolled in Early Intervention

DEFINITION

Children enrolled in Early Intervention is the percentage of children under age 3 who have an active Individual Family Service Plan through a Rhode Island Early Intervention provider during calendar year 2004.

SIGNIFICANCE

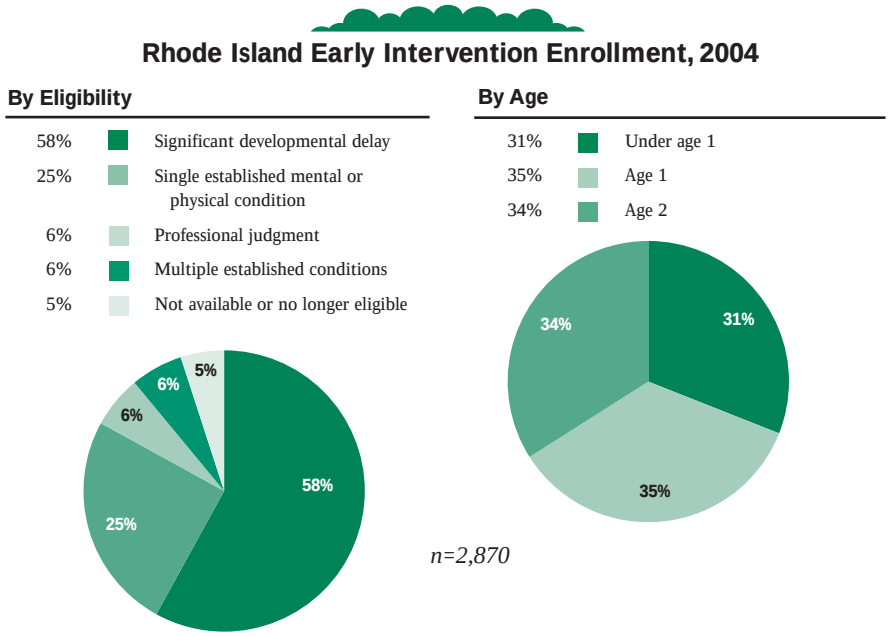
During the first few years of life, children develop the linguistic, cognitive, emotional, social, and behavioral capabilities that are the foundation for subsequent development.[1] Development in the early years is vigorous but highly vulnerable.[2]

The Individuals with Disabilities Education Act, Part C (IDEA, Part C) requires states to identify and provide appropriate early intervention services to children from birth through age 2 who are developmentally delayed or have a physical or mental condition with a high probability of resulting in developmental delay. States may choose to serve children more broadly at risk of delay. In order for a state to participate in the program it must assure that early intervention will be available to every eligible child and his or her family.[3]

Rhode Island's eligibility criteria for Early Intervention includes children with a physical or mental condition known to impact development, children with established developmental delays and children at significant risk for developmental delays or with multiple established conditions which collectively increase the probability of atypical development.[4]

Infants and toddlers with diagnosed conditions such as Down syndrome, cerebral palsy, or hearing loss clearly benefit from Early Intervention. Appropriate services and supports, such as physical therapy, speech and language therapy, special education, home visits and family support increase the chances a child with disabilities or at risk will develop to his or her full potential. Young children with developmental delays who receive Early Intervention services are better prepared for school and later life.[5]

Early Intervention services can have a significant positive impact for young children with medical risk factors such as growth problems and elevated blood lead levels and environmental risk factors such as poverty or family mental health problems.[6] Rhode Island Early Intervention screens children to identify those with multiple medical and/or environmental risks. Children who have four or more factors that place them at risk of developmental delay are eligible for Early Intervention services.[7]



◆ During 2004 in Rhode Island, 2,870 children received Early Intervention services. This is 8% of the 37,775 Rhode Island children under age 3.[8,9]

◆ In 2003, 812 children were discharged from Rhode Island's Early Intervention program upon reaching age 3. Of these children, 594 (73%) were referred to the local school district to continue necessary special education services. An additional 158 (19%) children completed the program because they had achieved their goals and 49 (6%) were discharged because they refused services, moved out of state or were unreachable. Eleven children (1%) were discharged for unknown reasons.[10]

◆ There are three categories of risk for adverse developmental outcomes that states use to define eligibility for Early Intervention services: established risk (e.g. Down syndrome), biological/medical risk (e.g. failure-to-thrive), and environmental risk (e.g. poverty). IDEA requires states to provide services to "established risk" children by virtue of their diagnosis, regardless of whether a measurable delay exists. Serving children with biological/medical and/or environmental risks is optional.[11]

Children Enrolled in Early Intervention

Table 25.

Infants and Toddlers Enrolled in Early Intervention, Rhode Island, 2004

CITY/TOWN	# OF CHILDREN UNDER AGE 3*	# OF CHILDREN ENROLLED IN EARLY INTERVENTION	% OF CHILDREN UNDER AGE 3 ENROLLED
Barrington	570	43	8%
Bristol	655	48	7%
Burrillville	509	41	8%
Central Falls	990	82	8%
Charlestown	289	32	11%
Coventry	1,243	109	9%
Cranston	2,455	201	8%
Cumberland	1,136	98	9%
East Greenwich	384	25	7%
East Providence	1,552	106	7%
Exeter	187	14	7%
Foster	113	7	6%
Glocester	335	18	5%
Hopkinton	282	26	9%
Jamestown	132	8	6%
Johnston	893	73	8%
Lincoln	662	63	10%
Little Compton	107	6	6%
Middletown	700	41	6%
Narragansett	403	26	6%
New Shoreham	35	2	6%
Newport	941	60	6%
North Kingstown	1,034	102	10%
North Providence	885	65	7%
North Smithfield	337	38	11%
Pawtucket	2,957	259	9%
Portsmouth	583	44	8%
Providence	7,642	552	7%
Richmond	321	12	4%
Scituate	371	39	11%
Smithfield	499	23	5%
South Kingstown	868	62	7%
Tiverton	461	26	6%
Warren	355	30	8%
Warwick	2,714	199	7%
West Greenwich	192	9	5%
West Warwick	1,136	78	7%
Westerly	827	58	7%
Woonsocket	2,020	145	7%
Core Cities	*15,686*	*1,176*	*7%*
Remainder of State	*22,089*	*1,694*	*8%*
Rhode Island	*37,775*	*2,870*	*8%*

*Population under age 3 is based on Census 2000 and may not reflect increases or decreases in population.

Source of Data for Table/Methodology

Rhode Island Department of Human Services, Center for Child and Family Health, children enrolled in Early Intervention in calendar year 2004.

The denominator is the number of children under age 3, according to Census 2000, Summary File 1.

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

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Children Enrolled in Early Head Start

DEFINITION

Children enrolled in Early Head Start is the percentage of eligible children under age 3 enrolled in a Rhode Island Early Head Start program as of October 2004.

SIGNIFICANCE

Early Head Start was established in 1994 to promote healthy prenatal outcomes for pregnant women, support the early care and education of infants and toddlers younger than age three and foster healthy familial relationships while building community resources.[1]

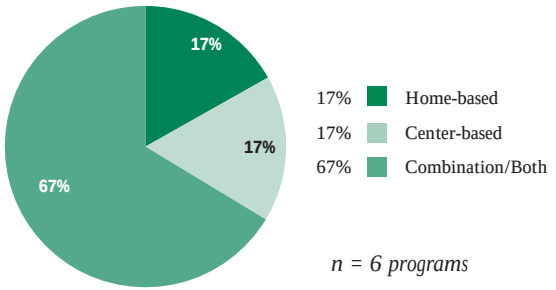
Children are eligible for Early Head Start if their families' incomes are below 100% of the federal poverty guidelines, the family receives Supplemental Security Income, is enrolled in the Family Independence Program or is using supportive services that are federal Temporary Assistance for Needy Families benefits (i.e. transportation vouchers, subsidized child care, or job training). Children in foster care and pregnant women who intend to enroll children after birth are also eligible to participate.[2,3]

There are three types of Early Head Start Programs: home-based, center-based and a combination of the two. Home-based programs use weekly home visits to support child development and the parent-child relationship and offer group activities two times per month. Center-based programs provide enrollment for children in an early care and education program and twice yearly home visits. Combination programs combine regular home visits with center-based programming. Nationally, 46% of Early Head Start programs are center-based, 43% are home-based, and the remainder are either combination or locally designed models.[4]

Pregnant women enrolled in Early Head Start are assessed for risks to a successful pregnancy (e.g. environmental toxins, domestic violence and inadequate nutrition and prenatal care). Pregnancy plans are developed to support prenatal health, the promotion of healthy behaviors and preparation for each baby's arrival.[5]

The National Evaluation of Early Head Start showed that the program produced significant cognitive and language development gains in participating children and more positive interaction with their parents. Early Head Start parents provided more emotional support and greater opportunities for language and learning to their children. Early Head Start mothers also have fewer subsequent births within two years of enrollment and are more likely to participate in education and job-training activities.[6]

Type of Early Head Start Programs in Rhode Island, 2004



Note: percentages do not total 100% due to rounding.

◆ During 2004 in Rhode Island, 31 pregnant women and 379 infants and toddlers received Early Head Start services, representing approximately 5% of the income-eligible children younger than 3 in Rhode Island.[7]

Quality Standards for Early Head Start Programs

◆ Teachers in Early Head Start centers must have, at a minimum, a Child Development Associate (CDA) credential or its equivalent at the time of hire or within one year of hire.[8]

◆ The staff-to-child ratio for all infants and toddlers in an Early Head Start center must be no less than 1:4. The maximum group size is limited to no more than 8 children for all age groups.[9]

◆ Each child in an Early Head Start center is assigned a primary caregiver who is responsible for his or her regular care. These primary care giving relationships are continued throughout the child's tenure in the program.[10]

◆ Early Head Start programs must ensure that child care services used by families meet the Early Head Start Performance Standards either by providing the care directly or by working in collaboration with other community providers.[11]

Table 26. **Percent of Eligible Children Under Age 3 Enrolled in Early Head Start, Rhode Island, 2004**

CITY/TOWN	# OF PREGNANT WOMEN ENROLLED IN EARLY HEAD START	ESTIMATED ELIGIBLE CHILDREN UNDER AGE 3*	# OF CHILDREN ENROLLED IN EARLY HEAD START	% OF ELIGIBLE CHILDREN UNDER AGE 3 ENROLLED
Barrington	0	13	0	0%
Bristol	0	57	1	2%
Burrillville	0	50	8	16%
Central Falls	1	400	53	13%
Charlestown	0	11	0	0%
Coventry	2	72	23	32%
Cranston	2	211	24	11%
Cumberland	0	51	0	0%
East Greenwich	1	28	1	4%
East Providence	1	204	30	15%
Exeter	0	26	0	0%
Foster	0	0	0	N/A
Glocester	0	15	3	20%
Hopkinton	0	17	0	0%
Jamestown	0	0	1	100%*
Johnston	1	81	10	12%
Lincoln	0	33	0	0%
Little Compton	0	5	0	0%
Middletown	1	40	12	30%
Narragansett	0	22	0	0%
New Shoreham	0	2	0	0%
Newport	3	371	52	14%
North Kingstown	0	114	0	0%
North Providence	1	99	8	8%
North Smithfield	0	26	0	0%
Pawtucket	1	842	0	0%
Portsmouth	0	33	2	6%
Providence	4	3,092	36	1%
Richmond	0	10	0	0%
Scituate	0	17	0	0%
Smithfield	0	6	7	100%*
South Kingstown	0	41	0	0%
Tiverton	0	25	1	4%
Warren	0	23	5	22%
Warwick	8	188	55	29%
West Greenwich	0	8	0	0%
West Warwick	5	299	47	16%
Westerly	0	77	0	0%
Woonsocket	0	733	0	0%
Core Cities	*14*	*5,737*	*188*	*3%*
Remainder of State	*17*	*1,605*	*191*	*12%*
Rhode Island	*31*	*7,342*	*379*	*5%*

**Estimated Number Eligible is based on Census 2000 and may not reflect increases or decreases in eligible population*

Source of Data for Table/Methodology

Rhode Island Early Head Start Programs, children enrolled as of October 2004.

The denominator is the estimated number of eligible children based on the number of children under age 3 in each community multiplied by the poverty rate for children under 5, according to Census 2000, Summary File 3 tables P87 and P8. 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. Children younger than 3 are more likely to be poor than children ages 3 to 5. Thus, using the poverty rate for children under 5 probably underestimates the numbers of children younger than 3 below poverty (and eligible for Early Head Start).

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

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[7] Rhode Island Early Head Start Programs, children enrolled as of October 2004.

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 licensed child care center slots and certified family child care home slots.

SIGNIFICANCE

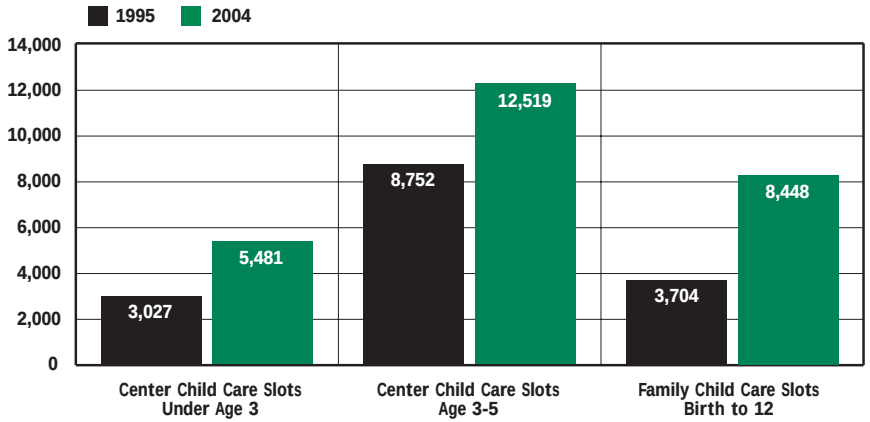
Child care has become a fundamental need for Rhode Island families over the past two decades. In Rhode Island in 2000, 62% (45,820) of children under age 6 had all parents in the workforce, higher than the U.S. average of 59%.[1]

Families use many different arrangements to provide care for children while parents are at work. There are three broad categories of child care options: non-certified, home-based care by relatives or non-relatives; state licensed child care centers; or state certified family child care homes.[2] Families' child care choices are based on factors such as the availability of care near parents' work or home, ease of transportation, hours of operation, affordability and the quality of the setting.

As part of Rhode Island's effort to facilitate the transition of families from welfare to employment, legislation, known as Starting RIght, was passed in 1997. Starting RIght is an initiative to improve the access for low-income families, affordability and quality of child care in Rhode Island. Since the passage of Starting RIght, Rhode Island has experienced significant growth in the availability of regulated child care.[3] The availability of stable child care is critical for Rhode Island's economy. When parents have difficulty finding and keeping child care, they miss work more frequently and are more likely to leave their jobs.[4]

Recent research shows that families using Rhode Island's child care subsidy program are increasingly more likely to choose licensed and certified care over non-certified care, even though subsidies are available for both options.[5] When the availability of child care is sufficient to meet demand and child care subsidies are available, families have more options and can make decisions based on the quality of the options available.

Infant and Pre-School Licensed Child Care Capacity, Rhode Island, 1995 and 2004



Source: Options for Working Parents, 1995 and 2004

◆ In 2004 in Rhode Island, there were 26,448 slots in licensed child care centers or certified family child care homes for children under age six, as compared with 15,483 slots in 1995. Between 1995 and 2004, there has been a 71% increase in the availability of licensed and certified child care.[6]

Gaps in Infant Child Care Supply

◆ Child care for infants is more expensive to provide than for older children due to the need for more intensive supervision and interaction. Many states have established differential child care subsidy rates to provide higher payments for infant care as an incentive for providers to serve this population.[7]

◆ Rhode Island licensing regulations require one teacher for every 4 infants under 18 months of age and a nurse in child care centers serving infants.[8] Family child care homes are limited to serving a maximum of 4 children if any of the children are under the age of 18 months.[9]

Table 27.

Child Care for Children Under Age 6, Rhode Island, 2004

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	90	170	52	312	386	81
Bristol	33	108	68	209	447	47
Burrillville	33	107	53	193	408	47
Central Falls	66	205	277	548	520	105
Charlestown	23	35	17	75	170	44
Coventry	115	213	128	456	962	47
Cranston	493	966	593	2,052	1,799	114
Cumberland	95	149	196	440	912	48
East Greenwich	225	422	41	688	277	248
East Providence	230	671	160	1,061	1,168	91
Exeter	8	45	14	67	189	35
Foster	31	35	8	74	107	69
Glocester	16	68	44	128	264	48
Hopkinton	0	0	14	14	283	5
Jamestown	31	33	8	72	83	87
Johnston	140	375	144	659	702	94
Lincoln	260	351	41	652	565	115
Little Compton	0	0	0	0	53	0
Middletown	134	391	26	551	463	119
Narragansett	41	90	0	131	228	57
New Shoreham	6	30	0	36	27	133
Newport	146	268	39	453	615	74
North Kingstown	127	328	80	535	805	66
North Providence	75	213	156	444	662	67
North Smithfield	0	0	46	46	285	16
Pawtucket	314	872	583	1,769	2,103	84
Portsmouth	90	141	36	267	411	65
Providence	972	2,264	4,630	7,866	4,002	197
Richmond	30	45	71	146	255	57
Scituate	12	47	32	91	288	32
Smithfield	160	346	44	550	400	138
South Kingstown	172	338	84	594	590	101
Tiverton	25	125	58	208	358	58
Warren	43	130	45	218	325	67
Warwick	746	1,463	267	2,476	2,119	117
West Greenwich	119	183	0	302	173	175
West Warwick	138	383	121	642	737	87
Westerly	72	336	13	421	644	65
Woonsocket	170	573	259	1,002	1,100	91
Core Cities	*1,806*	*4,565*	*5,909*	*12,280*	*9,077*	*135*
Remainder of State	*3,675*	*7,954*	*2,539*	*14,168*	*16,808*	*84*
Rhode Island	*5,481*	*12,519*	*8,448*	*26,448*	*25,885*	*102*

Source of Data for Table/Methodology

The denominator is the Census 2000 number of children under age 6 with both parents in the workforce, multiplied by 56.5% (the percentage of employed 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 child care center slots for children under age 6 and the number of certified family child care home slots, as of December, 2004 (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.

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Accredited Early Care and Education

DEFINITION

Accredited early care and education is the percentage of nationally-accredited child care centers, private preschools, and family child care homes as of January 2005. Child care centers and preschools are accredited by the National Association for the Education of Young Children (NAEYC). Family child care homes are accredited by the National Association for Family Child Care (NAFCC).

SIGNIFICANCE

Research on early care and education reveals associations between the quality of the program and children's developing skills and well-being. The quality of child care is clearly linked to children's developmental outcomes. The quality of child care is a more important predictor of positive development than the hours in child care, the stability of child care, or the type of child care.[1]

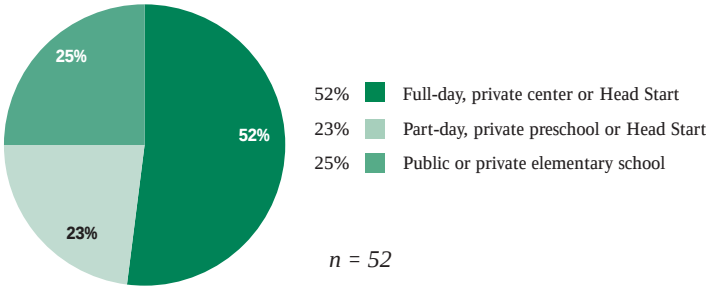
High-quality child care and early education is discernible by smaller numbers of children in a classroom or group, fewer children per adult, educated and experienced caregivers, nurturing and dependable relationships between staff and children, and safe and stimulating environments.[2] Research shows that children in preschool classrooms are better prepared for school when teachers have at least an associate's degree, and optimally, a bachelor's degree.[3,4]

Children from all backgrounds who have received high-quality early care and education score higher on tests of both cognitive and social skills in their early school years than children in poor quality care.[5,6] 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 thinking, and working with others.[7,8]

The quality of child care can also influence a parent's employment and education. When parents are using higher quality child care, they are more likely to keep their jobs, work more hours, and increase their educational attainment.[9]

Investments in high-quality early care and education programs consistently generate at least a 3 to 1 return on investment or better by reducing public education expenses, lowering criminal justice costs, increasing lifetime earnings of both the child and the parents (and thus increasing tax revenues), and reducing public welfare expenditures.[10]

NAEYC Accredited Programs by Type, Rhode Island, 2005



◆ NAEYC accredits full-day and part-day programs in public or private settings. In January 2005, 52% of the NAEYC accredited programs in Rhode Island were full-day, private child care centers or Head Start programs; 23% were part-day, private preschools or Head Starts; and 25% were public or private schools.[11]

◆ In January 2005 in Rhode Island, 10% of the full-day child care centers or Head Start programs and 18% of the part-day preschools or Head Start programs were accredited by NAEYC.[12] One percent of the certified family child care homes were NAFCC accredited.[13]

Strategies to Improve the Quality of Child Care

◆ The quality of child care is strongly related to the wages, education, and retention of teachers. Scholarship and compensation initiatives can improve child care workforce education and retention, particularly when professional development and education are linked to pay increases.[14]

◆ Thirty-four states have developed tiered quality rating systems to promote large-scale quality improvements including child care consumer guides with quality ratings for child care programs, rated child care licensing, and tiered reimbursement policies that provide higher subsidy rates to child care programs that achieve higher levels of quality. NAEYC and NAFCC accreditation are often used to mark a higher level of quality in tiered quality strategies.[15]

◆ Enhancing the capacity of child care licensing agencies and making inspection and verified complaint data public has also been used as an effective strategy to improve the quality of child care.[16]

Table 28.

Programs with NAEYC or NAFCC Accreditation, Rhode Island, 2005

CITY/TOWN	PART-DAY PROGRAMS NUMBER	PART-DAY PROGRAMS NAEYC ACCREDITED	PART-DAY PROGRAMS %NAEYC ACCREDITED	FULL-DAY PROGRAMS NUMBER	FULL-DAY PROGRAMS NAEYC ACCREDITED	FULL-DAY PROGRAMS %NAEYC ACCREDITED	CERTIFIED FAMILY CHILD CARE HOMES NUMBER	CERTIFIED FAMILY CHILD CARE HOMES NAFCC ACCREDITED	CERTIFIED FAMILY CHILD CARE HOMES %NAFCC ACCREDITED
Barrington	4	1	25%	6	0	0%	8	0	0%
Bristol	1	0	0%	5	1	20%	10	0	0%
Burrillville	1	1	100%	2	0	0%	9	0	0%
Central Falls	0	0	N/A	4	0	0%	44	0	0%
Charlestown	2	0	0%	2	0	0%	3	0	0%
Coventry	2	0	0%	6	1	17%	21	0	0%
Cranston	8	1	13%	24	1	4%	92	1	1%
Cumberland	4	0	0%	4	0	0%	31	1	3%
East Greenwich	3	2	67%	9	1	11%	6	1	17%
East Providence	1	0	0%	18	2	11%	25	0	0%
Exeter	0	0	N/A	2	0	0%	2	0	0%
Foster	0	0	N/A	2	0	0%	1	0	0%
Glocester	1	1	100%	1	0	0%	7	0	0%
Hopkinton	2	1	50%	1	0	0%	2	2	100%
Jamestown	0	0	N/A	1	0	0%	1	0	0%
Johnston	1	0	0%	11	2	18%	21	0	0%
Lincoln	1	1	100%	6	0	0%	7	0	0%
Little Compton	1	0	0%	0	0	N/A	0	0	N/A
Middletown	2	0	0%	7	2	29%	5	0	0%
Narragansett	1	0	0%	2	0	0%	0	0	N/A
New Shoreham	0	0	N/A	1	0	0%	0	0	N/A
Newport	3	1	33%	5	0	0%	5	0	0%
North Kingstown	3	0	0%	9	1	11%	13	0	0%
North Providence	2	0	0%	6	1	17%	24	0	0%
North Smithfield	1	0	0%	0	0	N/A	6	0	0%
Pawtucket	3	1	33%	14	0	0%	92	1	1%
Portsmouth	2	0	0%	3	1	33%	6	0	0%
Providence	5	1	20%	48	3	6%	720	1	<1%
Richmond	0	0	N/A	1	0	0%	10	0	0%
Scituate	0	0	N/A	1	0	0%	4	0	0%
Smithfield	0	0	N/A	7	0	0%	7	0	0%
South Kingstown	5	0	0%	9	2	22%	13	0	0%
Tiverton	0	0	N/A	2	0	0%	9	0	0%
Warren	1	0	0%	3	0	0%	6	0	0%
Warwick	2	1	50%	27	3	11%	43	0	0%
West Greenwich	1	0	0%	3	1	33%	0	0	N/A
West Warwick	1	0	0%	6	1	17%	21	0	0%
Westerly	2	0	0%	6	0	0%	2	0	0%
Woonsocket	1	0	0%	10	4	40%	40	0	0%
Core Cities	*13*	*3*	*23%*	*87*	*8*	*9%*	*922*	*2*	*<1%*
Remainder of State	*54*	*9*	*17%*	*187*	*19*	*10%*	*394*	*5*	*1%*
Rhode Island	*67*	*12*	*18%*	*274*	*27*	*10%*	*1,316*	*7*	*1%*

Source of Data for Table/Methodology

Data are from Options for Working Parents, January 2005. Rhode Island Department of Elementary and Secondary Education, January 2005, National Association for the Education of Young Children, January 2005 and National Association for Family Child Care, January 2005.

Part-day programs are child care centers and preschool programs that operate for less than 7 1/2 hours a day.

As of January 2005, there were 86 family child care homes listed as "inactive" in the Options for Working Parents database because of a delay with certification renewals. These providers were not included in the table.

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

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(continued on page 146)

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 2004.

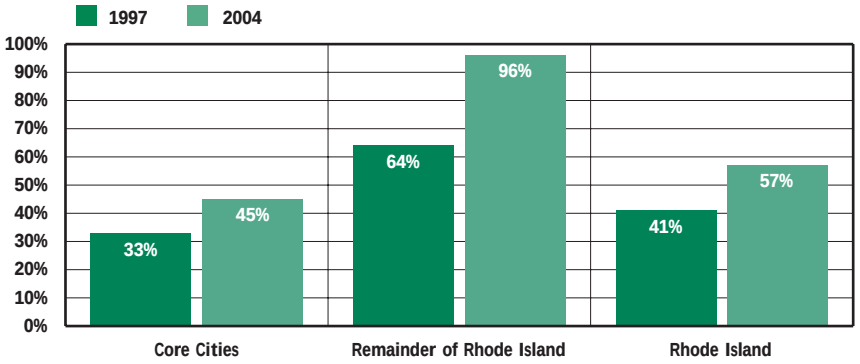
SIGNIFICANCE

Head Start is a comprehensive early childhood program for low-income preschool children and their families. Children are eligible for Head Start if their family's income is below 100% of the federal poverty guidelines; 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.[1,2]

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 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.[3]

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.[4,5] 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]

Percentage of Eligible Rhode Island 3-and 4-year-olds Served in Head Start, Core Cities, Remainder of the State and Rhode Island, 1997 and 2004



Source: Rhode Island Head Start Programs, 1997 and 2004.

◆ As of 2004, Head Start served 57% of the estimated 4,847 eligible children ages 3 and 4 in Rhode Island.[8] In the core cities, 45% of the eligible children were enrolled in Head Start whereas 96% of the eligible children in the remainder of the state were served by Head Start.[9]

◆ Since 1997 there has been a consistent increase in the number of children who participate in Head Start. In Rhode Island in 2004, the Head Start Program experienced its highest enrollment with 2,780 children, an increase of 411 children since 1997.[10]

◆ Because Head Start is available to only approximately half of Rhode Island's lowest-income children, resources were appropriated under Starting RIght (Rhode Island's child care initiative) to create Comprehensive Child Care Services Programs which provide developmentally appropriate education and support services to children and families in underserved communities.[11]

◆ As of January 2005, Comprehensive Child Care Services Programs were providing services to 300 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.[12]

Table 29.

Children Enrolled in Head Start, Rhode Island, 2004

CITY/TOWN	ESTIMATED ELIGIBLE CHILDREN AGED 3&4*	NUMBER OF CHILDREN ENROLLED IN HEAD START	% OF ELIGIBLE 3&4 YEAR OLDS ENROLLED
Barrington	10	2	20%
Bristol	54	24	44%
Burrillville	35	30	86%
Central Falls	260	92	35%
Charlestown	7	13	100%*
Coventry	45	43	96%
Cranston	143	228	100%*
Cumberland	32	6	19%
East Greenwich	29	5	17%
East Providence	134	109	81%
Exeter	35	3	9%
Foster	0	0	NA
Glocester	18	7	39%
Hopkinton	19	5	26%
Jamestown	0	1	100%*
Johnston	55	48	87%
Lincoln	24	3	13%
Little Compton	3	2	67%
Middletown	30	40	100%*
Narragansett	18	12	67%
New Shoreham	1	0	0%
Newport	223	150	67%
North Kingstown	85	33	39%
North Providence	60	61	100%*
North Smithfield	13	5	38%
Pawtucket	643	220	34%
Portsmouth	24	11	46%
Providence	1,919	892	46%
Richmond	7	8	100%*
Scituate	6	3	50%
Smithfield	5	9	100%*
South Kingstown	33	25	76%
Tiverton	12	32	100%*
Warren	17	30	100%*
Warwick	137	217	100%*
West Greenwich	11	0	0%
West Warwick	207	81	39%
Westerly	51	88	100%*
Woonsocket	443	242	55%
Core Cities	*3,695*	*1,677*	*45%*
Remainder of State	*1,153*	*1,103*	*96%*
Rhode Island	*4,848*	*2,780*	*57%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled as of October 2004. Based on survey responses from Head Start Programs, collected by Rhode Island KIDS COUNT.

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 age 5 in that community, according to Census 2000, Summary File 3. 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. There is no available poverty rate by community for 3 and 4 year olds. Since children younger than 3 are more likely to be poor than children ages 3 to 5, using the poverty rate for children under 5 may over estimate the number of children ages 3 and 4 in poverty (and eligible for Head Start) and underestimate the number of children younger than 3 in poverty (and eligible for Early Head Start).

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

References for Indicator

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[8,9,10] Rhode Island Head Start Programs, children enrolled as of October 1997 and 2004.

[11] Rhode Island General Statute, 42-12-26.

[12] Rhode Island Department of Human Services, Office of Child Care, January 2005.

Full-Day Kindergarten

DEFINITION

Full-day kindergarten is the percentage of public school children enrolled in a full-day kindergarten program as of October 2004. 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

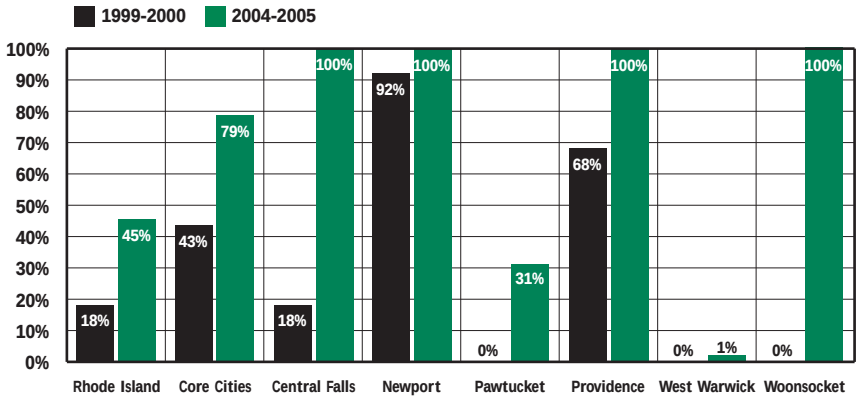
Research shows that many children benefit academically from participation in full-day kindergarten and are more likely to be ready for first grade than children in half-day kindergarten programs.[1,2] Full-day kindergarten programs are especially beneficial to children from low-income and educationally 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. Full-day kindergarteners are also more likely to approach their teachers and experience fewer feelings of anger, shyness and withdrawal.[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 full-day programs, 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 2004-2005



Source: Rhode Island Department of Elementary and Secondary Education, 1999-2000 and 2004-2005 school years.

◆ In Rhode Island in 2004-2005, 45% of the children who attended kindergarten were in a full day program.[12]

◆ As of the 2004-2005 school year, eleven school districts offered universal access to full-day kindergarten programs.[13]

◆ Sixty-two percent of full-day kindergarteners attend public school in one of the six core cities, 32% in the remainder of the state and the remaining 6% were served in a state run or charter school.[14]

◆ Since the benefits of full-day kindergarten are closely related to the quality of curriculum and instruction, the most effective full-day kindergarten programs spend time assessing the school readiness and curricular needs of their kindergarten population, create specific program goals and design programs based on developmentally appropriate practices.[15]

◆ Cost is a major consideration for most districts considering full-day kindergarten. Some research suggests that districts can save money over the long term because full-day kindergarten programs are more effective and reduce the need to retain students.[16]

Table 30. **Children Enrolled in Full-Day Kindergarten Programs, Rhode Island, 1999-2000 and 2004-2005**

SCHOOL DISTRICT	1999-2000 SCHOOL YEAR TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL-DAY K	% OF CHILDREN IN FULL-DAY K	2004-2005 SCHOOL YEAR TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL DAY K	% CHILDREN IN FULL DAY K
Barrington	214	0	0%	180	22	12%
Bristol-Warren	255	0	0%	223	222	100%
Burrillville	164	0	0%	162	162	100%
Central Falls	250	44	18%	224	224	100%
Chariho	292	0	0%	246	43	17%
Coventry	381	0	0%	304	0	0%
Cranston	737	0	0%	587	0	0%
Cumberland	373	0	0%	326	6	2%
East Greenwich	165	0	0%	91	3	3%
East Providence	443	0	0%	282	42	15%
Exeter-W. Greenwich	129	0	0%	108	0	0%
Foster	55	0	0%	33	0	0%
Foster-Glocester	0	0	NA	0	0	NA
Glocester	124	0	0%	85	0	0%
Jamestown	59	0	0%	47	0	0%
Johnston	241	0	0%	128	1	1%
Lincoln	232	0	0%	221	0	0%
Little Compton	38	0	0%	46	0	0%
Middletown	258	211	82%	203	203	100%
Narragansett	125	0	0%	92	92	100%
New Shoreham	8	8	100%	10	10	100%
Newport	225	206	92%	155	155	100%
North Kingstown	313	0	0%	265	38	14%
North Providence	211	0	0%	147	0	0%
North Smithfield	122	55	45%	134	134	100%
Pawtucket	788	0	0%	648	204	31%
Portsmouth	214	0	0%	167	0	0%
Providence	2,117	1,431	68%	1,480	1,480	100%
Scituate	107	0	0%	107	16	15%
Smithfield	177	0	0%	126	0	0%
South Kingstown	278	0	0%	211	21	10%
Tiverton	144	0	0%	120	0	0%
Warwick	766	29	4%	606	38	6%
West Warwick	260	0	0%	216	2	1%
Westerly	282	10	4%	216	216	100%
Woonsocket	522	0	0%	399	399	100%
Charter Schools	*NA*	*NA*	*NA*	*221*	*221*	*100%*
State Run Schools	*NA*	*NA*	*NA*	*8*	*8*	*100%*
Core Cities	*4,162*	*1,681*	*40%*	*3,122*	*2,464*	*79%*
Remainder of State	*6,907*	*313*	*5%*	*5,473*	*1,269*	*23%*
Rhode Island	*11,069*	*1,994*	*18%*	*8,824*	*3,962*	*45%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education. Data are as of October for the 1999-2000 and 2004-2005 school years.

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

Charter schools reported for this indicator are CVS Highlander Charter School, The Compass Charter School, International Charter School, Kingston Hill Academy, The Learning Community, and Paul Cuffee Charter School. The state-run school is the Rhode Island School for the Deaf.

Note: In large part as a result of the change in the kindergarten entry age enacted in the 2004-2005 school year, there is a 1,900 child difference in the number of children in kindergarten programs between the 2003-2004 school year and the 2004-2005 school year.

References for Indicator

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(continued on page 146)

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

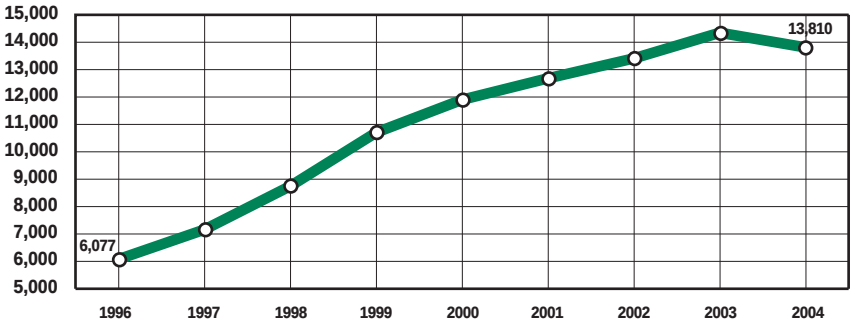
Families rely on child care to enable them to work and to provide the early education experiences needed to prepare their children for school.[1] Yet the high cost of child care puts quality care out of reach for many families, particularly low-income families.[2] National studies have shown that child 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]

The high cost of child care disproportionately affects the lowest income families. Nationally, families with earnings below the federal poverty threshold 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 guidelines ($42,413 for a family of four in 2004) are entitled to a child care subsidy for their children through age 15. 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 high quality care.[10,11]

Child Care Subsidies, Rhode Island, 1996-2004



Source: Rhode Island Department of Human Services, December 1996-December 2004.

◆ The number of children receiving child care subsidies has increased from 6,077 in 1996 to a high of 14,333 in 2003. This number decreased slightly in 2004 to 13,810. In 2004, 67% of Rhode Island families receiving child care subsidies chose licensed child care centers, 23% chose certified family child care homes and 10% chose a relative, friend or neighbor for their child care arrangements.[12]

◆ In December 2004, 76% of all child care subsidies in Rhode Island were being used by low-income working families not receiving cash assistance and 19% by families receiving cash assistance through the Family Independence Program (FIP) and engaged in education, training or employment.[13]

Estimating Child Care Subsidy Eligibility

◆ Estimating the number of children eligible for child care subsidies in the U.S. is difficult because of differences in state definitions of the eligible population, differences in funding, local child care costs, reimbursement rates, co-payment policies and the number of low- and moderate-income working parents in each state.[14]

◆ The most recent study available estimates that 31,428 Rhode Island children were eligible for child care subsidies under state rules in October 2001.[15] In 2001, in Rhode Island, 12,682 — or 40% of those eligible — received child care subsidies.[16]

Table 31.

Child Care Subsidies, Rhode Island, 2004

CITY/TOWN	SUBSIDY USE AMONG WORKING FAMILIES: ENROLLED IN FIP	SUBSIDY USE AMONG WORKING FAMILIES: NOT 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	0	50	3	10	35	2	50
Bristol	8	33	7	17	15	2	41
Burrillville	15	81	14	38	43	1	96
Central Falls	100	291	66	126	188	11	391
Charlestown	8	19	4	18	5	0	27
Coventry	26	174	59	68	71	2	200
Cranston	100	690	210	274	278	28	790
Cumberland	20	103	31	44	47	1	123
East Greenwich	7	94	46	41	14	0	101
East Providence	75	412	107	155	209	16	487
Exeter	7	19	5	12	9	0	26
Foster	4	17	4	9	8	0	21
Glocester	3	17	12	7	1	0	20
Hopkinton	8	13	9	5	7	0	21
Jamestown	1	15	5	3	7	1	16
Johnston	27	165	45	76	69	2	192
Lincoln	13	229	81	102	57	2	242
Little Compton	0	0	0	0	0	0	0
Middletown	26	242	97	132	33	6	268
Narragansett	4	45	9	19	16	5	49
New Shoreham	0	2	0	2	0	0	2
Newport	101	122	47	65	107	4	223
North Kingstown	45	125	35	57	78	0	170
North Providence	32	209	48	84	95	14	241
North Smithfield	6	10	2	5	9	0	16
Pawtucket	232	1,118	298	459	545	48	1,350
Portsmouth	8	41	12	17	18	2	49
Providence	1,226	4,315	1,354	1,724	2,085	378	5,541
Richmond	1	24	8	16	1	0	25
Scituate	6	2	1	2	5	0	8
Smithfield	2	114	33	51	31	1	116
South Kingstown	35	84	19	56	40	4	119
Tiverton	11	21	2	17	13	0	32
Warren	15	54	14	31	22	2	69
Warwick	97	915	238	380	366	28	1,012
West Greenwich	0	40	11	25	4	0	40
West Warwick	31	307	54	142	139	3	338
Westerly	28	51	18	27	34	0	79
Woonsocket	211	298	130	191	159	29	509
Out-of-State	*NA*	*NA*	*25*	*50*	*15*	*2*	*92*
Core Cities	*1,901*	*6,451*	*1,949*	*2,707*	*3,223*	*473*	*8,352*
Remainder of State	*638*	*4,110*	*1,189*	*1,800*	*1,640*	*119*	*4,748*
Rhode Island	*2,539*	*10,561*	*3,163*	*4,557*	*4,878*	*594**	*13,192*

FIP is the Family Independence Program.

Notes to Table

*Of these, 50 subsidies were used by older youth. This small number of subsidies for older 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 2004. Subsidy data by age of child are reported by location of the child care program not the residence of the child. Subsidy data by FIP status are reported by residence of the child. Children not enrolled in FIP include the 754 children in the care of the Department of Children, Youth and Families who are receiving subsidies.

This table does not include retroactive payment data for December and therefore the total number of subsidies differs slightly from the total reported on the previous page.

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 years of age and up to $175 for children two years and older. The child care disregard is a form of subsidy not included in this table. In 2004, families of 168 children used child care disregards.

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(continued on page 146)

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

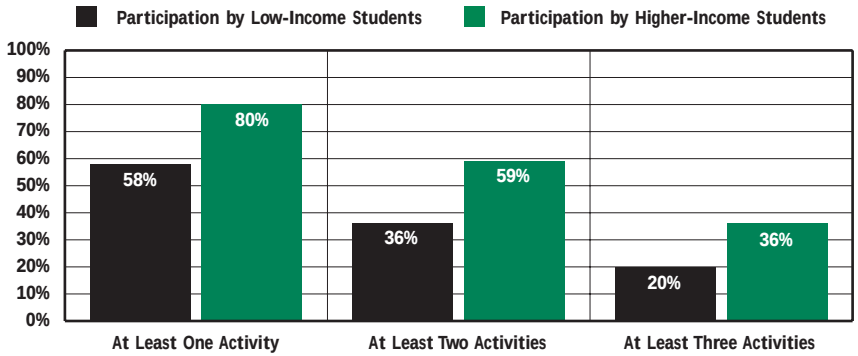
Many children are without adult supervision during the hours before and after school.[1] Many parents need care for their school-age children during work hours. Children spend only 20% of their waking hours in school. The gap between parents' work schedules and students' school schedules can amount to 20-25 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]

When school is out, children and young adolescents need a safe place 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.[5,6] Programs for older youth can be particularly successful if they treat youth as a resource and provide opportunities to contribute to the community.[7]

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. Their parents are more likely to be involved in school activities.[8,9,10,11,12] Yet, many programs are of poor quality due to a lack of resources, staff turnover, and inappropriate space. Resources are particularly scarce in low-income communities where they are needed most.[13]

During the 2003-2004 school year, one in five (18%) Rhode Island school children in grades 5 through 8 were home after school without adult supervision for more than three hours on at least three days per week. An additional 4% were 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.[14]

Middle School Students Participation in Extracurricular Activities, Rhode Island, 2003-2004 School Year



Number of Extracurricular Activities

Source: Felner, R. PhD. (2003). *SALT Survey Reports, School Year 2003-2004.* Rockland, IL: University of Rhode Island, National Center on Public Education and Policy. Low-income students are those receiving free or reduced price lunch.

◆ Nationally and in Rhode Island, middle school students from low-income families are less likely to participate in extracurricular activities and programs than students from higher-income families.[15,16]

◆ Low-income children and 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.[17] Students who are low-income, or have low school attendance, limited English proficiency or poor test scores show the greatest gains linked to participation in after-school programs.[18]

◆ Youth outcomes improve as the amount of time students attend a program during a given period increases. Frequency of attendance is positively associated with improved academic achievement, higher occupational expectations and university enrollments, and better emotional adjustment, increased happiness, and lower suicidal risk.[19]

◆ Since 1995, the number of licensed school-age child care slots in Rhode Island increased 151% from 5,570 in 1995 to 14,006 in 2004.[20]

Table 32. **Licensed School-Age Child Care for Children Ages 6 to 12, Rhode Island, 2004**

CITY/TOWN	NUMBER OF CHILDREN AGES 6 TO 12	PROGRAMS	SLOTS
Barrington	2,064	9	379
Bristol	1,784	5	176
Burrillville	1,672	4	243
Central Falls	2,190	5	422
Charlestown	717	1	26
Coventry	3,431	11	432
Cranston	7,115	20	687
Cumberland	3,135	5	225
East Greenwich	1,581	5	247
East Providence	4,292	17	946
Exeter	684	5	130
Foster	489	2	68
Glocester	1,105	2	101
Hopkinton	802	0	0
Jamestown	576	1	50
Johnston	2,490	7	218
Lincoln	2,206	5	265
Little Compton	322	1	26
Middletown	1,787	7	248
Narragansett	1,144	1	60
New Shoreham	69	0	0
Newport	2,056	9	413
North Kingstown	2,823	12	584
North Providence	2,444	3	160
North Smithfield	988	1	100
Pawtucket	7,477	14	1,171
Portsmouth	1,839	2	92
Providence	18,592	43	3,138
Richmond	830	4	130
Scituate	1,102	2	68
Smithfield	1,653	5	242
South Kingstown	2,630	7	250
Tiverton	1,452	2	95
Warren	1,032	4	152
Warwick	7,630	25	1,234
West Greenwich	592	2	36
West Warwick	2,618	7	390
Westerly	2,160	7	270
Woonsocket	4,373	13	532
Core Cities	*37,306*	*91*	*6,066*
Remainder of State	*64,640*	*184*	*7,940*
Rhode Island	*101,946*	*275*	*14,006*

Source of Data for Table/Methodology

The number of children ages 6 to 12 years old are from the U.S. Census Bureau, Census 2000, Summary File 1, P.14.

Programs and slots data are from Options for Working Parents, Greater Providence Chamber of Commerce. Numbers of licensed school-age child care programs and slots for children ages 6 to 12 are as of December 2004. 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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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.

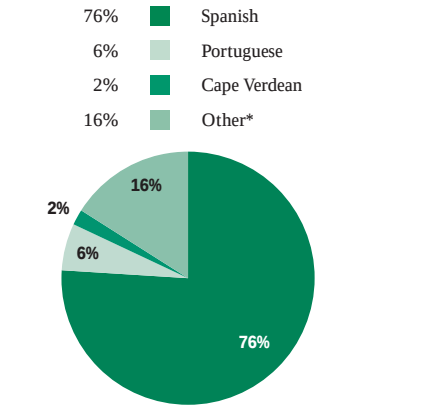
SIGNIFICANCE

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]

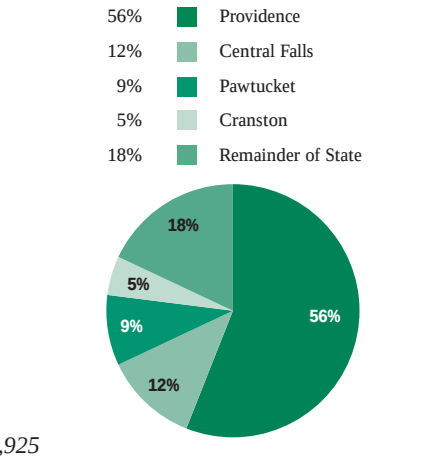
Adults who report that they have some difficulty with English are twelve times as likely to have completed less than five years of schooling and half as likely to have graduated from high school. Children who live in these households are 50% more likely to live in poverty.[3] These children are more likely to be concentrated in under-resourced schools in high poverty communities.[4] In 2003-2004 in Rhode Island, 6,244 (70%) of all English language learner students live in low-income families.[5]

According to Census 2000, one out of every five children in the United States is an immigrant or the child of immigrant parents.[6] In Rhode Island the largest numbers of immigrants originate from Latin America (37%), Europe (33%) and Asia (16%).[7] Immigrant students may enter school after extended absences from formal education and with deficits 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.[8] Rhode Island schools are legally mandated to provide programs to English language learners that are comparable in structure and content to instruction provided to English proficient students. 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 system.[9]

English Language Learners, by Language, Rhode Island, 2004



English Language Learners, by Community, Rhode Island, 2004



n = 8,925

** Includes African and Asian languages, Creole, French, Arabic, Chinese, Cambodian, Italian, and others.*

Source: Rhode Island Department of Elementary and Secondary Education, 2003-2004. All data are for public school students in Rhode Island.

◆ For Rhode Island as a whole, the number of English language learners decreased from 9,723 students in 2002-2003 to 8,925 students in 2003-2004. Eighty-two (82%) percent of all English language learners live in the core cities, with the majority residing in Providence, Central Falls and Pawtucket.[10]

◆ Spanish is the most commonly spoken language of Rhode Island's public school students who are English language learners.[11] This is consistent with the increase in the Latino child population in Rhode Island from 16,000 in 1990 to 35,000 in 2000.[12]

◆ Six percent or 11,484 of Rhode Island's children ages 5 to 17 live in linguistically isolated households, defined as a household in which no one 14 years of age or older speaks English very well. Two-thirds of these children live in Central Falls or Providence, accounting for 28% of the children in Central Falls and 19% of the children in Providence.[13]

Table 33.

English Language Learners, Rhode Island, 2003-2004

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	3,305	1	5	2	1	9	<1%
Bristol-Warren	3,576	21	77	15	11	124	3%
Burrillville	2,527	1	0	0	2	3	<1%
Central Falls	3,704	109	459	237	228	1,033	28%
Chariho	3,733	1	6	1	7	15	<1%
Coventry	5,699	3	12	1	1	17	<1%
Cranston	10,873	34	237	100	63	434	4%
Cumberland	5,088	16	70	9	10	105	2%
East Greenwich	2,399	2	12	3	6	23	1%
East Providence	5,945	70	134	31	29	264	4%
Exeter-W. Greenwich	2,091	2	2	3	1	8	<1%
Foster	349	0	0	0	0	0	0%
Foster-Glocester	1,685	0	0	0	0	0	0%
Glocester	749	0	0	0	0	0	0%
Jamestown	548	5	5	0	0	10	2%
Johnston	3,165	0	19	11	7	37	1%
Lincoln	3,453	8	21	5	5	39	1%
Little Compton	313	0	0	0	0	0	0%
Middletown	2,680	6	17	14	15	52	2%
Narragansett	1,655	3	6	2	0	11	1%
New Shoreham	140	1	1	2	1	5	4%
Newport	2,782	11	75	10	4	100	4%
North Kingstown	4,535	5	28	12	7	52	1%
North Providence	3,373	5	23	14	15	57	2%
North Smithfield	1,868	0	0	0	1	1	<1%
Pawtucket	9,518	90	364	179	209	842	9%
Portsmouth	2,965	0	0	0	0	0	0%
Providence	27,399	651	2,878	770	702	5,001	18%
Scituate	1,731	0	2	0	1	3	<1%
Smithfield	2,651	2	6	0	0	8	<1%
South Kingstown	4,018	2	16	4	11	33	1%
Tiverton	2,127	0	0	0	0	0	0%
Warwick	11,626	13	50	15	11	89	1%
West Warwick	3,776	14	31	12	14	71	2%
Westerly	3,695	15	30	14	13	72	2%
Woonsocket	6,631	47	165	47	16	275	4%
Charter Schools	*921*	*23*	*70*	*0*	*0*	*93*	*10%*
State Run Schools	*1,166*	*0*	*0*	*0*	*39*	*39*	*3%*
Core Cities	*53,810*	*922*	*3,972*	*1,255*	*1,173*	*7,322*	*14%*
Remainder of State	*98,562*	*216*	*779*	*258*	*218*	*1,471*	*1%*
Rhode Island	*154,459*	*1,161*	*4,821*	*1,513*	*1,430*	*8,925*	*6%*

Sources of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2003-2004 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 2003-2004 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.

Because of a change in methodology, the percentage of English language learners by district cannot be compared with percentages given in Factbooks previous to the 2004 Factbook. This year's % of Total District was based on the total number of English language learners divided by the average daily membership as of June 2004.

State run schools include: Davies Career and Technical school and the Metropolitan Career Technical Center. Charter schools include: CVS Highlander, Paul Cuffee Charter School, Kingston Hill Academy, International Charter, Blackstone Academy, The Compass School and Beacon Charter School.

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

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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

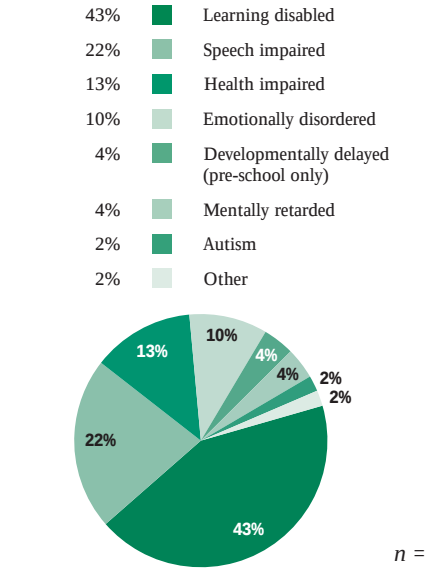
Special education and related services are important resources for improving long-term outcomes for children with special needs, such as improving student achievement and graduation rates, increasing participation in postsecondary education and increasing wages.[1,2] The No Child Left Behind Act now requires 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, a student must be provided with an Individualized Education Program (IEP) laying out goals, outlining specific steps for achieving the goals and providing services for the student based on their individual needs. 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.

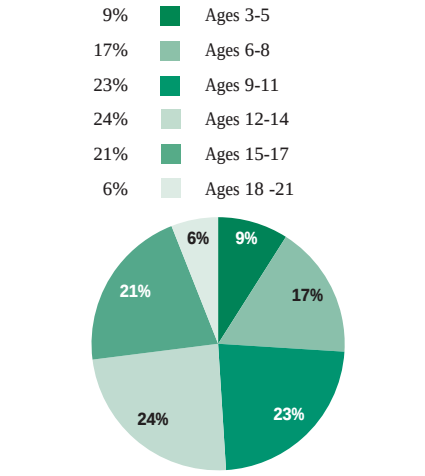
The percentage of students identified for special education services in Rhode Island has increased substantially over the past twenty years.[4] In the 2000-2001 school year (the most recent year national data were tabulated), Rhode Island had the highest percentage of public school students identified as disabled and receiving special education services under IDEA in the nation.[5] Between the 1992-1993 and 2003-2004 school years, special education enrollment increased from 16% to 21% of all enrolled students.[6]

In 2002, the President's Commission on Excellence in Special Education called for reform to the national special education system by increasing efforts to identify problems earlier and to provide swift intervention to prevent failure rather than waiting for a child to fail.[7]

Special Education Enrollment by Disability, Rhode Island, 2003-2004



Special Education Enrollment by Age, Rhode Island, 2003-2004



n = 32,925

Source: Rhode Island Department of Elementary and Secondary Education, Office of Special Education, 2003-2004 school year.

◆ Students with learning disabilities and students with speech/language impairments accounted for nearly than two-thirds (65%) of special education enrollment in 2003-2004.[8]

◆ In 2004, children between the ages of 3 and 8 years old accounted for more than one-quarter of all children enrolled in special education.[9]

Reading Difficulties and Special Education

◆ National data show that almost half of the children in special education are identified as having a learning disability, with 80% of these children receiving services because they have not learned to read.[10]

Table 34.

Children and Youth in Special Education, by Primary Disability, Ages 3-21, Rhode Island, 2003-2004

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	3,305	56	8	26	88	214	148	23	25	588	18%
Bristol-Warren	3,576	68	50	26	31	338	169	32	26	740	21%
Burrillville	2,527	69	20	24	126	167	124	19	14	563	22%
Central Falls	3,704	107	41	7	85	541	133	48	18	980	26%
Chariho	3,712	59	15	20	49	271	212	39	22	687	19%
Coventry	5,699	69	35	12	60	782	155	50	23	1,186	21%
Cranston	10,784	185	56	43	306	1,288	390	86	47	2,401	22%
Cumberland	5,088	139	25	36	308	345	315	49	32	1,249	25%
East Greenwich	2,399	31	5	21	91	106	143	14	14	425	18%
East Providence	5,945	190	62	29	330	512	299	29	42	1,493	25%
Exeter-W. Greenwich	2,095	41	15	10	111	104	127	11	9	428	20%
Foster	349	1	1	1	3	12	34	0	2	54	15%
Foster-Glocester	1,685	21	11	7	26	96	52	0	5	218	13%
Glocester	748	1	6	4	12	45	78	9	4	159	21%
Jamestown	548	5	3	14	36	44	22	5	1	130	24%
Johnston	3,165	78	21	21	182	331	189	42	24	888	28%
Lincoln	3,453	53	19	24	168	261	166	30	18	739	21%
Little Compton	313	4	1	1	7	41	29	1	4	88	28%
Middletown	2,607	46	7	17	89	259	158	4	14	594	23%
Narragansett	1,655	17	3	10	46	122	140	19	8	365	22%
New Shoreham	140	0	1	1	0	6	13	0	0	21	15%
Newport	2,738	86	10	23	27	422	106	74	23	771	28%
North Kingstown	4,338	66	19	11	52	409	226	23	27	833	19%
North Providence	3,373	81	25	16	165	203	152	21	22	685	20%
North Smithfield	1,868	20	6	3	44	156	96	13	12	350	19%
Pawtucket	9,518	236	119	57	167	828	402	139	36	1,984	21%
Portsmouth	2,851	44	10	26	85	166	212	3	14	560	20%
Providence	27,399	680	392	27	193	2,910	956	124	41	5,323	19%
Scituate	1,731	8	2	11	33	87	146	11	1	299	17%
Smithfield	2,648	9	11	14	72	157	145	14	13	435	16%
South Kingstown	4,018	72	20	34	149	347	254	32	28	936	23%
Tiverton	2,123	32	5	11	44	232	148	5	15	492	23%
Warwick	11,626	147	72	57	507	976	397	159	73	2,388	21%
West Warwick	3,772	134	27	13	30	437	243	39	29	952	25%
Westerly	3,694	82	11	22	91	237	176	31	18	668	18%
Woonsocket	6,583	219	145	29	373	521	304	87	57	1,735	26%
Charter Schools	*922*	*5*	*0*	*2*	*7*	*55*	*54*	*1*	*4*	*128*	*14%*
State Run Schools	*1,278*	*7*	*0*	*0*	*31*	*114*	*9*	*0*	*82*	*243*	*19%*
*DCYF**	*NA*	*134*	*1*	*0*	*0*	*10*	*0*	*2*	*0*	*147*	*NA*
Core Cities	*53,714*	*1,462*	*734*	*156*	*875*	*5,659*	*2,144*	*511*	*204*	*11,745*	*22%*
Remainder of State	*98,063*	*1,694*	*545*	*552*	*3,311*	*8,314*	*4,915*	*774*	*557*	*20,662*	*21%*
Rhode Island	*153,977*	*3,302*	*1,280*	*710*	*4,224*	*14,152*	*7,122*	*1,288*	*847*	*32,925*	*21%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2003-2004 school year. Office of Special Populations, June 30, 2004.

The denominator (number of students) is the "resident average daily membership" provided by the RI Department of Elementary and Secondary Education. For regional school districts, state-run schools and independent charter schools, a measure provided by the Rhode Island Department of Elementary and Secondary Education equivalent to resident average daily membership was used.

"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 "emotionally disordered" was called "behaviorally disordered."

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

Independent charter schools reported for this indicator are Beacon Charter School, Blackstone Academy, Compass School, CVS Highlander 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. This category does 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.

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(continued on page 146)

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

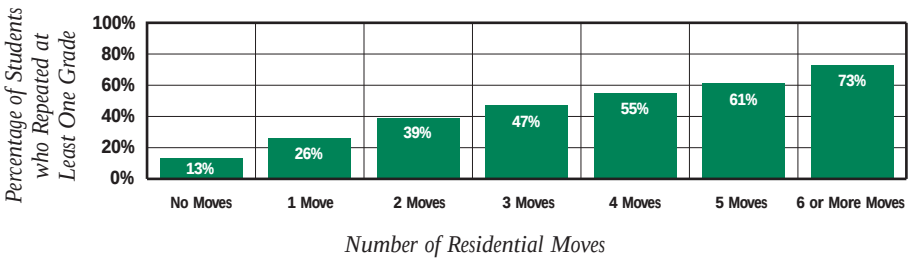
Families move for a variety of reasons that may include changes in household structure, parental employment status, an inability to pay the rent, dissatisfaction with neighborhood conditions or a desire to improve overall quality of family life.[2,3]

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 classroom of which he or she is a member. Changing schools causes a disruption in a child's learning experience and may accentuate learning difficulties if the classroom a child enters is at a different point in the curriculum than the classroom the child left.[5]

Research shows that frequent moves can have a negative effect on school performance, behavior and other areas of child well-being.[6,7] Strong evidence exists that mobility during both elementary and high school reduces the chance that a student will graduate.[8] 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 students' previously developed knowledge and skill sets.[9]

Nationally, children under age five, children of color, children living in low-income households or renter households, children whose parents did not complete high school and immigrants have the highest rates of mobility.[10] Children who are English Language Learners (ELL) are more than twice as likely to change schools frequently as those who are non-ELL students.[11] Mobility also has a strong relationship 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.[12,13]

Students Who Repeated at Least One Grade by Number of Residential Moves, Providence, 1987 - 2001



Source: *Development and use of neighborhood health analysis: Residential mobility in context.* (2002). Providence, RI: The Providence Plan. Data represents 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 three times had repeated a grade at least once.[14]

Mobility and Education Outcomes in Rhode Island

◆ In Rhode Island, students who move are absent more often than students who do not move. Thirty-one percent of students who did not move missed 16 or more days of school, compared to 42% of students who moved at least once during the same period.[15]

◆ Children who move perform worse on standardized tests than children who have not experienced mobility. The more frequent the number of moves the worse the performance. Sixty-six percent 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.[16]

◆ Rhode Island recently implemented a statewide student identifier system that assigns each student a unique identifying number to track his or her progress through the public school systems. Unique student identifiers allow states to better chart the paths and progress of students, ensure that students are not miscounted as they move between districts and understand the patterns and effects of student mobility.[17] The first complete set of data using the student identifier will be available for the 2004-2005 school year.

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.* (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.[18]

◆ 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.[19]

◆ Rhode Island children born to teen mothers, single mothers or mothers with less than a high school diploma are most likely to experience residential mobility.[20]

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.[21]

◆ 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.[22]

◆ 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.[23]

References for Indicator

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[2] *Why people move: Exploring the March 2000 Current Population Survey: March 1999 to March 2000.* (2001). Washington, DC: U.S. Bureau of the Census.

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[6] *Kids Mobility Project report.* (2002). Minneapolis, MN: Family Housing Fund.

[7,13] Scanlon, E., & Devine, K. (2001). Residential mobility and youth well-being: Research, policy and practice Issues. *Journal of Sociology and Social Welfare*, XXVIII(1), 119-138.

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[14,15,16,18,19,20,21] *Development and use of neighborhood health analysis: Residential mobility in context.* (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.

[17] Hamilton, L. S. (2002). *Benefits of a statewide student identifier system for California.* Santa Monica, CA: RAND.

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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 2004. The exam measures reading and writing skills. Data from the two reading sub-tests are reported here: *Basic Understanding* focuses on the student's ability to comprehend text and *Interpretation and Analysis* focuses on the student's ability to correctly interpret and analyze text.

SIGNIFICANCE

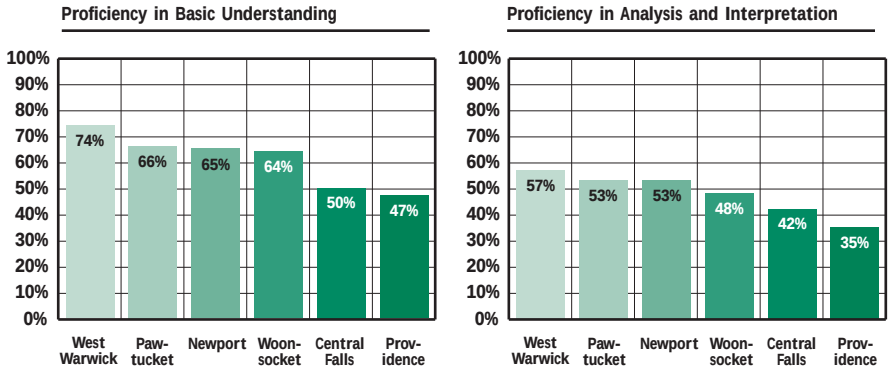
Reading skills are critical to a student's success in school and in the workforce. Students who are beyond 4th grade who cannot read are more likely to be absent from school, exhibit behavior problems, have low levels of self-confidence, perform poorly in school and drop-out of school before graduation. 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 correlate 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]

When students continue to have difficulty reading beyond third grade, they can face tremendous difficulty catching up. Older students can learn to read when they attend schools that identify reading difficulties early, intervene quickly to teach the foundation skills students have missed, address special needs and provide many opportunities to practice reading with meaningful, age-appropriate books. Teaching older students with reading difficulties requires that teachers be well prepared and supported and that students receive intensive instruction, time, and incentives to overcome reading and language challenges.[8]

Rhode Island Public School 4th Grade Reading Proficiency, Core Cities, 2003-2004



Source: RI Department of Elementary and Secondary Education, *New Standards English Language Arts Reference Exam* at Grade 4, 2003-2004 school year.

◆ In 2004, 73% of Rhode Island fourth graders scored at or above proficiency in *Basic Understanding* and 62% scored at or above proficiency in *Analysis and Interpretation*. All of Rhode Island's core cities had reading proficiency levels below the state rates except West Warwick which exceeded the state rate for Basic Understanding by one percentage point.[9]

◆ Before children can learn to read, they need to learn that words are made up of speech sounds, or phonemes, and that there is a relationship between the letters of written language and the individual sounds of spoken language. Effective early reading instruction includes activities that teach children to notice, think about, and manipulate sounds in spoken language as well as direct teaching of letter-sound relationships.[10]

◆ Repeated and monitored oral reading improves children's ability to recognize words automatically and understand what they read. Improving children's vocabulary helps develop reading skills. Children have a much more difficult time reading words that are not already part of their oral vocabulary.[11]

◆ Teaching specific reading comprehension strategies helps children improve their understanding of what they read and their ability to remember and communicate with others what they read.[12]

Table 35.

Fourth-Grade Reading Proficiency, Rhode Island, 2003-2004

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	# OF ELIGIBLE 4TH GRADE TEST TAKERS		
Barrington	92%	2%	<1%	279	93%	85%
Bristol-Warren	NA	8%	3%	267	80%	72%
Burrillville	80%	5%	<1%	170	80%	69%
Central Falls	49%	36%	28%	274	50%	42%
Chariho	NA	4%	<1%	287	83%	69%
Coventry	83%	6%	<1%	462	84%	69%
Cranston	79%	8%	4%	851	85%	75%
Cumberland	81%	3%	2%	439	84%	73%
East Greenwich	93%	4%	1%	215	91%	84%
East Providence	71%	9%	4%	472	76%	63%
Exeter-W. Greenwich	NA	4%	<1%	160	84%	61%
Foster	88%	6%	0%	70	76%	69%
Foster-Glocester	NA	4%	0%	0	NA	NA
Glocester	87%	8%	0%	141	83%	77%
Jamestown	93%	2%	2%	56	80%	75%
Johnston	78%	9%	1%	259	75%	67%
Lincoln	82%	6%	1%	275	81%	72%
Little Compton	91%	1%	0%	38	87%	68%
Middletown	91%	8%	2%	204	79%	69%
Narragansett	91%	7%	1%	142	85%	80%
New Shoreham	95%	8%	4%	5	100%	100%
Newport	87%	22%	4%	196	65%	53%
North Kingstown	92%	7%	1%	359	87%	83%
North Providence	77%	9%	2%	240	80%	65%
North Smithfield	82%	2%	<1%	144	81%	65%
Pawtucket	66%	21%	9%	815	66%	53%
Portsmouth	91%	3%	0%	254	84%	75%
Providence	66%	36%	18%	2,272	47%	35%
Scituate	87%	4%	<1%	137	88%	81%
Smithfield	85%	4%	<1%	222	89%	81%
South Kingstown	91%	4%	1%	328	85%	81%
Tiverton	80%	3%	0%	161	76%	62%
Warwick	85%	7%	1%	879	82%	73%
West Warwick	76%	15%	2%	324	74%	57%
Westerly	82%	7%	2%	288	80%	71%
Woonsocket	64%	27%	4%	540	64%	48%
Charter Schools	*NA*	*NA*	*10%*	*76*	*72%*	*58%*
Core Cities	*NA*	*30%*	*14%*	*4,421*	*56%*	*43%*
Remainder of State	*NA*	*6%*	*1%*	*7,804*	*83%*	*73%*
Rhode Island	*78%*	*15%*	*6%*	*12,301*	*73%*	*62%*

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, 2002. % of Adults Completing High School or higher is from Census 2000 and consequently cannot be given for regional districts for which census data does not exist. As such these districts are marked NA. All other data are from the Rhode Island Department of Elementary and Secondary Education, 2003-2004 school year.

All students eligible to take the test, whether or not they actually took the test, are counted in the district's or school's proficiency rate. All enrolled students are eligible unless their IEP specifically exempts them or unless they are beginning English Language Learners.

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

Independent charter schools reported for this indicator are the Compass School, CVS Highlander Charter School, International Charter School and Paul Cuffee Charter School.

References for Indicator

[1,4] Federal Interagency Forum on Child and Family Statistics. (2003). *America's children: Key national indicators of well-being.* Washington, DC: U.S. Government Printing Office.

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Math Skills

DEFINITION

Math skills is the percentage of fourth-grade and eighth-grade students who scored at or above the proficiency level for math on the *New Standards Reference Exam* in 2004. The exam consists of three parts: *Skills*, *Concepts* and *Problem Solving*. Reported here are the overall score on the exam and data from the *Problem Solving* sub-test.

SIGNIFICANCE

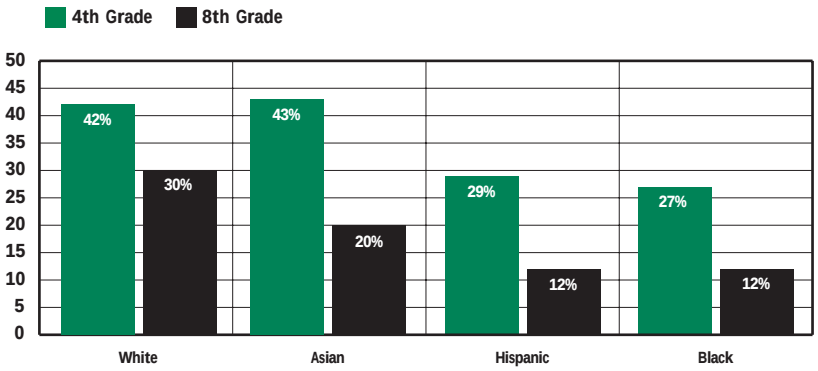
The ability to understand and use mathematics is critical in life. Students must rely on math skills not only for advanced education, but also in the course of daily activities. Schools in Rhode Island typically teach mathematics every year through eighth grade and require students to take three years of mathematics and one year of mathematics related work to graduate from high school.[1]

State, national and international assessments show that students may fare well when asked to perform straightforward computational procedures, but tend to have limited mathematical skills needed to solve simple problems. Performance in mathematics, while generally low, has been improving over the past decade.[2] Nationally, approximately one in four elementary and middle school students are proficient in math, with gaps in performance existing between low-income children and higher-income children.[3] In Rhode Island in 2004, 35% of economically disadvantaged fourth grade students were proficient in math compared to 51% of fourth grade students statewide. Nineteen percent of economically disadvantaged eighth grade students were proficient in math compared to 40% of eighth graders statewide.[4]

Family risk factors, such as poverty, language barriers and low maternal education, negatively impact achievement in mathematics.[5] Students with a poor understanding of mathematics will have fewer opportunities to pursue higher levels of education and secure high-level employment.[6]

Frequent engagement in classroom activities such as doing math problems from a textbook, talking to others about how to solve math problems and using a calculator, are associated with higher scores on assessments.[7] Students' achievement in math is highest when they are taught by teachers with strong backgrounds and training in math.[8]

4th and 8th Grade Math Proficiency by Race and Ethnicity, in Public Schools, Core Cities, 2003-2004



Source: RI Department of Elementary and Secondary Education, New Standards Mathematics Reference Exam at Grades 4 and 8, 2003-2004 School year.

◆ In 2004, 51% of Rhode Island fourth graders and 40% of eighth graders scored at or above proficiency in math. In the six core cities fourth and eighth grade students at all races scored below the state average. Black and Hispanic students scored lower than their White and Asian counterparts.[9]

◆ While all races experienced decreases in math proficiency between fourth and eighth grade, Hispanic, Black and Asian students experienced a decline almost twice that of White students. This decline in performance between fourth and eighth grades was consistent across economic status and presence of a disability.[10]

◆ In Rhode Island in 2004, 33% of fourth grade students with disabilities were proficient in math and 15% of eighth grade students with disabilities were proficient in math.[11]

◆ Proficiency for all students requires that changes be made in curriculum, instructional materials, assessments, classroom practice, teacher preparation and professional development.[12]

Table 36.

Fourth and Eighth Grade Math Proficiency, Rhode Island 2004

SCHOOL DISTRICT	FOURTH GRADE NUMBER OF TEST TAKERS	FOURTH GRADE % MEETING OR EXCEEDING STANDARDS FOR MATH PROFICIENCY	FOURTH GRADE % MEETING OR EXCEEDING STANDARDS FOR PROBLEM SOLVING	EIGHTH GRADE NUMBER OF TEST TAKERS	EIGHTH GRADE % MEETING OR EXCEEDING STANDARDS FOR MATH PROFICIENCY	EIGHTH GRADE % MEETING OR EXCEEDING STANDARDS FOR PROBLEM SOLVING
Barrington	279	70%	65%	243	76%	71%
Bristol Warren	266	62%	52%	323	45%	38%
Burrillville	151	56%	35%	210	43%	34%
Central Falls	279	34%	23%	295	17%	11%
Chariho	286	64%	50%	291	58%	55%
Coventry	460	72%	67%	483	58%	58%
Cranston	861	65%	55%	924	48%	43%
Cumberland	439	56%	40%	447	48%	37%
East Greenwich	214	55%	38%	231	75%	73%
East Providence	472	54%	40%	547	32%	24%
Exeter-West Greenwich	160	50%	34%	207	56%	52%
Foster	70	65%	50%	NA	NA	NA
Foster-Glocester	NA	NA	NA	269	50%	40%
Glocester	141	53%	30%	NA	NA	NA
Jamestown	56	53%	34%	69	70%	65%
Johnston	258	63%	53%	275	45%	36%
Lincoln	275	59%	44%	320	45%	35%
Little Compton	38	80%	76%	47	49%	53%
Middletown	205	62%	55%	205	47%	40%
Narragansett	142	58%	40%	135	63%	58%
New Shoreham	5	NA	80%	19	58%	47%
Newport	200	45%	35%	198	37%	32%
North Kingstown	364	70%	60%	352	61%	54%
North Providence	242	50%	33%	314	35%	25%
North Smithfield	144	41%	18%	133	46%	41%
Pawtucket	816	39%	25%	890	21%	15%
Portsmouth	254	65%	51%	248	49%	40%
Providence	2,248	28%	17%	2,223	13%	9%
Scituate	137	69%	64%	177	66%	63%
Smithfield	222	60%	42%	230	54%	45%
South Kingstown	327	64%	49%	347	60%	54%
Tiverton	160	55%	34%	206	52%	42%
Warwick	875	64%	50%	988	45%	35%
West Warwick	322	43%	30%	292	47%	38%
Westerly	289	64%	52%	323	46%	37%
Woonsocket	545	38%	25%	517	17%	9%
Charter Schools	*76*	*NA*	*13%*	*37*	*NA*	*11%*
Core Cities	*4,410*	*33%*	*22%*	*4,415*	*19%*	*13%*
Remainder of State	*7,792*	*62%*	*48%*	*8,563*	*50%*	*43%*
*Rhode Island**	*12,202*	*51%*	*39%*	*12,978*	*40%*	*33%*

**This total excludes Charter Schools because the number of students meeting or exceeding standards for math proficieny was not available.*

Source of Data for Table/Methodology

All data are from the Rhode Island Department of Elementary and Secondary Education, *New Standards Mathematics Reference Exam* at Grades 4 and 8, 2003-2004 School year.

Charter Schools are Blackstone Academy, Compass Charter School, CVS Highlander School, International Charter School and the Paul Cuffee Charter School.

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

References for Indicator

[1,7] U.S. Department of Education. Office of Educational Research and Improvement. National Center for Education Statistics. *The nation's report card: Mathematics 2000*, NCES 2001-517, by J.S. Braswell, A..D. Lutkus, W.S. Grigg, S.L. Santapau, B.S.-H. Tay-Lim, and M.S. Johnson, Washington, DC: 2001.

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[6] National Research Council. (2002). *Helping children learn mathematics.* J. Kilpatrick, J. Swafford, and B. Findell. (Eds.). Mathematics Learning Study Committee, Center for Education, Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

High Performing Schools

DEFINITION

High performing schools is the percentage of schools in Rhode Island that are classified as high performing by the Rhode Island Department of Elementary and Secondary Education through the Rhode Island School and District Performance and Accountability System. As required by the No Child Left Behind Act of 2001, the Rhode Island Department of Education established 21 annual targets for each school level, out to the year 2014. Schools are classified as high performing if they have 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]

2004 School Performance

	% HIGH PERFORMING	% IN NEED OF IMPROVEMENT
Core Cities	12%	65%
Remainder of State	73%	10%
Rhode Island	53%	26%

Source: *Rhode Island Department of Education, 2004.*

School Performance Classifications, Rhode Island 2004

◆ 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. In 2004 a total of 168 schools (53%), compared to 92 schools (29%) in 2003, across Rhode Island were classified as high performing.[7]

◆ Schools are moderately performing if they have met all of their current year targets. There were 65 schools (21%) classified as moderately performing.[8]

◆ 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: Asian, Black, Hispanic, Native American, White, students in poverty, students with disabilities and English language learners (ELL). In 2004 in Rhode Island, 83 schools (26%) (compared to 123 schools (38%) in 2003) were classified as in need of improvement. Of these, 28 schools (9% of all schools) were classified as in need of improvement / making progress and 55 schools (17% of all schools) are in need of improvement / insufficient progress.[9]

Annual School Performance Targets

As required by federal law, 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 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]

School Performance, Rhode Island District Profile 2004

Table 37.

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	6	0	0	0	100%	0%
Bristol-Warren	9	5	1	1	2	56%	33%
Burrillville	5	3	0	2	0	60%	40%
Central Falls	7	1	0	4	2	14%	86%
Chariho	7	6	0	0	1	86%	14%
Coventry	9	7	1	1	0	78%	11%
Cranston	25	19	6	0	0	76%	0%
Cumberland	8	5	2	1	0	63%	13%
East Greenwich	6	6	0	0	0	100%	0%
East Providence	11	3	6	1	1	27%	18%
Exeter-W. Greenwich	5	3	1	1	0	60%	20%
Foster	1	1	0	0	0	100%	0%
Foster-Glocester	2	2	0	0	0	100%	0%
Glocester	2	2	0	0	0	100%	0%
Jamestown	2	2	0	0	0	100%	0%
Johnston	9	6	2	1	0	67%	11%
Lincoln	8	4	1	1	2	50%	38%
Little Compton	1	1	0	0	0	100%	0%
Middletown	5	5	0	0	0	100%	0%
Narragansett	3	3	0	0	0	100%	0%
New Shoreham	1	1	0	0	0	100%	0%
Newport	8	1	7	0	0	13%	0%
North Kingstown	10	8	1	0	1	80%	10%
North Providence	9	2	5	1	1	22%	22%
North Smithfield	4	3	0	0	1	75%	25%
Pawtucket	15	3	3	3	6	20%	60%
Portsmouth	5	5	0	0	0	100%	0%
Providence	45	2	5	9	29	4%	84%
Scituate	5	5	0	0	0	100%	0%
Smithfield	6	5	1	0	0	83%	0%
South Kingstown	9	7	0	0	2	78%	22%
Tiverton	5	4	1	0	0	80%	0%
Warwick	26	19	6	0	1	73%	4%
West Warwick	6	1	2	1	2	17%	50%
Westerly	7	7	0	0	0	100%	0%
Woonsocket	12	3	5	1	3	25%	33%
Charter Schools	*7*	*2*	*5*	*0*	*0*	*29%*	*0%*
State Run Schools	*3*	*0*	*3*	*0*	*0*	*0%*	*0%*
RITS	*1*	*0*	*0*	*0*	*1*	*0%*	*100%*
UCAP	*1*	*0*	*1*	*0*	*0*	*0%*	*0%*
Core Cities	*93*	*11*	*22*	*18*	*42*	*12%*	*65%*
Remainder of State	*221*	*155*	*34*	*10*	*12*	*73%*	*10%*
Rhode Island	*316*	*168*	*65*	*28*	*55*	*53%*	*26%*

Source of Data for Table/Methodology

All data are from the Rhode Island Department of Elementary and Secondary Education. This year, the Rhode Island Department of Elementary and Secondary Education determined school performance classifications based on whichever was higher – the average of the past three years of data (2002-2004) or the current single year (2004).

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

See methodology on page 143.

References for Indicator

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[7, 8, 9] Rhode Island Department of Education, 2004 School Performance Classification.

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 un-graded classrooms are not included.

SIGNIFICANCE

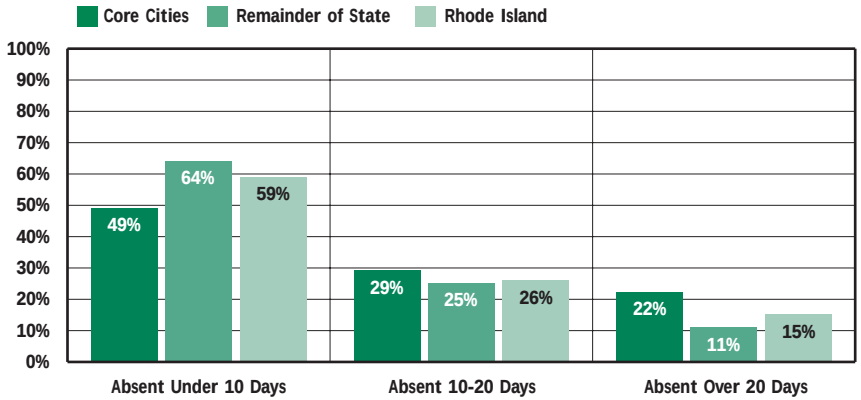
An important aspect of students' access to education is the amount of time actually spent in the classroom. When students are absent from school they forgo opportunities to learn.[1] Lower attendance rates are linked to lower reading scores and are an important factor in variation in states' mathematics scores.[2,3] Additionally, students who think of dropping out have already begun 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 those expectations. The relationships between students and their teachers are critical in shaping the 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]

School Attendance, Core Cities and Rhode Island, by the Number of School Days Missed, 2003-2004



Source: Rhode Island Department of Elementary and Secondary Education. 2003-2004 school year.

◆ More than one out of five (22%) students in the core cities missed over 20 days of school, compared to more than one out of ten (11%) students in the remainder of Rhode Island and nearly one out of seven (15%) students statewide.[12]

◆ With 14,756 high school students in the core cities, improving the core cities' attendance rate from 85% to 92% would mean that 1,033 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 38.

School Attendance Rates, Rhode Island, 2003-2004

SCHOOL DISTRICT	GRADES 1-5 AVERAGE DAILY ATTENDANCE	GRADES 1-5 TOTAL # OF STUDENTS	GRADES 1-5 ATTENDANCE RATE	GRADES 6-8 AVERAGE DAILY ATTENDANCE	GRADES 6-8 TOTAL # OF STUDENTS	GRADES 6-8 ATTENDANCE RATE	GRADES 9-12 AVERAGE DAILY ATTENDANCE	GRADES 9-12 TOTAL # OF STUDENTS	GRADES 9-12 ATTENDANCE RATE
Barrington	1,239	1,287	96%	769	804	96%	1,031	1,081	95%
Bristol-Warren	1,237	1,303	95%	850	909	94%	1,061	1,184	90%
Burrillville	821	860	95%	624	662	94%	815	864	94%
Central Falls	1,425	1,516	94%	815	889	92%	796	937	85%
Chariho	1,332	1,395	95%	861	910	95%	1,141	1,231	93%
Coventry	2,090	2,178	96%	1,364	1,434	95%	1,710	1,882	91%
Cranston	4,023	4,207	96%	2,631	2,778	95%	3,184	3,506	91%
Cumberland	1,999	2,071	97%	1,225	1,277	96%	1,364	1,491	91%
East Greenwich	944	976	97%	654	677	97%	630	669	94%
East Providence	2,078	2,174	96%	1,479	1,567	94%	1,677	1,952	86%
Exeter-W. Greenwich	744	792	94%	509	538	95%	650	692	94%
Foster	310	324	96%	NA	NA	NA	NA	NA	NA
Foster-Glocester	NA	NA	NA	718	753	95%	858	932	92%
Glocester	653	683	96%	NA	NA	NA	NA	NA	NA
Jamestown	255	266	96%	200	209	96%	NA	NA	NA
Johnston	1,228	1,282	96%	785	856	92%	786	864	91%
Lincoln	1,277	1,328	96%	884	924	96%	972	1,045	93%
Little Compton	162	171	95%	118	126	94%	NA	NA	NA
Middletown	1,054	1,091	97%	582	608	96%	695	746	93%
Narragansett	625	652	96%	378	394	96%	482	508	95%
New Shoreham	53	57	93%	38	41	93%	28	31	90%
Newport	1,019	1,095	93%	574	621	92%	698	799	87%
North Kingstown	1,703	1,766	96%	1,041	1,089	96%	1,397	1,493	94%
North Providence	1,127	1,182	95%	877	926	95%	1,067	1,156	92%
North Smithfield	688	715	96%	448	468	96%	501	528	95%
Pawtucket	3,807	3,989	95%	2,436	2,589	94%	2,176	2,476	88%
Portsmouth	1,112	1,157	96%	683	715	96%	928	983	94%
Providence	10,222	11,010	93%	5,930	6,634	89%	6,290	7,528	84%
Scituate	659	688	96%	437	466	94%	468	498	94%
Smithfield	933	968	96%	690	725	95%	805	866	93%
South Kingstown	1,408	1,472	96%	1,009	1,059	95%	1,177	1,322	89%
Tiverton	708	745	95%	555	594	93%	655	713	92%
Warwick	4,182	4,372	96%	2,793	2,941	95%	3,525	3,845	92%
West Warwick	1,468	1,551	95%	885	952	93%	1,005	1,114	90%
Westerly	1,316	1,378	96%	851	895	95%	1,040	1,111	94%
Woonsocket	2,567	2,731	94%	1,456	1,587	92%	1,616	1,902	85%
Charter Schools	*497*	*521*	*95%*	*80*	*86*	*93%*	*157*	*184*	*85%*
State Operated	*34*	*36*	*94%*	*22*	*24*	*92%*	*1,103*	*1,199*	*92%*
UCAP	*NA*	*NA*	*NA*	*118*	*128*	*92%*	*8*	*9*	*89%*
Core Cities	*20,508*	*21,892*	*94%*	*12,096*	*13,272*	*91%*	*12,581*	*14,756*	*85%*
Remainder of State	*35,960*	*37,540*	*96%*	*24,053*	*25,345*	*95%*	*28,647*	*32,583*	*88%*
Rhode Island	*56,999*	*59,989*	*95%*	*36,369*	*38,855*	*94%*	*42,496*	*47,341*	*90%*

Note to Table

Attendance rates are calculated by dividing "the average daily attendance" by the "average daily membership," as of June 2004. Both measures are provided by the Rhode Island Department of Elementary and Secondary Education.

Pre-Kindergarten and kindergarten are not included in average daily attendance or average daily membership.

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2003-2004 school year.

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

References for Indicator

[1, 15] *Student truancy, ERIC Digest, number 125.* (1999). Eugene, OR: ERIC Clearinghouse on Educational Management.

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[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.

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(continued on page 146)

Suspensions

DEFINITION

Suspensions is the rate of infractions and disciplinary actions per 100 students in kindergarten through twelfth grade in Rhode Island public schools. It does not reflect the total number of students disciplined because each student can receive more than one disciplinary action during the school year. Disciplinary actions include in-school suspensions, out-of-school suspensions, and alternative program placements. Data are for the 2003-2004 school year.

SIGNIFICANCE

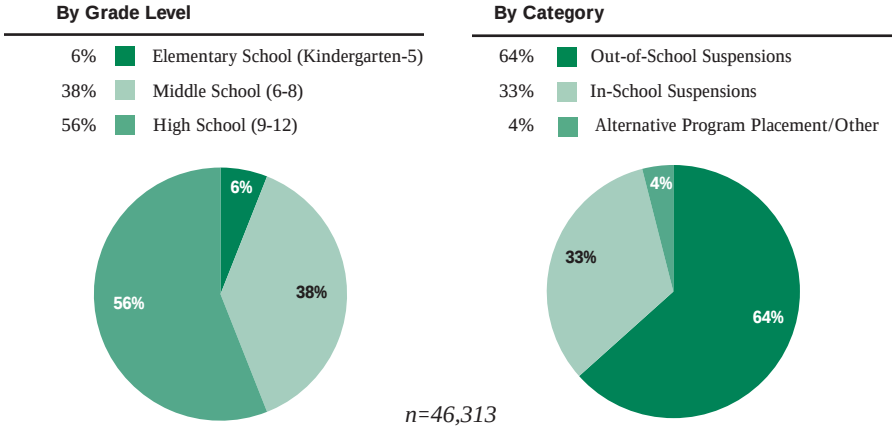
Effective school disciplinary practices ensure the safety and dignity of students and educators, preserve the integrity of the learning environment, and address the causes of student misbehavior in order to encourage positive behavior and improve long-term outcomes.[1] Out-of-school suspension is the 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.[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 2003-2004 school year in Rhode Island, 46,313 disciplinary actions were attributed to 17,867 students.[12] Of these disciplinary actions, 13,161 (28%) were attributed to 4,629 students enrolled in special education, accounting for 26% of the students disciplined. The total number of disciplinary actions is more than twice the number of students disciplined because some students were disciplined multiple times.[13]

Disciplinary Actions, Rhode Island Schools, 2003-2004



Disciplinary Actions, Rhode Island Public Schools, 2003-2004

By Type of Infraction	#	%	By Type of Infraction	#	%
Attendance Offenses	15,143	33%	Assault	2,310	5%
Disorderly Conduct	7,767	17%	Harassment/Intimidation/Threat	1,713	4%
Insubordination/Disrespect	6,699	14%	Arson/Larceny/Theft/Vandalism	956	2%
Fighting	3,752	8%	Alcohol/Drug/Tobacco Offenses	1,130	2%
Other Offenses*	3,637	8%	Weapon Possession	402	1%
Obscene/ Abusive Language	2,804	6%	*Total*	*46,313*	*99%*

**Examples of other offenses include forgery, trespassing and communication/electronic devices. The percentages do not total 100% because of rounding.*

Source: Rhode Island Department of Elementary and Secondary Education, 2003-2004 school year.

◆ 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 attend schools with high rates of suspension.[14]

Table 39.

Disciplinary Actions, Rhode Island School Districts, 2003-2004

SCHOOL DISTRICT	TOTAL # OF STUDENTS ENROLLED	TYPE OF DISCIPLINARY ACTION: SUSPENDED OUT-OF-SCHOOL	SUSPENDED IN-SCHOOL	ALTERNATE PROGRAM PLACEMENT	OTHER	TOTAL DISCIPLINARY ACTIONS	ACTIONS PER 100 STUDENTS
Barrington	3,290	142	19	0	0	161	5
Bristol Warren	3,560	692	719	0	17	1,428	40
Burrillville	2,505	324	111	0	1	436	17
Central Falls	3,657	449	686	0	0	1,135	31
Chariho	3,696	584	0	7	0	591	16
Coventry	5,682	864	202	674	0	1,740	31
Cranston	10,833	2,055	0	0	0	2,055	19
Cumberland	5,038	311	22	0	0	333	7
East Greenwich	2,392	141	29	0	0	170	7
East Providence	5,913	755	1	0	0	756	13
Exeter-West Greenwich	2,075	327	14	0	0	341	16
Foster	349	0	0	0	0	0	0
Foster-Glocester	1,685	373	0	0	0	373	22
Glocester	742	1	8	0	0	9	1
Jamestown	531	4	0	0	0	4	1
Johnston	3,147	834	73	3	2	912	29
Lincoln	3,419	105	328	3	0	436	13
Little Compton	313	NA	NA	NA	NA	NA	NA
Middletown	2,657	395	155	0	0	550	21
Narragansett	1,641	102	207	0	0	309	19
New Shoreham	140	0	4	0	0	4	3
Newport	2,761	822	16	9	0	847	31
North Kingstown	4,519	385	183	0	0	568	13
North Providence	3,361	747	585	0	1	1,333	40
North Smithfield	1,844	324	0	1	0	325	18
Pawtucket	9,471	1,695	892	0	0	2,587	27
Portsmouth	2,953	194	0	938	0	1,132	38
Providence	27,307	9,463	3,095	0	0	12,558	46
Scituate	1,726	80	63	0	0	143	8
Smithfield	2,638	328	2	1	0	331	13
South Kingstown	3,981	586	10	0	0	596	15
Tiverton	2,127	392	1,152	14	0	1,558	73
Warwick	11,558	1,780	2,343	0	0	4,123	36
West Warwick	3,755	792	975	0	0	1,767	47
Westerly	3,669	370	0	0	0	370	10
Woonsocket	6,603	2,721	3,221	3	2	5,947	90
Charter Schools	*922*	*114*	*85*	*5*	*0*	*204*	*22*
State-Operated Schools	*843*	*179*	*2*	*0*	*0*	*181*	*21*
Core Cities	*53,554*	*15,942*	*8,885*	*12*	*2*	*24,841*	*46*
Remainder of State	*97,984*	*13,195*	*6,230*	*1,641*	*21*	*21,087*	*22*
Rhode Island	*153,303*	*29,430*	*15,202*	*1,658*	*23*	*46,313*	*30*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2003-2004 school year.

The 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 2004.

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. The rate does not signify the number of students out of every 100 disciplined, but the number of disciplinary actions per 100 students enrolled.

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 schools includes data for the Rhode Island School for the Deaf and Davies Career Technical School.

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

References for Indicator

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High School Graduation Rate

DEFINITION

High school graduation rate is the number of 2004 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 six times more likely to drop out than high-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]

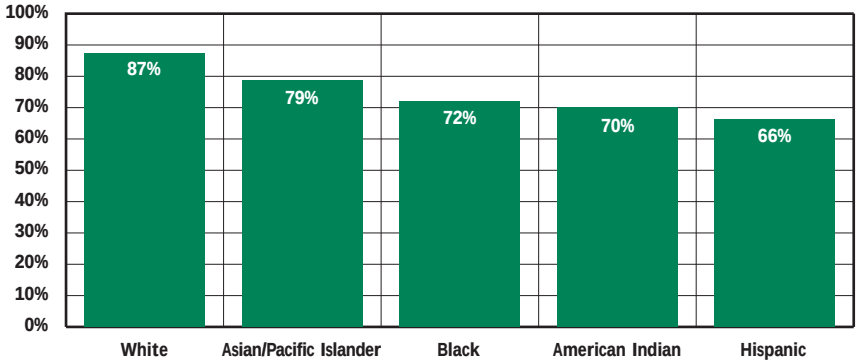
Percent of Teens Who are High School Dropouts, Ages 16-19

	1996	2001
RI	11%	10%
US	10%	9%
National Rank*		*29th*
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 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

High School Graduation Rates, by Race and Ethnicity, Rhode Island, 2004



Source: Rhode Island Department of Elementary and Secondary Education

◆ In 2004 in Rhode Island, 87% of White students, 79% of Asian Pacific Islander students, 72% of Black students, 70% of American Indian students and 66% of Hispanic students graduated from high school.[10]

◆ In Rhode Island and nationwide, Hispanic students have a lower high school graduation rate than non-Hispanic White students and non-Hispanic Black students.[11]

◆ Hispanic male students in Rhode Island have a lower graduation rate (60%) than Black males students (69%), Asian Pacific Islander male students (77%), American Indian male students (77%) and White male students (85%).[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]

Table 40.

High School Graduation Rate, Rhode Island, 2004

SCHOOL DISTRICT	COMMUNITY CONTEXT						2004 GRADUATION RATE
	% CHILDREN IN POVERTY	% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% ENGLISH LANGUAGE LEARNERS	% MINORITY ENROLLMENT	% OF STUDENTS TAKING THE SAT	
Barrington	2%	92%	3,434	<1%	4%	86%	93%
Bristol-Warren	8%	NA	3,688	3%	4%	64%	76%
Burrillville	5%	80%	2,590	<1%	3%	66%	93%
Central Falls	36%	49%	3,734	28%	79%	39%	75%
Chariho	4%	NA	3,863	<1%	4%	51%	90%
Coventry	6%	83%	5,862	<1%	4%	54%	95%
Cranston	8%	79%	11,222	4%	18%	55%	88%
Cumberland	3%	81%	5,349	2%	7%	62%	93%
East Greenwich	4%	93%	2,466	1%	4%	79%	97%
East Providence	9%	71%	6,386	4%	19%	54%	84%
Exeter-W. Greenwich	4%	NA	2,204	<1%	4%	67%	95%
Foster	6%	88%	369	0%	5%	NA	NA
Foster-Glocester	4%	NA	1,693	0%	1%	57%	95%
Glocester	8%	87%	743	0%	4%	NA	NA
Jamestown	2%	93%	545	2%	4%	NA	NA
Johnston	9%	78%	3,285	1%	9%	59%	90%
Lincoln	6%	82%	3,649	1%	7%	77%	97%
Little Compton	1%	91%	327	0%	0%	NA	NA
Middletown	8%	91%	2,769	2%	15%	58%	96%
Narragansett	7%	91%	1,673	1%	6%	79%	85%
New Shoreham	8%	95%	151	4%	15%	88%	100%
Newport	22%	87%	2,826	4%	42%	66%	82%
North Kingstown	7%	92%	4,626	1%	5%	76%	94%
North Providence	9%	77%	3,473	2%	17%	47%	87%
North Smithfield	2%	82%	2,006	<1%	2%	68%	95%
Pawtucket	21%	66%	9,654	9%	51%	47%	65%
Portsmouth	3%	91%	3,066	0%	6%	70%	96%
Providence	36%	66%	27,900	18%	85%	66%	62%
Scituate	4%	87%	1,817	<1%	2%	72%	95%
Smithfield	4%	85%	2,710	<1%	2%	72%	95%
South Kingstown	4%	91%	4,174	1%	10%	84%	88%
Tiverton	3%	80%	2,224	0%	1%	76%	90%
Warwick	7%	85%	11,993	1%	6%	59%	89%
West Warwick	15%	76%	3,710	2%	13%	49%	72%
Westerly	7%	82%	3,838	2%	9%	60%	89%
Woonsocket	27%	64%	6,928	4%	36%	45%	72%
Charter Schools	*NA*	*NA*	*930*	*10%*	*61%*	*NA*	*NA*
State Operated	*NA*	*NA*	*1,314*	*3%*	*50%*	*NA*	*NA*
UCAP	*NA*	*NA*	*134*	*NA*	*85%*	*NA*	*NA*
Core Cities	*30%*	*NA*	*54,752*	*14%*	*65%*	*57%*	*67%*
Remainder of State	*6%*	*NA*	*102,245*	*2%*	*8%*	*63%*	*91%*
Rhode Island	*15%*	*78%*	*159,375*	*6%*	*29%*	*61%*	*83%*

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, 2002. % 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, 2003-2004 school year.

The denominator for the indicator is the sum of 2004 graduates plus the number of grade 9 dropouts in 2000-01 plus the number of grade 10 dropouts in 2001-02 plus grade 11 dropouts in 2002-03 plus grade 12 dropouts in 2003-04.

NA: Community has a regional high school for which data does not exist or data is unavailable for the given school or schools.

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

References

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[8] U.S. Bureau of the Census, Current Population Survey, March 2002, Table 8.

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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] Youth living in economically disadvantaged families are six times more likely to drop out of high school than their more affluent peers.[2] 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.[3] Caring parent-child interactions, positive peer influences, and support from siblings, teachers and mentors can greatly influence a teen's choices and attitudes.[4,5] 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.[6,7]

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 negative behaviors.[11] In addition, they are at an increased risk of needing public assistance.[12,13]

In 2002, 4.8% of Rhode Island teens ages 16 to 19 were neither in school nor working, a decrease of one-third from 7.1% of youth in 2001.[14] This represents a decrease of nearly 1,000 young adults that were disconnected from school systems

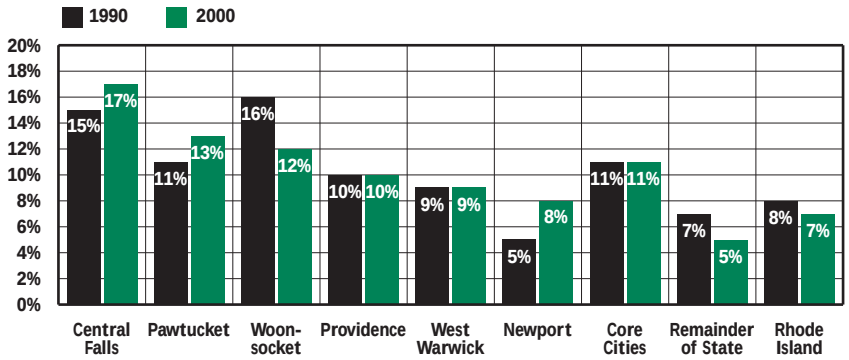
Teens Not in School and Not Working 1990 and 2000

	1996	2001
RI	9%	9%
US	9%	8%
National Rank		*27th
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.* (2004). 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.Summary Tape File 3 and Summary File 3.

◆ In 2000 in Rhode Island, 8,954 (7%) of teens ages 16 to 19 were not in school and not working.[16]

America's Disconnected Youth

◆ There are currently 5 million youth (15% of the young adult population) between the ages of 16 and 24 who are not in school and not working. Three million of these young adults are teen parents, juvenile offenders, homeless youth, high school dropouts or youth exiting foster care.[17]

◆ Unemployed and undereducated youth are at greatest risk for earning low wages, being incarcerated, living in under-resourced neighborhoods, and continuing the cycle of poverty with their own children.[18]

◆ The Adult Education and Family Literacy Act of 1998 is a federal program that assists individuals 16 years of age and older not enrolled in secondary school in improving their literacy skills. The Act funds programs that address the educational needs of English Language Learners, young parents, and youth without GED credentials.[19]

Table 41. **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, Summary File 3.

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 the Census 2000.

References for Indicator

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[18] *KIDS COUNT data book: State profiles of child well-being, 2004.* (2004). Baltimore, MD: The Annie E. Casey Foundation.

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Methodology and Acknowledgements

Methodology

The *2005 Rhode Island KIDS COUNT Factbook* examines 59 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 1996. The New England Rank highlights Rhode Island's rank among the 6 New England states – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Data are from the *KIDS COUNT Data Book, State Profiles of Child Well-Being 2004*, unless otherwise noted. Data from this publication comes from different data sources depending on the indicator.
- *City/Town Tables:* Data 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 as Rhode Island communities in which more than 15% of the children live below the poverty threshold according to the 2000 Census. They include: Central Falls, Newport, Pawtucket, Providence,West Warwick and Woonsocket.
- *Most Recent Available Data:* The 2005 Factbook uses the most current, reliable data available for each indicator.
- *New Indicators:* Five new indicators have been added to the 54 indicators included in the *2004 Rhode Island KIDS COUNT Factbook:* "Overweight Children and Youth," "Accredited Early Care and Education" "Early Intervention," "Early Head Start" and "Math Skills."

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 1999 and 2003. 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 with low birthweight.

Rates and Percentages

A rate is a measure of the frequency of an event - e.g., out of every 1,000 live births, how many infants will be breastfed. A percentage is another measure of frequency - 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.

Census 2000, Population Estimates and the Current Population Surveys

General information on state population is taken from three sources: Census 2000, the Current Population Survey and the Population Estimates. In all city/town tables that require population statistics, data is from Census 2000 as is stated in Source sections. Throughout the text portions of each indicator, all three sources are used and the relevant citation provides clarification on which source data come from. In instances where Census 2000 data is used in a denominator, caution should be taken when comparing new rates with those for past years as the

population numbers have changed. Finally, because of improved accuracy of the Current Population Survey, three-year averages have replaced the five-year averages used in previous Factbooks.

State Run and Charter Schools

The state run schools and charter schools included in each table are listed in the Source/Methodology Section next to the table. Charter schools include only privately-run charter schools and not those affiliated with a district. Textron/Chamber of Commerce Academy, Times2 Academy and the New England Laborers'/Cranston Public Schools Construction Career Academy are all district-affiliated charter schools, and consequently their data are reported within district categories instead of the charter school category.

The Urban Collaborative Accelerated Program is listed separately when data are available. RITS is the Rhode Island Training School for Youth, Rhode Island's state owned and operated juvenile correctional facility.

Methodology for Children with Asthma

Data in the *2005 Factbook* cannot be compared with previous Factbooks. Previously, asthma hospitalization data included only those cases in which asthma was the primary cause of hospitalization. Data for 1999-2003 include cases in which asthma was listed as the primary or other cause of hospitalization.

Methodology for Children Receiving Child Care Subsidies

Estimated Number of Children Eligible for Child Care Subsidies: The number of children eligible for child care subsidies attributed to Oliver et al. (2002) is an estimate generated by using Rhode Island eligibility rules as of 2001. This estimate is generated using The Urban Institute's Transfer Income Model, version 3 (TRIM3). TRIM3 used census survey data on individuals, families and households to simulate the effects of major government programs. Because of a small samples size for Rhode Island, there is a wide margin of error for the estimate of eligible children. The 95% confidence interval is reported as 21,772 – 41,085.

Previous estimates of the number of children eligible for subsidies at the city/town level have not been included in the 2005 Factbook because of inaccuracies associated with the estimation technique. These estimates ranged in accuracy due to the process of merging Census 2000 tables that describe populations slightly different from that actually eligible for subsidies in Rhode Island.

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, all students eligible to take the test are counted, whether or not they take the test or score. All students are eligible unless their IEP specifically exempts them or unless they are Beginning English Language Learners. 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.

Methodology for English Language Learners

Because of a change in methodology, English Language Learners (ELL) cannot be compared with Factbooks previous to 2004. The percentage of ELL is based on the total number of public school children receiving English as a Second Language or Bilingual Education services divided by the "average daily membership," as of June 2004. Using "average daily membership" in the denominator accounts for the mobility of students throughout the course of the academic year.

Methodology for High Performing Schools

The target scores (annual measurable objectives) which 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.

continued, next page

Methodology

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.

Methodology for School Attendance

Because of a change in methodology, School Attendance Rates cannot be compared with Factbooks previous to 2004. The attendance rates are based on the "average daily attendance" divided by the "average daily membership," as of June 2004. Using "average daily membership" in the denominator is a more accurate reflection of the mobility of students throughout the course of the academic year.

Methodology for Suspensions

Because of a change in methodology, Suspensions cannot be compared with Factbooks previous to 2004. The 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 2004. Using "average daily membership" in the denominator is a more accurate reflection of the mobility of students throughout the course of the academic year.

Methodology for High School Graduation

Because of a change in methodology, High School Graduation Rates in this Factbook cannot be compared with Factbooks previous to 2004. The Rhode Island Department of Elementary and Secondary Education had changed its method for calculating graduation rates to conform to the National Center for Education Statistics definition. The High School Graduation rate is the sum of 2004 graduates plus the number of grade 9 dropouts in 2000-01 plus the number of grade 10 dropouts in 2001-02 plus grade 11 dropouts in 2002-03 plus grade 12 dropouts in 2003-04.

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 59 indicators were collected through routine data collection systems operated by different federal and state agencies. We do not have estimates of the completeness of reporting to these systems.

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 2004 federal poverty threshold for a family of three with two children is $15,219 and $19,157 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 for use for administrative purposes such as determining financial eligibility for certain federal programs. Often, government assistance programs, including many of those administered by 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

2005 Federal Poverty Guidelines	Annual Income Family of Three	Annual Income Family of Four
50%	$8,045	$9,425
100%	$16,090	$19,350
130%	$20,917	$25,155
185%	$29,767	$35,798
200%	$32,180	$38,700
225%	$36,203	$43,538
250%	$40,225	$48,375

Source: U.S. Department of Health and Human Services. (2005). 2005 Federal Poverty Guidelines. *Federal Register,* 70(33), 8373-8375.

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Acknowledgements

The *2005 Rhode Island KIDS COUNT Factbook* was made possible by the efforts of many dedicated individuals. Rhode Island KIDS COUNT gratefully acknowledges their assistance. Special thanks to:

William O'Hare, Don Crary, Cory Anderson and Laura Beavers of The Annie E. Casey Foundation for their support and technical assistance.

The State Agency Directors of the Rhode Island Children's Cabinet for their ongoing support of Rhode Island KIDS COUNT and for the work of their data and policy staff as we produce the Factbook each year.

Members of the Rhode Island KIDS COUNT Factbook Advisory Committee and the State Agency Data Liaisons for their assistance in shaping the format and content of the Factbook.

Jack D. Combs, Research Administrator at the A. Alfred Taubman Center for Public Policy and American Institutions, Brown University, for data analyses; Samara Viner-Brown, Chief of the Office of Data and Evaluation at the Division of Family Health, for coordination and analyses of data from the RI Department of Health; Randy Rosati, Chief Human Services Policy & Systems Specialist, for coordination and analysis of data from the RI Department of Human Services; Kenneth Gu, Senior Data Systems Administrator, for coordination and analysis of data from the RI Department of Elementary and Secondary Education; and, David Allenson, Senior Programmer Analyst, for coordination and analysis of data from the RI Department of Children, Youth and Families.

Megan Kurth, a volunteer at Rhode Island KIDS COUNT, and Lynne Pistritto, Student Intern for their research, writing and data analysis.

Greenwood Associates for the design and layout of the Factbook, Chil Mott and Gail Greenwood for the illustrations, and E.A. Johnson Co. for the printing of the Factbook.

Ron Gallo, Karen Voci, and Rick Schwartz of The Rhode Island Foundation for their ongoing support and assistance.

Members of the Rhode Island KIDS COUNT Board of Directors for their support.

For their technical assistance with the following sections of the Factbook:

Child Population, Children in Single Parent Families, Racial and Ethnic Diversity, Racial and Ethnic Disparities: Linda Katz, Lenore Olsen, Rhode Island College School of Social Work; Thomas Anton, Jack Combs, A. Alfred Taubman Center for Public Policy, Brown University; Samara Viner-Brown, Ana Novais, RI Department of Health; Patricia Martinez, RI Department of Children, Youth and Families; Neda Ashtari, Scott Gausland, Kenneth Gu, Rhode Island Department of Elementary & Secondary Education; Paula Jo Gaines Mays, Providence School Department; Pablo Rodriguez, Women and Infants Hospital; Dennis Langley, Urban League; Autumn Leaf Spears, Narragansett Indian Tribe; Darrell Waldron, RI Indian Council.

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Children Receiving School Breakfast: Kathleen Gorman, University of Rhode Island Feinstein Center for a Hunger Free America; Adrienne DiMeo, RI Department of Elementary and Secondary Education; Bernard Beaudreau, RI Community Food Bank; Henry Shelton, William Flynn, George Wiley Center.

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Acknowledgements

Inc; Linda Katz, The Poverty Institute at Rhode Island College School of Social Work.

Childhood Immunizations: William Hollinshead, MD, Samara Viner-Brown, Hamma Kim, Mimi Lazerele, Paula Lopes, Ana Novais, Don Perry, Rosemary Reilly-Chammat, Susan Shepardson, Kathy Marceau, RI Department of Health.

Access to Dental Care: John A.Y. Andrews, Martha Dellapenna, Lissa DiMauro, Tricia Leddy, RI Department of Human Services; Jay Buechner, Maureen Ross, RI Department of Health; Robert Persson, Christine Vallee, St. Joseph Health Services of RI; Karen Voci, The Rhode Island Foundation; Linda Katz, The Poverty Institute at Rhode Island College; Julie Allen, Laura Neumann, American Dental Association; Christine Benoit, DMD; Sandra Saunders, University of Rhode Island; Val Donnelly, Rhode Island Dental Association; Shirley Spater, Mamie Wakefield, Samuels Dental Center/RI Hospital; Karen Bogen, Jane Griffin, MCH Evaluation.

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Breastfeeding: Becky Bessette, Charles White, Rachel Cain, Samara Viner-Brown, Bethany DiNapoli, Erin Dugan, RI Department of Health.

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Children with Lead Poisoning: Al Cabral, Magaly Angeloni, Peter Simon, MD, Robert Vanderslice, William Hollinshead, MD, Anne Primeau-Faubert, Enkhjin Bavuu, Brian Campbell, RI Department of Health; Jeremy Giller, Jeff Brown, MD, June Tourangeau, HELP Lead Safe Center; Katie Murray, The Providence Plan; Roberta Hazen Aaronson, Childhood Lead Action Project; Simon Kue, RI Housing Commission; David Homa, Tim Dignam, Centers for Disease Control and Prevention.

Children with Asthma: Myra Edens, Hasbro Children's Hospital; Jay Buechner, Samara Viner-Brown, William Hollinshead, MD, Rachel Cain, Janet Dubois, RI Department of Health; David Gagnon, National Perinatal Information Center; Chris Camillo, Draw A Breath Clinic; Robert Klein, MD, Rhode Island Hospital.

Births to Teens: Samara Viner-Brown, Rachel Cain, Ana Novais, RI Department of Health; Suzanne Grossman, RI March of Dimes; Miriam Inocencio, Planned Parenthood; Myra Edens, Patricia Flanagan, MD, Hasbro Children's Hospital; William O'Hare, The Annie E. Casey Foundation.

Alcohol, Drug, and Cigarette Use by Teens: Cynthia Corbridge, Elliot Krieger, Jennifer Wood, RI Department of Elementary and Secondary Education; Elizabeth Gilheeney, Rhode Island Justice Commission; Don Perry, Jan Shedd, Samara Viner-Brown, Jana Hesser, RI Department of Health; Brenda Amodei, Bette McHugh, Sharon Tourigny, Sheila Whalen, RI Department of Mental Health, Retardation and Hospitals; Paula Jo Gaines Mays, The Providence Public School Department; Robert Felner, Linda Hurditch, Anne Seitsinger, Julia Steiny, National Center on Public Education and Social Policy.

Overweight Children and Youth: Don Perry, Rachel Cain, Samara Viner-Brown, William Hollinshead MD, Rosemary Reilly-Chammat, RI Department of Health; Kathleen Gorman, URI Feinstein Center for a Hunger Free America.

Additional Children's Health Issues: Robert Felner, Lynda Hurditch, Anne Seitsinger, Julia Steiny, National Center on Public Education and Social Policy; Alison Croke, Lisa Franchetti, Brenda Whittle, Beth Marootian, Neighborhood Health Plan of RI; Jan Shedd, Don Perry, Rosemary Reilly-Chammat, Tricia Washburn, RI Department of Health; Kathleen Gorman, Feinstein Center for a Hunger Free America, University of Rhode Island; Paula Jo Gaines Mays, Providence Public School Department.

Child Deaths and Teen Deaths: Samara Viner-Brown, Nancy Libby-Fisher, Liz Arouth, Jay Buechner, Rachel Cain, Janet Dubois, RI Department of Health; David Pugatch, MD, Hasbro Children's Hospital; William O'Hare, The Annie E. Casey Foundation.

Gun Violence: Samara Viner-Brown, Rachel Cain, Janet Dubois, RI Department of Health.

Homeless Children and Homeless Youth: Linda Dziobek, Crossroads, RI; Eric Hirsch, Providence College and RI Emergency Food and Shelter Board; Noreen Shawcross, RI Coalition for the Homeless; Michelle Malloy, RI Corporation for Supportive Housing; Lisa Robinson, Judy Jones, RI Housing and Mortgage Finance Corp.; Virginia Bilotti, Janis Stravos, RI Department of Elementary and Secondary Education; Brother Michael Reis, Tides Family Services; Laureen D'Ambra, RI Family Court; Jay Burdick,

Acknowledgements

RI Department of Human Services; John Plonski, Denise Shaw, Covenant House; Russ Partridge, Crossroads RI; Mitch Walden, National Runaway Switchboard.

Juveniles Referred to Family Court: Buddy Croft, Laureen D'Ambra, Marguerite DiPalma, Richard Scarpellino, Ron Pagliarini, Ron Pirolli, Joseph Baxter, RI Family Court; David Allenson, Mike Burk, RI Department of Children, Youth and Families; Elizabeth Gilheeney, Rhode Island Justice Commission; Jan Dion Fontes, Office of the Child Advocate; Warren Hurlbut, Arlene J. Chorney, Sara Little, RI Training School; Susan Brazil, Susan Urso, Attorney General's Office; Brother Michael Reis, Tides Family Services; Robert Felner, National Center for Public Education and Social Policy; Patricia Flanagan MD, Hasbro Children's Hospital; Alyssa Benedict, CORE Associates.

Juveniles at the Training School: Arlene J. Chorney, Sara Little, RI Training School; Leon Saunders, David Allenson, Sue Bowler, Carol Whitman, RI Department of Children, Youth and Families; Brother Michael Reis, Robert Aichen, Tides Family Services; Mark Motte, Rhode Island College; Warren Hurlbut, Susan Brazil, Susan Urso, RI Office of the Attorney General; Laureen D'Ambra, RI Family Court; Elizabeth Gilheeny, RI Justice Commission.

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Children Witnessing Domestic Violence: Sage Bauer, Deborah DeBare, Patricia Loomis, Mao Yang, RI Coalition Against Domestic Violence; Wendy Verhoek-Oftedahl, RI Department of Health; Janice Dubois, Nancy King, Amaryllis Rivera, RI Supreme Court Domestic Violence Training and Monitoring Unit; Eric Hirsch, Providence College and the RI Emergency Food and Shelter Board; Deborah Linnell, Women's Resource Centers of Newport and Bristol.

Child Abuse and Neglect: Leon Saunders, Tom Dwyer, David Allenson, RI Department of Children, Youth and Families; Jan Dion Fontes, Sharon O'Keefe, Valerie Thomas, Office of the Child Advocate; Deborah DeBare, Francie Mantak, RI Coalition Against Domestic Violence; Lenette Azzi-Lessing, Children's Friend and Service; Lenore Olsen, Rhode Island College; Margaret Holland McDuff, Family Service; Peg Langhammer, Sexual Assault & Trauma Resource Center of RI; Samara Viner-Brown, Rachel Cain, Janet Dubois, RI Department of Health; Bernard Smith, St. Mary's Home for Children; Kate Begin, Prevent Child Abuse Rhode Island; Cathy Lewis, Casey Family Services.

Children in Out-of-Home Placement: Janet Anderson, Lee Baker, Leon Saunders, David Allenson, RI Department of Children, Youth and Families; Joseph Baxter, Laureen D'Ambra, David Tassoni, RI Family Court; Jan Fontes, Sharon O'Keefe, Valerie Francis, Office of the Child Advocate; Bernard Smith, St. Mary's Home for Children; Cathy Lewis, Casey Family Services; Darlene Allen, Adoption RI; Elizabeth Fuerte, New Visions Project Head Start; Randi Braunstein, RI Family Works; Lenore Olsen, Rhode Island College; Kate Begin, Prevent Child Abuse RI; Charlene Zienowicz, Urban League; Patricia Beede, Sherlock Center on Disabilities, Rhode Island College.

Adoption and Permanency: Janet Anderson, David Allenson, Rick Barry, RI Department of Children, Youth and Families; Darlene Allen, Adoption RI; Sharon O'Keefe, Office of the Child Advocate; Cathy Lewis, Casey Family Services.

Early Intervention: Deb Florio, Cynthia Holmes, Patricia Luce, Christine Robin, RI Department of Human Services; Dawn Wardyga, Family Voices/RIPIN.

Infant and Pre-School Child Care, School-Age Child Care, Children Receiving Child Care Subsidies: Julie Valladares, Options for Working Parents; Reeva Sullivan Murphy, Larry Pucciarelli, Sherry Campanelli, Randy Rosati, RI Department of Human Services; Jo Ann Flodin, RI Department of Children, Youth and Families; Barbara Burgess, RI Department of Elementary and Secondary Education; Nancy Benoit, Alexandra Freed-Santos, Kim Maine, RI Child Care Director's Association; Joyce Butler, Ready to Learn Providence; Maryann Finamore-Allmark, RI Public Policy Coalition for Child Care; Lenette Azzi-Lessing, Teri DeBoise, Children's Friend and Service; Lynda Dickinson, CHILD, Inc.; Thomas Anton, Jack Combs, Brown University; Robert Felner, Lynda Hurditch, Julia Steiny, National Center for Public Education and Social Policy; Blythe Berger, RI Department of Health; Hillary Salmons, Providence After School Alliance.

Accredited Early Care and Education: Blythe Berger, RI Department of Health; Barbara Burgess, Gayle Justynski, RI Department of Elementary and Secondary Education; Jo Ann Flodin, RI Department of Children, Youth and Families; Cynthia Roberts, Shevaun Keogh-Walker, Nancy West, CHILDSPAN; Reeva Sullivan Murphy, RI Department of Human Services; Julie Valladeres, Options for Working Parents.

Children Enrolled in Head Start and Early Head Start: Susan Libutti, Reeva Sullivan Murphy, Larry Pucciarelli, Sherry Campanelli, RI Department of Human Services; Roy Walker, Administration for Children and Families; Toni Enright, Cranston Child Development Center; Lynda Dickinson, Kathy DiPinto, CHILD, Inc.; Carylon Cooper, Mary Dean, Linda C. Clinton, Providence Head Start, Inc.; Julie Bircher, Carol Hemingway, South County Community Action; Linda Laliberte, Mary Nugent, Donna Ramos, Barbara Schermack, East Bay Community Action Program; Jody Cloutier, Susan Connaughton, Rhonda Farrell, Tri-Town Community Action Agency; Karen Bouchard, Dee Henry, Woonsocket Head Start and Day Care; Dawn Britto, Lenette Azzi-Lessing, Teri DeBoise, Children's Friend and Service; Susan Dickstein, Bradley Hospital/Brown University; Karen Pucciarelli, RI Department of Elementary and Secondary Education.

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Children Enrolled in Special Education: Kenneth Gu, Jennifer Wood, Charlene Gilman, Thomas DiPaola, Barbara Burgess, Karen Cooper, Neda Ashtari, Elliot Krieger, RI Department of Elementary and Secondary Education; William Hollinshead, MD,

Acknowledgements

Samara Viner-Brown, Rachel Cain, Peter Simon, MD, David Hamel, RI Department of Health; John A.Y. Andrews, RI Department of Human Services; Dawn Wardyga, Family Voices; Jane Griffin, MCH Evaluation, Inc; Steve Nardilli, RI Charter Schools Association.

Student Mobility: Katie Murray, The Providence Plan; Jim Vandermillen; Julia Steiny; Robert Oberg, The Children's Crusade; Nicole Hebert, Children's Friend and Service; Terese Curtin, Connecting for Children and Families, Inc.; Christine Arouth, Newport School Department; Samara Viner-Brown, RI Department of Health; Susanna Greschner, RI Public Expenditure Council; Scott Gausland, Kenneth Gu, Elliot Krieger, RI Department of Elementary and Secondary Education.

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Math Skills: Kenneth Gu, Elliot Krieger, Diane Schaefer, RI Department of Elementary and Secondary Education; Marika Ripke, KIDS COUNT Hawaii, Center on the Family; Darcy Sawatzki, Hager Sharp; Julia Steiny; Linda Tilly, VOICES for Alabama's Children.

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School Attendance: Kenneth Gu, Elliot Krieger, RI Department of Elementary and Secondary Education; John Wirt, U.S. Department of Education; Patrick McGuigan, The Providence Plan; Michael Jolin, East Greenwich School District; Judge Joan Byer, Linda Wilhelms, Truancy Diversion Project of Jefferson County, Kentucky; Steve Nardilli, RI Charter Schools Association; Sergeant Richard Rodriguez, New Haven Department of Police Services.

Suspensions: Virginia da Mota, George McDonough, Kenneth Gu, Elliot Krieger, RI Department of Elementary and Secondary Education; Aisha Abdulla Odiase; Thomas Mezzanotti.

High School Graduation Rate: Cynthia Garcia Coll, Brown University; Jane Nugent, United Way of Rhode Island; Lenette Azzi-Lessing, Children's Friend and Service; Virginia da Mota, Kenneth Gu, Elliot Krieger, Bob Mason, RI Department of Elementary and Secondary Education; Karen Voci, The Rhode Island Foundation.

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