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. Rhode Island KIDS COUNT appreciates the generous support of The Rhode Island Foundation, United Way of Rhode Island, The Annie E. Casey Foundation, Prince Charitable Trusts, Alliance for Early Success, Robert Wood Johnson Foundation, DentaQuest Foundation, Neighborhood Health Plan of Rhode Island, Blue Cross & Blue Shield of Rhode Island, Delta Dental of Rhode Island, and Hasbro Children's Fund.

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 Data Book with comparable data for the U.S. is produced annually by The Annie E. Casey Foundation.

Additional copies of the *2015 Rhode Island Kids Count Factbook* are available for $20.00 per copy. Reduced rates are available for bulk orders. To receive copies of the 2015 Factbook, please contact:

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Illustrations by Gail Greenwood.

2015 Rhode Island Kids Count Factbook

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Overview

Lemonade Stand

by Myra Cohn Livingston

Every summer
under the shade
we fix up a stand
to sell lemonade.

A stack of cups,
a pitcher of ice,
a shirtboard sign
to tell the price.

A dime for the big,
A nickel for small.
The nickel cup's short.
The dime cup's tall.

Plenty of sugar
to make it sweet,
and sometimes cookies
for us to eat.

But when the sun
moves into the shade
it gets too hot
to sell lemonade.

Nobody stops
so we put things away
and drink what's left
and start to play.

Overview

The *2015 Rhode Island Kids Count Factbook* is the 21st 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 *2015 Rhode Island Kids Count Factbook* provides a statistical portrait of the status of Rhode Island's children and youth. Information is presented for the state of Rhode Island, for each city and town, and for an aggregate of the four cities in which the highest percentages of children are living in poverty. These four core cities are Central Falls, Pawtucket, Providence, 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 *2015 Rhode Island Kids Count Factbook* examines 71 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 *2015 Rhode Island Kids Count Factbook* reflects these interrelationships and builds a framework to guide policy, programs, and individual services on behalf of children and youth.

Family Economic Security

Children most at risk of not achieving their full potential are children in poverty. Rhode Island's child poverty rate was 19.5% between 2009 and 2013, during which time there were 42,247 children living in families with incomes below the federal poverty threshold. Many families with incomes above the poverty level also have a difficult time meeting the high costs of housing, utilities, food, child care, and health care. Access to affordable and high-quality early learning opportunities, Pre-K to 12 education, health insurance coverage, housing and nutrition, along with policies that support working families, are important tools to ensure the economic well-being of Rhode Island families and to improve child outcomes.

Child Poverty is Concentrated in Four Core Cities

Poverty is linked to every KIDS COUNT indicator. Children most at risk of not achieving their full potential are children in poverty. Between 2009 and 2013, nearly two-thirds (64%) of Rhode Island's children living in poverty lived in just four cities. These communities (Central Falls, Pawtucket, Providence, and Woonsocket) are the four core cities highlighted throughout the Factbook. Children in poverty live in every community in Rhode Island, but these four communities deserve special attention because they are where child poverty is most concentrated.

Ensuring Educational Attainment for All Children

Improving student achievement and high school graduation rates in Rhode Island will require focused leadership to ensure that all young children have access to the high quality early learning experiences, health care, and developmental services needed for school readiness. Schools and community leaders can implement comprehensive, evidence-based strategies from birth through third grade that lead to proficiency in reading and math, maintain high academic standards across the curriculum in all grades, and ensure that all youth graduate from high school with the skills they need to succeed in college and in Rhode Island's workforce.

Family and Community

Grandma's Lap

by Joy N. Hulme

Come.
Climb on Grandma's knee.
Curl up in my lap.
Bring a book to share with me
Before we take our nap.
We'll read and rock and rock and read
Until we start to doze.
Then, with my arms held round you tight,
We'll let our eyelids softly close.

Child Population

DEFINITION

Child population is the total number of children under age 18 and the percentage change between 2000 and 2010 in the total number of children under age 18.

SIGNIFICANCE

According to the American Community Survey conducted by the U.S. Census Bureau, there were 1,051,511 Rhode Island residents in 2013, with children under age 18 making up 20% of the population. Between 2000 and 2013, Rhode Island's child population decreased by 14% from 247,822 to 212,847.[1,2] Between 2011 and 2013, there were 120,642 households with children under age 18 in Rhode Island, representing almost one-third (29%) of all households.[3] Twenty-five percent of Rhode Island children were under age five, 27% were ages five to nine, 30% were ages 10 to 14, and 18% were ages 15 to 17.[4]

In Rhode Island between 2011 and 2013, 121,899 (56%) children under age 18 lived in married-couple households with their parents, 71,388 (33%) children lived in single-parent households, and 18,979 (9%) children lived with relatives, including grandparents and other relatives. A total of 3,374 (2%) children lived with foster families or other non-relative heads of household. There were 953 (<1%) children and youth under age 18 who lived in group quarters and 48 (<1%) youth who were householders or spouses.[5,6,7]

Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Mirroring national trends, the number of Hispanic children in Rhode Island has grown since 2000, both in numbers and as a percentage of the child population. Hispanics now make up 24% of children under age 18 in the United States and 22% of children under age 18 in Rhode Island.[8,9,10,11]

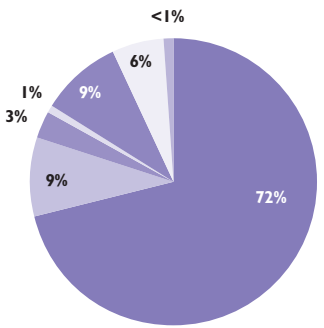
Between 2011 and 2013, there were 9,111 foreign-born children under the age of 18 living in Rhode Island, representing approximately 4% of the child population.[12] Of Rhode Island children ages five to 17, 77% speak only English at home, 16% speak Spanish, 4% speak other Indo-European languages, 2% speak an Asian or Pacific Island language, and less than 1% speak some other language at home.[13]

Sexual orientation is another important facet of diversity among youth. According to the *2013 Youth Risk Behavior Survey*, 8% of high school students in Rhode Island described themselves as lesbian, gay, or bisexual. This does not include students who responded "not sure" when asked about their sexual orientation.[14]

Rhode Island Children Under Age 18, 2011-2013

By Race/Ethnicity*

72%	White
9%	Black
3%	Asian
1%	American Indian and Alaska Native
9%	Some Other Race
6%	Two or More Races
<1%	Race Unknown



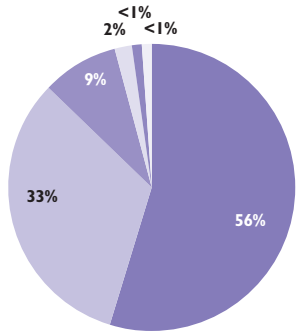
n=216,641

**Hispanic children may be included in any race category. Of Rhode Island's 216,641 children, 47,513 (22%) were Hispanic.*

Source: U.S. Census Bureau, American Community Survey, 2011-2013. Tables C01001A, C01001B, C01001C, C01001D, C01001F, C01001G, and C01001I.

By Family Structure

56%	Married-Couple**
33%	Single-Parent**
9%	Other Relatives
2%	Foster Family or Other Unrelated Household
<1%	Group Quarters
<1%	Child is Head of Household



n=216,641

***Only includes children who are related to the head of household by birth or adoption.*

Source: U.S. Census Bureau, American Community Survey, 2011-2013. Table B09001, B09002, and B09018.

◆ **In 2013, children under age 18 made up 20% of Rhode Island's population. Of the 212,847 children under age 18 in Rhode Island in 2013, 52% were male and 48% were female.[15]**

◆ **Between 2011 and 2013, 59% of children in Rhode Island lived in owner-occupied housing units and 41% lived in renter-occupied units.[16]**

◆ **Of children ages three to 17 enrolled in school in Rhode Island between 2011 and 2013, 84% were enrolled in public schools and 16% were enrolled in private schools.[17]**

Table 1.

Child Population, Rhode Island, 2000 and 2010

CITY/TOWN	2000 TOTAL POPULATION UNDER AGE 18	2010 TOTAL POPULATION UNDER AGE 18	CHANGE IN POPULATION UNDER AGE 18	% CHANGE IN POPULATION UNDER AGE 18
Barrington	4,745	4,597	-148	-3.1%
Bristol	4,399	3,623	-776	-17.6%
Burrillville	4,043	3,576	-467	-11.6%
Central Falls	5,531	5,644	113	2.0%
Charlestown	1,712	1,506	-206	-12.0%
Coventry	8,389	7,770	-619	-7.4%
Cranston	17,098	16,414	-684	-4.0%
Cumberland	7,690	7,535	-155	-2.0%
East Greenwich	3,564	3,436	-128	-3.6%
East Providence	10,546	9,177	-1,369	-13.0%
Exeter	1,589	1,334	-255	-16.0%
Foster	1,105	986	-119	-10.8%
Glocester	2,664	2,098	-566	-21.2%
Hopkinton	2,011	1,845	-166	-8.3%
Jamestown	1,238	1,043	-195	-15.8%
Johnston	5,906	5,480	-426	-7.2%
Lincoln	5,157	4,751	-406	-7.9%
Little Compton	780	654	-126	-16.2%
Middletown	4,328	3,652	-676	-15.6%
Narragansett	2,833	2,269	-564	-19.9%
New Shoreham	185	163	-22	-11.9%
Newport	5,199	4,083	-1,116	-21.5%
North Kingstown	6,848	6,322	-526	-7.7%
North Providence	5,936	5,514	-422	-7.1%
North Smithfield	2,379	2,456	77	3.2%
Pawtucket	18,151	16,575	-1,576	-8.7%
Portsmouth	4,329	3,996	-333	-7.7%
Providence	45,277	41,634	-3,643	-8.0%
Richmond	2,014	1,849	-165	-8.2%
Scituate	2,635	2,272	-363	-13.8%
Smithfield	4,019	3,625	-394	-9.8%
South Kingstown	6,284	5,416	-868	-13.8%
Tiverton	3,367	2,998	-369	-11.0%
Warren	2,454	1,940	-514	-20.9%
Warwick	18,780	15,825	-2,955	-15.7%
West Greenwich	1,444	1,477	33	2.3%
West Warwick	6,632	5,746	-886	-13.4%
Westerly	5,406	4,787	-619	-11.5%
Woonsocket	11,155	9,888	-1,267	-11.4%
Four Core Cities	*80,114*	*73,741*	*-6,373*	*-8.0%*
Remainder of State	*167,708*	*150,215*	*-17,493*	*-10.4%*
Rhode Island	*247,822*	*223,956*	*-23,866*	*-9.6%*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2000, Summary File 1 and Census 2010, Summary File 1.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

[1,15] U.S. Census Bureau, American Community Survey, 2013. Table S0201.

[2] U.S. Census Bureau, Census 2000 Summary File 1. Table DP-1.

[3] U.S. Census Bureau, American Community Survey, 2011-2013. Table S1101.

[4,9] U.S. Census Bureau, American Community Survey, 2011-2013. Table B01001.

[5] U.S. Census Bureau, American Community Survey, 2011-2013. Table B09002.

[6] U.S. Census Bureau, American Community Survey, 2011-2013. Table B09018.

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[12] U.S. Census Bureau, American Community Survey, 2011-2013. Table B05003.

[13] U.S. Census Bureau, American Community Survey, 2011-2013. Table B16007.

[14] Rhode Island Department of Health, *2013 Youth Risk Behavior Survey.*

[16,17] U.S. Census Bureau, American Community Survey, 2011-2013. Table S0901.

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

According to the U.S. Census Bureau's American Community Survey, there were 193,287 children living with one or more parents in Rhode Island between 2011 and 2013. Of these, 37% (71,388) were living with an unmarried parent, up from 31% of children between 2005 and 2007.[1,2]

Children living in single-parent families are more likely to live in poverty than children living in two-parent families. Single-parent families have only one potential wage earner, compared with the two potential wage earners in a two-parent family.[3]

Between 2011 and 2013, 76% of children living in poverty in Rhode Island were living in single-parent families. Children in single-parent families in Rhode Island were five times more likely to be living in poverty than those in married-couple families. Between 2011 and 2013 in Rhode Island, 40% of children in single-parent households lived in poverty, compared to 8% of children in married-couple households.[4]

The financial hardship and time constraints experienced by many single-parents explain some of the differences in well-being between the children in single-parent households and those in two-parent households.[5] Regardless of parents' race and level of educational attainment, children who reside in single-parent households (whether due to divorce or the parents never having been married) are at an increased risk for low academic achievement and low levels of social and emotional well-being.[6,7] Compared to children in married families, children in single-parent families are more likely to lack health insurance coverage, drop out of school, disconnect from the labor force, and become teen parents.[8,9] Regardless of whether children grow up with one or two parents, parenting quality is an important predictor of children's well-being.[10]

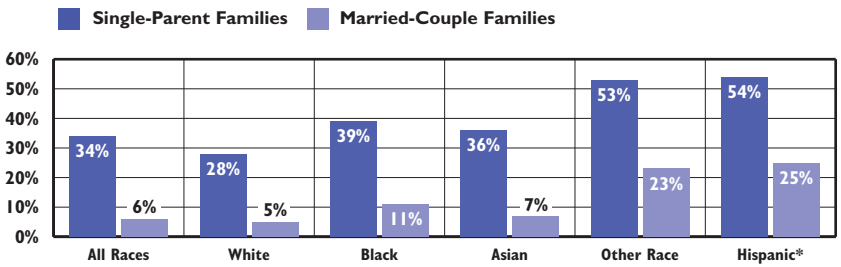
Single-Parent Families

	2003	2013
RI	32%	41%
US	31%	35%
National Rank*		*33rd*
New England Rank**		*6th*

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

The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

Families With Children Under Age 18 and Income Below the Poverty Threshold by Race & Ethnicity, Rhode Island, 2011-2013



Source: U.S. Census Bureau, American Community Survey, 2011-2013. Tables B17010, B17010A, B17010B, B17010D, B17010F, B17010I. *Hispanics may be in any race category.

◆ **Hispanic single-parent families in Rhode Island are nearly twice as likely as White single-parent families to live in poverty. Hispanic, Other race, and Black married-couple families are more likely than White and Asian married-couple families in Rhode Island to live in poverty.[11]**

Economic Well-Being and Family Structure

◆ **Economic status during early childhood can have a profound effect on children's health and development. Stable family structure is strongly correlated with economic well-being. Married-parent families have the highest economic status, followed by cohabiting-parent families, and then by single-parent families. For women, entering marriages or cohabiting relationships (especially with the child's biological father) is associated with increased economic status. Divorces and exits from cohabiting relationships are associated with declines in economic well-being.[12]**

◆ **Approximately one-third (35%) of unmarried parenting couples still live together five years after the child's birth and less than half of them are married.[13]**

◆ **More than half of unmarried births occur among cohabiting parents. Although there are variations by race, ethnicity, age, and poverty status, 58% of non-marital births in the U.S. between 2006 and 2010 were to cohabiting parents, compared with 40% in 2002.[14]**

Table 2.

Children's Living Arrangements, Rhode Island, 2010

CITY/TOWN	CHILDREN LIVING IN HOUSEHOLDS	CHILDREN WHO ARE A HOUSEHOLDER OR SPOUSE		CHILDREN LIVING WITH NON-RELATIVES		CHILDREN LIVING WITH OTHER RELATIVES		CHILDREN LIVING IN MARRIED-COUPLE FAMILIES		CHILDREN LIVING WITH GRANDPARENTS		CHILDREN LIVING IN SINGLE-PARENT FAMILIES	
		N	%	N	%	N	%	N	%	N	%	N	%
Barrington	4,597	2	<1%	31	1%	15	0%	3,871	84%	85	2%	593	13%
Bristol	3,621	1	<1%	37	1%	51	1%	2,564	71%	225	6%	743	21%
Burrillville	3,548	0	0%	110	3%	26	1%	2,353	66%	232	7%	827	23%
Central Falls	5,634	3	<1%	90	2%	209	4%	2,159	38%	429	8%	2,744	49%
Charlestown	1,506	0	0%	15	1%	20	1%	1,059	70%	106	7%	306	20%
Coventry	7,762	2	<1%	148	2%	72	1%	5,343	69%	549	7%	1,648	21%
Cranston	16,262	5	<1%	226	1%	324	2%	10,462	64%	1,027	6%	4,218	26%
Cumberland	7,535	0	0%	97	1%	53	1%	5,651	75%	334	4%	1,400	19%
East Greenwich	3,436	0	0%	21	1%	13	0%	2,889	84%	71	2%	442	13%
East Providence	9,100	2	<1%	127	1%	154	2%	5,329	59%	675	7%	2,813	31%
Exeter	1,300	0	0%	23	2%	16	1%	996	77%	82	6%	183	14%
Foster	986	0	0%	24	2%	10	1%	741	75%	69	7%	142	14%
Glocester	2,098	0	0%	39	2%	26	1%	1,581	75%	137	7%	315	15%
Hopkinton	1,845	0	0%	46	2%	24	1%	1,327	72%	113	6%	335	18%
Jamestown	1,043	0	0%	3	0%	5	0%	799	77%	49	5%	187	18%
Johnston	5,473	2	<1%	90	2%	114	2%	3,591	66%	380	7%	1,296	24%
Lincoln	4,743	3	<1%	61	1%	52	1%	3,270	69%	211	4%	1,146	24%
Little Compton	654	0	0%	5	1%	1	0%	528	81%	42	6%	78	12%
Middletown	3,634	3	<1%	45	1%	38	1%	2,606	72%	166	5%	776	21%
Narragansett	2,240	2	<1%	35	2%	25	1%	1,533	68%	105	5%	540	24%
New Shoreham	163	0	0%	1	1%	1	1%	111	68%	4	2%	46	28%
Newport	4,060	2	<1%	66	2%	56	1%	2,034	50%	204	5%	1,698	42%
North Kingstown	6,322	1	<1%	57	1%	49	1%	4,639	73%	247	4%	1,329	21%
North Providence	5,481	0	0%	81	1%	131	2%	3,266	60%	378	7%	1,625	30%
North Smithfield	2,456	0	0%	40	2%	13	1%	1,831	75%	96	4%	476	19%
Pawtucket	16,550	17	<1%	239	1%	460	3%	7,488	45%	1,228	7%	7,118	43%
Portsmouth	3,940	2	<1%	47	1%	24	1%	2,977	76%	172	4%	718	18%
Providence	41,497	41	<1%	632	2%	1,663	4%	16,931	41%	3,094	7%	19,136	46%
Richmond	1,836	0	0%	32	2%	16	1%	1,437	78%	104	6%	247	13%
Scituate	2,272	0	0%	24	1%	22	1%	1,731	76%	139	6%	356	16%
Smithfield	3,615	2	<1%	46	1%	29	1%	2,802	78%	164	5%	572	16%
South Kingstown	5,364	0	0%	81	2%	31	1%	3,951	74%	248	5%	1,053	20%
Tiverton	2,998	1	<1%	41	1%	20	1%	2,109	70%	162	5%	665	22%
Warren	1,935	4	<1%	42	2%	19	1%	1,124	58%	136	7%	610	32%
Warwick	15,795	3	<1%	308	2%	223	1%	10,476	66%	1,109	7%	3,676	23%
West Greenwich	1,468	2	<1%	22	1%	13	1%	1,131	77%	79	5%	221	15%
West Warwick	5,746	1	<1%	151	3%	121	2%	3,118	54%	365	6%	1,990	35%
Westerly	4,787	4	<1%	82	2%	83	2%	3,012	63%	269	6%	1,337	28%
Woonsocket	9,842	10	<1%	203	2%	176	2%	4,237	43%	683	7%	4,533	46%
Four Core Cities	*73,523*	*71*	*<1%*	*1,164*	*2%*	*2,508*	*3%*	*30,815*	*42%*	*5,434*	*7%*	*33,531*	*46%*
Remainder of State	*149,621*	*44*	*<1%*	*2,304*	*2%*	*1,890*	*1%*	*102,242*	*68%*	*8,534*	*6%*	*34,607*	*23%*
Rhode Island	*223,144*	*115*	*<1%*	*3,468*	*2%*	*4,398*	*2%*	*133,057*	*60%*	*13,968*	*6%*	*68,138*	*31%*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2010.

The denominator is the number of children under age 18 living in family households according to Census 2010. 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 include others not related to the householder.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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(continued on page 170)

Grandparents Caring for Grandchildren

DEFINITION

Grandparents caring for grandchildren is the percentage of family households in which a grandparent is financially responsible for food, shelter, clothing, child care, etc. for any or all grandchildren under age 18 living in the household.

SIGNIFICANCE

One in ten children in the United States lives with a grandparent. The number of children living with grandparents increased slowly over the last decade, rising sharply at the start of the recession. Black children are more likely to be cared for primarily by a grandparent than White, Hispanic, or Asian children.[1]

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, incarcerated, ill, struggling with substance abuse, or coping with other problems.[2]

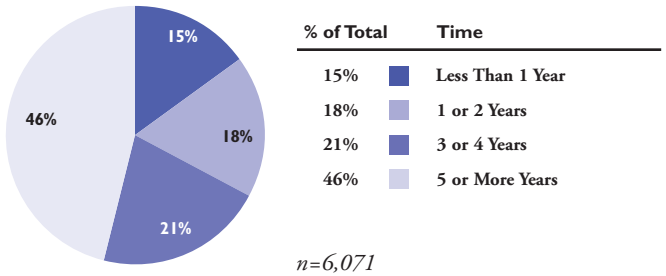
Grandparents who are financially responsible for their grandchildren have higher rates of poverty compared to other adults. Twenty-two percent of grandparent caregivers live below the poverty line, compared to 10% of the population age 50 and over.[3,4]

Many grandparent and other relative caregivers have informal custody arrangements and are not involved with child welfare agencies, which means that they receive less monitoring and support. Relative caregivers are more likely to have lower incomes and have more children in the home than traditional foster parents.[5]

Grandparents and other relative caregivers often are isolated and lack information about the support services, resources, programs, benefits, laws, and policies available to them.[6] Nearly all children in kinship care are eligible for cash assistance through Temporary Assistance for Needy Families (TANF) regardless of their household's income level, yet children in informal custody arrangements are much less likely to receive these payments.[7]

Grandparent caregivers are at risk for poor physical and mental health. They may have difficulty enrolling children in school and/or seeking health insurance or medical care for the children. Many caregivers do not pursue the required legal process required for permanent status such as adoption or guardianship in order to avoid strain on family relationships.[8,9] Grandparents make up the largest percentage of relative caregivers, but aunts, uncles, cousins, siblings and other relative caregivers may face similar obstacles.[10,11]

Rhode Island Grandparents Financially Responsible for Their Grandchildren, by Length of Time Responsible, 2011-2013



Source: U.S. Census Bureau, American Community Survey, 2011-2013. Table B10050.

◆ **Between 2011 and 2013, there were a total of 13,367 children in Rhode Island living in households headed by grandparents.[12] During this time period, there were 6,071 grandparents who were financially responsible for their grandchildren, two-thirds (67%) of whom had been financially responsible for three or more years.[13]**

◆ **In 2010, 6% (13,968) of all children in Rhode Island lived with a grandparent caregiver and 2% (4,398) lived with other relatives.[14]**

◆ **Children in informal kinship care (i.e., placed with relatives without the involvement of a child welfare agency) are more likely to live in poverty than children living with their parents. Nationally, over one-third (38%) of children in public and private kinship care live in poverty and only 42% of eligible children in kinship care receive Medicaid coverage.[15]**

◆ **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.[16] On December 31, 2014, there were 696 children in DCYF care who were in out-of-home placements with a grandparent or other relative. These children made up 34% of all children in out-of-home placements in Rhode Island.[17]**

◆ **The federal *Fostering Connections to Success and Increasing Adoptions Act* helps children and youth in foster care establish permanent families through subsidized guardianship and adoption.[18] Rhode Island is one of 31 states with a Guardianship Assistance Program that provides financial assistance payments to grandparents and other relative caregivers who assume legal guardianship.[19]**

Grandparents Caring for Grandchildren

Table 3.

Children's Living Arrangements, Rhode Island, 2010

CITY/TOWN	CHILDREN LIVING IN HOUSEHOLDS	CHILDREN WHO ARE A HOUSEHOLDER OR SPOUSE		CHILDREN LIVING WITH NON-RELATIVES		CHILDREN LIVING WITH OTHER RELATIVES		CHILDREN LIVING IN MARRIED COUPLE FAMILIES		CHILDREN LIVING IN SINGLE PARENT FAMILIES		CHILDREN LIVING WITH GRANDPARENTS	
		N	%	N	%	N	%	N	%	N	%	N	%
Barrington	4,597	2	<1%	31	1%	15	0%	3,871	84%	593	13%	85	2%
Bristol	3,621	1	<1%	37	1%	51	1%	2,564	71%	743	21%	225	6%
Burrillville	3,548	0	0%	110	3%	26	1%	2,353	66%	827	23%	232	7%
Central Falls	5,634	3	<1%	90	2%	209	4%	2,159	38%	2,744	49%	429	8%
Charlestown	1,506	0	0%	15	1%	20	1%	1,059	70%	306	20%	106	7%
Coventry	7,762	2	<1%	148	2%	72	1%	5,343	69%	1,648	21%	549	7%
Cranston	16,262	5	<1%	226	1%	324	2%	10,462	64%	4,218	26%	1,027	6%
Cumberland	7,535	0	0%	97	1%	53	1%	5,651	75%	1,400	19%	334	4%
East Greenwich	3,436	0	0%	21	1%	13	0%	2,889	84%	442	13%	71	2%
East Providence	9,100	2	<1%	127	1%	154	2%	5,329	59%	2,813	31%	675	7%
Exeter	1,300	0	0%	23	2%	16	1%	996	77%	183	14%	82	6%
Foster	986	0	0%	24	2%	10	1%	741	75%	142	14%	69	7%
Glocester	2,098	0	0%	39	2%	26	1%	1,581	75%	315	15%	137	7%
Hopkinton	1,845	0	0%	46	2%	24	1%	1,327	72%	335	18%	113	6%
Jamestown	1,043	0	0%	3	0%	5	0%	799	77%	187	18%	49	5%
Johnston	5,473	2	<1%	90	2%	114	2%	3,591	66%	1,296	24%	380	7%
Lincoln	4,743	3	<1%	61	1%	52	1%	3,270	69%	1,146	24%	211	4%
Little Compton	654	0	0%	5	1%	1	0%	528	81%	78	12%	42	6%
Middletown	3,634	3	<1%	45	1%	38	1%	2,606	72%	776	21%	166	5%
Narragansett	2,240	2	<1%	35	2%	25	1%	1,533	68%	540	24%	105	5%
New Shoreham	163	0	0%	1	1%	1	1%	111	68%	46	28%	4	2%
Newport	4,060	2	<1%	66	2%	56	1%	2,034	50%	1,698	42%	204	5%
North Kingstown	6,322	1	<1%	57	1%	49	1%	4,639	73%	1,329	21%	247	4%
North Providence	5,481	0	0%	81	1%	131	2%	3,266	60%	1,625	30%	378	7%
North Smithfield	2,456	0	0%	40	2%	13	1%	1,831	75%	476	19%	96	4%
Pawtucket	16,550	17	<1%	239	1%	460	3%	7,488	45%	7,118	43%	1,228	7%
Portsmouth	3,940	2	<1%	47	1%	24	1%	2,977	76%	718	18%	172	4%
Providence	41,497	41	<1%	632	2%	1,663	4%	16,931	41%	19,136	46%	3,094	7%
Richmond	1,836	0	0%	32	2%	16	1%	1,437	78%	247	13%	104	6%
Scituate	2,272	0	0%	24	1%	22	1%	1,731	76%	356	16%	139	6%
Smithfield	3,615	2	<1%	46	1%	29	1%	2,802	78%	572	16%	164	5%
South Kingstown	5,364	0	0%	81	2%	31	1%	3,951	74%	1,053	20%	248	5%
Tiverton	2,998	1	<1%	41	1%	20	1%	2,109	70%	665	22%	162	5%
Warren	1,935	4	<1%	42	2%	19	1%	1,124	58%	610	32%	136	7%
Warwick	15,795	3	<1%	308	2%	223	1%	10,476	66%	3,676	23%	1,109	7%
West Greenwich	1,468	2	<1%	22	1%	13	1%	1,131	77%	221	15%	79	5%
West Warwick	5,746	1	<1%	151	3%	121	2%	3,118	54%	1,990	35%	365	6%
Westerly	4,787	4	<1%	82	2%	83	2%	3,012	63%	1,337	28%	269	6%
Woonsocket	9,842	10	<1%	203	2%	176	2%	4,237	43%	4,533	46%	683	7%
Four Core Cities	*73,523*	*71*	*<1%*	*1,164*	*2%*	*2,508*	*3%*	*30,815*	*42%*	*33,531*	*46%*	*5,434*	*7%*
Remainder of State	*149,621*	*44*	*<1%*	*2,304*	*2%*	*1,890*	*1%*	*102,242*	*68%*	*34,607*	*23%*	*8,534*	*6%*
Rhode Island	*223,144*	*115*	*<1%*	*3,468*	*2%*	*4,398*	*2%*	*133,057*	*60%*	*68,138*	*31%*	*13,968*	*6%*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2010.

The denominator is the number of children under age 18 living in family households according to Census 2010. 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 include others not related to the householder.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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(continued on page 170)

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 an impact on his child's development, this indicator uses maternal education level because a significant number of birth records lack information on paternal education level.

SIGNIFICANCE

Parental educational attainment can have an impact on many aspects of child well-being, including children's health and health-related behaviors, children's access to sufficient educational resources, and the level of education they will ultimately achieve. Children of less educated parents are less likely to succeed in school, more likely to be poor for at least of half of their lives from birth through age 17, and more likely to be in poor health.[1,2]

Infant mortality rates increase as mother's education levels decrease.[3,4] For example, between 2009-2013, Rhode Island mothers with a high school degree or less had a higher infant mortality rate (6.4 per 1,000) than mothers with more advanced educational degrees (4.8 per 1,000 births).[5]

Children of more highly educated parents participate in early learning programs and home literacy activities more frequently, enter school with higher levels of academic skills, and earn higher average reading and math test scores. Increasing maternal education can improve children's school readiness, language and academic skills.[6,7] Increases in education levels also have been linked to improved health, better employment opportunities, and higher earnings.[8] Higher levels of parental education can decrease the likelihood that a child will live in poverty.[9] Women with bachelor's degrees in Rhode Island earn more than twice as much as those with less than a high school diploma.[10]

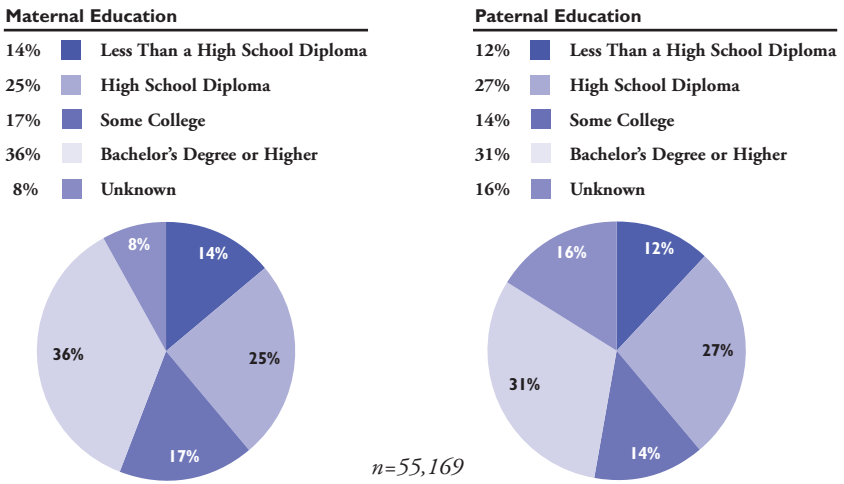
Between 2009 and 2013, 14% of Rhode Island births were to mothers with less than a high school diploma and 36% were to mothers with a bachelor's degree or higher.[11] Nationally, mothers with infants are more educated than ever before. In 2013, 12% of all U.S. births were to mothers with less than a high school diploma, and 63% were to mothers with at least some college education.[12]

Births to Mothers With Less Than a High School Diploma

CITY/TOWN	% OF CHILDREN
Central Falls	36%
Pawtucket	18%
Providence	25%
Woonsocket	21%
Four Core Cities	*24%*
Remainder of State	*7%*
Rhode Island	*14%*

Source: Rhode Island Department of Health, Hospital Discharge Database, 2009-2013.

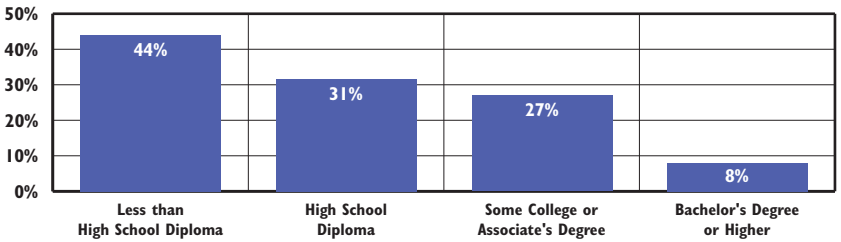
Births by Parental Education Levels, Rhode Island, 2009-2013



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2009-2013. Data for 2013 are provisional.

◆ **In Rhode Island between 2009 and 2013, 39% of all infants were born to mothers with a high school diploma or less, and 39% were born to fathers with a high school diploma or less.[13]**

Poverty Rates for Families Headed by Single Females by Educational Attainment, Rhode Island, 2011-2013



Source: U.S. Census Bureau, American Community Survey, 2011-2013. Table S1702.

◆ **The poverty rate among families headed by single females is directly correlated with the mother's educational level. In Rhode Island between 2011 and 2013, 44% of families headed by single females with less than a high school diploma were poor, compared with 8% of those with a bachelor's degree or higher.[14]**

Table 4.

Births by Education Level of Mother, Rhode Island, 2009-2013

CITY/TOWN	TOTAL # OF BIRTHS	BACHELOR'S DEGREE OR ABOVE		SOME COLLEGE		HIGH SCHOOL DIPLOMA		LESS THAN HIGH SCHOOL DIPLOMA	
		N	%	N	%	N	%	N	%
Barrington	497	386	78%	48	10%	33	7%	5	1%
Bristol	812	432	53%	149	18%	146	18%	39	5%
Burrillville	655	227	35%	152	23%	183	28%	45	7%
Central Falls	1,654	117	7%	197	12%	566	34%	603	36%
Charlestown	269	124	46%	58	22%	56	21%	14	5%
Coventry	1,444	648	45%	323	22%	295	20%	95	7%
Cranston	3,915	1,695	43%	733	19%	881	23%	338	9%
Cumberland	1,586	877	55%	271	17%	237	15%	75	5%
East Greenwich	524	363	69%	68	13%	58	11%	8	2%
East Providence	2,536	1,028	41%	458	18%	658	26%	200	8%
Exeter	257	132	51%	36	14%	57	22%	22	9%
Foster	146	68	47%	30	21%	29	20%	6	4%
Glocester	365	178	49%	76	21%	65	18%	20	5%
Hopkinton	357	154	43%	76	21%	90	25%	24	7%
Jamestown	120	86	72%	7	6%	10	8%	2	2%
Johnston	1,318	535	41%	277	21%	321	24%	97	7%
Lincoln	904	444	49%	183	20%	155	17%	57	6%
Little Compton	84	51	61%	12	14%	13	15%	3	4%
Middletown	845	416	49%	154	18%	174	21%	43	5%
Narragansett	405	235	58%	63	16%	58	14%	12	3%
New Shoreham	55	32	58%	6	11%	11	20%	4	7%
Newport	1,366	638	47%	164	12%	261	19%	159	12%
North Kingstown	992	566	57%	150	15%	156	16%	47	5%
North Providence	1,533	631	41%	336	22%	364	24%	100	7%
North Smithfield	433	225	52%	80	18%	82	19%	19	4%
Pawtucket	5,020	1,109	22%	898	18%	1,553	31%	902	18%
Portsmouth	593	341	58%	110	19%	95	16%	10	2%
Providence	13,131	2,940	22%	1,860	14%	3,746	29%	3,294	25%
Richmond	365	199	55%	63	17%	59	16%	15	4%
Scituate	310	172	55%	52	17%	61	20%	9	3%
Smithfield	615	373	61%	96	16%	98	16%	14	2%
South Kingstown	947	558	59%	138	15%	136	14%	47	5%
Tiverton	572	247	43%	114	20%	126	22%	27	5%
Warren	470	192	41%	101	21%	110	23%	45	10%
Warwick	3,888	1,810	47%	806	21%	781	20%	230	6%
West Greenwich	240	121	50%	55	23%	44	18%	6	3%
West Warwick	1,843	520	28%	355	19%	581	32%	247	13%
Westerly	1,030	346	34%	247	24%	286	28%	89	9%
Woonsocket	3,056	516	17%	519	17%	1,020	33%	652	21%
Unknown	*17*	*7*	*NA*	*5*	*NA*	*3*	*NA*	*1*	*NA*
Four Core Cities	*22,861*	*4,682*	*20%*	*3,474*	*15%*	*6,885*	*30%*	*5,451*	*24%*
Remainder of State	*32,291*	*15,050*	*47%*	*6,047*	*19%*	*6,770*	*21%*	*2,173*	*7%*
Rhode Island	*55,169*	*19,739*	*36%*	*9,526*	*17%*	*13,658*	*25%*	*7,625*	*14%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2009-2013. Data for 2013 are provisional. Data are self-reported and reported by the mother's place of residence, not the place of the infant's birth.

Percentages may not sum to 100% for all communities and the state because the number and percentage of births with unknown maternal education levels are not included in this table. Between 2009 and 2013, maternal education levels were unknown for 4,621 births (8%).

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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(continued on page 170)

Racial and Ethnic Diversity

DEFINITION

Racial and ethnic diversity is the percentage of children under age 18 by racial and ethnic categories as defined by the U.S. Census. Racial and ethnic categories are chosen by the head of household or person completing the Census form.

SIGNIFICANCE

Racial and ethnic diversity has increased in the United States over the last several decades and is projected to rise in the future.[1] Since 2000, all of the growth in the child population in the U.S. has been among groups other than non-Hispanic Whites.[2] In Rhode Island, the non-Hispanic White child population declined by 21% between 2000 and 2010, while the Hispanic child population grew by 31%.[3] In 2013, 52% of all U.S. children were non-Hispanic White.[4] The U.S. will become even more racially and ethnically diverse. By 2023, more than half of all children in the U.S. will be children of color.[5]

In 2010, 64% of children in Rhode Island were non-Hispanic White, down from 73% in 2000. The number of minority children grew by about 13,000 between 2000 and 2010. The number of non-Hispanic White children dropped by over 37,000 during the same period.[6]

In 2010 in Rhode Island, 72% of children under age 18 were White, 8% were Black or African American, 3% were Asian, less than 1% were American Indian or Alaska Native, 9% of children were identified as Some other race and 7% as Two or more races. In 2010, 21% of children living in Rhode Island were Hispanic.[7]

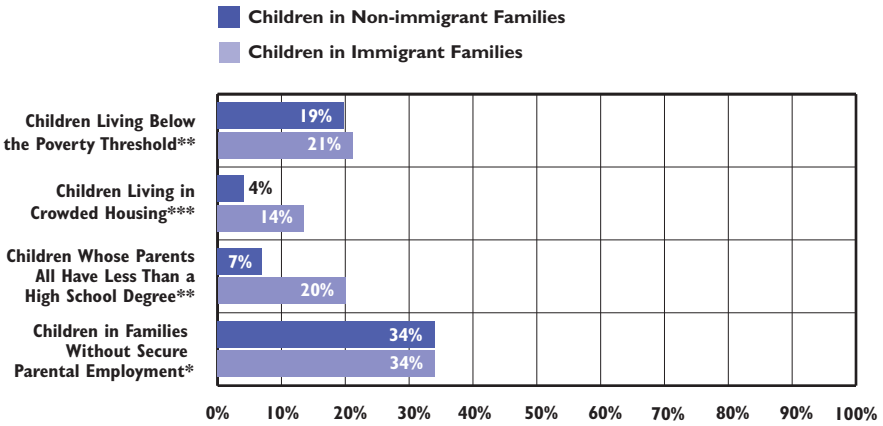
More than two-thirds (67%) of all minority children in Rhode Island live in Rhode Island's four core cities, Central Falls, Pawtucket, Providence, and Woonsocket. Almost three-quarters (74%) of children living in the four core cities are minority children.[8]

Between 2011 and 2013, there were 9,111 foreign-born children living in Rhode Island, 32% of whom were naturalized U.S. citizens.[9] Of Rhode Island's immigrant children, 23% were born in Central or South America, 25% were born in the Caribbean, 24% were born in Asia, 15% were born in Africa, 11% were born in Europe and 2% were born in North America (Canada, Bermuda, or Mexico).[10]

Between 2011 and 2013, 23% of children between the ages of five and 17 living in Rhode Island spoke a language other than English at home, 96% of whom spoke English well or very well.[11]

Diversity presents both opportunities and challenges to adapt current practices to meet the needs of a changing population.[12]

Characteristics of Children Living in Immigrant and Non-immigrant Families, Rhode Island



Source: The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org.
*Data are for 2010. **Data are for 2012. ***Data are for 2013.

◆ **Ninety-six percent of children in Rhode Island were born in the United States.[13] Twenty-six percent of children in Rhode Island live in immigrant families (either they are foreign-born or they have at least one parent who is foreign-born), higher than the U.S. rate of 24%.[14] Most immigrant families in Rhode Island are not new arrivals to the United States; 98% of children in Rhode Island immigrant families have parents who arrived in this country more than five years ago.[15]**

◆ **Nineteen percent of Rhode Island children in non-immigrant families are poor, compared with 21% of children in immigrant families.[16] Two-thirds (67%) of Rhode Island's poor children live in families with U.S.-born parents.[17]**

◆ **The economic, physical, and academic well-being of immigrant children is influenced by their parents' proficiency in English. Limited English proficiency can be a barrier to employment opportunities, higher earnings, access to health care, and parental engagement with education.[18] Fifteen percent of Rhode Island children in immigrant families live in linguistically-isolated households, meaning no one 14 years or older either speaks only English or speaks English "very well."[19]**

Table 5.

Child Population, by Race and Ethnicity, Rhode Island, 2010

CITY/TOWN	UNDER AGE 18 BY RACE AND ETHNICITY: HISPANIC OR LATINO	WHITE	BLACK	AMERICAN INDIAN AND ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	SOME OTHER RACE	TWO OR MORE RACES	2010 POPULATION UNDER AGE 18
Barrington	154	4,096	22	8	163	0	13	141	4,597
Bristol	130	3,298	43	4	40	0	3	105	3,623
Burrillville	115	3,310	32	2	12	0	4	101	3,576
Central Falls	3,950	747	492	17	20	2	179	237	5,644
Charlestown	46	1,331	8	50	16	0	1	54	1,506
Coventry	312	7,065	64	19	77	0	14	219	7,770
Cranston	2,966	10,819	693	48	1,075	15	73	725	16,414
Cumberland	542	6,348	154	7	204	3	31	246	7,535
East Greenwich	106	3,014	26	5	174	0	6	105	3,436
East Providence	799	6,619	619	42	142	1	281	674	9,177
Exeter	66	1,216	7	7	10	0	3	25	1,334
Foster	24	913	14	1	16	0	0	18	986
Glocester	63	1,942	13	2	24	0	7	47	2,098
Hopkinton	48	1,690	7	15	16	0	3	66	1,845
Jamestown	36	947	4	1	8	0	2	45	1,043
Johnston	640	4,364	148	1	135	0	22	170	5,480
Lincoln	353	3,885	114	7	164	0	25	203	4,751
Little Compton	18	606	8	1	6	3	2	10	654
Middletown	295	2,779	159	10	124	3	20	262	3,652
Narragansett	91	1,998	30	32	16	0	9	93	2,269
New Shoreham	10	149	1	0	0	0	0	3	163
Newport	703	2,405	337	37	39	1	33	528	4,083
North Kingstown	289	5,598	75	31	85	2	6	236	6,322
North Providence	796	3,833	397	15	158	0	74	241	5,514
North Smithfield	114	2,241	15	2	33	0	4	47	2,456
Pawtucket	4,785	6,513	2,727	83	256	7	1,004	1,200	16,575
Portsmouth	157	3,537	53	11	58	1	13	166	3,996
Providence	23,166	6,737	6,682	375	2,095	15	494	2,070	41,634
Richmond	44	1,729	12	7	15	0	0	42	1,849
Scituate	54	2,145	8	4	29	0	3	29	2,272
Smithfield	117	3,337	46	6	41	0	9	69	3,625
South Kingstown	192	4,687	80	81	115	1	18	242	5,416
Tiverton	84	2,741	31	3	34	2	9	94	2,998
Warren	75	1,736	38	10	11	0	4	66	1,940
Warwick	1,048	13,365	275	38	457	2	39	601	15,825
West Greenwich	60	1,353	15	5	16	0	1	27	1,477
West Warwick	590	4,554	142	11	128	3	20	298	5,746
Westerly	252	4,068	68	52	127	2	10	208	4,787
Woonsocket	2,650	5,147	676	37	592	2	35	749	9,888
Four Core Cities	*34,551*	*19,144*	*10,577*	*512*	*2,963*	*26*	*1,712*	*4,256*	*73,741*
Remainder of State	*11,389*	*123,718*	*3,758*	*575*	*3,768*	*39*	*762*	*6,206*	*150,215*
Rhode Island	*45,940*	*142,862*	*14,335*	*1,087*	*6,731*	*65*	*2,474*	*10,462*	*223,956*

Source of Data for Table/Methodology

U.S. Census Bureau, Census 2010 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.

Core cities are Central Falls, Pawtucket, Providence, 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 well-being, health, safety and education.

SIGNIFICANCE

Rhode Island's children are diverse in racial and ethnic background. In 2010 in Rhode Island, 72% of children under age 18 were White, 8% were Black or African American, 3% were Asian, 1% were Native American, 9% of children were identified as "Some other race," and 7% as "Two or more races." In 2010, 21% of children living in Rhode Island were Hispanic.[1]

Children who live in poverty, especially those who experience poverty in early childhood and for extended periods of time, are more likely to have health, behavioral, educational and social problems.[2,3] Between 2011 and 2013, 21% of all Rhode Island children lived in poverty, 68% of whom were minorities.[4]

Black, Hispanic, and Native American children are more likely than White and Asian children to live in neighborhoods that lack the resources needed for them to grow up healthy and successful.[5] In 2010, two-thirds (67%) of Rhode Island's minority children lived in one of the four core cities (those cities with the highest percentage of children living in poverty). In 2010, more than three-quarters of the children in Providence (84%) and Central Falls (87%) were of minority racial and ethnic backgrounds.[6] Children living in areas of concentrated poverty, who are more likely to be Black or Hispanic, face challenges above and beyond the burdens of individual poverty. The Providence metropolitan area has the 56th highest rate of concentrated poverty in the U.S.[7]

Residential segregation between Whites and Blacks has decreased in the U.S. since the 1970s, but high levels of residential segregation still exist. Hispanics and Asians experience less segregation than Blacks, but the rate of segregation for these groups has been increasing in recent years.[8] The Providence-New Bedford-Fall River metropolitan area was the ninth most segregated metropolitan area in the nation for Hispanics in 2010.[9]

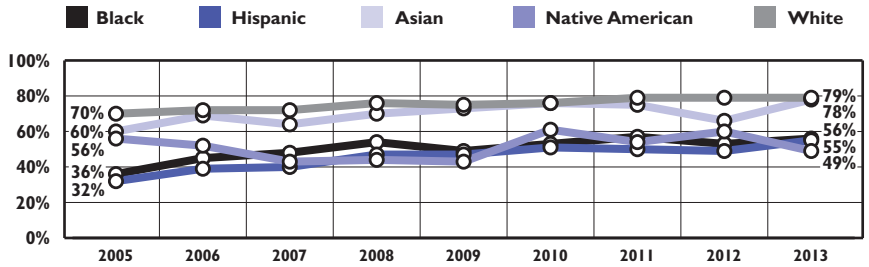
Even in good economic climates, minority families are more likely to be unemployed, have higher poverty rates and receive lower wages than White families. Minority families also face greater negative impacts during economic recessions and their recovery from economic downturns is slower than that of White families. Even when controlling for educational achievement, age and gender, minority workers have consistently higher unemployment rates than White workers.[10,11]

Residential Segregation and Its Impact on Education

◆ **In the U.S., Black and Hispanic students are now more segregated from White students than at any point in the past four decades.[12] As a result, White students generally attend schools that are disproportionately White and low-poverty, while Black and Hispanic students attend schools that are disproportionately minority and high-poverty.[13]**

◆ **Many urban communities have high concentrations of poverty, which can be related to unequal educational opportunities. School district boundaries often determine access to challenging curricula, academic expectations, educator quality, facilities quality, adequacy of school funding, access to instructional supports (like technology), and school safety.[14,15]**

Racial and Ethnic Disparities in Fourth Grade Reading Proficiency Rates, Rhode Island, 2005-2013



Source: Rhode Island Department of Education, *New England Common Assessment Program (NECAP)*, 2005-2013.

◆ **In Rhode Island between 2005 and 2013, White fourth-graders were more likely to achieve proficiency on the *NECAP* reading exam than minority fourth-graders.[16]**

◆ **Racial and ethnic disparities in education are evident before children enter kindergarten and persist throughout high school and college. Black and Hispanic students are much less likely to graduate from high school, go to college, and graduate from college than their White peers.[17,18,19,20]**

◆ **Factors that impact educational achievement gaps include school issues, family participation, and before- and beyond-school concerns (e.g., poor child health or access to out-of-school and early-learning opportunities).[21,22,23]**

Economic Well-Being Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Children in Poverty	15%	45%	38%	20%	44%	21%
Births to Mothers With <12 Years Education	9%	33%	20%	11%	36%	15%
Unemployment Rate	7%	16%	15%	NA	NA	8%
Median Family Income	$78,294	$30,611	$40,420	$68,610	$22,023	$72,152
Homeownership	65%	26%	31%	48%	19%	60%

Sources: *Children in Poverty* data are from the U.S. Census Bureau, American Community Survey, 2011-2013. Tables B17001, B17020A, B17020B, B17020C, B17020D & B17020I. *Maternal Education* data are from the Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013. *Unemployment Rate* data are from the Bureau of Labor Statistics, Local Area Unemployment Statistics, 2014. *Median Family Income* data are from the U.S. Census Bureau, American Community Survey, 2011-2013, Tables B19113, B19113A, B19113B, B19113C, B19113D & B19113I. *Homeownership* data are from the U.S. Census Bureau, American Community Survey, 2011-2013, Tables B25003, B25003A, B25003B, B25003C, B25003D & B25003I. Hispanics also may be included in any of the race categories. All Census data refer only to those individuals who selected one race. NA indicates that the rate was not calculated because the number was too small to calculate a reliable rate.

◆ **Between 2011 and 2013 in Rhode Island, 21% of all children, 45% of Hispanic children, 44% of Native American children, 38% of Black children, 20% of Asian children, and 15% of White children in Rhode Island lived in families with incomes below the federal poverty level.[24]**

◆ **Between 2011 and 2013 in Rhode Island, White households were the most likely to own their homes while Native American and Hispanic households were the most likely to live in rental units.[25]**

◆ **In 2014 in Rhode Island, the unemployment rate among White people was 7%, compared to 15% for Black people and 16% for Hispanic people. Nationally, the unemployment rate for White people in 2014 was 6%, compared to 11% for Black people and 7% for Hispanic people.[26]**

◆ **Education is essential for economic success. Adults with less than a high school diploma are at particular risk of living in poverty and other negative outcomes.[27] Hispanic, Black, and Native American children in Rhode Island are all more likely than White and Asian children to be born to mothers with less than a high school diploma.[28]**

Health Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Children Without Health Insurance	4.0%	7.2%	7.9%	6.2%	5.3%	4.6%
Women With Delayed Prenatal Care	10.5%	16.2%	18.7%	16.3%	NA	12.8%
Preterm Births	9.6%	12.0%	14.7%	11.6%	NA	10.7%
Low Birthweight Infants	6.8%	7.7%	11.4%	9.4%	NA	7.6%
Infant Mortality (per 1,000 live births)	7.1	5.8	11.2	1.5	NA	6.6
Asthma Hospitalizations (per 1,000 children)	1.4	2.4	5.1	1.3	NA	2.0
Births to Teens Ages 15-19 (per 1,000 teens)	13.1	50.5	35.9	14.3	62.9	21.0

Sources: All data are from the Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013 unless otherwise specified. Information is based on self-reported race and ethnicity. *Children Without Health Insurance* data are from the U.S. Census Bureau, American Community Survey, 2011-2013, tables B27001, B27001A, B27001B, B27001C, B27001D & B27001I. *Asthma Hospitalizations* data are from the Rhode Island Department of Health, Hospital Discharge Database, 2009-2013 and refer only to hospitalizations due to primary diagnoses of asthma. For *Asthma Hospitalizations* the denominators are the child population under age 18 by race from the U.S. Census Bureau, Census 2010, SF1. For *Births to Teens* the denominators are the female populations ages 15-19 by race from the U.S. Census Bureau, Census 2010, SF1. For all indicators other than *Asthma Hospitalizations*, Hispanics also may be included in any of the race categories. NA indicates that the rate was not calculated because the number was too small to calculate a reliable rate.

◆ **Although progress has been made on many health indicators across racial and ethnic populations, disparities still exist for a number of maternal and infant health outcomes in Rhode Island. Minority women are more likely than White women to receive delayed or no prenatal care and to have preterm births. Black children are more likely to die in infancy than White, Hispanic, or Asian children. Native American, Hispanic, and Black youth are more likely than White and Asian youth to give birth as teenagers.[29]**

◆ **Black and Hispanic children in Rhode Island are more likely to be hospitalized as a result of asthma than White and Asian children.[30] Nationally, Blacks and Native Americans are the most likely of all racial and ethnic groups to have asthma.[31]**

◆ **In the U.S., 93% of children have health insurance coverage. Hispanic (89%) and Native American (84%) children have the lowest rates of coverage.[32]**

Racial and Ethnic Disparities

Safety Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
Youth at the Training School* (per 1,000 youth ages 13-18)	2.9	10.9	18.4	1.5	17.4	5.8
Children of Incarcerated Parents (per 1,000 children)	9.0	14.5	67.1	5.6	28.5	13.4
Children in Out-of-Home Placement (per 1,000 children)	6.6	12.3	22.3	3.0	14.7	9.3

Sources: *Youth at the Training School* data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Training School, Calendar Year 2014. (*These data represent all youth in the care and custody of the Training School during 2014. Prior Factbooks used point-in-time data to calculate rates and are not comparable). *Children of Incarcerated Parents* data are from the Rhode Island Department of Corrections, October 10, 2014 and reflect the race of the incarcerated parent (includes only the sentenced population). *Children in Out-of-Home Placement* data are from the Rhode Island Department of Children, Youth and Families, RICHIST Database, December 31, 2014. Population denominators used for *Youth at the Training School* are youth ages 13-18 by race from the U.S. Census Bureau, Census 2010, SF1. Population denominators used for *Children of Incarcerated Parents* and *Children in Out-of-Home Placement* are the populations under age 18 by race from the U.S. Census Bureau, Census 2010, SF1.

◆ **Racial and ethnic minority youth continue to be disproportionately represented in the U.S. juvenile justice system. Minority youth (especially Latino and Black youth) are treated more harshly than White youth for the same type and severity of offenses, including detention, processing, and incarceration in juvenile and adult correctional facilities.[33] Rhode Island's juvenile justice system has some of the widest residential placement disparities between White and minority youth in the nation.[34]**

◆ **Black and Hispanic children in Rhode Island are more likely than their Native American, White, and Asian peers to be placed out-of-home through the child welfare system.[35] Nationally, minority children experience disparate treatment as they enter the foster care system and while they are in the system. They are more likely than White children under similar circumstances to be placed in foster care, remain in the child welfare system longer, have less contact with child welfare staff, and to have lower reunification rates.[36]**

◆ **Disproportionality in child welfare and juvenile justice systems is in part a reflection of differential poverty rates between minority and White communities. However, while addressing poverty through policies would reduce child maltreatment and juvenile offending rates, policies that work directly to reduce disparities are necessary as well.[37]**

Education Outcomes, by Race and Ethnicity, Rhode Island

	WHITE	HISPANIC	BLACK	ASIAN	NATIVE AMERICAN	ALL RACES
4th Grade Students Reading at or Above Proficiency	79%	55%	56%	78%	49%	71%
4th Grade Students at or Above Proficiency in Mathematics	73%	44%	42%	68%	33%	63%
Students Attending Schools Identified for Intervention	2%	36%	29%	19%	17%	13%
Four-Year High School Graduation Rates	85%	72%	72%	88%	57%	81%
% of Adults Over Age 25 With a Bachelor's Degree or Higher	34%	12%	18%	44%	8%	32%

Sources: *Reading and Math Proficiency* data are from the Rhode Island Department of Education, October 2013 *NECAP. Students Attending Schools Identified for Intervention* and *Four-Year High School Graduation Rates* data are from the Rhode Island Department of Education, 2013-2014 school year. *Adult Educational Attainment* data are from the U.S. Census Bureau, American Community Survey, 2011-2013, Tables C15002, C15002A, C15002B, C15002C, C15002D & C15002I. All Census data refer only to those individuals who selected one race and Hispanics also may be included in any of the race categories.

◆ **In Rhode Island, Hispanic, Native American, and Black children are less likely to be proficient in reading and mathematics in fourth grade than White or Asian children.[38] Native American, Hispanic, and Black adults living in Rhode Island are less likely to have a bachelor's degree than White or Asian adults.[39]**

◆ **Nationally, Black, Hispanic, and Native American students are more likely than White and Asian students to be disciplined in school. Schools' disproportionate use of disciplinary techniques that remove children from the classroom, such as out-of-school suspension or expulsion, may contribute to racial and ethnic gaps in school achievement and drop-out rates. Rhode Island has one of the highest rates in the U.S. for disciplinary out-of-school suspensions among Black students with disabilities.[40] In Rhode Island during the 2013-2014 school year, minority students received 57% of all disciplinary actions, although they made up only 39% of the student population.[41]**

◆ **During the 2013-2014 school year, Rhode Island's Hispanic and Black children were 17 times as likely as White children to attend schools identified for intervention.[42]**

Rhode Island's Hispanic Children and Youth

◆ **In 2010, there were 45,940 Hispanic children under age 18 living in Rhode Island, up from 35,326 in 2000. Hispanic children made up 21% of Rhode Island's child population in 2010, compared with 14% in 2000.[43]**

◆ **In 2010, three-quarters (75%) of the Hispanic children in Rhode Island lived in the four core cities of Central Falls, Pawtucket, Providence, and Woonsocket. While Providence has the largest Hispanic child population overall, Central Falls has the highest percentage of Hispanic children.[44]**

Economics

◆ **In 2013, 50% percent of Rhode Island's Hispanic children were living in poverty, compared to the national rate of 33%.[45] The median family income for Hispanics in Rhode Island was $30,611, compared to $72,152 overall in Rhode Island.[46]**

Health

◆ **In Rhode Island between 2009 and 2013, 16.2% percent of Hispanic babies were born to women who received delayed or no prenatal care, compared with 12.8% of all babies in the state.[47]**

◆ **Between 2009 and 2013, Hispanic female teens between the ages of 15 and 19 in Rhode Island had a birth rate that was more than two times higher than the overall teen birth rate in Rhode Island (50.5 per 1,000 Hispanic teens ages 15 to 19 compared to 21.0 per 1,000 for all teens).[48,49]**

Education

◆ **The four-year high school graduation rate among Hispanic youth in the class of 2014 was 72%, lower than Rhode Island's four-year high school graduation rate of 81%.[50]**

◆ **The achievement gap between White and Latino students in Rhode Island is among the largest in the U.S.[51]**

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Economic Well-Being

Hush, Little Baby

Anonymous

Hush, little baby, don't say a word.
Poppa's gonna buy you a mocking bird.

If that mocking bird don't sing,
Poppa's gonna buy you a diamond ring.

If that diamond ring turns brass,
Poppa's gonna buy you a looking-glass.

If that looking-glass gets broke,
Poppa's gonna buy you a billy goat.

If that billy goat runs away,
Poppa's gonna buy you a bale of hay.

If you grow up and get real tall
You'll be the prettiest baby of all.

Median Family Income

DEFINITION

Median family income is the dollar amount which divides Rhode Island families' income distribution into two equal groups – half with incomes above the median and half with incomes below the median. The numbers include only families with their "own children" under age 18, defined as never-married children who are related to the family head by birth, marriage, or adoption.

SIGNIFICANCE

Median family income is a measure of the ability of families to meet the costs of food, clothing, housing, health care, transportation, child care, and higher education. In 2013, the median family income for Rhode Island families with their own children was $64,985.[1] Rhode Island had the 12th highest median family income nationally and the 4th highest in New England.[2]

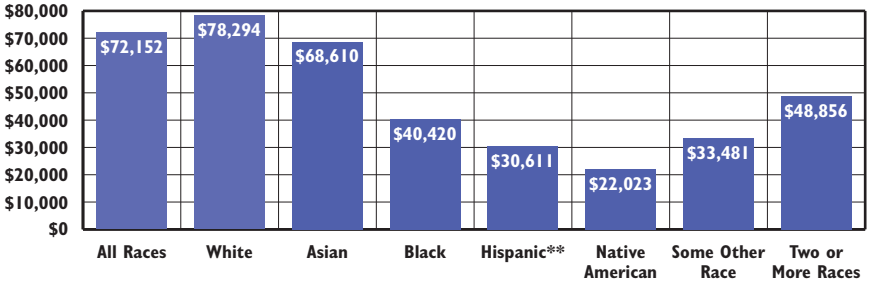
Between 2011 and 2013, Rhode Island's median income for families with their own children differed significantly by family type. The median family income for married two-parent families ($96,919) was more than two and a half times that of male-headed single-parent families ($37,600) and more than three and a half times that of female-headed single-parent families ($26,155).[3]

Despite significant increases in worker productivity in the U.S. during the 2000s, the real incomes of most families remained stagnant or decreased.[4] It was the first business cycle (a predicable long-term pattern of alternating periods of economic growth and decline) during which the median family income did not rise.[5] Median incomes for working-age households (headed by someone under age 65) decreased by 10.2% between 2000 and 2010.[6]

Over the past 30 years, the income gap between the wealthiest families and low- and middle-income families has tripled, resulting in a greater concentration of wealth at the top than any time since 1928.[7] Several factors have contributed to this rising income inequality, including a severe drop in minimum wage, the stagnation of wages and compensation, the decline of unionization, high levels of unemployment, high school and college graduates starting at lower wages, and degrees bringing less value over time.[8]

In Rhode Island, the average income of the wealthiest 20% of families increased by 99% (or $94,170) during the past thirty years, while the average income of the poorest 20% of families increased by 12% (or $2,480). The wealthiest 20% of families in Rhode Island have average incomes that are 7.5 times larger than the average incomes of the poorest 20% of families. Rhode Island is among the top ten states with the fastest growing income inequality.[9]

Median Family Income by Race and Ethnicity, Rhode Island, 2011-2013*



Source: U.S. Census Bureau, American Community Survey, 2011-2013. Tables B19113, B19113A, B19113B, B19113C, B19113D, B19113F, B19113G, and B19113I. *Median Family Income by race and ethnicity includes all families because data for families with "own children" are not available by race and ethnicity. **Hispanics may be in any race category.

◆ **The median income for White families in Rhode Island is higher than that of Asian families, and much higher than that of Black, Hispanic, and Native American families.[10]**

◆ **Intergenerational income mobility is influenced by race and ethnicity. National research shows that White children are more likely to move up the economic ladder, while middle-income Black children are more likely to fall into lower income brackets. In addition, 63% of Black children born into poor families stay in the lowest income levels, compared to 32% of White children born into poor families.[11]**

◆ **According to the *2014 Rhode Island Standard of Need*, it costs a single-parent family with two young children $51,492 a year to pay basic living expenses, including housing, food, health care, child care, transportation, and other miscellaneous items. This family would need an annual income of $59,083 to meet this budget without government subsidies.[12]**

◆ **Income support programs (including RIte Care health insurance, child care subsidies, SNAP/food stamp benefits, and the Earned Income Tax Credit) are critical for helping low- and moderate-income working families in Rhode Island make ends meet.[13]**

Table 6. **Median Family Income, Rhode Island, 2009-2013**

CITY/TOWN	1999 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18 (ADJUSTED TO 2013 DOLLARS*)	2009-2013 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18	
		ESTIMATES WITH HIGH MARGINS OF ERROR**	ESTIMATES WITH LOWER, ACCEPTABLE MARGINS OF ERROR
Barrington	$124,137		$131,656
Bristol	$74,555		$100,913
Burrillville	$77,011		$71,013
Central Falls	$30,768		$28,953
Charlestown	$77,004		$72,054
Coventry	$85,777		$83,156
Cranston	$79,554		$80,105
Cumberland	$95,473		$96,629
East Greenwich	$151,764		$167,539
East Providence	$68,329		$55,127
Exeter	$102,391		$120,441
Foster	$88,615	$79,728	
Glocester	$85,194		$91,327
Hopkinton	$82,581		$85,071
Jamestown	$111,248		$137,734
Johnston	$79,186		$80,784
Lincoln	$90,132		$98,803
Little Compton	$79,239	$124,028	
Middletown	$77,313		$84,038
Narragansett	$95,416		$103,654
New Shoreham	$76,674	$106,071	
Newport	$60,290		$54,412
North Kingstown	$93,368		$107,165
North Providence	$70,591		$68,904
North Smithfield	$99,353		$97,353
Pawtucket	$46,921		$41,421
Portsmouth	$94,193		$101,250
Providence	$34,316		$33,154
Richmond	$88,736		$116,500
Scituate	$96,653		$87,083
Smithfield	$93,738		$92,596
South Kingstown	$95,437		$104,334
Tiverton	$89,223		$91,103
Warren	$74,854		$70,203
Warwick	$79,741		$79,162
West Greenwich	$98,072		$104,323
West Warwick	$58,480		$53,558
Westerly	$72,662	$64,375	
Woonsocket	$48,183		$31,307
Four Core Cities	*NA*		*NA*
Remainder of State	*NA*		*NA*
Rhode Island	*$70,681*		*$67,904*

Source of Data for Table/Methodology

Median family income data include only households with children under age 18 who meet the U.S. Census Bureau's definition of a family. The U.S. 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 householder by birth, marriage, or adoption.

*The 1999 median family income data are adjusted to 2013 constant dollars by multiplying 1999 dollar values by 1.39803841 as recommended by the U.S. Census Bureau.

The 2009-2013 data come from a Population Reference Bureau analysis of 2009-2013 American Community Survey data. The American Community Survey is a sample survey, and therefore the median family income is an estimate. The reliability of estimates vary by community. In general, estimates for small communities are not as reliable as estimates for larger communities.

**The Margin of Error around the estimate is greater than or equal to 25 percent of the estimate.

The Margin of Error is a measure of the reliability of the estimate and is provided by the U.S. Census Bureau. The Margin of Error means that there is a 90 percent chance that the true value is no less than the estimate minus the Margin of Error and no more than the estimate plus the Margin of Error. See the Methodology Section for Margins of Errors for all communities.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

NA: Median family income cannot be calculated for combinations of cities and towns (i.e., Four Core Cities and Remainder of State).

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[12,13] *The 2014 Rhode Island Standard of Need.* (2014). Providence, RI: The Economic Progress Institute.

Cost of Housing

DEFINITION

Cost of housing is the percentage of income needed by a very low-income family to cover the average cost of rent.[1] The U.S. Department of Housing and Urban Development (HUD) defines a very low-income family as a family with an income less than 50% of the median family income. 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, and emotional well-being and on a family's ability to meet a child's basic needs. Children who live in families with cost burdens may live in low-quality and overcrowded housing and move frequently, all of which have been linked to lower educational achievement.[2,3]

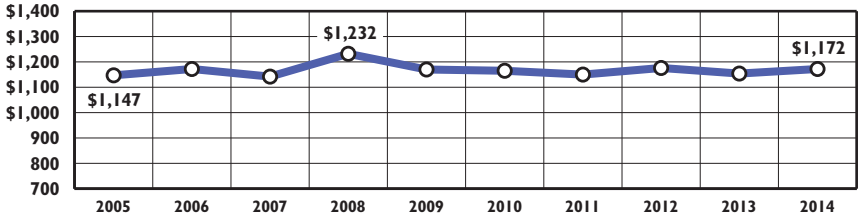
The growth in families' housing expenses has outpaced income growth, both nationally and in Rhode Island.[4,5] In 2012, 23% of Rhode Island's 155,803 working households spent more than half of their income on housing costs, making Rhode Island the second most housing cost-burdened state in New England.[6]

In 2014, a worker would have to earn $22.54 an hour and work 40 hours a week year-round to be able to afford the average rent in Rhode Island without a cost burden. This hourly wage is nearly three times the state's 2014 minimum wage of $8.00 per hour.[7] In 2014, Rhode Island required the 16th highest hourly wage to afford the rent for a two-bedroom home of any state.[8]

In 2014, the area median income for families in Rhode Island was $73,695.[9] Families with this income can afford to purchase a median-priced, single-family home in 22 of the 39 communities in the state.[10] In 2013, the median cost of a single-family home in Rhode Island was $205,000, 31% higher than in 2001 but 28% lower than in 2006.[11,12]

Federally-funded Section 8 housing choice rental vouchers can help low-income individuals and families afford the high cost of housing; however there are not enough vouchers to meet the need. Long waiting periods are common and housing authorities often close waiting lists when there are more families on the list than can be helped in the near future.[13] Rhode Island's FY 2015 budget increased the real estate conveyance tax and allocated new revenue to the Housing Resources Commission, creating a dedicated funding stream for housing subsidies as well as homelessness prevention, housing retention, and lead abatement.[14]

Average Rent, Two-Bedroom Apartment, Rhode Island, 2005-2014



Source: Rhode Island Housing, Annual Rent Surveys, 2005-2014. Rents include adjustments for the cost of heat, cooking fuel, electricity, and hot water. Adjustments for utilities for each year vary according to HUD annual utility allowances. The HUD utility allowance decreased in 2013, so average rents which include this allowance also decreased.

◆ **Between 2005 and 2014, the average cost of rent in Rhode Island remained fairly stable, increasing from $1,147 to $1,172 and continuing a trend of high rents that have not decreased since the beginning of the housing crisis.[15] The percentage of renters in Rhode Island who spent 30% or more of their household income on rent increased from 48% in 2005 to 52% in 2013. The percentage of homeowners who had a cost burden due to their mortgages decreased slightly between 2005 and 2013, from 38% to 36%.[16,17]**

Cost of Heating and Other Utilities

◆ **High energy costs make housing even less affordable for low-income families. Research shows that children in households experiencing energy shutoffs also are at risk of hunger and problems with health and development.[18]**

◆ **Rhode Island state law prohibits utility shutoffs for protected customers (such as the unemployed and low-income families with children under age two) and all customers facing financial hardships during the moratorium period from November 1 through April 15.[19]**

◆ **The federally-funded Low Income Home Energy Assistance Program (LIHEAP) provides financial assistance to Rhode Island's low-income households to meet home heating and energy costs.[20] In FY 2013, 27,731 low-income Rhode Island families received heating assistance through LIHEAP.[21]**

Table 7.

Cost of Housing for Very Low-Income Families, Rhode Island, 2014

	FAMILY INCOME		HOMEOWNERSHIP COSTS		RENTAL COSTS		
CITY/TOWN	2014 POVERTY LEVEL FAMILY OF THREE	2014 VERY LOW-INCOME FAMILY	TYPICAL MONTHLY HOUSING PAYMENT	% INCOME NEEDED FOR HOUSING PAYMENT, VERY LOW-INCOME FAMILY	AVERAGE RENT 2-BEDROOM APARTMENT	% INCOME NEEDED FOR RENT POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT VERY LOW-INCOME FAMILY
Barrington	$19,790	$32,500	$2,817	104%	$1,292	78%	48%
Bristol	$19,790	$32,500	$2,010	74%	$1,232	75%	45%
Burrillville	$19,790	$32,500	$1,543	57%	$1,047	63%	39%
Central Falls	$19,790	$32,500	$873	32%	$893	54%	33%
Charlestown	$19,790	$32,500	$1,998	74%	$1,307	79%	48%
Coventry	$19,790	$32,500	$1,365	50%	$1,156	70%	43%
Cranston	$19,790	$32,500	$1,433	53%	$1,187	72%	44%
Cumberland	$19,790	$32,500	$1,778	66%	$1,223	74%	45%
East Greenwich	$19,790	$32,500	$3,404	126%	$1,358	82%	50%
East Providence	$19,790	$32,500	$1,389	51%	$1,232	75%	45%
Exeter*	$19,790	$32,500	$2,182	81%	$944	57%	35%
Foster*	$19,790	$32,500	$1,638	60%	$944	57%	35%
Glocester*	$19,790	$32,500	$1,708	63%	$944	57%	35%
Hopkinton*	$19,790	$38,550	$1,669	52%	$979	59%	30%
Jamestown*	$19,790	$32,500	$3,133	116%	$944	57%	35%
Johnston	$19,790	$32,500	$1,463	54%	$1,275	77%	47%
Lincoln	$19,790	$32,500	$1,988	73%	$1,185	72%	44%
Little Compton*	$19,790	$32,500	$3,564	132%	$944	57%	35%
Middletown	$19,790	$40,500	$2,393	71%	$1,398	85%	41%
Narragansett	$19,790	$32,500	$2,492	92%	$1,278	77%	47%
New Shoreham*	$19,790	$38,550	$6,960	217%	$979	59%	30%
Newport	$19,790	$40,500	$2,748	81%	$1,424	86%	42%
North Kingstown	$19,790	$32,500	$2,204	81%	$1,333	81%	49%
North Providence	$19,790	$32,500	$1,331	49%	$1,207	73%	45%
North Smithfield	$19,790	$32,500	$1,708	63%	$1,173	71%	43%
Pawtucket	$19,790	$32,500	$1,117	41%	$1,021	62%	38%
Portsmouth	$19,790	$40,500	$2,220	66%	$1,281	78%	38%
Providence	$19,790	$32,500	$866**	32%**	$1,126	68%	42%
Richmond*	$19,790	$32,500	$1,732	64%	$944	57%	35%
Scituate	$19,790	$32,500	$1,774	66%	$1,240	75%	46%
Smithfield	$19,790	$32,500	$1,719	63%	$1,169	71%	43%
South Kingstown	$19,790	$32,500	$2,190	81%	$1,301	79%	48%
Tiverton	$19,790	$32,500	$1,765	65%	$1,238	75%	46%
Warren	$19,790	$32,500	$1,786	66%	$1,155	70%	43%
Warwick	$19,790	$32,500	$1,318	49%	$1,308	79%	48%
West Greenwich*	$19,790	$32,500	$2,073	77%	$944	57%	35%
West Warwick	$19,790	$32,500	$1,288	48%	$1,075	65%	40%
Westerly	$19,790	$38,550	$1,890	59%	$1,167	71%	36%
Woonsocket	$19,790	$32,500	$1,160	43%	$983	60%	36%
Four Core Cities	*$19,790*	*$32,500*	*$1,004*	*37%*	*$1,006*	*61%*	*37%*
Remainder of State	*$19,790*	*$33,704*	*$2,134*	*76%*	*$1,240*	*75%*	*44%*
Rhode Island	*$19,790*	*$33,581*	*$1,580*	*56%*	*$1,172*	*71%*	*42%*

Source of Data for Table/Methodology

2014 poverty level for a family of three as reported in: *Federal Register, 79*(14), January 22, 2014, pages 3593-3594.

A very low-income family as defined by the U.S. Department of Housing and Urban Development (HUD) is a three-person family with income 50% of the median family income and is calculated separately for each of the three metropolitan areas comprising Rhode Island. Reported by Rhode Island Housing (2014). *2014 Rhode Island income limits for low- and moderate-income households.* Retrieved February 5, 2015, from www.rhodeislandhousing.org

Data on typical monthly housing payments are from HousingWorks' *RI 2014 housing fact book.* (2014). Providence, RI: HousingWorks RI. They are based on the median selling price of a single-family home using year-end 2013 data and calculated based on a 30-year mortgage at a 3.98% interest rate with a 3.5% down payment. The typical monthly housing payment for the state comes from HousingWorks RI, but core city and remainder of state are calculated using un-weighted community data.

Rhode Island Housing, *Rhode Island Rent Survey*, 2014. Average rents are based on a survey of rents in Rhode Island between January and December, 2014. 2014 rents are adjusted using HUD's utility allowance of $223 for a two-bedroom apartment (includes heat, cooking fuel, electricity, and hot water) unless the listing stated that utilities were included in the rent, in which case the adjustment was not made.

*Rhode Island Housing 2014 *Rent Survey* data are not available. Average rent used for these communities is the HUD 2014 Fair Market Rent for the metropolitan area as reported by Rhode Island Housing.

The average rent calculated for the state as a whole, for the remainder of state, and four core cities do not include communities for which data from the *Rent Survey* were not available.

Statewide average rent is calculated by taking an average of all listings statewide. Rent averages for the four core cities and the remainder of state are calculated using un-weighted community data.

**Typical monthly housing payment for Providence does not include the East Side and therefore cannot be compared to data reported for Providence in Factbooks prior to 2013.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References are on page 171.

Homeless Children

DEFINITION

Homeless children is the number of children under age 18 who stayed at homeless shelters, domestic violence shelters or transitional housing facilities in Rhode Island with their families. This number does not include homeless and runaway youth who are unaccompanied by their families.

SIGNIFICANCE

In the United States, 2.5 million children (one in 30) are homeless each year.[1] Families can become homeless due to lack of affordable housing, unemployment, low-paying jobs, extreme poverty and decreasing government supports. Other causes include domestic violence, mental illness, substance abuse, and frayed social support networks.[2,3,4]

Compared with their peers, homeless children are more likely to become ill, (particularly with illnesses such as stomach problems, ear infections, and asthma), develop mental health issues (such as anxiety, depression, and withdrawal), experience significant educational disruption, and exhibit delinquent or aggressive behaviors. Homeless children go hungry at twice the rate of other children.[5]

Families that have experienced homelessness have higher rates of family separation than other low-income families, with children separated from their parents due to shelter rules, state intervention, and/or parents' desires to protect their children from homelessness. Homeless children are more likely to have been placed in foster care (12%) than other children (1%). Homelessness also can be a barrier to reunification; it is estimated that more than 30% of children in foster care in the U.S. could return home if their parents had adequate housing.[6]

In 2014, 535 families with children stayed at an emergency homeless shelter, domestic violence shelter, or transitional housing facility in Rhode Island. These families included 986 children. Children made up 24% of the people who used emergency homeless shelters, domestic violence shelters, and transitional housing in 2014, and half (49%) of these children were under age six.[7] Other families are on the state's family shelter waiting list, awaiting placement when a slot opens up. During 2014, United Way 211 received 47,991 calls from individuals and families seeking emergency shelter, 62,249 calls seeking affordable housing, and 8,570 calls related to foreclosure prevention.[8]

In December 2014, Rhode Island had the fourth highest unemployment rate (6.8%) in the U.S. and Rhode Island continues to have a high foreclosure rate.[9,10] In 2014, the average rent for a two-bedroom apartment in Rhode Island was $1,172 or 85% of the monthly earnings of a full-time worker earning the minimum wage.[11,12]

Rhode Island's Plan to Prevent and End Homelessness

◆ **In 2012, Rhode Island released a statewide strategic plan to transform the provision of services to decrease the number of homeless individuals and families. Rhode Island's plan *(Opening Doors Rhode Island)* is based on a comparable federal initiative called *Opening Doors, the Federal Strategic Plan to Prevent and End Homelessness.*[13]**

◆ **Rhode Island's plan includes a focus on family homelessness. The plan recommends creating housing options for families involved with the Department of Children, Youth and Families (DCYF); increasing access to wraparound services for families at risk of involvement with DCYF; expanding access to affordable child care options; and improving access to services that foster early childhood development, educational stability, and youth development.[14]**

Supporting Homeless Children in Schools

◆ **Family residential instability and homelessness contribute to poor educational outcomes for children. Homeless children are more likely to change schools, be absent from school, and have lower reading and math scores than children who have housing.[15]**

◆ **The federal *McKinney-Vento Homeless Assistance Act* requires that states identify homeless children, allow them to enroll in school even if they lack required documents, allow them to stay in their "home school," provide transportation when needed, and offer services to help them succeed in school.[16]**

◆ **The *McKinney-Vento Act* defines a child as homeless if he or she does not have a "fixed, regular and adequate nighttime residence."[17] During the 2013-2014 school year, Rhode Island public school personnel identified 1,023 children as homeless. Of these children, 59% (602) lived with other families ("doubled up"), 33% (333) lived in shelters, 8% (78) lived in hotels or motels, and 1% (7) were unsheltered.[18]**

◆ **Schools can support homeless families by identifying children and youth experiencing homelessness, ensuring that families and staff are aware of students' rights under the *McKinney-Vento Act*, developing relationships with community agencies serving homeless families, and helping homeless children get clothing, school supplies, tutoring, and referrals to other services they may need to succeed in school.[19]**

Table 8. **Homeless Children Identified by Public Schools, Rhode Island, 2013-2014 School Year**

SCHOOL DISTRICT	TOTAL ENROLLMENT	# OF CHILDREN IDENTIFIED AS HOMELESS BY PUBLIC SCHOOL PERSONNEL
Barrington	3,334	0
Bristol Warren	3,429	17
Burrillville	2,401	53
Central Falls	2,694	33
Chariho	3,427	26
Coventry	4,992	22
Cranston	10,552	21
Cumberland	4,531	10
East Greenwich	2,410	*
East Providence	5,321	18
Exeter-West Greenwich	1,648	*
Foster	272	0
Foster-Glocester	1,153	10
Glocester	529	*
Jamestown	507	*
Johnston	3,095	*
Lincoln	3,182	*
Little Compton	260	0
Middletown	2,267	119
Narragansett	1,396	*
New Shoreham	114	*
Newport	1,996	50
North Kingstown	4,056	31
North Providence	3,498	23
North Smithfield	1,729	*
Pawtucket	8,953	26
Portsmouth	2,647	22
Providence	23,827	135
Scituate	1,448	0
Smithfield	2,396	30
South Kingstown	3,397	14
Tiverton	1,873	0
Warwick	9,393	74
West Warwick	3,421	*
Westerly	3,016	57
Woonsocket	5,920	151
Charter Schools	*4,974*	*12*
State-Operated Schools	*1,813*	*25*
UCAP	*137*	*0*
Four Core Cities	*41,394*	*345*
Remainder of State	*93,690*	*641*
Rhode Island	*142,008*	*1,023*

Source of Data for Table/Methodology

Rhode Island Department of Education, Public School Enrollment in grades preschool to 12 on October 1, 2013.

Number of children identified as homeless by public school personnel includes children in preschool through grade 12 who are identified by public school personnel as meeting the *McKinney-Vento* definition of homelessness, which includes any child who does not have a "fixed, regular, and adequate nighttime residence."

Charter schools reporting include Achievement First Rhode Island, Blackstone Academy, Blackstone Valley Prep Mayoral Academy, Paul Cuffee Charter School, Segue Institute for Learning, and Trinity Academy for the Performing Arts. The only state-operated school reporting is the Metropolitan Regional Career & Technical Center.

The Middletown, Newport, North Kingstown, Warwick, and Woonsocket school districts received grants that provided additional resources to identify and serve homeless students.

*Fewer than 10 students are in this category. Actual numbers are not shown to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

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[7] Rhode Island Emergency Shelter Information Project, 2014.

(continued on page 171)

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 increases family income and reduces poverty. Children with parents who have steady employment are more likely to have access to health care. Secure parental employment improves family functioning by reducing the stress brought on by unemployment and underemployment of parents.[1] Among poor families, children with working parents are more engaged academically and less likely to repeat a grade or be suspended or expelled from school than children with non-working parents.[2]

In December 2014, Rhode Island's unemployment rate was 6.8%, the fourth highest in the nation, and higher than the U.S. unemployment rate of 5.6%. However, it was considerably lower than at the height of Rhode Island's recession in December 2009, when it was 11.9%.[3,4]

Rhode Island has the highest rate of children with at least one unemployed parent (12%), compared the U.S. average of 8%.[5] Children with unemployed parents are at increased risk for homelessness, child abuse or neglect, and failure to finish high school or college.[6,7]

Between 2011 and 2013, 72% of children under age six and 77% of children ages six to 17 in Rhode Island had all parents in the labor force. In comparison, nationally, 65% of children under age six and 71% of children ages six to 17 had all parents in the labor force.[8]

Even when families have adults with secure parental employment, low wages cause many families to remain in poverty. Nationally, nearly one in three (32%) working families with children are low income (10.4 million working families with a total of 23.5 million children).[9] Welfare reform aimed to transition welfare recipients to work, yet when these individuals enter the workforce, they tend to earn low wages and have limited benefits. In addition, despite gaining experience and seniority, many low-income workers never move out of low-wage jobs.[10]

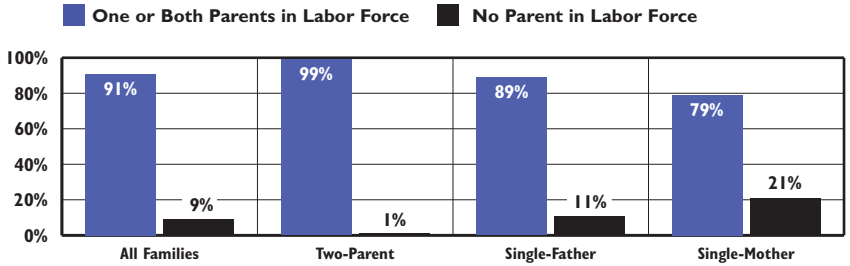
Children Living in Families Where No Parent Has Full-Time, Year-Round Employment

	2008	2013
RI	30%	34%
US	27%	31%
National Rank*		*38th*
New England Rank**		*6th*

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

Source: The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

Employment Status of Parents by Family Type, Rhode Island, 2011-2013



Source: U.S. Census Bureau, American Community Survey, 2011-2013. Table B23008.

◆ **The majority of children living in Rhode Island between 2011 and 2013 had one or both parents in the labor force. Children living with a single parent were 16 times more likely than children living in a two-parent family to have no parents in the labor force. Of children in two-parent families, 72% had both parents in the labor force.[11]**

◆ **Between 2011 and 2013, there were 17,579 Rhode Island children living in families with no parent in the labor force. Children living in families with a single parent represented 91% (16,032) of families with no employed parents.[12]**

◆ **Between 2011 and 2013, 15% (4,029) of Rhode Island families with incomes below the federal poverty threshold had at least one adult with full-time, year-round employment.[13] Between 1998 and 2012, the percentage of Rhode Island children living in low-income families (below 200% of the federal poverty threshold) with no employed parents fell from 34% to 26%.[14,15]**

◆ **According to the *2014 Rhode Island Standard of Need*, 82% of Rhode Island single parent families and 26% of two-parent families with two or more children earn less than the income required to meet their basic needs without public benefits such as SNAP/food stamps, the Earned Income Tax Credit (EITC), child care subsidies, and health insurance.[16]**

Secure Parental Employment

Barriers to Secure Employment for Low-Income Families

◆ There are many barriers to employment for those leaving welfare for work. Research shows that welfare leavers who return to welfare after working are much more likely to be in poor health, to have low levels of education, and to have young children than those who remain employed.[17]

◆ Poor health or a disability may make it difficult for parents to secure or sustain employment. One national study found that 13% of low-income working mothers had some type of disability and 6% had a severe disability. It also found that 16% of low-income working mothers had a child with a disability and 9% had a child with a severe disability. Higher-income mothers reported lower disability rates for themselves and their children.[18]

◆ Low-income workers are less likely to have benefits, such as paid time off and flexible work schedules, that would allow them to address the needs of sick children.[19,20] Approximately 60% of the entire U.S. workforce qualifies for the federal *Family and Medical Leave Act (FMLA)*, but many who are eligible cannot afford to take it.[21] In 2013, Rhode Island passed legislation that created the Temporary Caregivers Insurance Program (TCI), which provides up to four weeks of benefits for workers who need to care for a seriously ill family member or to bond with a newborn, foster, or adopted child.[22] Rhode Island is one of three states that offer paid family and medical leave.[23]

◆ Limited education also can be a barrier to sustained employment. Between 2011 and 2013 in Rhode Island, adults without a high school diploma were four times as likely to be as unemployed as those without a Bachelor's degree.[24]

◆ Having access to work supports, such as health insurance, SNAP/food stamp benefits and child care subsidies, can facilitate steady employment over time. Researchers have found links between these programs and positive employment outcomes for parents regarding work stability and earnings.[25]

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(continued on page 171)

Secure Employment and Child Care

◆ Research shows a link between adequate child care availability and sustained maternal labor force participation. Studies find that mothers report that the lack of reliable and dependable child care arrangements affected their ability to remain employed.[26]

◆ In Rhode Island, a single mother earning the state median income for a single-mother family ($25,929) would have to spend 48.8% of her income to pay for child care for an infant in center-based care.[27]

◆ In Rhode Island, child care assistance is available to all income-eligible working families. During the 2007 legislative session, eligibility for child care was rolled back from 225% to 180% of the federal poverty level ($36,162 for a family of three in 2015).[28,29]

Rhode Island Earned Income Tax Credit (EITC)

◆ State and federal Earned Income Tax Credits (EITCs) provide tax reductions and wage supplements for low- and moderate-income working families. EITCs reduce child poverty, decrease taxes, and increase work incentives for families struggling to make ends meet. The federal EITC is the nation's most effective antipoverty program for working families.[30] It lifted 6.2 million people, nearly half of them children, out of poverty in 2013.[31]

◆ The EITC's benefits extend well beyond the time families receive the credit. EITC recipients are more likely to work and earn higher wages, and their children do better in school, are more likely to attend college, and earn more as adults.[32]

◆ State EITCs can supplement the federal EITC to further support working families. In 2014, the Rhode Island General Assembly passed legislation that decreased the state's EITC from 25% to 10% of the federal EITC and made the credit fully refundable. In 2014, 84,091 Rhode Island working families and individuals received a total of $190 million in federal EITC tax credits for tax year 2013.[33]

Paid Family Leave

DEFINITION

Paid family leave is the number of approved claims for partial wage replacement to bond with a new child or to care for a seriously ill family member through Rhode Island's Temporary Caregiver Insurance Program (TCI).

SIGNIFICANCE

Rhode Island's Temporary Caregiver Insurance (TCI) program, launched in 2014, provides up to four weeks of wage replacement benefits to eligible workers who need to take time off from work to bond with a newborn, adopted or foster child or to care for a seriously ill family member. The TCI program is financed entirely by employee contributions.[1]

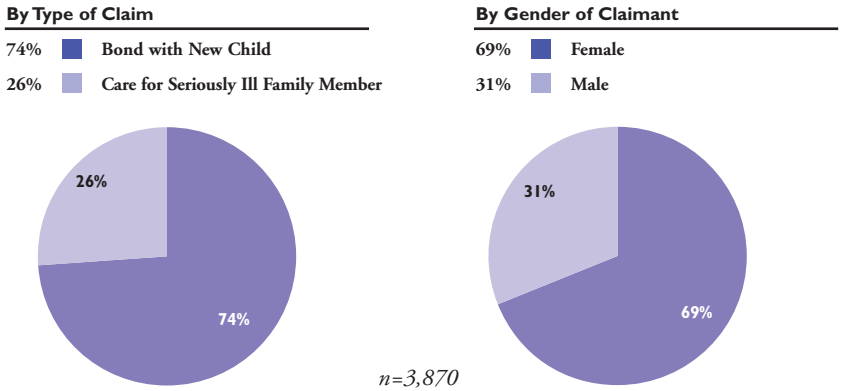
Almost all advanced, industrialized nations guarantee paid leave for new mothers and many include new fathers. In many European countries, families receive at least six months of paid leave to care for a new baby.[2] The U.S. requires employers with 50 or more workers to offer 12 weeks of leave for workers to care for a new child or to care for a seriously ill family member; however the time off can be unpaid.[3] Rhode Island's 1987 *Parental and Family Medical Leave Act* requires a 13-week leave, but does not require that the leave be paid.[4]

Although some workers in the U.S. have access to paid family leave through their employers (estimated at 11% of private sector workers and 17% of public sector workers), the majority do not. High-wage workers are much more likely to have access to paid family leave than low-wage workers. More than three in four employees in the U.S. report not being able to take family leave when needed because it was unpaid.[5]

Paid family leave provides job security and consistent income so that working parents can care for a new child or any worker can care for a seriously ill family member.[6] Taking time off from work to care for a new child reduces infant mortality rates, improves breastfeeding rates and duration, and increases the likelihood that infants receive preventive medical care and immunizations. Mothers who take at least 12 weeks off of work after the birth of a child are less likely to experience depression, which can improve the quality of the care they are able to provide to their infants.[7] Providing time off from work for new parents gives babies time to form secure attachments, which form the foundation for future relationships and development.[8]

Rhode Island's Temporary Disability Insurance Program (TDI) provides partial wage replacement for participating workers who are temporarily unable to work because of a physical or mental condition, including pregnancy complications and recovery from childbirth.[9,10] TCI supplements TDI; women who give birth are eligible for both.

Approved Temporary Caregiver Insurance (TCI) Claims, Rhode Island, 2014



Source: Rhode Island Department of Labor and Training, TCI Program, 2014.

◆ **There were 3,870 approved claims for Temporary Caregiver Insurance during 2014; 74% were to bond with a new child and 26% were to care for a seriously ill family member.[11]**

◆ **Of the 2,847 approved claims to bond with a new child, 98% were for a newborn child, 1% were for a newly adopted child, and 1% were for a new foster child. Thirty-two percent of claims to bond with a new child were filed by men and 68% were filed by women.[12]**

◆ **Of the 1,023 approved claims to care for a seriously ill family member, 46% were to care for a spouse or domestic partner, 31% were to care for a parent or parent-in-law, 22% were to care for a child, and 1% were to care for a grandparent. Twenty-eight percent of claims to care for a seriously ill family member were filed by men and 72% were filed by women.[13]**

Temporary Disability Insurance for Pregnancy Complications & Childbirth

◆ **In 2014, there were 969 approved TDI claims for disabling pregnancy complications and 3,502 TDI claims to recover from childbirth. Recovery from childbirth is a disabling condition covered by TDI. In general, six weeks is covered for vaginal births and eight weeks for cesarean section births.[14] More time can be approved for postpartum complications, based on the health care provider's determination. TDI is not available to new parents who do not give birth (e.g., fathers and adoptive parents).[15]**

Table 9. **Approved Temporary Disability Insurance (TDI) Claims for Pregnancy/Childbirth & Temporary Caregiver Insurance (TCI), Rhode Island, 2014**

	TEMPORARY DISABILITY INSURANCE (TDI) CLAIMS			TEMPORARY CAREGIVER INSURANCE (TCI) CLAIMS		
CITY/TOWN	TDI FOR PREGNANCY COMPLICATIONS	TDI FOR CHILDBIRTH	TOTAL TDI CLAIMS	TCI TO BOND WITH NEW CHILD	TCI TO CARE FOR FAMILY MEMBER	TOTAL TCI CLAIMS
Barrington	6	32	38	34	11	45
Bristol	14	59	73	50	21	71
Burrillville	13	40	53	28	12	40
Central Falls	21	44	65	27	14	41
Charlestown	5	25	30	18	11	29
Coventry	26	115	141	106	47	153
Cranston	82	229	311	219	85	304
Cumberland	28	117	145	110	43	153
East Greenwich	15	48	63	34	10	44
East Providence	42	135	177	141	52	193
Exeter	7	18	25	12	9	21
Foster	*	*	*	16	9	25
Glocester	4	23	27	23	15	38
Hopkinton	7	20	27	25	12	37
Jamestown	*	*	*	*	*	*
Johnston	29	75	104	75	39	114
Lincoln	16	77	93	65	18	83
Little Compton	*	*	*	*	*	*
Middletown	6	56	62	31	9	40
Narragansett	*	*	*	10	6	16
New Shoreham	*	*	*	*	*	*
Newport	18	65	83	36	14	50
North Kingstown	20	93	113	53	16	69
North Providence	38	110	148	85	35	120
North Smithfield	5	26	31	26	11	37
Pawtucket	76	256	332	155	57	212
Portsmouth	5	37	42	25	12	37
Providence	171	525	696	340	91	431
Richmond	*	*	*	*	*	*
Scituate	15	48	63	41	12	53
Smithfield	6	46	52	47	16	63
South Kingstown	7	59	66	54	20	74
Tiverton	8	30	38	33	33	66
Warren	10	25	35	29	9	38
Warwick	83	253	336	292	108	400
West Greenwich	6	15	21	*	*	*
West Warwick	42	117	159	102	34	136
Westerly	6	48	54	35	11	46
Woonsocket	35	113	148	58	31	89
Out-of-State	*92*	*469*	*561*	*373*	*81*	*454*
Four Core Cities	*303*	*938*	*1,241*	*580*	*193*	*773*
Remainder of State	*574*	*2,095*	*2,669*	*1,894*	*749*	*2,643*
Rhode Island	*877*	*3,033*	*3,910*	*2,474*	*942*	*3,416*
Total Program Claims	*969*	*3,502*	*4,471*	*2,847*	*1,023*	*3,870*

Source of Data for Table/Methodology

Rhode Island Department of Labor and Training, Approved TDI claims for pregnancy complications and childbirth and approved TCI claims, 2014.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Out-of-State are approved claims for residents of states other than Rhode Island. TDI and TCI are available to employees of Rhode Island companies and organizations, including employees who are not residents of the state.

*Numbers less than 3 are suppressed by the Rhode Island Department of Labor and Training.

References

[1] Rhode Island Department of Labor and Training. (2014). *Temporary Caregiver Insurance*. Retrieved March 2, 2015, from www.dlt.ri.gov/tdi

[2,5] Ochshorn, S. & Skinner, C. (2012). *Building a competitive future right from the start: How paid leave strengthens 21st century families.* New York, NY: National Center for Children in Poverty.

[3] *Business support for the Family and Medical Leave Act.* (2013). Washington, DC: Center for Law and Social Policy.

[4] *Rhode Island Parental and Family Medical Leave Act,* Title 28 Rhode Island General Law § 28-48-2 (1987, 1990).

[6,8] *Family leave in the early years.* (2013). Washington, DC: Zero to Three.

[7] Gault, B., Hartmann, H., Hegewisch, A., Milli, J. & Reichlin, L. (2014). *Paid parental leave in the United States: What the data tell us about access, usage, and economic and health benefits.* Washington, DC: Institute for Women's Policy Research.

[9] *Annual statistical supplement to the Social Security Bulletin, 2013.* (2014). Washington, DC: Social Security Administration, Office of Retirement and Disability Policy.

[10,15] *Existing temporary disability insurance programs.* (2015). Washington, DC: National Partnership for Women and Families.

[11,12,13,14] Rhode Island Department of Labor and Training, 2014.

Children Receiving Child Support

DEFINITION

Children receiving child support is the percentage of parents who make child support payments on time and in full as indicated in the Rhode Island Office of Child Support Services system. 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 and medical support require establishment of paternity.

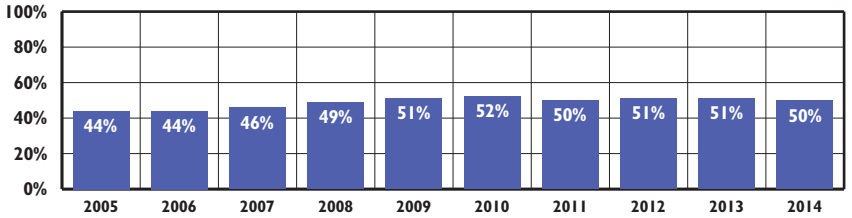
SIGNIFICANCE

Child support is a major part of the safety net for children and families. In 2013, nearly one in four U.S. children (16.9 million) received public child support services.[1] Child support provides a mechanism for non-custodial parents (usually fathers) to contribute to the financial and medical support of their children. Child support programs can increase the reliability of child support paid by helping custodial parents locate the non-custodial parent, establishing paternity and support orders, and removing barriers to payment, such as referring parents to employment services, supporting co-parenting relationships, and helping to prevent family violence.[2]

The receipt of child support payments can significantly improve the economic well-being of a child growing up in a family with a non-resident parent. In 2011, child support lifted more than 500,000 U.S. children out of poverty, and for poor custodial parents that received full child support, these payments represented two-thirds (66.7%) of their mean personal income.[3,4] Custodial parents who receive steady child support payments are less likely to rely on public assistance programs and more likely to find work faster and stay employed longer than those who do not.[5,6]

For many families, even when a child support order is in place, payments can be unreliable. Noncustodial parents of poor children are often poor themselves and have limited ability to provide financial support to their children.[7] Fatherhood programs that target low-income, non-custodial parents and provide a combination of job skills training and employment assistance, parenting skills, relationship building with the co-parent, and links to the child support system have been shown to increase child support payments.[8] Non-custodial parents who pay regular child support are more involved with their children, providing them with emotional and financial support. Research also shows that the receipt of regular child support payments can have a positive effect on children's academic achievement.[9]

Non-Custodial Parents With Court Orders Who Pay Child Support on Time and in Full, Rhode Island, 2005-2014



Sources: Rhode Island Department of Human Services, Office of Child Support Services, 2005-2014.

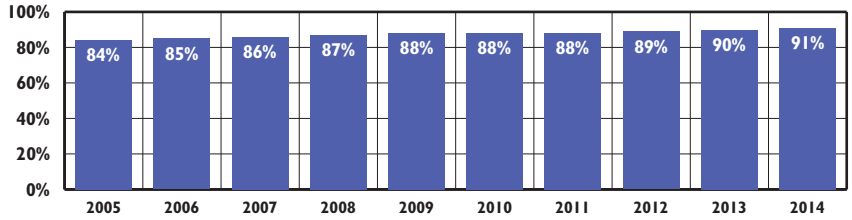
◆ **As of December 1, 2014, there were 79,936 children in Rhode Island's Office of Child Support Services system, including private, interstate and IV-D cases (i.e., families receiving RI Works, RIte Care or child-care assistance). Forty-eight percent of the children in the Child Support system with a known Rhode Island residence lived in the four core cities. Half (50%) of non-custodial parents under court order in Rhode Island were making child support payments on time and in full.[10]**

◆ **In 2014, the Rhode Island Office of Child Support Services collected $92.3 million in child support, an increase of $1.7 million over the previous year. Collections go toward both child support and medical support. Eighty-five percent ($78.4 million) of the funds collected were distributed directly to families and the remainder was retained by the state and federal governments as reimbursement for RI Works (cash assistance), RIte Care health coverage, and other expenses.[11]**

◆ **In Federal Fiscal Year (FFY) 2013, the Rhode Island Office of Child Support Services collected $5.44 for every $1.00 Rhode Island spent on administering the program.[12]**

◆ **During FFY 2014, there were 20,930 court orders for non-custodial parents to provide medical insurance and 14,052 orders for non-custodial parents to contribute funds toward medical coverage. More than $6 million in payments (known as "cash medical") was retained by the state to offset the cost of RIte Care, while approximately $1.9 million was disbursed directly to families to offset the cost of private health insurance coverage or other medical expenses.[13]**

Rhode Island Children in the Office of Child Support Services System With Paternity Established, 2005-2014



Sources: Rhode Island Department of Human Services, Office of Child Support Services, 2005-2014. Includes all children in the child support system -- private, interstate, and IV-D cases (i.e., cases that received assistance with child support because they were receiving RI Works, RIte Care, or child care assistance benefits).

◆ **The percentage of children in the Rhode Island child support system with paternity established increased from 84% of children in 2005 to 91% of children in 2014.[14]**

◆ **When applying for cash assistance, child care assistance, or RIte Care, parents are asked to provide information on the other parent to the Office of Child Support Services. This information is used to establish paternity (if not already established), and to seek child support payments and/or medical support. Victims of domestic violence can apply for a waiver of this requirement if providing this information could endanger themselves or their children.[15,16]**

◆ **In FFY 2013, Rhode Island had the lowest rate of court orders established for child support in New England (Maine – 90%; Vermont – 89%; New Hampshire – 86%; Massachusetts – 85%; Connecticut – 77%; Rhode Island – 69%). The national average for cases with child support orders established is 83%.[17] In FFY 2013, Rhode Island had the highest case/staff ratio in New England at 827 cases per person, more than five times that of the lowest state, Vermont.[18] In recent years, the Office of Child Support Services lost more than one-third of its staff, which affects the office's ability to establish court orders for child support.[19]**

References

[1] Rhode Island KIDS COUNT analysis of data from the U.S. Office of Child Support Enforcement, Administration for Children & Families and U.S. Census Bureau, *Current Population Reports*, 2013.

[2] U.S. Office of Child Support Enforcement, Administration for Children & Families. (n.d.). *OCSE fact sheet.* Retrieved January 12, 2015, from www.acf.hhs.gov

(continued on page 172)

Child Support and Rhode Island Works

◆ **As of December 1, 2014, Rhode Island's Office of Child Support Services system included 7,080 children enrolled in Rhode Island Works (RI Works).[20]**

◆ **In 2014, the average child support obligation for children enrolled in RI Works was $250 per month, compared to an average child support obligation of $376 per month for children in non-RI Works families.[21] Calculations for child support payments are based on both parents' incomes, so it is expected that the average child support obligation for children enrolled in RI Works would be lower.**

◆ **In 2014, Rhode Island's Office of Child Support Services collected $4.6 million in child support for children enrolled in RI Works. The federal and state governments retained $4.1 million, and the remaining $424,676 was passed through to families.[22]**

◆ **In Rhode Island, only the first $50 of child support paid on time each month on behalf of a child receiving RI Works cash assistance (called a "pass-through" payment) goes to the custodial parent caring for the child.[23] The remainder of the payment is retained by the federal and state governments as reimbursement for assistance received through RI Works. In FFY 2014 in Rhode Island, an average of 733 families received at least one "pass-through" payment each month.[24]**

◆ **States have the option to increase the amount of money passed through to children. States that pass through up to $100 per month for one child (and up to $200 per month for two or more children) and disregard this income in calculating eligibility for cash assistance do not have to reimburse the federal government for its share of the child support collected. Since this federal policy change went into effect, a number of states have increased the amount they pass through to children.[25] Rhode Island has not implemented this option.[26]**

◆ **More generous child support "pass-through" policies for families receiving cash assistance provide a greater incentive for custodial parents to seek child support and for noncustodial parents to make regular payments because more of the child support payment goes to the child. Increased "pass-throughs" could therefore increase total child support collections, increase family income and potentially reduce the amount of other benefits.[27]**

Children in Poverty

DEFINITION

Children in poverty is the percentage of children under age 18 who are living in households with incomes below the poverty threshold, as defined by the U.S. Census Bureau. 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 who experience poverty in early childhood and for extended periods, are more likely to have physical and behavioral health problems, experience difficulty in school, become teen parents, and earn less or be unemployed as adults.[1,2,3] Children in poverty are less likely to be enrolled in preschool, more likely to attend schools that lack resources and rigor, and have fewer opportunities to participate in extracurricular activities.[4,5,6]

Nationally and in Rhode Island, minority children are more likely to grow up poor than White children. Children under age six, who have single parents, whose parents have low educational levels, or whose parents work part-time or are unemployed are at increased risk of living in poverty.[7,8]

In 2014, the federal poverty threshold was $19,073 for a family of three with two children and $24,008 for a family of four with two children.[9] The official poverty measure does not reflect the effects of key government policies and programs that support families living in poverty, does not take into account the increased cost of transportation, child care, housing, and medical care, and does not consider geographic variations in the cost of living. To address these limitations, in 2011, the U.S. Census Bureau began releasing a Supplemental Poverty Measure. This measure does not replace the official measure, but provides policy makers with a new way to evaluate the effects of anti-poverty policies.[10]

According to the *2014 Rhode Island Standard of Need*, a single-parent family with two children would need $51,492 a year to meet its basic needs, far more than the federal poverty level for a family of three. Work supports, such as subsidized child care, health care (RIte Care), food assistance and tax credits, can help families with incomes below the federal poverty threshold meet their basic needs.[11]

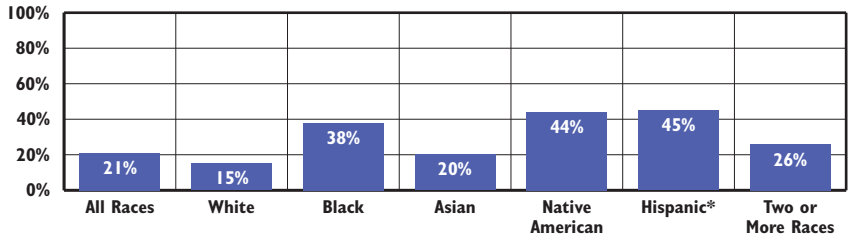
Children in Poverty

	2010	2011	2012	2013
RI	19.0%	21.9%	19.5%	21.5%
US	21.6%	22.5%	22.6%	22.2%
National Rank*				*26th*
New England Rank**				*6th*

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

Source: U.S. Census Bureau, American Community Survey, 2010-2013. Table R1704.

Children in Poverty, by Race and Ethnicity, Rhode Island, 2011-2013



Source: U.S. Census Bureau, American Community Survey, 2011-2013. Tables S1701, B17020A, B17020B, B17020C, B17020D, B17020G, and B17020I. *Hispanic children may be included in any race category.

◆ **Between 2011 and 2013, 21% (44,833) of Rhode Island's 213,152 children under age 18 with known poverty status lived in households with incomes below the federal poverty threshold.[12]**

◆ **In Rhode Island as well as in the United States as a whole, Hispanic, Black and Native American children are more likely than White and Asian children to live in families with incomes below the federal poverty threshold. Between 2011 and 2013, 45% of Hispanic, 44% of Native American, 38% of Black, and 20% of Asian children in Rhode Island lived in poverty, compared to 15% of White children.[13]**

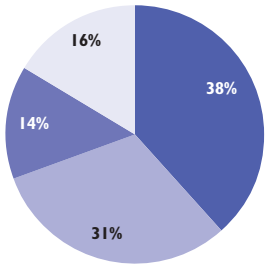
◆ **Between 2011 and 2013, of all children living in poverty in Rhode Island, over half (53%) were White, 16% were Black, 3% were Asian, 1% were Native American, 20% were Some other race, and 7% were Two or more races.[14]**

◆ **Between 2011 and 2013, 47% of Rhode Island's poor children were Hispanic. Hispanic children may be included in any race category. The Census Bureau asks about race separately from ethnicity, and the majority of families who identify as Some other race also identify as Hispanic.[15]**

Rhode Island's Poor Children, 2011-2013

By Age

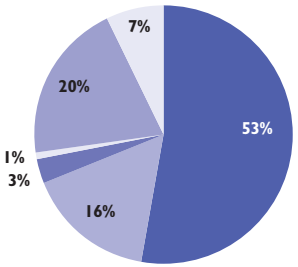
38%	Ages 5 and Younger
31%	Ages 6 to 11
14%	Ages 12 to 14
16%	Ages 15 to 17



n=44,833

By Race*

53%	White
16%	Black
3%	Asian
1%	Native American
20%	Some Other Race
7%	Two or More Races

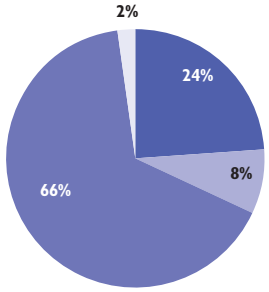


n=44,833

**Hispanic children may be included in any race category. Between 2011 and 2013, 21,073 (47%) of Rhode Island's 44,833 poor children were Hispanic.*

By Family Structure

24%	Married Couple Family
8%	Unmarried Male Householder
66%	Unmarried Female Householder
2%	Not in Related-Family Households



n=44,833

Source: U.S. Census Bureau, American Community Survey, 2011-2013. Tables S1701, B17001, B17006, B17020A, B17020B, B17020C, B17020D, B17020F, B17020G & B17020I. Population includes children for whom poverty status was determined. Percentages may not sum to 100% due to rounding.

Child Poverty Concentrated in Four Core Cities, Rhode Island, 2009-2013

CITY/TOWN	NUMBER IN POVERTY	PERCENTAGE IN POVERTY	NUMBER IN EXTREME POVERTY	PERCENTAGE IN EXTREME POVERTY
Central Falls	2,334	41.1%	1,064	18.8%
Pawtucket	4,550	28.9%	2,228	14.2%
Providence	16,049	39.7%	7,841	19.4%
Woonsocket	4,222	42.8%	1,922	19.5%
Rhode Island	*42,247*	*19.5%*	*19,361*	*8.9%*

Source: Population Reference Bureau analysis of 2009-2013 American Community Survey data.

◆ **Between 2009 and 2013, almost two-thirds (64%) of Rhode Island's children living in poverty lived in just four cities. These cities, termed core cities, include Central Falls, Pawtucket, Providence, and Woonsocket, all communities where more than one in four (25%) children live below the poverty threshold. The four core cities also have substantial numbers of children living in extreme poverty, defined as families with incomes below 50% of the federal poverty level, $9,537 for a family of three with two children and $12,004 for a family of four with two children in 2014.[16,17]**

Young Children Under Age Six in Poverty, Four Core Cities and Rhode Island, 2009-2013

CITY/TOWN	NUMBER	PERCENTAGE
Central Falls	1,042	43.8%
Pawtucket	1,835	32.9%
Providence	5,213	39.4%
Woonsocket	1,614	42.3%
Rhode Island	*15,234*	*22.7%*

Source: Population Reference Bureau analysis of 2009-2013 American Community Survey data.

◆ **Between 2009 and 2013, 22.7% (15,234) of Rhode Island children under age six lived below the poverty threshold.[18] Children under age six are at higher risk of living in poverty than any other age group.[19] Increased exposure to risk factors associated with poverty, including inadequate nutrition, exposure to environmental toxins, crowded and unstable housing, maternal depression, trauma and abuse, lower quality child care and parental substance abuse interferes with young children's emotional, physical, and intellectual development.[20,21]**

Children in Poverty

Financial Asset Building

◆ Having assets such as bank or credit union accounts provides families with a safe place to store their money and allows families to conduct basic financial transactions, manage financial emergencies related to unemployment or illness, and plan for their future.[22,23]

◆ Many low-income families lack knowledge about or access to traditional banks and instead rely on cash transactions or alternative financial services, such as check-cashing stores, payday lenders, rent-to-own stores, and refund anticipation loans. These families pay high fees for financial transactions and high interest rates on loans, and often struggle to build credit histories and achieve economic security.[24,25]

◆ Rhode Island, in 2013, 6.2% of households did not have a checking or savings account, compared to 7.7% for the U.S. as a whole. Nationally, households with incomes less than $15,000 and households where Spanish is the only language spoken are less likely to have a checking or savings account. These households are more likely to use alternative financial services, such as money orders, cash checking services, or payday lenders.[26]

◆ Raising awareness about the importance of saving and consumer protections, providing financial education and counseling, preventing predatory lending, and connecting families to safe and affordable financial products can support families in using traditional banking institutions and increase their savings.[27]

◆ State and federal policies that protect families from predatory mortgage lending and payday lending and expand access to convenient, cost-effective, and safe financial services would allow families to keep more of their earnings, save and invest more, and could ultimately promote a more stable workforce and stronger communities.[28,29,30]

◆ Many public assistance programs have eligibility provisions that limit the amount of assets and/or the value of vehicles a family can own. Such policies discourage families from saving and building the assets they need to improve their economic security.[31]

◆ Rhode Island currently has a $1,000 asset limit to qualify for and retain RI Works cash assistance and is one of only nine states with such a restrictive asset limit. Under Rhode Island law, the value of one vehicle for each adult household member (not to exceed two vehicles per household) does not count toward the family's asset limit.[32,33]

Building Blocks of Economic Security

Income Supports

◆ The Supplemental Poverty Measure shows the positive impact of government programs, such as the Earned Income Tax Credit (EITC), Social Security, SNAP, and housing subsidies. These programs kept millions of children out of poverty.[34]

Access to Health Care

◆ People with incomes below the poverty level are at the highest risk of being uninsured. Some are uninsured because they have lost their jobs, others are ineligible for health insurance through their employers because they work part-time, and some simply cannot afford to pay their share of the insurance premium.[35] Children with health insurance (public or private) are more likely to have a regular and accessible source of health care.[36]

Affordable Quality Child Care

◆ In Rhode Island, in 2013, the average cost of center-based child care for one infant was $12,662 per year or almost two-thirds of a family's income at the poverty level. Child care subsidies can help poor families afford the cost of high-quality child care. High-quality, affordable child care helps parents maintain employment and supports children's development.[37,38]

Educational Attainment

◆ Fifty-one percent of Rhode Island children whose parents lack a high school diploma and 34% of children whose parents have only a high school diploma live in poor families.[39] The share of jobs that require a college degree has increased in recent decades and is expected to increase further. By 2020, 71% of all jobs in Rhode Island will require postsecondary training beyond high school.[40]

Affordable Housing

◆ In 2014, the average rent for a two-bedroom apartment in Rhode Island was $1,172.[41] In Rhode Island, a family of three with an income at the federal poverty level would need to spend 71% of its income on rent to pay this amount, well above the recommended percentage of 30%.[42] Nationally, only one in four low-income families eligible receive rental assistance to help them afford the high cost of housing.[43]

Table 10. **Children Living Below the Federal Poverty Threshold, Rhode Island, 2000 and 2009-2013**

	CHILDREN UNDER AGE 18 LIVING BELOW POVERTY, 2000		CHILDREN UNDER AGE 18 LIVING BELOW POVERTY 2009-2013			
			ESTIMATES WITH HIGH MARGINS OF ERROR*		ESTIMATES WITH LOWER, ACCEPTABLE MARGINS OF ERROR	
CITY/TOWN	N	%	N	%	N	%
Barrington	127	2.7%			53	1.2%
Bristol	436	10.0%			167	4.8%
Burrillville	236	6.0%	372	11.7%		
Central Falls	2,210	40.9%	2,334	41.1%		
Charlestown	78	4.7%	273	18.3%		
Coventry	481	5.9%			866	11.6%
Cranston	1,496	9.1%			2,189	13.9%
Cumberland	237	3.1%			480	6.4%
East Greenwich	147	4.1%	207	6.5%		
East Providence	1,126	10.8%			1,592	16.7%
Exeter	112	7.5%	80	6.6%		
Foster	32	2.9%	66	7.9%		
Glocester	178	6.7%			82	4.6%
Hopkinton	115	5.9%	50	3.6%		
Jamestown	17	1.4%	103	10.6%		
Johnston	527	9.0%			642	11.7%
Lincoln	329	6.5%			232	5.0%
Little Compton	8	1.0%	37	5.7%		
Middletown	264	6.2%			666	16.8%
Narragansett	235	8.6%			127	5.6%
New Shoreham	19	10.2%	21	23.1%		
Newport	1,267	24.4%	533	14.5%		
North Kingstown	663	9.7%			683	11.1%
North Providence	579	10.1%			630	12.1%
North Smithfield	72	3.0%			163	7.1%
Pawtucket	4,542	25.3%			4,550	28.9%
Portsmouth	118	2.8%			250	7.4%
Providence	18,045	40.5%			16,049	39.7%
Richmond	82	4.2%	134	7.3%		
Scituate	113	4.3%	174	8.6%		
Smithfield	153	3.9%			66	1.8%
South Kingstown	324	5.3%			247	4.9%
Tiverton	92	2.8%			133	4.4%
Warren	205	8.4%			230	11.1%
Warwick	1,243	6.7%			1,260	8.4%
West Greenwich	40	2.7%	74	5.1%		
West Warwick	1,186	18.1%	1,309	22.4%		
Westerly	534	10.0%	901	18.9%		
Woonsocket	3,494	31.8%	4,222	42.8%		
Four Core Cities	*28,291*	*35.9%*			*27,155*	*37.9%*
Remainder of State	*12,871*	*7.8%*			*15,092*	*10.4%*
Rhode Island	*41,162*	*16.9%*			*42,247*	*19.5%*

Source of Data for Table/Methodology

Data are from the U.S. Census Bureau, Census 2000, Summary File 3, P.87 and PCT.50 and Population Reference Bureau analysis of 2009-2013 American Community Survey data. The data include the poverty rate for all children for whom poverty was determined, including "related" children and "unrelated children" living in the household.

The American Community Survey is a sample survey, and therefore the number and percentage of children living in poverty provided are estimates, not actual counts. The reliability of these estimates varies by community. In general, estimates for small communities and communities with relatively low poverty rates are not as reliable as estimates for larger communities and communities with higher poverty rates.

*The Margin of Error around the percentage is greater than or equal to five percentage points.

The Margin of Error is a measure of the reliability of the estimate and is provided by the U.S. Census Bureau. The Margin of Error means that there is a 90 percent chance that the true value is no less than the estimate minus the Margin of Error and no more than the estimate plus the Margin of Error. (See the Methodology Section for Margins of Errors for all communities.)

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

[1] Ratcliffe, C. & McKernan, S. (2012). *Child poverty and its lasting consequence.* Washington, DC: The Urban Institute.

[2,4,20] Moore, K. A., Redd, Z., Burkhauser, M., Mbwana, K. & Collins, A. (2009). *Children in poverty: Trends, consequences, and policy options.* Washington, DC: Child Trends.

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[5] Laughlin, L. (2013). *Who's minding the kids? Child care arrangements: Spring 2011.* Washington, DC: U.S. Census Bureau.

(continued on page 172)

Children in Families Receiving Cash Assistance

DEFINITION

Children in families receiving cash assistance is the percentage of children under age 18 who were living in families receiving cash assistance through the Rhode Island Works Program (RI Works). These data measure the number of children and families enrolled in RI Works at a single point in time. Children and families who participated in the program at other points in the year but who were not enrolled on that day are not included.

SIGNIFICANCE

The goal of the Rhode Island Works Program (RI Works) is to help very low-income families meet their basic needs by providing cash assistance and work supports, including employment services, SNAP benefits, health insurance, and subsidized child care. Children and families qualify for cash assistance based on their income, resources, and the number of people in their families.[1]

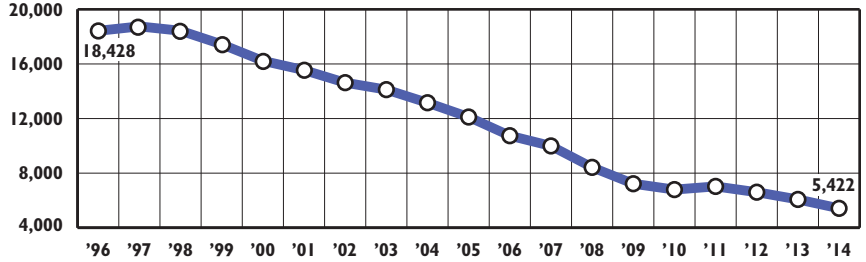
RI Works cash assistance recipients must participate in an employment plan unless they meet specific criteria for an exemption. This employment plan must take into account the parent's skills, education, and family responsibilities as well as local employment opportunities and should outline a process for helping the parent meet his or her employment goals. Parents should be informed about opportunities to seek additional education or training to improve their employability prospects.[2]

RI Works provides a safety net for some children whose parents are unable to work due to a disability and can function as an unemployment system for parents who do not have sufficient earnings or work experience to qualify for unemployment benefits. RI Works also provides time-limited supplementary cash assistance to very low-income working families.[3] In December 2014, the average hourly wage of working parents enrolled in RI Works was $9.81 per hour.[4]

RI Works connects families to the Office of Child Support Services, which assists families in establishing paternity (when applicable), identifying and locating non-custodial parents, and obtaining child support payments from non-custodial parents.[5] In Rhode Island, the first $50 of child support paid on time each month on behalf of a child enrolled in RI Works goes to the custodial parent caring for the child. The balance is shared by the state and federal governments as reimbursement for assistance received through RI Works.[6,7]

The maximum monthly RI Works benefit for a family of three is $554 per month.[8] Families receiving the maximum monthly cash benefit have incomes that are less than one-half the federal poverty level and are living in extreme poverty.[9]

Cash Assistance Caseload, Rhode Island, 1996-2014*



Source: Rhode Island Department of Human Services, InRhodes Database, December 1, 1996-2014. Cases can be child-only or whole families and multiple people can be included in one case. *The Rhode Island Department of Human Services changed the method for calculating the caseload data starting in the 2012 Factbook. This change is reflected in 2010-2014 caseload data. Comparisons to earlier years should be made with caution.

◆ **Between 1996 (when the program began) and 2014, the Rhode Island cash assistance caseload decreased by 71%, from 18,428 cases to 5,422 cases.[10]**

◆ **The RI Works caseload has declined due to policies implemented in 2008, when the program changed from the Family Independence Program (FIP) to RI Works. These policies included new time limits (a 48-month lifetime limit for benefits and a periodic time limit that limits assistance to no more than 24 months of assistance in any 60-month period), closing child-only cases when parents reach their time limit, and limiting eligibility for legal permanent residents to those who have had that status for five years.[11]**

◆ **Rhode Island continues to have a high unemployment rate. Despite families' continued high need for assistance, the RI Works caseload continues to decrease, reducing or ending benefits for many families.[12]**

◆ **In December 2014, there were 3,918 adults and 9,077 children under age 18 enrolled in RI Works. More than two-thirds (70%) of RI Works beneficiaries were children, and nearly half (45%) of the children enrolled in RI Works were under the age of six.[13]**

◆ **Continued high unemployment, particularly for adults with limited education, coupled with shorter time limits for cash assistance leaves many families with children experiencing deep poverty, hardship, and homelessness. In 2013, 19,262 children in Rhode Island lived in extreme poverty, yet only 9,077 received cash assistance in 2014.[14,15]**

RI Works Policies

Work Requirements

◆ Single-parent families must participate in a work activity for a minimum of 20 hours per week if they have a child under age six and a minimum of 30 hours per week if their youngest child is age six or older. Single parents can combine 10 hours of job skills training, education that is directly related to employment, or a GED program with 20 hours of work to reach the 30-hour work requirement.[16]

Time Limits

◆ The lifetime limit for RI Works is 48 months. Families also are limited to no more than 24 months of cash assistance in a 60-month period. All cash assistance issued in Rhode Island or any other state since May 1997 counts toward the lifetime limit, while assistance received since July 1, 2008 counts toward the 24-month periodic time limit.[17]

Hardship Extensions

◆ Families can apply for hardship extensions that allow them to continue receiving cash assistance after reaching the time limit if the parent has a documented significant disability, is caring for a significantly disabled family member, is unable to pursue employment due to domestic violence, is homeless, or is unable to work because of "a critical other condition or circumstance." While parents must submit requests for hardship extensions (initially for six months, and then for three month extensions), there is no limit on the total time a family can receive a hardship extension.[18,19]

Child-Only Cases

◆ Child-only cases are those that receive assistance for only the children in the family because the child's parent is ineligible. Child-only cases include children living with a non-parent or a parent who is disabled and receiving Supplemental Security Income.[20]

Sanctions

◆ If a parent misses a required appointment, refuses or quits a job, or in some other way fails to comply with an employment plan and is not able to establish "good cause" (e.g., lack of child care, illness, a family crisis or other allowed circumstance), the family's cash benefit is reduced. If benefits are reduced for a total of three months (consecutive or not) due to non-compliance, the family's case is closed and the entire family loses the RI Works benefit. Benefits can be restored in the month after the parent reapplies and comes into compliance.[21]

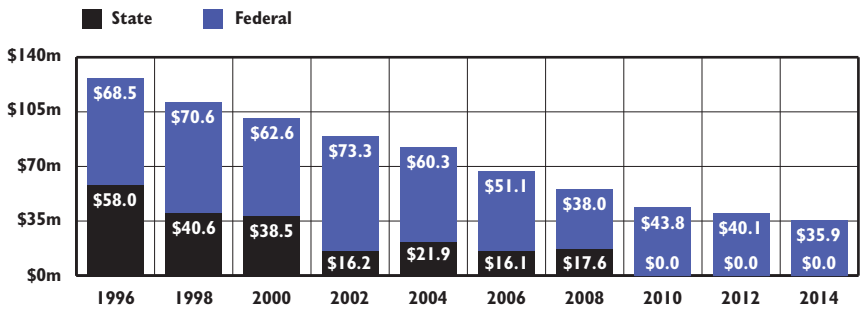
RI Works by Case Type, 2014

	NUMBER	PERCENTAGE
Child-only cases	1,891	35%
Cases with adults required to engage in a work activity	3,123	58%
Cases with adults exempt from a work activity*	408	8%
Total RI Works Caseload	*5,422*	

Source: Rhode Island Department of Human Services, InRhodes Database, 2014.

**RI Works regulations require that all parents and caretaker relatives included in the cash assistance grant participate in a work activity unless they receive a temporary exemption. Exemptions from work activities include: youngest child under age one (240), in third trimester of pregnancy (130), caring for a disabled spouse or child (13), being a victim of domestic violence (25), or being a recipient of SSI/SSDI or determined to be eligible for SSI/SSDI (0). Percentages may not sum to 100% due to rounding.*

Rhode Island Cash Assistance Expenditures, State Fiscal Years 1996-2014

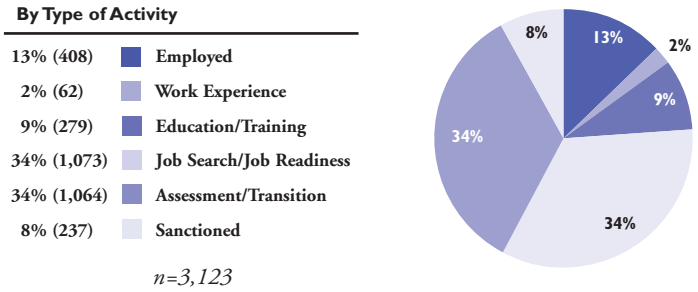


Sources: Rhode Island Department of Human Services, *Family Independence Program 2007 annual report.* (FY 1996-2000); House Fiscal Advisory Staff. (2004-2014). Budget as enacted: Fiscal Years 2005-2015. (FY 2002-2014). Fiscal years 1996-2012 are funds spent and FY 2014 is final budget.

◆ In State Fiscal Year 2014, for the fifth year in a row, no state general revenue was allocated for cash assistance. State general revenue spending for cash assistance has decreased steadily over the past 18 years. The cash assistance program is now entirely supported by federal Temporary Assistance for Needy Families (TANF) block grant funds. The total expenditures for cash assistance in Rhode Island (federal and state) decreased by 72% between 1996 (when the program began) and 2014, from $126.5 million to $35.9 million.[22,23]

Children in Families Receiving Cash Assistance

Activities of Families Enrolled in the RI Works Program, December 2014



Source: Rhode Island Department of Human Services, InRhodes Database, December 2014. Percentages may not sum to 100% due to rounding.

◆ As of December 2014, 13% of families that were required to engage in work-related activities were employed, down from 38% in December 2007, when the recession began. An additional 2% were in unpaid work experience.[24,25] In December 2014, Rhode Island's unemployment rate was 6.8%, only slightly higher than the December 2007 (pre-recession) rate of 6.0%.[26]

◆ Parents with very limited literacy or English-language skills can participate in basic education and work skills programs. Parents also can receive up to one year of vocational education as part of their 48-month lifetime limit.[27] As of December 2014, 9% of families were participating in education or training programs.[28]

◆ One-third (34%) of families were participating in job search/job readiness activities, including job search and job skills development programs delivered in partnership with the Rhode Island Department of Labor and Training, primarily through their netWORKri one-stop career center locations, and vocational rehabilitation services delivered by the Office of Rehabilitation Services. Thirty-four percent of families were in assessment or transition, which includes preparing an employment plan, receiving educational or vocational assessments, or waiting to begin an education program or job.[29,30]

◆ About one in twelve families (8%) required to engage in a work-related activity were sanctioned, meaning they lost benefits due to non-compliance with their employment plan.[31]

Support for Young Parents

◆ A child is nine times more likely to grow up in poverty if that child's mother gave birth as a teen, the parents were unmarried when the child was born, and the mother did not receive a high school diploma or GED.[32]

◆ RI Works provides additional support to young parents. Parents who are under age 20 and do not have a high school diploma or GED receive mandatory parenting skills training and are supported in completing their high school education while enrolled in RI Works. In addition, pregnant, or parenting teens under age 18 are required to live with their parent, legal guardian, or adult relative or in an adult-supervised setting if it is not possible to live at home.[33]

◆ In December 2014, there were 192 families with a head of household under the age of 20 enrolled in RI Works, representing 4% of the total caseload.[34]

Support for Individuals with Disabilities and Their Families

◆ Nationally, more than one-quarter (27%) of cash assistance recipients have a physical, mental, or emotional problem that keeps them from working or limits the type or amount of work they can do, compared to 6% of all low-income single mothers.[35]

◆ Under RI Works, parents with disabilities may be exempt from work requirements only if they are receiving SSI or SSDI or determined to be eligible for SSI or SSDI. Other parents with disabilities are referred to the Office of Rehabilitation Services for further assessment, vocational rehabilitation services, and help applying for SSI.[36]

◆ As of December 1, 2014, 860 families (or 16% of the total RI Works caseload) had hardship extensions, 174 for a physical or mental disability, seven who were unable to work due to a domestic violence situation, nine to care for a disabled family member, four due to homelessness, and 666 for another reason (e.g., they were unable to find work due to the recession).[37] Nationally, many families leave cash assistance not because they find work, but because they reach their time limit or are sanctioned. These families often have barriers to employment, such as a mental or physical impairment, or a child with a disability.[38]

Children in Families Receiving Cash Assistance

Education and Training Supporting Employment

◆ An estimated 150,000 working-age adults (ages 16 or older) in Rhode Island are not enrolled in school and have no high school diploma or have limited English-language skills. Many face both of these obstacles to success in the labor market.[39]

◆ Projections suggest that adults who drop out of high school will qualify for only 12% of jobs in 2020, while 65% of jobs in the U.S. will require postsecondary education, up from 28% in 1973.[40] Between 2011 and 2013, the unemployment rate for Rhode Islanders without high school diplomas (17.1%) was nearly one and a half times higher than it was for those with high school degrees (11.7%) and more than four times higher than it was for those with a Bachelor's degree or higher (4.1%).[41]

◆ Parents enrolled in RI Works face significant barriers to success in the labor market. Thirty-nine percent of parents enrolled in RI Works report not finishing high school.[42] Among a recently tested group of parents receiving cash assistance, one-third (36%) of those tested in English tested at or below the sixth-grade reading level, while almost two-thirds (65%) of native Spanish speakers enrolled in RI Works tested at or below the sixth-grade reading level on a Spanish-language version of the test.[43]

◆ Research comparing mandatory job-search-first and mandatory education-or-training-first programs has found that the most effective approach is a mixed strategy where beneficiaries are encouraged to look for and take full-time jobs that pay above the minimum wage, offer benefits, have the potential for advancement, and also are offered high-quality, work-focused, and short-term education or training to improve their employability.[44]

Source of Data for Table/Methodology

Rhode Island Department of Human Services, InRhodes Database, December 2014. The Rhode Island Department of Human Services changed the method for calculating the caseload and persons receiving cash assistance starting in the 2012 Factbook. Comparisons to data presented in previous Factbooks should be made with caution.

The denominator is the total number of children under age 18 from U.S. Census Bureau, Census 2010, Summary File 1.

Communities may have more families than children receiving cash assistance because a pregnant woman without children is eligible if in the final trimester of her pregnancy.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

[1,2,3,5,8,16,17,18,20,21,30,33,36] Rhode Island Department of Human Services. (2014). *Rhode Island Department of Human Services Code of Rules: RI Works Program (Policy #1400)*. Retrieved February 18, 2015, from www.policy.dhs.ri.gov

(continued on page 173)

Table 11. **Children in Families Receiving Cash Assistance (RI Works), Rhode Island, December 1, 2014**

CITY/TOWN	# OF CHILDREN UNDER AGE 18	NUMBER RECEIVING CASH ASSISTANCE		% OF CHILDREN RECEIVING CASH ASSISTANCE
		FAMILIES	CHILDREN	
Barrington	4,597	6	7	<1%
Bristol	3,623	21	33	1%
Burrillville	3,576	28	34	1%
Central Falls	5,644	283	489	9%
Charlestown	1,506	9	11	1%
Coventry	7,770	64	103	1%
Cranston	16,414	263	418	3%
Cumberland	7,535	62	101	1%
East Greenwich	3,436	17	26	1%
East Providence	9,177	127	183	2%
Exeter	1,334	5	7	1%
Foster	986	9	11	1%
Glocester	2,098	3	3	0%
Hopkinton	1,845	11	16	1%
Jamestown	1,043	3	5	<1%
Johnston	5,480	77	103	2%
Lincoln	4,751	50	78	2%
Little Compton	654	3	4	1%
Middletown	3,652	41	53	1%
Narragansett	2,269	11	18	1%
New Shoreham	163	1	1	1%
Newport	4,083	118	206	5%
North Kingstown	6,322	50	83	1%
North Providence	5,514	109	175	3%
North Smithfield	2,456	34	57	2%
Pawtucket	16,575	590	949	6%
Portsmouth	3,996	22	32	1%
Providence	41,634	2,256	4,063	10%
Richmond	1,849	9	11	1%
Scituate	2,272	10	14	1%
Smithfield	3,625	17	26	1%
South Kingstown	5,416	41	63	1%
Tiverton	2,998	32	51	2%
Warren	1,940	38	55	3%
Warwick	15,825	197	258	2%
West Greenwich	1,477	7	7	<1%
West Warwick	5,746	135	209	4%
Westerly	4,787	54	84	2%
Woonsocket	9,888	589	990	10%
Other/Unknown	*NA*	*20*	*40*	*NA*
Four Core Cities	*73,741*	*3,718*	*6,491*	*9%*
Remainder of State	*150,215*	*1,684*	*2,546*	*2%*
Rhode Island	*223,956*	*5,422*	*9,077*	*4%*

Children Receiving SNAP Benefits

DEFINITION

Children receiving SNAP benefits is the number of children under age 18 who participated in the Supplemental Nutrition Assistance Program (SNAP) in 2014 and the percentage change between 2009 and 2014 in the number of children under age 18 participating.

SIGNIFICANCE

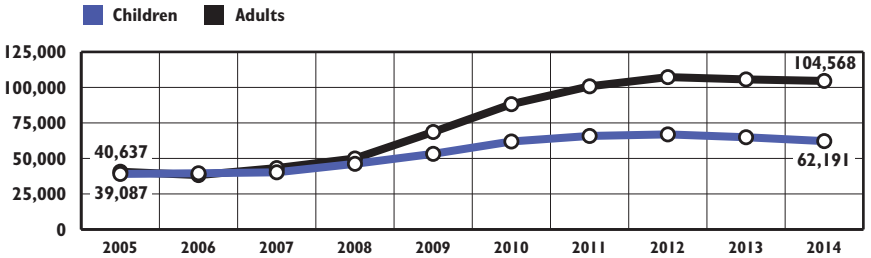
Hunger and lack of regular access to sufficient food are linked to serious physical, psychological, emotional, and academic problems in children and can interfere with their growth and development.[1,2] The Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program, helps low-income individuals and families obtain better nutrition through monthly benefits they can use to purchase food at retail stores and some farmers' markets.[3] Young children under the age of three who are eligible but do not receive SNAP benefits are 50% more likely to go hungry than those who receive these benefits.[4]

In the past, SNAP had been available to Rhode Island households with gross incomes below 130% of the federal poverty level, net incomes below 100% of the federal poverty level, and no more than $2,000 in resources.[5] In 2009, Rhode Island implemented expanded categorical eligibility, an option encouraged by the U.S. Department of Agriculture (USDA), which allowed Rhode Island to increase the gross income limit and remove the resource limit for most applicants.[6,7] The gross income limit for Rhode Island is now 185% of the federal poverty level ($36,612 per year for a family of three in 2014).[8,9] Households must still meet the net income limit of 100% of the federal poverty level after allowable deductions, which include deductions for housing costs and child care.[10]

SNAP is an important anti-hunger program that helps individuals and families purchase food when they have limited income, face unemployment or reduced work hours, or experience a crisis.[11] On October 1, 2014, three-fourths (75%) of Rhode Island families receiving SNAP benefits had incomes below 100% of the federal poverty level ($19,790 for a family of three in 2014).[12,13] In 2014, the average monthly SNAP benefit for a family of three in Rhode Island was $367.[14]

Participation in SNAP has been associated with improved health outcomes among low-income or food insecure children, and has been linked to lower risk of adverse outcomes such as nutritional deficiency, hospitalization, and obesity.[15] SNAP also is a quick and effective form of economic stimulus because it moves money directly into the local economy.[16]

Participation in the Supplemental Nutrition Assistance Program, Children and Adults, Rhode Island, 2005-2014



Source: Rhode Island Department of Human Services, InRhodes Database, 2005-2014. Data represent children under age 18 and adults who participated in SNAP during the month of October.

◆ **Of the 166,759 Rhode Islanders enrolled in SNAP in October 2014, 63% were adults and 37% were children. More than one-third (35%) of the children enrolled in SNAP were under the age of six.[17]**

◆ **From 2008 to 2012, the number of Rhode Islanders receiving SNAP benefits increased steadily. However, the number of children and adults receiving SNAP benefits has been decreasing slowly since 2012.[18] SNAP is designed to respond quickly to economic changes; enrollment expands when the economy is weak and shrinks when the economy begins to recover.[19]**

Food Insecurity in Rhode Island

◆ **The USDA defines food insecurity as not always having access to enough food for an active, healthy life. Between 2011 and 2013, 14.4% of Rhode Island households and 14.6% of U.S. households were food insecure. In 2013, 19.5% of all U.S. households with children were food insecure, while 45.6% of U.S. households with children with incomes below the poverty level experienced food insecurity.[20]**

◆ **Five federal nutrition programs provide nutrition assistance to children and families, including SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the National School Lunch Program, the National School Breakfast Program, and the Summer Food Service Program. In 2014, food pantries and soup kitchens provided emergency food assistance to an average of 63,000 Rhode Islanders who needed additional help to meet their nutritional needs each month.[21]**

Children Receiving SNAP Benefits

SNAP Participation in Rhode Island

- Between October 1, 2009 and October 1, 2014, the number of Rhode Island children receiving SNAP benefits increased by 14%, from 53,632 to 60,982. SNAP participation rates among children increased by 10% in the four core cities and 19% in the remainder of the state.[22]

- In recent years, Rhode Island has implemented a number of strategies to improve access to SNAP benefits, including implementing "expanded categorical eligibility" so more families qualify, developing an online SNAP application, conducting telephone interviews so applicants do not need to apply in person, requiring less frequent recertification, and implementing same-day SNAP processing when possible.[23,24,25,26]

- Improving coordination with other work support programs, reducing documentation requirements, simplifying renewal processes and improving communications (i.e., phone systems and notices) are additional strategies that could be implemented to further increase access to SNAP benefits for children and families in Rhode Island.[27]

Table 12. **Children Under Age 18 Receiving SNAP Benefits, Rhode Island, October 1, 2009, 2013, and 2014**

CITY/TOWN	NUMBER PARTICIPATING IN 2009	NUMBER PARTICIPATING IN 2013	NUMBER PARTICIPATING IN 2014	% CHANGE IN NUMBER PARTICIPATING FROM 2009 TO 2014
Barrington	85	144	102	20%
Bristol	363	458	444	22%
Burrillville	456	562	530	16%
Central Falls	2,917	3,502	3,368	15%
Charlestown	152	220	205	35%
Coventry	772	1,187	1,048	36%
Cranston	2,857	3,728	3,485	22%
Cumberland	617	891	776	26%
East Greenwich	190	192	169	-11%
East Providence	1,608	2,201	2,067	29%
Exeter	86	113	88	2%
Foster	79	109	104	32%
Glocester	158	138	122	-23%
Hopkinton	209	234	222	6%
Jamestown	40	36	36	-10%
Johnston	839	1,148	1,054	26%
Lincoln	551	668	671	22%
Little Compton	46	46	48	4%
Middletown	392	421	418	7%
Narragansett	218	299	235	8%
New Shoreham	5	11	10	100%
Newport	1,202	1,315	1,277	6%
North Kingstown	634	841	828	31%
North Providence	907	1,401	1,315	45%
North Smithfield	213	266	303	42%
Pawtucket	5,790	7,414	7,250	25%
Portsmouth	237	257	253	7%
Providence	20,771	23,238	22,226	7%
Richmond	125	152	134	7%
Scituate	149	174	155	4%
Smithfield	457	315	252	-45%
South Kingstown	406	621	572	41%
Tiverton	321	380	350	9%
Warren	373	482	431	16%
Warwick	2,295	2,742	2,642	15%
West Greenwich	129	106	77	-40%
West Warwick	1,472	1,771	1,787	21%
Westerly	815	1,019	934	15%
Woonsocket	4,696	5,064	4,913	5%
Unknown	*NA*	*105*	*81*	*NA*
Four Core Cities	*34,174*	*39,218*	*37,757*	*10%*
Remainder of State	*19,458*	*24,648*	*23,144*	*19%*
Rhode Island	*53,632*	*63,971*	*60,982*	*14%*

Note to Table

In 2008, the Food Stamp Program was renamed the Supplemental Nutrition Assistance Program (SNAP).

Source of Data for Table/Methodology

Supplemental Nutrition Assistance Program (SNAP) data are from the Rhode Island Department of Human Services, InRhodes Database, October 1, 2009, 2013, and 2014.

The data in the city/town table may differ from the data elsewhere in this indicator as this table uses point-in-time data for October 1st, rather than data based on participation for the entire month.

Due to changes in Rhode Island's SNAP eligibility criteria (e.g., implementation of expanded categorical eligibility) many children in families with gross incomes up to 185% of the federal poverty level (FPL) are now eligible for SNAP. For this reason, Census data on the number of children in families with incomes below 130% FPL no longer provides an accurate estimate of the number of income-eligible children, and this year's Factbook does not present participation rates. Instead, the number of children participating in 2009 is presented as a baseline and data for 2013 and 2014 are presented for comparison. Due to this change in methodology, Children Receiving SNAP Benefits cannot be compared with Factbooks prior to 2010.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

[1] Hickson, M., Ettinger de Cuba, S., Weiss, I., Donofrio, G. & Cook, J. (2013). *Too hungry to learn: Food insecurity and school readiness.* Boston, MA: Children's Health Watch.

[2] Perez-Escamilla, R. & Pinheiro de Toledo Vianna, R. (2012). Food insecurity and the behavioral and intellectual development of children: A review of the evidence. *Journal of Applied Research on Children, 3*(1), 1-15.

[3] United States Department of Agriculture, Food and Nutrition Service. (n.d.). *Supplemental Nutrition Assistance Program (SNAP).* Retrieved February 12, 2015, from www.fns.usda.gov

(continued on page 173)

Women and Children Participating in WIC

DEFINITION

Women and children participating in WIC is the percentage of eligible women, infants, and children enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

SIGNIFICANCE

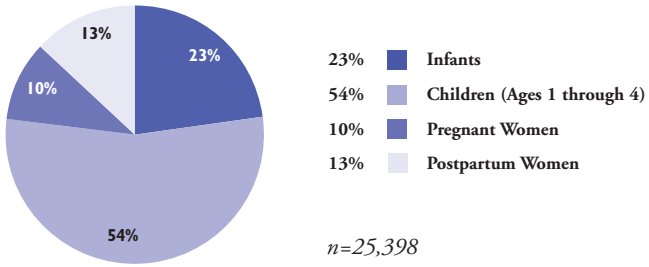
The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a federally-funded preventive program that provides participants with nutritious food, nutrition education, and access to health care and social services. WIC serves pregnant, postpartum, and breastfeeding women, infants, and children under five years of age with household incomes at or below 185% of the federal poverty level. Any individual who participates in SNAP (formerly the Food Stamp Program), RIte Care, Medicaid, or Rhode Island Works, or is a member of a family in which a pregnant woman or an infant receives Medicaid benefits, is automatically income-eligible for WIC. Participants also must have a specified nutritional risk, such as anemia, high-risk pregnancy, or abnormal growth, or be in need of supplemental food to qualify.[1,2]

Compared to children who receive WIC benefits, young children who are eligible for WIC but not participating are more likely to be in poor health, at risk for developmental delays, underweight, short for their age, and/or experience food insecurity (i.e., live in families that do not always have enough food for an active healthy life).[3] Food insecurity in early childhood can lead to impaired cognitive, behavioral, and psychosocial development, and can limit academic achievement.[4] Pregnant women also have special nutritional needs that influence pregnancy outcomes and the health of their children.[5]

WIC participation has been shown to reduce infant mortality, improve birth outcomes (including reducing the likelihood of low birthweight and prematurity), enhance maternal and child dietary intake, reduce child abuse and neglect risk, improve child growth rates, boost cognitive development, and increase the likelihood of having a regular source of medical care.[6,7]

Recent enhancements to the WIC food package have increased access to a wider variety of nutritious foods and strengthened incentives for continued breastfeeding.[8] WIC consistently promotes breastfeeding as the optimal method of infant feeding.[9] In Rhode Island, 18% of infants participating in WIC were breastfed in Federal Fiscal Year (FFY) 2014. This was a slight decline from a rate between 19-20% over the past six years.[10]

Women, Infants, and Children Enrolled in WIC, Rhode Island, September 2014



n=25,398

Source: Rhode Island Department of Health, WIC Program, September 2014.

◆ **Infants and children ages one through four comprised more than three-quarters (77%) of the population being served by WIC in September 2014 in Rhode Island. Women accounted for over one-fifth (10% pregnant and 13% postpartum) of the population being served.[11]**

◆ **In September 2014, 70% of WIC participants in Rhode Island were White, 17% were Black or African-American, 3% were Asian, and 10% identified as other races or more than one race. Forty-three percent of WIC participants identified as Hispanic or Latino. Hispanics are included in the racial groups above.[12]**

◆ **The four core cities - Central Falls (75%), Providence (75%), Pawtucket (66%), and Woonsocket (72%) - had WIC participation rates exceeding the statewide enrollment rate of 65% in 2014.[13]**

◆ **WIC is not an entitlement program. Congress determines funding annually and WIC is not funded at a level that is sufficient to serve all eligible women, infants and children.[14,15] Rhode Island received $24.9 million in federal funding for WIC during FFY 2014.[16]**

◆ **The WIC Farmers' Market Nutrition Program (FMNP) improves participants' intake of fresh fruits and vegetables by enabling participants to purchase produce at authorized local farmers' markets using WIC benefits.[17] In Rhode Island, 30 farmers' markets provided fresh produce to 15,861 WIC participants during the Farmers' Market Nutrition Program in FFY 2014.[18]**

Table 13. **Women, Infants and Children Enrolled in WIC, Rhode Island, September 2014**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	86	43	50%
Bristol	416	229	55%
Burrillville	355	232	65%
Central Falls	1,910	1,434	75%
Charlestown	131	58	44%
Coventry	698	392	56%
Cranston	2,345	1,497	64%
Cumberland	539	297	55%
East Greenwich	146	62	42%
East Providence	1,458	905	62%
Exeter	101	56	55%
Foster	99	34	34%
Glocester	132	49	37%
Hopkinton	194	89	46%
Jamestown	26	4	15%
Johnston	802	509	63%
Lincoln	1,425	225	16%
Little Compton	31	13	42%
Middletown	389	252	65%
Narragansett	164	81	49%
New Shoreham	17	0	0%
Newport	907	625	69%
North Kingstown	516	287	56%
North Providence	911	570	63%
North Smithfield	228	111	49%
Pawtucket	4,402	2,922	66%
Portsmouth	227	141	62%
Providence	12,547	9,459	75%
Richmond	96	76	79%
Scituate	130	59	45%
Smithfield	213	104	49%
South Kingstown	417	228	55%
Tiverton	303	138	46%
Warren	198	152	77%
Warwick	1,806	995	55%
West Greenwich	83	50	60%
West Warwick	1,222	694	57%
Westerly	645	376	58%
Woonsocket	2,724	1,950	72%
Four Core Cities	*21,583*	*15,765*	*73%*
Remainder of State	*17,456*	*9,633*	*55%*
Rhode Island	*39,039*	*25,398*	*65%*

Source of Data for Table/Methodology

Rhode Island Department of Health, WIC Program, September 30, 2014.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Note: WIC participation rates in this Factbook can be compared to all Factbooks, with the exception of the 2011 Factbook, which used a July rather than September 30 reference date. Additionally, since 2007, the "estimated number eligible" is based on calculations done by the Rhode Island Department of Health to determine the number of pregnant and postpartum women, infants and children under age five who live in families with an income less than 185% of the federal poverty level. In previous years, the "estimated number eligible" was based on 2000 Census data (2005 and 2006 Factbooks) and 1990 Census data (all Factbooks prior to 2005).

References

[1,14] Food Research & Action Center. (n.d.). *Child nutrition fact sheet: Women, Infants, and Children (WIC).* Retrieved January 14, 2015, from www.frac.org

[2,15] U.S. Department of Agriculture, Food and Nutrition Service. (2014). *WIC: The special supplemental nutrition program for women, infants and children (nutrition program facts).* Retrieved January 14, 2015, from www.fns.usda.gov

[3] *Children's HealthWatch policy action brief: Federal programs that protect young children's health.* (2011). Boston, MA: Children's HealthWatch.

[4] *Food insecurity.* (2014). Washington, DC: Child Trends Data Bank.

[5] U.S. Department of Health and Human Services, Office on Women's Health. (2010). *Pregnancy: Staying healthy and safe.* Retrieved January 14, 2015, from www.womenshealth.gov

[6,9] U.S. Department of Agriculture, Food and Nutrition Service. (2013). *How WIC helps.* Retrieved January 14, 2015, from www.fns.usda.gov

[7] Martinez-Schiferl, M. (2012). *WIC participants and their growing need for coverage.* Washington, DC: Urban Institute.

(continued on page 173)

Children Participating in School Breakfast

DEFINITION

Children participating in school breakfast is the percentage of low-income 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

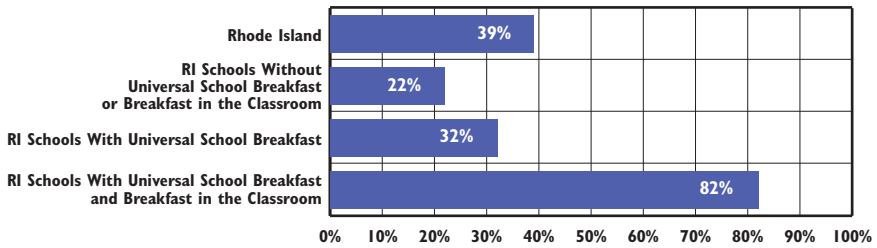
The School Breakfast Program helps ensure that the nation's most vulnerable children start their day off with a healthy meal. During the 2013-2014 school year, 11.2 million low-income children in the U.S. participating in the School Breakfast Program ate breakfast at school each day, continuing a pattern of steady year-over-year growth in student participation over the past decade.[1] The School Breakfast Program offers nutritious meals which together with school lunches make up a large proportion of the daily dietary intake of participating children.[2] The School Breakfast Program helps schools support academic success and improved attendance, behavior and health, including reduced obesity rates.[3]

Food-insecure families often do not have sufficient food to provide nutritious breakfasts every morning, and children in these families are at risk of falling behind their peers physically, cognitively, academically, emotionally and socially. Children who are undernourished are more likely to have poorer cognitive functioning when they miss breakfast. They are more likely to have behavior, emotional, and academic problems, more likely to repeat a grade, and more likely to be suspended.[4,5] Nationally, kindergarteners in households experiencing food insecurity are more likely to be chronically absent than their peers in food-secure households.[6]

Rhode Island law requires that all public schools make breakfasts and lunches available to all students, including students who qualify for free or reduced-price meals based on their income (less than 130% of the federal poverty level for free meals and between 130% and 185% of the federal poverty level for reduced-price meals).[7,8]

During the 2013-2014 school year in Rhode Island, 50 low-income students participated in the School Breakfast Program for every 100 low-income students who participated in the School Lunch Program. Rhode Island ranks 28th in the U.S. for participation in the School Breakfast Program, down from 25th last year. If Rhode Island increased low-income student participation in the School Breakfast Program from 50% to 70% of School Lunch Program participation, the state would receive $2.7 million in additional federal funds to support the School Breakfast Program.[9]

Low-Income Children Participating in the School Breakfast Program, Rhode Island, October 2014



Source: Rhode Island Department of Education, Office of School Food Services, Office of Statewide Efficiencies, October 2014.

◆ **Universal School Breakfast Programs, which provide free breakfast to all children regardless of income, increase school breakfast participation by removing the stigma often associated with school breakfast and can reduce administrative costs.[10,11] During the 2014-2015 school year, all schools in Central Falls, Cranston, Pawtucket, Providence, and Woonsocket; selected schools in two other districts; 10 charter schools; and the Urban Collaborative Accelerated Program (UCAP) offered universal school breakfast.[12]**

◆ **Offering breakfast in the classroom at the start of the school day is another proven strategy for increasing breakfast participation, reducing stigma, increasing convenience, and proving additional opportunities for social and emotional learning in the classroom.[13,14] During the 2014-2015 school year, Central Falls, Cranston, East Providence, Glocester, Providence, and Warwick offered breakfast in the classroom at some schools, primarily elementary schools.[15]**

◆ **In Rhode Island, 22% of low-income students participated in School Breakfast Programs in schools not offering universal school breakfast or breakfast in the classroom, compared with 32% of low-income students in schools offering universal programs and 82% of low-income students in schools offering universal programs and breakfast in the classroom.[16]**

◆ **During the summer, millions of low-income children lose access to the free and reduced-price meals they rely on during the school year. In Rhode Island, 14% of the children who participated in the School Lunch Program during the 2012-2013 school year participated in the Summer 2013 nutrition programs. During July 2013, 135,089 lunches were served through summer nutrition programs, an 8% increase over the previous year.[17]**

Children Participating in School Breakfast

Table 14.

Children Participating in School Breakfast, Rhode Island, October 2014

SCHOOL DISTRICT	OCTOBER 2014 ENROLLMENT	ESTIMATED AVERAGE DAILY PARTICIPATION IN BREAKFAST	% OF ALL CHILDREN PARTICIPATING IN BREAKFAST	# OF LOW-INCOME STUDENTS	ESTIMATED LOW-INCOME AVERAGE DAILY PARTICIPATION IN BREAKFAST	% OF ALL LOW-INCOME CHILDREN PARTICIPATING IN SCHOOL BREAKFAST
Barrington	3,288	*	<1%	145	*	3%
Bristol Warren	3,358	153	5%	1,216	137	11%
Burrillville	2,408	198	8%	872	150	17%
Central Falls**	2,683	1,598	60%	2,124	1,291	61%
Chariho	3,305	284	9%	692	168	24%
Coventry	4,854	403	8%	1,644	350	21%
Cranston**	10,457	2,801	27%	4,436	1,641	37%
Cumberland	4,543	441	10%	1,139	344	30%
East Greenwich	2,412	33	1%	155	23	15%
East Providence	5,280	476	9%	2,641	396	15%
Exeter-West Greenwich	1,645	112	7%	238	63	27%
Foster	284	23	8%	66	20	30%
Foster-Glocester	1,121	54	5%	208	42	20%
Glocester	529	75	14%	85	67	79%
Jamestown	500	10	2%	61	*	9%
Johnston	3,116	328	11%	1,144	276	24%
Lincoln	3,084	193	6%	845	165	19%
Little Compton	248	*	2%	33	*	5%
Middletown	2,285	157	7%	645	134	21%
Narragansett	1,340	131	10%	280	72	26%
New Shoreham	118	13	11%	20	*	43%
Newport	2,072	368	18%	1,292	332	26%
North Kingstown	4,088	267	7%	894	206	23%
North Providence	3,560	381	11%	1,756	282	16%
North Smithfield	1,775	97	5%	302	63	21%
Pawtucket**	9,057	2,238	25%	6,599	1,902	29%
Portsmouth	2,563	118	5%	388	84	22%
Providence**	23,907	12,897	54%	19,229	11,548	60%
Scituate	1,419	33	2%	278	24	9%
Smithfield	2,372	126	5%	388	72	19%
South Kingstown	3,321	199	6%	642	172	27%
Tiverton	1,871	116	6%	538	84	16%
Warwick	9,277	722	8%	3,187	582	18%
West Warwick	3,417	513	15%	1,689	457	27%
Westerly	3,022	411	14%	1,199	352	29%
Woonsocket**	5,995	2,322	39%	4,287	1,885	44%
Charter Schools	*5,445*	*2,393*	*44%*	*3,548*	*1,929*	*54%*
State-Operated Schools	*1,801*	*364*	*20%*	*1,150*	*345*	*30%*
*UCAP***	*139*	*114*	*82%*	*101*	*96*	*95%*
Four Core Cities	*41,642*	*19,054*	*46%*	*32,239*	*16,625*	*52%*
Remainder of State	*92,932*	*9,246*	*10%*	*29,118*	*6,778*	*23%*
Rhode Island	*141,959*	*31,170*	*22%*	*66,156*	*25,773*	*39%*

Source of Data for Table/Methodology

Rhode Island Department of Education, October 2014.

*Fewer than 10 students are in this category. Actual numbers are not shown to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

**These districts offer Universal School Breakfast in all of their schools.

Charter schools include Achievement First Rhode Island, Beacon Charter High School for the Arts, Blackstone Academy, Blackstone Valley Prep, The Compass School, Paul Cuffee Charter School, The Greene School, Highlander Charter School, the Hope Academy, International Charter School, Kingston Hill Academy, The Learning Community, RI Nurses Institute Middle College Charter School, Segue Institute for Learning, Sheila Skip Nowell Leadership Academy, SouthSide Elementary Charter School, Trinity Academy for the Performing Arts, and Village Green Virtual Charter School. State-operated schools include William M. Davies Jr. Career & Technical High School, the Rhode Island Training School operated by DCYF, Metropolitan Regional Career and Technical Center, and the Rhode Island School for the Deaf. UCAP is the Urban Collaborative Accelerated Program.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

The October 2014 enrollment and number of low-income students come from RIDE's official October 1 enrollment census. Data are not comparable to Factbooks prior to 2011.

"Estimated Average Daily Participation in Breakfast" is the average number of students who ate breakfast in school per school day during October 2014. "Estimated Low-Income Average Daily Participation in Breakfast" is the average number of students eligible for and enrolled in free or reduced-price meals who ate breakfast in school per school day during October 2014.

Children are counted as low-income if they are eligible for a Free or Reduced-Price Lunch Program. To participate in the Reduced-Price Breakfast Program, students' household income must fall between 130% and 185% of the federal poverty guideline. For the Free Breakfast Program, household income must fall below 130% of the federal poverty guideline. Children in foster care, households receiving SNAP Benefits and households participating in the Rhode Island Works Program are automatically eligible for free meals.

References are on page 173.

Health

Reading: Summer

by Myra Cohn Livingston

Summer is with it,
she's wild,
she likes
bare legs and cutoffs
and camping
and hikes;
she dives in deep water,
she wades in a stream,
she guzzles cold drinks
and she drowns in ice cream;
she runs barefoot,
she picnics,
she fishes,
digs bait,
she pitches a tent
and she stays up too late
while she counts out the stars,
swats mosquitoes and flies,
hears crickets,
smells pine trees,
spies night-creature eyes;
she rides bareback,
goes sailing,
plays tennis,
climbs trees;
she soaks in the sunshine;
she gulps in a breeze;
she tastes the warm air
on the end of her tongue,

and she falls asleep
reading
alone
in the sun.

Children's Health Insurance

DEFINITION

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

SIGNIFICANCE

Children who have health insurance coverage are healthier and have fewer preventable hospitalizations. They are more likely to receive preventive care, be screened for the achievement of developmental milestones, miss fewer days of school, have access to prescription medications, and get treatment for illnesses and chronic conditions. Compared to children with coverage, uninsured children are less likely to have a usual place for health care and have fewer visits to doctors and dentists.[1,2] A child's insurance status is closely associated with their parent's coverage status; children are more likely to be insured if their parents also have health insurance (especially continuous coverage).[3,4]

Medicaid and the Children's Health Insurance Program (CHIP) provide low-income children with affordable, comprehensive health benefits.[5] RIte Care/RIte Share, Rhode Island's Medicaid/CHIP 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. On December 31, 2014, 72% (93,687) of RIte Care members who qualified based on family income were children under age 19. There were 47,816 low-income parents with RIte Care coverage on December 31, 2014.[6,7] RIte Care enrollment rose to a new high of 130,639 in December 2014 (up from 117,963 in December 2013).[8,9,10]

In 2013 in Rhode Island an estimated 5.4% of children were uninsured. Children ages six to 17, Black, Asian, Hispanic, and Native American children, and those living in urban communities are most likely to be uninsured.[11,12,13,14]

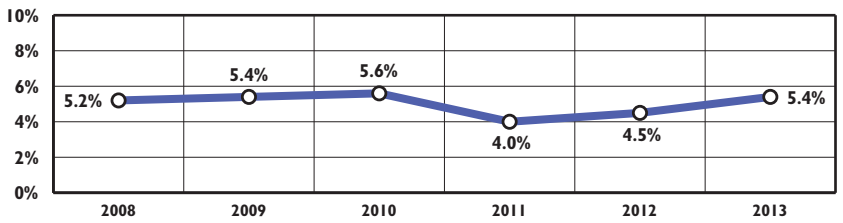
Children Without Health Insurance

	2008	2013
RI	5.2%	5.4%
US	9.3%	7.1%
National Rank*		*16th*
New England Rank**		*5th*

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

Source: For 2013: U.S. Census Bureau, American Community Survey, 2013. Table R2702. For 2008: U.S Census Bureau, American Community Survey, 2012. Table CP03.

Children Without Health Insurance, Rhode Island, 2008-2013



Source: U.S. Census Bureau, American Community Survey, 2012 and 2013, Table CP03. Data are for children under 18 years of age and are not comparable to previous Factbooks*.

◆ **In 2013, 5.4% of Rhode Island's children under age 18 were uninsured. Rhode Island ranks 16th best in the U.S., with 94.6% of children with health insurance. Just over half (56%) of Rhode Island children are covered by private health insurance, most of which is obtained through their parents' employers.[15,16]**

◆ **Approximately 74% (7,590) of the estimated 10,286 uninsured children under age 18 in Rhode Island between 2011 and 2013 were eligible for RIte Care coverage based on their family incomes, but were not enrolled. An estimated 2,696 uninsured children lived in families with incomes above 261% of the federal poverty level (the income limit for RIte Care eligibility) during this time period, and 56% (1,521) of them were eligible for financial assistance through HealthSource RI based on income.[17,18]**

◆ **The RIte Share premium assistance program helps low-income families afford the cost of employer-sponsored coverage. As of December 31, 2014, 7,297 children and 2,530 parents (9,827 total) were enrolled in RIte Share.[19]**

◆ **Between 2009 and 2013, the percentage of children covered exclusively by their parents' employer-sponsored health plan decreased from 54% to 50%, while the percentage of children insured exclusively by Medicaid/RIte Care increased from 25% to 31%.[20]**

◆ **Children and families in need of health insurance can enroll in coverage though HealthSource RI, Rhode Island's health insurance marketplace under the federal *Affordable Care Act (ACA)*. As of November 15, 2014, 1,282 children were enrolled in commercial coverage in the individual market of HealthSource RI.[21]**

Table 15. **Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 31, 2014**

CITY/TOWN	RITE CARE	SSI	KATIE BECKETT PROVISION	ADOPTION SUBSIDY	FOSTER CARE	TOTAL
Barrington	405	11	42	19	9	486
Bristol	1,535	27	15	43	14	1,634
Burrillville	940	58	21	61	39	1,119
Central Falls	4,474	277	2	32	21	4,806
Charlestown	412	12	8	15	6	453
Coventry	1,890	81	49	116	68	2,204
Cranston	6,283	277	89	171	123	6,943
Cumberland	1,560	81	54	48	45	1,788
East Greenwich	428	25	32	20	14	519
East Providence	3,457	183	43	88	79	3,850
Exeter	261	8	5	18	7	299
Foster	250	13	6	14	5	288
Glocester	344	18	9	42	31	444
Hopkinton	469	15	6	25	9	524
Jamestown	93	2	6	4	8	113
Johnston	2,049	82	35	46	47	2,259
Lincoln	1,194	59	32	49	25	1,359
Little Compton	129	0	6	1	2	138
Middletown	894	45	22	24	36	1,021
Narragansett	424	23	14	24	42	527
New Shoreham	60	0	4	0	0	64
Newport	1,812	117	5	28	52	2,014
North Kingstown	1,452	63	37	36	28	1,616
North Providence	2,278	141	24	61	48	2,552
North Smithfield	491	45	14	41	33	624
Pawtucket	10,376	588	33	121	139	11,257
Portsmouth	636	22	20	18	44	740
Providence	29,911	2,026	49	541	629	33,156
Richmond	243	15	10	26	15	309
Scituate	490	12	26	35	12	575
Smithfield	635	19	23	31	32	740
South Kingstown	1,203	53	39	38	23	1,356
Tiverton	779	36	14	18	14	861
Warren	162	30	13	28	23	256
Warwick	4,591	219	114	185	144	5,253
West Greenwich	225	6	6	16	15	268
West Warwick	2,683	122	15	72	54	2,946
Westerly	1,711	84	27	29	22	1,873
Woonsocket	6,226	552	28	109	96	7,011
Unknown Residence	*232*	*51*	*2*	*1*	*1*	*287*
Four Core Cities	*50,987*	*3,443*	*112*	*803*	*885*	*56,230*
Remainder of State	*42,468*	*2,004*	*885*	*1,490*	*1,168*	*48,015*
Rhode Island	*93,687*	*5,498*	*999*	*2,294*	*2,054*	*104,532*

Source of Data for Table/Methodology

Rhode Island Executive Office of Health and Human Services, MMIS Database, December 31, 2014.

Since October 2008, all new children with special health care needs are required to enroll in RIte Care managed care. Children with special health care needs who are covered through RIte Care include those who qualify for Medical Assistance because they receive SSI, adoption subsidies, or qualify for the Katie Beckett provision. Certain groups of children, including those with commercial health insurance, are exempt from transitions to RIte Care and thus remain in fee-for-service. The columns "RIte Care, SSI, Katie Beckett Provision and Adoption Subsidy" include children in fee-for-service Medicaid and RIte Care managed care as of December 31, 2014.

The RIte Care numbers include children who are also enrolled in RI Works. Prior to the 2015 Factbook, children enrolled in both RIte Care and RI Works were reported separately. Due to eligibility system changes and enrollment changes to RI Works and RIte Care, these data are no longer able to be reported.

The Providence numbers include some children in substitute care who live in other towns because the Medicaid database lists some foster children as Providence residents for administrative purposes.

Unknown residence: All children are Rhode Island residents, but specific city/town information was not reported.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

*Beginning with the 2015 Factbook, the children without health insurance trend line is based on U.S. Census Bureau American Community Survey (ACS) data due to changes in survey protocol and methodology with the Current Population Survey (CPS). Trend data reported prior to 2015 Factbook are not comparable.

References

[1] *America's uninsured crisis: Consequences for health and health care.* (2009). Washington, DC: National Academies Press, Institute of Medicine.

(continued on page 174)

Childhood Immunizations

DEFINITION

Childhood immunizations is the percentage of children ages 19 months to 35 months who have received the entire 4:3:1:3:3:1:4 series of vaccinations as recommended by the Advisory Committee on Immunization Practices (ACIP). In 2013, the complete series included 4 doses of diphtheria, tetanus and pertussis (DTaP); 3 doses of polio; 1 dose of measles, mumps, rubella (MMR); 3-4 doses of Haemophilus influenzae type b (Hib); 3 doses of hepatitis B vaccines; 1 dose of varicella (chickenpox); and 4 doses of pneumococcal conjugate vaccine (PCV).

SIGNIFICANCE

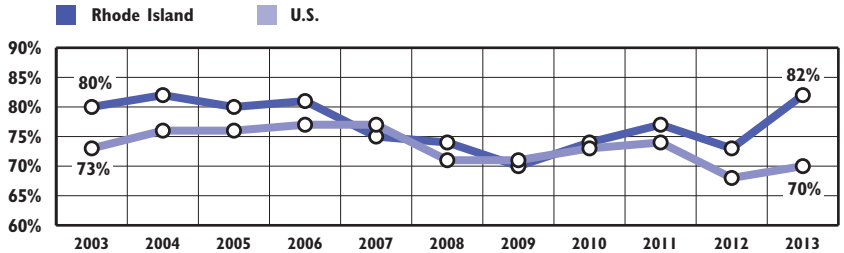
Timely and complete immunization protects children against a number of infectious diseases that were once common and resulted in death or disability. Vaccines interact with the immune system to produce antibodies that protect the body if it is later exposed to disease. The benefits of immunization include improved quality of life and productivity, reduced health spending, and prevention of illness and death. Society benefits from high vaccination levels because disease outbreaks are minimized. Although many of the diseases against which children are vaccinated are rare, it is important to continue to immunize against them until the diseases are completely eradicted.[1,2,3]

The federal Vaccines for Children program is used to eliminate cost as a barrier to vaccination. It allows states to obtain vaccines at a discounted price. Local providers then administer the vaccines at no cost to eligible children under age 19, including those who are uninsured, underinsured, or Medicaid-eligible.[4] Due to the federal *Affordable Care Act (ACA)*, children enrolled in new health insurance plans now have access to recommended vaccines without deductibles or copays, when delivered by an in-network provider.[5]

Rhode Island obtains vaccines for all children and distributes them to health care providers. The Rhode Island Department of Health works in partnership with local health care providers to maintain and share KIDSNET immunization data for children from birth to age 18.[6]

Starting August 2015, Rhode Island will require the following vaccinations prior to entry into licensed child care, preschool, and Head Start: diphtheria, tetanus, and pertussis; Haemophilus influenza type b; hepatitis A; influenza; hepatitis B; measles, mumps, and rubella; pneumococcal; polio; rotavirus; and varicella (chickenpox). Kindergarten entry requires all of these except influenza, Haemophilus influenza type b, and pneumococcal.[7,8]

Fully Immunized Children*, Ages 19 Months to 35 Months, Rhode Island and United States, 2003-2013



Source: Centers for Disease Control and Prevention, *National Immunization Survey*, 2003-2013. *Fully immunized children received the 4:3:1:3:3:1 series from 2003 to 2007; the 4:3:1:0:3:1:4 series in 2008 to 2010; and the 4:3:1:3:3:1:4 series from 2011 to 2013.

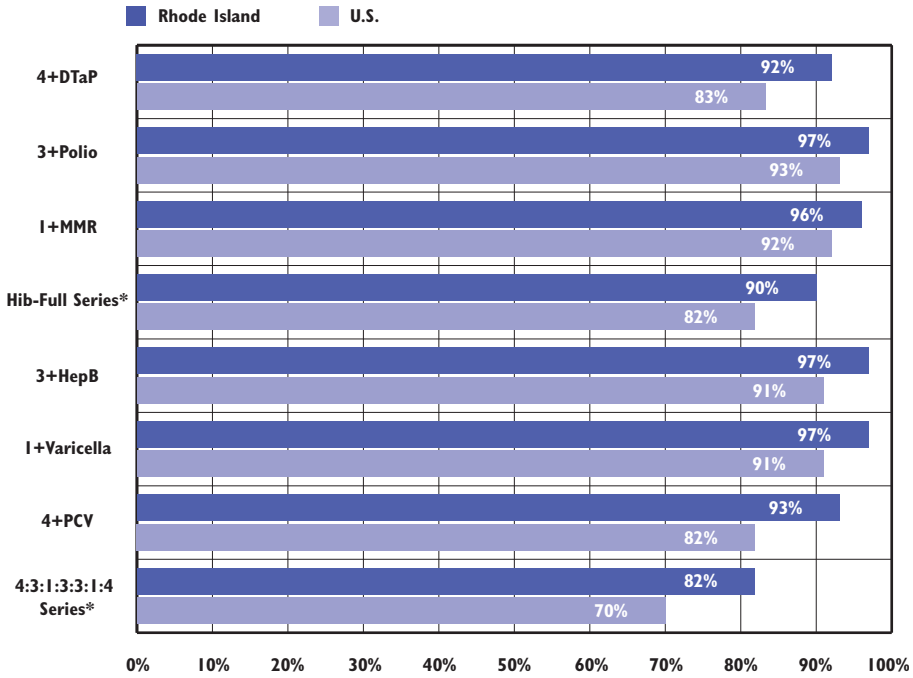
◆ **In 2013, Rhode Island's rate (82%) of children ages 19 months to 35 months that were fully immunized was above the national average of 70% and the best in the U.S.[9]**

◆ **In 2013, the U.S. rate for fully immunized children ages 19 months to 35 months ranged from 64% for children living below the federal poverty level to 74% for children living at or above the federal poverty level. The 2013 U.S. rate was 73% for Asian, non-Hispanic children, 72% for White, non-Hispanic children, 69% for Hispanic children, and 65% for Black, non-Hispanic children.[10]**

◆ **Concerns about vaccine safety have resulted in some parents refusing to have their children immunized and some requesting alternative vaccination schedules, both of which contribute to under-immunization.[11] As required by the *National Childhood Vaccine Injury Act*, families must be provided with informational materials about each vaccine and given the opportunity to clarify issues or concerns with their healthcare provider.[12] In Rhode Island, children may be exempt from receiving one or more vaccines for medical or religious reasons.[13] In the 2013-2014 school year, 1.0% (113) of kindergarten students and 0.6% (68) of 7th grade students received exemptions from vaccination requirements. Of the 181 exemptions, 35% (64) were for medical reasons and 65% (117) were for religious reasons.[14]**

◆ **Starting in 2015, Rhode Island child care workers will be required to obtain one dose of tetanus, diphtheria, pertussis (Tdap) vaccine, two doses of measles, mumps, and rubella (MMR) vaccine, two doses of varicella (chickenpox) vaccine, and an annual influenza vaccination.[15]**

Vaccination Coverage Among Children, Ages 19 Months to 35 Months, Rhode Island and United States, 2013



Source: Rhode Island Department of Health analysis of data from the *National Immunization Survey-Children*, 2013.
*Depending on the product type received, 3+ or 4+ doses of Hib vaccine is a full dose.

◆ **In 2013, Rhode Island ranked best in the U.S for the 3+HepB, 1+VAR, 4+PCV, and the rotavirus vaccines, second for the 4+DTaP vaccine, fifth for the 1+MMR vaccine, and seventh for the 3+Polio vaccine. Rhode Island's rate of completion for the 4:3:1:3:3:1:4 series (82%) exceeded the national *Healthy People 2020* target (80%).[16]**

Immunizations for Elementary and Middle School Students

◆ **The 2013-2014 *Rhode Island School Immunization Assessment* analyzed student immunization status reports through a web-based survey of all kindergarten and 7th grade school nurse teachers. The immunization statuses of 99% of kindergarten students and 97% of 7th grade students were reported. Of the five immunizations needed for school entry, entering kindergarteners had coverage rates between 95% and 98%, while entering middle school students had rates between 78% and 99%.[17,18]**

Adolescent Immunization

◆ **Effective August 2015, all Rhode Island students entering seventh grade will be required to receive one dose of the human papillomavirus (HPV), tetanus, diphtheria, pertussis (Tdap), and meningococcal conjugate (MCV) vaccines as well as any needed catch-up doses.[19]**

◆ **According to the 2013 *National Immunization Survey-Teen*, Rhode Island adolescents ranked best in the U.S. for all four HPV vaccines (1+HPV and 3+HPV for males and females) and 1+Tdap vaccine, third for 1+MCV vaccine, and fifth for 2+VAR and 3+HepB. In 2013, 96% of Rhode Island adolescents had received 2+MMR, 3+HepB, and 1+Tdap vaccines, 95% had received the 2+VAR vaccine, and 92% received the 1+MCV vaccine.[20]**

◆ **To ensure that all high school seniors are fully vaccinated before beginning college or work, the Rhode Island Office of Immunization runs the *Vaccinate Before You Graduate* (VBYG) program in high schools throughout the state. The program holds vaccination clinics throughout the year at each participating school. The immunizations are funded by the federal Vaccines for Children program, local insurers, and other federal grants and are offered at no cost to students.[21,22,23]**

◆ **During the 2013-2014 school year, 90 schools participated in VBYG. In total, 10,135 vaccine doses were administered to 8,073 students. The three most administered vaccines were influenza (7,312 doses), HPV (820 doses), and hepatitis A (529 doses). Other vaccines administered included hepatitis B, measles, mumps, and rubuella (MMR), meningitis, polio (IPV), tetanus, diphtheria (Td), tetanus, diphtheria, pertussis (Tdap), and varicella (chicken pox).[24]**

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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 June 30 who had received dental services at any point during the previous State Fiscal Year.

SIGNIFICANCE

Dental caries (tooth decay) is a common chronic disease among children. Poor oral health has immediate and serious negative impacts on children's overall health, school attendance, and academic achievement.[1,2]

Insurance is a strong predictor of access to health and dental care. More than one in five (21%) uninsured U.S. children have unmet dental needs, compared with 5% of those with Medicaid and 4% of those with private health insurance.[3] In 2012, 89% of children in Rhode Island had dental insurance that paid for routine dental care, up from 73% in 2001.[4,5]

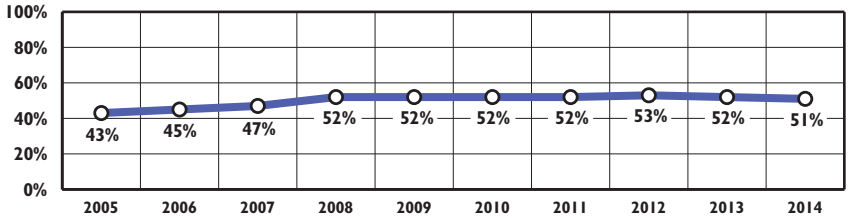
Children living in poverty are more likely to have untreated tooth decay than higher-income children. Medicaid-eligible children are twice as likely to have dental disease as higher-income children, although children with Medicaid coverage have better access to dental care than those without insurance. For children in low-income families, the efficacy and continuity of public dental insurance is a critical factor in access to dental care. In the U.S. and in Rhode Island, children who have public health insurance coverage have greater access to dental and medical care than children who have no insurance.[6,7,8]

Minority children have the highest rates of tooth decay and untreated dental problems. In Rhode Island and the U.S., non-Hispanic White children are more likely to have had a recent dental visit than non-Hispanic Black or Hispanic children.[9,10,11]

Poor oral health during pregnancy has been shown to be a potential risk factor contributing to pregnancy complications and poor birth outcomes, including preterm birth and low birthweight infants.[12,13] Although oral health care can be safely delivered during pregnancy, only half (53%) of Rhode Island women report having a dental visit during their pregnancy. Women with low incomes are less likely to see a dentist; 41% of women with RIte Care coverage and 42% of women participating in WIC reported a dental visit during their pregnancy.[14]

Children with special health care needs may have problems finding and accessing providers who are trained and equipped to address their special dental, medical, behavioral, and mobility needs. A dental home can provide comprehensive, continuously accessible, coordinated, and family-centered care for all children, especially those with special needs.[15,16]

Children Enrolled in Medical Assistance* Programs Who Received Any Dental Service, Rhode Island, SFY 2005-2014



Source: Rhode Island Executive Office of Health and Human Services, State Fiscal Years (SFY) 2005-2014.
*Medical Assistance includes RIte Care, RIte Share, and Medicaid fee-for-service.

◆ **Half (51%) of the children who were enrolled in RIte Care, RIte Share, or Medicaid fee-for-service on June 30, 2014 received a dental service during State Fiscal Year (SFY) 2014, up from 43% in SFY 2005 and down from 52% in SFY 2013.[17] Rhode Island ranked 29th in the nation for percent of children enrolled in Medicaid with a dental visit in 2012.[18]**

◆ **States are required to provide comprehensive dental benefits to children with Medicaid coverage as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.[19] New federal targets have been established for all states to increase preventive dental services for children with Medicaid and CHIP coverage by 10% between Federal Fiscal Year (FFY) 2010 and FFY 2015. Rhode Island's target baseline is 43% and the goal is 53%.[20] In FFY 2013, 40% of children with Medicaid in Rhode Island received a preventive dental visit.[21]**

◆ **RIte Smiles, Rhode Island's managed care oral health program for children born on or after May 1, 2000, has been credited with improving access to dental care (both preventive and treatment services) for young children.[22,23,24] As of December 31, 2014, there were 74,709 children enrolled in RIte Smiles, more than double the 34,000 children enrolled at launch in 2006.[25,26]**

◆ **The federal *Affordable Care Act (ACA)* made pediatric dental benefits mandatory offerings for plans sold in the individual and small group market.[27] As of November 2014, 1,282 children obtained commercial dental coverage through HealthSource RI (Rhode Island's state-based insurance marketplace).[28]**

Dental Provider Participation in Medicaid and RIte Smiles

◆ Nationally, children and adults with public insurance coverage face access problems because many private dentists do not accept Medicaid for payment. Dental providers cite low reimbursement rates, administrative requirements, and patient-related issues (e.g., missed appointments and poor treatment compliance) as reasons why they do not see more patients with Medicaid coverage. Additional access barriers for children and families with public insurance include difficulty with transportation, limited language proficiency, lack of oral health literacy, and negative provider experiences.[29,30]

◆ Since RIte Smiles (Rhode Island's managed care oral health program) started in 2006, reimbursement rates have been raised for participating dental providers.[31] The number of dentists accepting qualifying children increased from 27 before RIte Smiles began to 90 at the launch of RIte Smiles.[32] In October 2014, there were 351 dentists in 608 locations participating in RIte Smiles.[33]

◆ General dentists and dental specialists who provide dental care to older children who do not qualify for enrollment in RIte Smiles continue to be reimbursed at the Medicaid fee-for-service reimbursement rate.[34] Medicaid reimbursement rates often lag behind fees charged by dental providers and private commercial rates, which reduces incentives for providers to treat children with Medicaid coverage. In 2013, Rhode Island had the second lowest Medicaid fee-for-service reimbursement rate for pediatric dental services in the nation.[35]

Consequences of Untreated Dental Problems

◆ Between 2009 and 2013, an average of 730 children and youth under age 21 were treated for a primary dental-related condition in Rhode Island emergency departments annually. Of these children and youth, 19% were ages five and under, 15% were ages six to 11, 16% were ages 12 to 17, and 50% were age 18-21.[36]

◆ Each year between 2009 and 2013 in Rhode Island, an average of 64 children under age 19 were hospitalized with a diagnosis that included an oral health condition. During this time period, an average of 19 children per year under age 19 were hospitalized with an oral health condition as the primary reason for the hospitalization.[37]

Importance of Early Dental Visits for Young Children

◆ Clinical recommendations are that children first visit the dentist before age one.[38] However, only 1.8% of infants and one year old children in the U.S. have ever visited a dentist, compared with 89% who have seen a physician annually.[39] Half of children in the U.S. do not see a dentist until after age five.[40] In Rhode Island, children under age six (63%) are less likely to have received a dental check-up or cleaning in past year than children over age six (93% of 6-11 year olds and 90% of 12-17 year olds).[41]

◆ In 2012, 29% of children ages three to five enrolled in a sample of Rhode Island Head Start programs were found to have dental decay; 25% had dental decay that was untreated.[42]

◆ There are too few dentists trained to treat very young children, and too few who treat children with special health care needs or those who have public insurance.[43] Primary care providers can conduct oral health assessments, refer for dental care, and provide preventive services, all of which improve oral health outcomes and lead to a dental home.[44,45]

◆ In addition to covering dental visits for children before the age of one, Rhode Island is one of 40 state Medicaid programs that reimburse primary care medical providers for preventive oral health services for very young children, including risk assessment, caregiver education, and fluoride varnish application.[46,47,48]

References

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(continued on page 174)

Children's Mental Health

DEFINITION

Children's mental health is the number of acute care hospitalizations of children under age 18 with a primary diagnosis of a mental disorder. Hospitalization is the most intensive type of treatment for mental disorders and represents only one type of treatment category on a broad continuum available to children with mental health problems in Rhode Island.

SIGNIFICANCE

Mental health in childhood and adolescence is defined as the achievement of expected developmental, cognitive, social, and emotional milestones and the ability to have effective coping skills. Mental health status influences children's health and behavior at home, in child care or school, and in the community. Mental health conditions can impair academic achievement, increase involvement with the juvenile justice and child welfare systems, result in high treatment costs, diminish family incomes, and increase the risk for suicide. Children with mental health issues are also likely to have other chronic health conditions.[1,2,3,4]

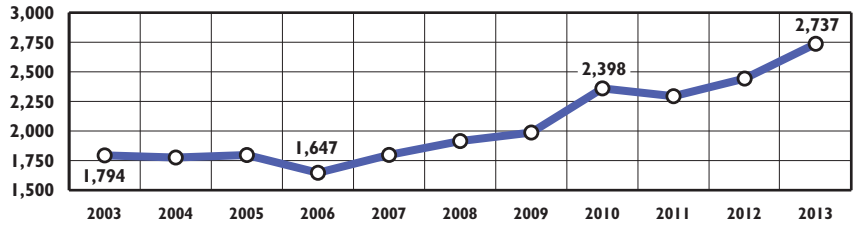
Behavioral health problems affect children of all backgrounds. In Rhode Island, one in five (19.0%) children ages six to 17 has a diagnosable mental health problem; one in ten (9.8%) has significant functional impairment.[5]

Children most at risk for mental disorders are those with prenatal exposure to alcohol, tobacco and other drugs; children born with low birthweight; those suffering abuse and neglect; children exposed to toxic stress; children of parents with a mental health disorder and/or an inherited predisposition to a mental disorder; and children living in poverty.[6,7] Young people in the juvenile justice and child welfare systems experience mental health problems at higher rates than their peers.[8]

Mental health problems, whether arising from biological, environmental, and/or psycho-social causes, affect the physical functioning of the brain and can be prevented or treated in many cases.[9,10] One survey found 34% of Rhode Island children who needed mental health treatment or counseling in the previous year did not receive it.[11]

Mental health treatment systems tend to be fragmented and crisis-driven with disproportionate spending on high-end hospital and residential care and often lack adequate investments in prevention and community-based services that would allow children to receive appropriate treatment levels of care in their own communities.[12,13,14,15,16] Over the past two decades, Rhode Island has worked to build a preventive and home- and community-based system of care, but more progress is still needed.[17,18,19]

Hospitalizations with Primary Diagnosis of Mental Disorder, Children Under Age 18, Rhode Island, 2003-2013*



Source: RI Hospital Discharge Database (HDD), RI Department of Health, 2003-2013. *Data are for hospitalizations, not number of children. Children may be hospitalized more than once. Mental disorders include ICD-9-CM codes 290-319, including alcohol/drug dependence, psychoses, anxiety and depressive, mood and personality disorders. Trend line is based on a new method of analyzing the HDD and is comparable to Factbooks since 2012.

◆ **In 2013, there were 2,737 hospitalizations of children with a primary diagnosis of mental disorder at Bradley, Butler, Hasbro Children's Hospital, Newport, and Memorial hospitals. This represents a 53% increase from 2003. This increase may be due to more children and youth being hospitalized for behavioral health problems, but it also has been partly attributed to the systemic problem of "pediatric boarders" and "stuck kids."[20,21]**

◆ **When a child or adolescent needs behavioral health treatment at an inpatient psychiatric hospital or in another placement in the community, but there is no appropriate placement available, they may wait for one day or more in emergency departments and/or be admitted to ("boarded at") medical floors at acute care hospitals. "Boarders" must wait for appropriate treatment and may require constant monitoring by staff so that they do not injure themselves or others.[22,23] In Federal Fiscal Year (FFY) 2014, 328 children and youth under age 18 with a psychiatric diagnosis were "boarded" for an average of two days at Hasbro Children's Hospital or Rhode Island Hospital. This is an increase from FFY 2013 (282), and a 15% reduction from FFY 2011, when 388 children were boarded.[24]**

◆ **When a child or adolescent is ready to leave the psychiatric hospital and needs a "step-down placement" of lesser clinical intensity but there is none available or there is no other safe placement at a treatment program or at home, they are referred to as "stuck." Bradley Hospital reported having an average of four stuck kids per day in FFY 2014. This is an increase from FFY 2013 when there were an average two stuck kids per day, but below the FFY 2011 average of five stuck kids per day.[25]**

Psychiatric Hospitals

Children Under Age 19 Treated at Rhode Island Psychiatric Hospitals, October 1, 2013-September 30, 2014 (FFY 2014)

	BRADLEY HOSPITAL GENERAL PSYCHIATRIC SERVICES		BRADLEY HOSPITAL DEVELOPMENTAL DISABILITIES PROGRAM		BUTLER HOSPITAL ADOLESCENT PSYCHIATRIC SERVICES	
	# TREATED	AVERAGE LENGTH OF STAY	# TREATED	AVERAGE LENGTH OF STAY	# TREATED	AVERAGE LENGTH OF STAY
Inpatient	1,054*	10 days	99*	27 days	501**	9 days
Residential	18	175 days	29	85 days	– –	– –
Partial Hospitalization	895*	16 days	14*	16 days	87	5 visits
Home-Based	– –	– –	20*	65 visits	– –	– –
Outpatient	2,014*	4 visits	34*	4 visits	42	NA

Source: Lifespan, 2013-2014 and Butler Hospital, 2013-2014. Programs can have overlapping enrollment. Number treated is based on the hospital census (i.e., the number of patients seen in any program during FFY 2014) unless otherwise specified. *Number treated is based on admissions. The average length of stay is based on discharges. **An additional 82 youth were treated in adult programs.

-- = Service not offered. NA = Data not available for this service.

◆ The two hospitals in Rhode Island that specialize in providing psychiatric care to children and youth are Bradley Hospital and Butler Hospital. In October 2012, Butler Hospital transferred its child and adolescent intensive treatment inpatient beds to adult inpatient beds. Children and adolescents needing this level of care are now referred to other inpatient providers.

◆ Inpatient treatment at a psychiatric hospital is the most intensive type of behavioral health care. The most common diagnoses for young people treated at Butler or Bradley Hospitals in FFY 2014 in an inpatient setting were depressive disorders (41%), bipolar disorders (38%), anxiety disorders (12%), and adjustment disorders (5%).[26,27]

◆ Bradley Hospital has a Developmental Disabilities Program that offers highly specialized inpatient and residential services to children and adolescents who show signs of serious emotional and behavioral problems in addition to developmental disabilities. Lifespan School Solutions owns and operates five Bradley schools for children with behavioral health problems and developmental disabilities, which together had an average daily enrollment of 365 students in FFY 2014.[28]

Rhode Island's Community Mental Health Organizations

◆ The six Community Mental Health Organizations (CMHOs) in Rhode Island are the primary source of public mental health treatment services available in the state for children and adults. During 2014, 6,099 children under age 18 were treated at CMHOs, and 4,037 children were receiving treatment as of December 31, 2014.[29]

◆ Among the children who receiving services through Rhode Island's CMHOs in 2014, 24% had a primary diagnosis of attention deficit disorders, 22% had depressive-related disorders, 16% had anxiety disorders, and 13% had conduct disorders.[30]

Child and Adolescent Intensive Treatment Services (CAITS)

◆ The CAITS program, which is administered by the Rhode Island Executive Office of Health and Human Services as an in-plan benefit under RIte Care, aims to reduce inpatient psychiatric hospitalizations and residential treatment among Medicaid-eligible children and youth with moderate to severe emotional and/or behavioral disorders. CAITS provides up to 16 weeks of intensive, home- and community-based treatment via individual and/or family therapy, family training, and support worker services per year.[31]

◆ In State Fiscal Year 2014, 1,960 children and youth received services from 15 CAITS provider agencies. Nearly half (49%) of the youth served by CAITS were over age 12, while 37% were ages six to 11, and 14% were age five or younger.[32]

Suicide Among Rhode Island Children and Youth

◆ Children and youth with mental health conditions are at increased risk for suicide.[33] In 2013, 14% of Rhode Island high school students reported attempting suicide one or more times during the past year, up from 10% in 1997.[34] In Rhode Island between 2009 and 2013, there were 916 emergency department visits and 406 hospitalizations of youth ages 13-19 due to suicide attempts.[35] Twenty-four children and youth under age 20 died due to suicide in Rhode Island between 2009 and 2013.[36]

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(continued on page 175)

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 generally by children. Special needs can be physical, developmental, behavioral, or emotional. This indicator measures the number of children enrolled in Early Intervention, special education, Supplemental Security Income (SSI) and Medical Assistance for children with special health care needs.

SIGNIFICANCE

An estimated 20% of children in the U.S. and 21% of children in Rhode Island have at least one special health care need.[1] Children with special health care needs (CSHCN) can have impairments of varying degrees in physical, developmental, emotional, and/or behavioral functioning.[2] Parental reports of developmental screening for young children during health care visits in Rhode Island increased from 15% in 2007 to 32% in 2012.[3] Nationally, 41% of CSHCN have two or more special health needs. Health conditions most commonly reported are Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, asthma, learning disabilities, speech problems, developmental delay, behavioral problems, anxiety, and depression.[4]

Children with mild or severe disabling conditions have special needs related to physical health, mental health, education, family support, housing, child care, and recreation.[5] Health-related needs are best met via a comprehensive, coordinated, continuous, accessible, and family-centered medical home.[6]

In 2013, 21% of Rhode Island public high school students reported having a disability. These students with disabilities reported experiencing physical fights, being electronically bullied and being bullied at school, and acute depression more frequently than their non-disabled peers. Rhode Island high school students with disabilities also reported higher rates of inactivity, poor academic achievement, and risky behaviors, including being sexually active, smoking tobacco, drinking, riding with a driver who drank alcohol, and marijuana use.[7]

Children with disabilities may require medical services, equipment, assistive technology or home modifications that may result in serious financial burdens on families.[8,9,10] Having children with special needs significantly impacts parents' finances, employment and family lives.[11,12] Adequate and affordable health insurance coverage for primary and specialty care, mental health and oral health care is important for CSHCN. Many families experience financial hardships due to lack of insurance or underinsurance.[13,14,15]

Children Enrolled in Early Intervention

◆ **States are required by the federal *Individuals with Disabilities Education Act (IDEA) Part C* to identify and provide appropriate Early Intervention services to all infants and toddlers under age three who have developmental delays or have a diagnosed physical or mental condition that is associated with a developmental delay.[16]**

◆ **In Rhode Island in 2014, 11 certified Early Intervention (EI) provider agencies served 4,339 children. As of June 30, 2014, there were 2,184 children enrolled in EI (6% of all children under age three). Of those children, nearly two-thirds (64%) of children receiving EI services were male and just over one-third (36%) were female. EI enrollment was not evenly distributed among children by age, with 17% less than one year old, 32% between ages one and two, and 51% between ages two and three during that time period.[17]**

Children Enrolled in Special Education

◆ **Under *IDEA Part B*, local school systems are responsible for identifying, evaluating, and serving students ages three to 21 who have disabilities that might require special education and related services.[18]**

◆ **As of June 30, 2014 in Rhode Island, there were 2,786 children ages three to five who received special education services.[19]**

◆ **In Rhode Island as of June 30, 2014, 15% (20,906) of students in public schools ages six to 21 received special education services. Thirty-eight percent of students receiving special education services in Rhode Island had a learning disability.[20]**

◆ **Early Intervention (EI) programs are required to provide transition services for children who are enrolled in EI and who may be eligible for special education at age three. In 2014, 65% of the 1,047 children who reached age three while in EI were determined to be eligible for preschool special education, 20% were found not eligible for special education and 11% did not have eligibility determined when exiting EI. The remainder completed their service plan prior to reaching the maximum age for EI, moved out of state, withdrew, or were otherwise unreachable for follow-up.[21]**

Medical Assistance for Children With Special Health Care Needs

◆ As of December 31, 2014, there were 5,498 Rhode Island children and youth under age 19 receiving Medical Assistance benefits through their enrollment in the federal Supplemental Security Income (SSI) program.[22,23]

◆ In Rhode Island, the Katie Beckett eligibility provision provides Medical Assistance coverage to children under age 19 who have serious disabling conditions, in order to enable them to be cared for at home instead of in an institution.[24] As of December 31, 2014, there were 999 Rhode Island children enrolled through the Katie Beckett provision, a decline of 44% from the peak enrollment of 1,770 in 2007.[25,26]

◆ Children with special needs enrolled in Medical Assistance in Rhode Island have shown significant gains in access to needed health services and reductions in emergency care and hospitalization use over the past decade.[27,28]

Children With Special Needs in the Child Welfare System

◆ Children and youth who are in the child welfare system are more likely to have special needs, including behavioral and emotional problems, developmental delays, and serious health problems than other children. Children often enter the child welfare system in poor health and face difficulties accessing services while in care.[29,30]

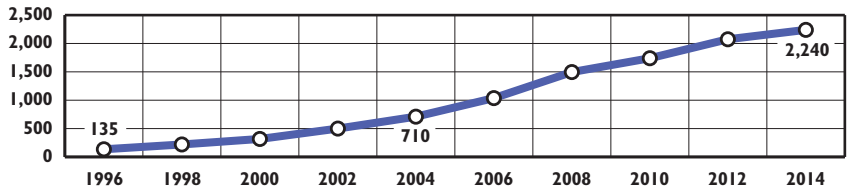
◆ As of December 31, 2014, 2,054 children in Rhode Island were enrolled in Medical Assistance through the child welfare system.[31] Per provisions of the federal *Affordable Care Act (ACA)*, all youth who turned age 18 while in foster care are eligible for Medicaid coverage until they reach age 26 in the state in which they aged out of care.[32,33] In Rhode Island, estimates show that nearly half (49%) of all eligible former foster youth were not enrolled in Medicaid coverage as of December 31, 2014.[34]

◆ Children who are adopted through the Rhode Island Department of Children, Youth and Families and have special needs may qualify for Medical Assistance coverage. As of December 31, 2014, 2,294 children were enrolled in Medical Assistance because of special needs adoptions.[35]

Children With Autism Spectrum Disorder (ASD)

◆ Autism Spectrum Disorder (ASD) is a developmental disability that can cause significant social, communication, and behavioral challenges. Children diagnosed with ASD have a variety of symptoms and experience challenges and abilities that range widely in severity. Many children with ASD face challenges in social interaction, speech/language, and communication and demonstrate repetitive behaviors and routines.[36,37]

Children Ages Three to 21 With Autism Spectrum Disorders (ASD), Rhode Island, December 1996-June 2014



Source: Rhode Island Department of Education, Office of Student, Community and Academic Supports, December 1996-June 2014. All data prior to 2000 is a December point-in-time run, and all data starting in 2000 and beyond are a June point-in-time run. Numbers include parentally placed students.

◆ The national ASD prevalence (including mild to severe disorders) among children age eight is estimated to be one out of every 68 children (one in 42 boys and one in 189 girls).[38] In June 2014, there were 2,240 Rhode Island children ages three to 21 with ASD who received special education services.[39] The increase in number of children with ASD has been attributed, in part, to improved awareness and better screening and evaluation tools, as well as the broadening of the definition of ASD.[40,41,42]

◆ Early and appropriate identification and sustained interventions can result in improvements in the levels of independent functioning of children and youth with ASD and long-term life outcomes. ASD interventions are costly and require skilled professionals to deliver them, often resulting in gaps in access.[43,44,45]

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(continued on page 175)

Infants Born at Highest Risk

DEFINITION

Infants born at highest risk is the percentage of babies born to Rhode Island women who were under age 20, unmarried and had fewer than 12 years of education.

SIGNIFICANCE

The basic architecture of the human brain develops during the infant and toddler years. By age three, a child's brain has grown to 90% of its adult size and the foundation of many cognitive structures and systems are in place. Early experiences lay the foundation for future learning, and strong, positive relationships are the building blocks for healthy development. Babies who have positive, predictable relationships with parents and other caregivers have a sturdy foundation to achieve healthy growth and development, while babies who do not have a strong relationship with a nurturing caregiver often encounter challenges in future learning and development.[1,2,3]

Infancy is a time of great opportunity and vulnerability. A child's development can be compromised by "toxic stress" and a variety of risk factors in infancy, including poverty, maternal depression, family chaos, exposure to violence, child maltreatment, and unsafe, low-quality child care.[4,5]

Maternal marriage status, age, and education level at birth influence the likelihood that a child will live in poverty and predict many developmental vulnerabilities. When a child is born to a teenage, unmarried mother who has not graduated from high school, he or she is nine times more likely to grow up in poverty than a child born to a married woman over age 20 with a high school diploma.[6] Most children facing these three economic and social risk factors at birth continue to face great challenges throughout childhood. In 2014 in Rhode Island, 210 babies (2% of all babies) were born to unmarried teen mothers without high school diplomas.[7]

Providing early and intensive support to families with multiple risk factors can help parents develop critical nurturing skills.[8] Evidence-based home visiting programs for vulnerable families beginning during pregnancy (or as early as possible) and continuing through infancy and toddlerhood improve outcomes for children facing significant adversity.[9]

Rhode Island offers three evidence-based home visiting programs shown to improve outcomes in vulnerable families – Nurse-Family Partnership, Healthy Families America, and Parents as Teachers.[10]

Declines in Overall Births and Infants Born at Highest Risk

◆ **The U.S. birth rate has been declining in recent years, and in 2013, reached another historic low. The most recent decline began in 2007 coinciding with the national economic recession.[11,12] Rhode Island has the sixth lowest birth rate in the U.S.[13]**

◆ **The total number of babies born to Rhode Island women has declined 7% between 2009 and 2014. The number of infants born at highest risk (babies born to unmarried teen mothers without a high school diploma) has fallen 64% in the same time period.[14]**

◆ **Between 2009 and 2014 in Rhode Island, the proportion of births to single mothers remained steady around 47%, births to mothers without a high school diploma fell from 16% to 12% and births to teen mothers fell from 9% to 6% of all births.[15]**

◆ **All babies born in Rhode Island are screened through the Rhode Island Department of Health's Newborn Risk Assessment Program. In 2014, there were 6,692 babies born (64% of all babies born) who "screened positive," indicating the presence of one or more risk factors associated with poor developmental outcomes.[16]**

Babies Born with Exposure to Opioids or Alcohol

◆ **Babies born with exposure to alcohol and/or opioids (pain medication) face immediate and long-term negative effects.[17,18] Births of babies with Neonatal Abstinence Syndrome (NAS) have been on the rise in Rhode Island and nationwide. NAS refers to the withdrawal and negative effects experienced by newborns born to mothers who used opioids during pregnancy. NAS is associated with increased risk of prematurity, respiratory and gastrointestinal complications, low birthweight, and seizures, as well as neurological and central nervous system problems and developmental delays.[19,20]**

◆ **In Rhode Island in 2013, 76 babies were diagnosed with NAS at birth, a rate of 72.0 per 10,000 births, nearly double the rate of 37.2 in 2006. Ninety percent of babies born with NAS between 2009-2013 in Rhode Island were born to white mothers and 32% lived in the four core cities.[21]**

◆ **In Rhode Island between 2009-2013, 16 babies were diagnosed with Fetal Alcohol Syndrome at birth.[22] Babies exposed to alcohol while in utero can display a range of symptoms and developmental delays.[23]**

Table 16.

Infants Born at Highest Risk, Rhode Island, 2014

CITY/TOWN	TOTAL # OF BIRTHS	BIRTHS TO MOTHERS WITHOUT A HIGH SCHOOL DIPLOMA	BIRTHS TO SINGLE MOTHERS	BIRTHS TO MOTHERS YOUNGER THAN AGE 20	BIRTHS TO MOTHERS WITH ALL 3 RISK FACTORS	% OF BIRTHS WITH ALL 3 RISK FACTORS
Barrington	106	2	7	0	0	0%
Bristol	131	5	53	4	0	0%
Burrillville	130	12	54	7	0	0%
Central Falls	322	111	245	44	21	7%
Charlestown	49	3	19	7	1	2%
Coventry	272	15	91	8	2	1%
Cranston	733	45	271	27	6	1%
Cumberland	320	11	83	6	3	1%
East Greenwich	118	3	25	3	0	0%
East Providence	446	25	184	19	5	1%
Exeter	46	5	21	5	4	9%
Foster	45	2	15	3	2	4%
Glocester	64	1	15	3	0	0%
Hopkinton	74	4	30	2	2	3%
Jamestown	21	0	2	0	0	0%
Johnston	235	17	90	10	2	1%
Lincoln	198	9	67	4	2	1%
Little Compton	11	0	5	0	0	0%
Middletown	159	3	33	6	1	1%
Narragansett	58	3	27	3	1	2%
New Shoreham	9	0	4	0	0	0%
Newport	211	19	94	7	3	1%
North Kingstown	232	12	77	8	2	1%
North Providence	354	18	156	15	4	1%
North Smithfield	74	4	23	3	0	0%
Pawtucket	978	152	577	67	25	3%
Portsmouth	98	3	23	3	1	1%
Providence	2,510	513	1,562	208	84	3%
Richmond	59	5	16	1	0	0%
Scituate	80	2	23	1	0	0%
Smithfield	111	5	25	1	1	1%
South Kingstown	145	7	45	2	1	1%
Tiverton	70	5	22	3	1	1%
Warren	88	7	39	4	1	1%
Warwick	712	40	243	20	4	1%
West Greenwich	48	4	14	3	1	2%
West Warwick	351	40	180	21	7	2%
Westerly	156	8	56	4	1	1%
Woonsocket	543	101	361	46	22	4%
Unknown	*24*	*0*	*4*	*1*	*0*	*NA*
Four Core Cities	*4,353*	*877*	*2,745*	*365*	*152*	*3%*
Remainder of State	*6,014*	*344*	*2,132*	*213*	*58*	*1%*
Rhode Island	*10,391*	*1,221*	*4,881*	*579*	*210*	*2%*

Source of Data for Table/Methodology

Rhode Island Department of Health, KIDSNET Database, 2014. This table shows the number and percentage of all births with three risk factors that place a child at very high risk for poor developmental outcomes.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in numerators and denominators.

References

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(continued on page 176)

Evidence-Based Family Home Visiting

DEFINITION

Evidence-based family home visiting is the number of families enrolled in evidence-based family home programs managed by the Rhode Island Department of Health.

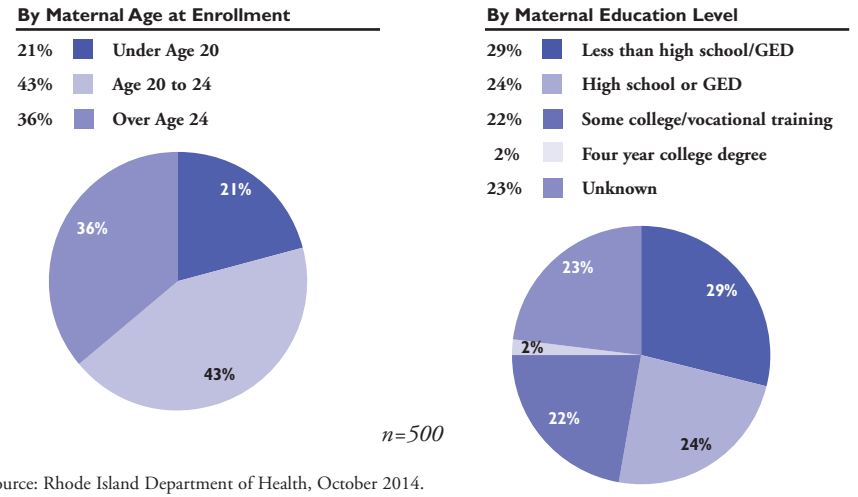
SIGNIFICANCE

Parents are the most important individuals in a child's life, particularly during infancy and early childhood. Infants and toddlers who receive responsive, nurturing care and are provided with opportunities to learn have a strong foundation for success. When parents lack the knowledge or resources to meet the needs of their babies, the child's health, development, and learning trajectory is threatened.[1,2]

Home visiting programs are designed to reach young children and their families at home. Each program is different, but all provide parenting education to foster healthy, safe, and stimulating environments for young children. Children in at-risk families who participate in high-quality home visiting programs have improved language, cognitive, and social-emotional development and are less likely to experience child abuse and neglect. Families who participate are more likely to provide an enriching home environment, use appropriate discipline strategies, and become more economically secure through education and employment. Some home visiting programs can also improve maternal and child health, reducing long-term health care costs.[3,4,5]

In 2010, federal legislation established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to expand and improve state-administered home visiting programs for at-risk families with young children. The majority of funding must be spent by states on approved models that meet rigorous evidentiary standards.[6] As of September 2014, there are 17 home visiting models that have been identified as effective, evidence-based programs for families during the prenatal period and early childhood years, with evidence showing they produce statistically significant improvements in outcomes for children and families.[7] Rhode Island uses MIECHV funding to support implementation of three of these evidence-based models: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers.[8] In order to achieve improved outcomes for children, evidence-based programs must follow national program guidelines, use professional staff trained in the model, be implemented in the appropriate timeframes, and be implemented with fidelity.[9]

Families Enrolled in Evidence-Based Family Home Visiting Programs, Rhode Island, October 2014



Source: Rhode Island Department of Health, October 2014.

◆ **As of October 2014, there were 500 families enrolled in one of the three MIECHV-funded evidence-based home visiting programs in Rhode Island (up from 288 in 2013). Of these, 88% lived in one of the four core cities and 12% lived in the remainder of the state.[10]**

◆ **Home-based Early Head Start is also recognized as an evidence-based home visiting program that improves child outcomes.[11] As of October 2014 in Rhode Island, there were 373 children enrolled in home-based Early Head Start.[12]**

◆ **Early Intervention (EI) programs serve infants and toddlers with developmental delays and disabilities in Rhode Island and deliver the majority of their services (94%) through home visits. As of June 2014, there were 2,184 children enrolled in EI in Rhode Island.[13]**

First Connections

◆ **Rhode Island also operates First Connections, a statewide, short-term home visiting program designed to help families get connected to needed resources.[14] In 2014, 3,801 children received at least one First Connections home visit. Fifty-seven percent of the children lived in one of the four core cities and 43% lived in the remainder of the state.[15]**

Table 17.

Evidence-Based Family Home Visiting, Rhode Island, 2014

CITY/TOWN	COMMUNITY CONTEXT, 2014			# RECEIVED FIRST CONNECTIONS VISIT IN 2014	# FAMILIES ENROLLED IN EVIDENCE-BASED HOME VISITING PROGRAMS, OCTOBER 1, 2014			
	TOTAL # OF BIRTHS	% OF BIRTHS WITH 1 OR MORE RISK FACTORS	% OF BIRTHS WITH 3 OR MORE KEY RISK FACTORS		HEALTHY FAMILIES AMERICA	NURSE-FAMILY PARTNERSHIP	PARENTS AS TEACHERS*	TOTAL
Barrington	106	27%	0%	8	0	0	0	0
Bristol	131	59%	0%	35	0	0	0	0
Burrillville	130	61%	0%	24	2	0	0	2
Central Falls	322	89%	7%	226	34	24	6	64
Charlestown	49	51%	2%	11	0	0	0	0
Coventry	272	56%	1%	81	0	0	0	0
Cranston	733	57%	1%	199	4	1	0	5
Cumberland	320	43%	1%	62	3	0	0	3
East Greenwich	118	34%	0%	19	0	0	0	0
East Providence	446	61%	1%	127	1	0	0	1
Exeter	46	59%	9%	15	0	0	0	0
Foster	45	56%	4%	8	0	0	0	0
Glocester	64	47%	0%	11	0	0	0	0
Hopkinton	74	50%	3%	11	0	0	0	0
Jamestown	21	38%	0%	3	0	0	0	0
Johnston	235	61%	1%	68	0	0	0	0
Lincoln	198	47%	1%	34	1	3	0	4
Little Compton	11	55%	0%	2	0	0	0	0
Middletown	159	39%	1%	35	3	0	0	3
Narragansett	58	69%	2%	19	0	0	0	0
New Shoreham	9	56%	0%	0	0	0	0	0
Newport	211	61%	1%	69	17	2	0	19
North Kingstown	232	53%	1%	70	3	0	0	3
North Providence	354	59%	1%	92	3	0	0	3
North Smithfield	74	54%	0%	22	0	0	0	0
Pawtucket	978	76%	3%	462	39	40	22	101
Portsmouth	98	41%	1%	24	1	0	0	1
Providence	2,510	80%	3%	1,261	122	57	35	214
Richmond	59	42%	0%	25	0	0	0	0
Scituate	80	44%	0%	16	0	0	0	0
Smithfield	111	38%	1%	22	0	0	0	0
South Kingstown	145	52%	1%	34	1	0	1	2
Tiverton	70	44%	1%	12	0	0	0	0
Warren	88	69%	1%	12	1	0	0	1
Warwick	712	52%	1%	231	4	0	0	4
West Greenwich	48	52%	2%	11	0	0	0	0
West Warwick	351	65%	2%	176	3	2	0	5
Westerly	156	54%	1%	63	3	0	0	3
Woonsocket	543	79%	4%	201	36	11	15	62
Unknown Residence	*24*	*42%*	*0%*	*0*	*0*	*0*	*0*	*0*
Four Core Cities	*4,353*	*79%*	*3%*	*2,150*	*231*	*132*	*78*	*441*
Remainder of State	*6,038*	*54%*	*1%*	*1,651*	*50*	*8*	*1*	*59*
Rhode Island	*10,391*	*64%*	*2%*	*3,801*	*281*	*140*	*79*	*500*

Source of Data for Table/Methodology

The number of births, the percentage of births by risk factor, the number of families that received a First Connections visit, and the number of families enrolled in an evidence-based home visiting program are from the Rhode Island Department of Health, 2014. Percentage of births with one or more risk factor is "risk positive" definition from the Developmental Risk Assessment. Percentage of births with three key risk factors are births to unmarried mothers under age 20 without a high school diploma.

*The city/town table only includes families enrolled in MIECHV-funded Parents as Teachers programs. There are other Parents as Teachers programs in Rhode Island.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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Women with Delayed Prenatal Care

DEFINITION

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

SIGNIFICANCE

Early prenatal care is an important way to identify and treat health problems as well as 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 poor birth outcomes such as having babies who are low birthweight or who die within the first year of life.[1]

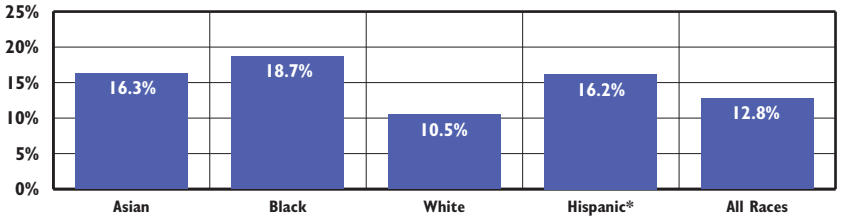
Effective prenatal care screens for and intervenes with a range of maternal needs including nutritional, social support, mental health, smoking cessation, substance use, domestic violence, and unmet needs for food and shelter.[2,3,4] A prenatal visit is the first step in establishing an infant's medical home and can provide valuable links to other health services.[5,6]

Timely initiation of prenatal care is especially important for women who face multiple risks for poor birth outcomes, as is ensuring access to preconception health care services before pregnancy. Effective monitoring and treatment of chronic disease, education on preventive health practices, implementing and enhancing Medicaid policies to improve health insurance coverage, and ensuring access to culturally and linguistically competent health providers can improve prenatal care for women of child-bearing age.[7]

Barriers to prenatal care include not knowing one is pregnant, not being able to get an appointment or start care when desired, lack of transportation or child care, inability to get time off work, and/or financial constraints, including lack of insurance and/or money to pay for care. Rhode Island women with delayed or no prenatal care were more likely to report their pregnancy was unintended than women who initiated care in the first trimester.[8]

In Rhode Island between 2009 and 2013, 12.8% of women who gave birth either received no prenatal care or did not begin care until the second or third trimester. Pregnant adolescents in Rhode Island are the most likely to delay prenatal care. Between 2009 and 2013, nearly one-quarter (23.3%) of pregnant teens ages 19 and under received delayed prenatal care, compared with 11.9% of pregnant women ages 20 and over.[9]

Women With Delayed Prenatal Care by Race/Ethnicity, Rhode Island, 2009-2013



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Database, 2009-2013. Data for 2013 are provisional. *Hispanic may be included in any racial category.

◆ **Between 2009 and 2013 in Rhode Island, Black women (18.7%), Asian women (16.3%), and Hispanic* women (16.2%) were more likely to receive delayed prenatal care than White women (10.5%).[10]**

◆ **Between 2009 and 2013 in Rhode Island, the rate of delayed prenatal care among pregnant women in the four core cities (16.6%) was higher than the rate among pregnant women in the remainder of the state (10.1%).[11]**

Insurance Coverage Improves Access to Prenatal Care

◆ **In the U.S. and Rhode Island, women with commercial insurance have the highest rates of timely prenatal care. Rhode Island women who were most likely to initiate care in the first trimester were older, married, and had higher levels of education.[12,13]**

◆ **Between 2009 and 2013, pregnant women with health coverage through RIte Care coverage (Rhode Island's Medicaid managed care health program) were much less likely (18.0%) to receive delayed prenatal care than women who were uninsured (33.3%). Pregnant women with private insurance coverage were the least likely to receive delayed prenatal care (7.7%) during this time period.[14]**

◆ **RIte Care has had a positive impact on the accessibility, timeliness, and quality of health care services for its members. RIte Care health plans rank above the 90th percentile in member access to timely prenatal care when compared to other Medicaid health plans in the nation.[15]**

Women with Delayed Prenatal Care

Table 18. **Delayed Prenatal Care, Rhode Island, 2009-2013**

CITY/TOWN	# BIRTHS	# DELAYED CARE	% DELAYED CARE
Barrington	497	43	NA
Bristol	812	86	10.6%
Burrillville	655	76	11.6%
Central Falls	1,654	256	15.5%
Charlestown	269	14	NA
Coventry	1,444	155	10.7%
Cranston	3,915	456	11.6%
Cumberland	1,586	135	8.5%
East Greenwich	524	55	10.5%
East Providence	2,536	240	9.5%
Exeter	257	22	NA
Foster	146	20	NA
Glocester	365	41	NA
Hopkinton	357	28	NA
Jamestown	120	12	NA
Johnston	1,318	156	11.8%
Lincoln	904	85	9.4%
Little Compton	84	2	NA
Middletown	845	72	8.5%
Narragansett	405	34	NA
New Shoreham	55	3	NA
Newport	1,366	114	8.3%
North Kingstown	992	86	8.7%
North Providence	1,533	168	11.0%
North Smithfield	433	43	NA
Pawtucket	5,020	796	15.9%
Portsmouth	593	36	6.1%
Providence	13,131	2,261	17.2%
Richmond	365	22	NA
Scituate	310	36	NA
Smithfield	615	43	7.0%
South Kingstown	947	75	7.9%
Tiverton	572	46	8.0%
Warren	470	72	NA
Warwick	3,888	413	10.6%
West Greenwich	240	26	NA
West Warwick	1,843	262	14.2%
Westerly	1,030	74	7.2%
Woonsocket	3,056	482	15.8%
Unknown	*17*	*1*	*NA*
Four Core Cities	*22,861*	*3,795*	*16.6%*
Remainder of State	*32,291*	*3,251*	*10.1%*
Rhode Island	*55,169*	*7,047*	*12.8%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013. Data for 2013 are provisional.

The denominator is the total number of live births to Rhode Island residents from 2009-2013.

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

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in numerators and denominators.

*The Rhode Island Birth Worksheet was changed in 2008 to allow for multiple race and Hispanic options for the first time, resulting in a decline in the number of women reported as White and an increase in women coded as "other."

During 2004, data on delayed prenatal care began to be collected via a review of medical records, rather than via self report by the mother. Due to this change in methodology, data in this indicator only are comparable to Factbooks since 2009.

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Preterm Births

DEFINITION

Preterm births is the percentage of births occurring before the 37th week of pregnancy. The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

Preterm birth is a major determinant of infant mortality and morbidity in the U.S. Infants born before 37 weeks gestation are at higher risk than full-term infants for neurodevelopmental, respiratory, gastrointestinal, immune system, central nervous system, hearing, dental, and vision problems. Children who were born preterm may experience physical disabilities, learning difficulties, and behavioral problems later in life.[1,2,3]

While the specific causes of spontaneous preterm births are largely unknown, research indicates that there are a number of inter-related risk factors involved. The three leading risk factors are a history of preterm birth, current multifetal pregnancy, and uterine and/or cervical abnormalities. Other risk factors include infections, diabetes, hypertension, late or no prenatal care, stress, domestic violence, and maternal use of tobacco, alcohol, and other drugs.[4,5]

Even "late preterm" infants (34-36 weeks gestation) can experience immediate and long-term complications. Infants born very preterm (<32 weeks gestation) are at highest risk for death and life-long disability, high hospitalization costs during their first year, and increased health care-related costs later in life.[6,7] Preventive interventions can improve outcomes for very preterm infants and their caregivers.[8,9]

After rising for more than two decades, the U.S. preterm birth rate has declined over the past seven years. In 2013, the U.S. preterm birth rate was 11.4%, a decrease of 11% from its peak in 2006. Preterm births also declined among White, non-Hispanic (down 13%), Black, non-Hispanic (down 12%), and Hispanic (down 8%) infants since 2006 in the U.S. While Black, non-Hispanic women continue to have the highest preterm birth rate, it has declined to a second consecutive historic low in 2013.[10] Preterm birth is a major contributor to infant mortality in the U.S., particularly among non-Hispanic Black, Native American/Alaska Native, and Puerto Rican infants.[11,12]

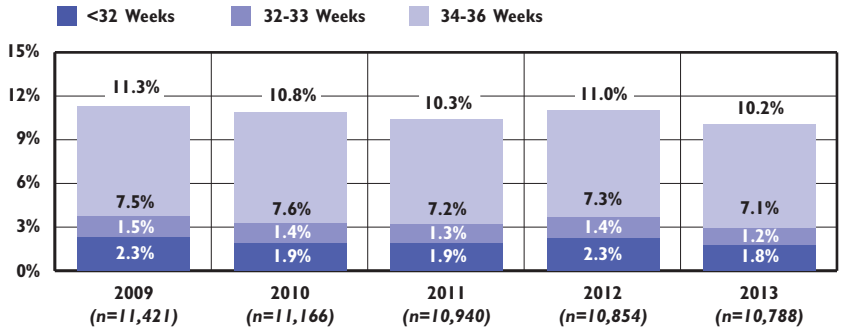
Preterm Births

	2003	2013
RI	11.6%	10.2%
US	12.3%	11.4%
National Rank*		*12th*
New England Rank**		*6th*

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

Sources: For 2013: Martin, J. A., et al. (2015). Births: Final data for 2013. *National Vital Statistics Reports, 64*(1), 1-65. For 2003: Martin, J. A., et al. (2005). Births: Final data for 2003. *National Vital Statistics Reports, 54*(2), 1-116.

Preterm Births by Gestational Age, Rhode Island, 2009-2013



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013. Percentages by gestational age may not sum to total percentage of preterm births due to rounding.

◆ **The single-year preterm birth rate in Rhode Island decreased from 11.0% in 2012 to 10.2% in 2013, after increasing in the year prior. In the five year period between 2009 and 2013, two-thirds (68.3%) of all preterm births in Rhode Island were late preterm births (34-36 weeks gestation) and 18.9% of all preterm births were very preterm (<32 weeks gestation).[13]**

◆ **Between 2009 and 2013, 14.7% of births of Black infants in Rhode Island were preterm, compared with 11.6% of Asian and 9.6% of White infants. During this same time period, 12.0% of births to Hispanic* women in Rhode Island were preterm (Hispanic women can be of any race).[14]**

◆ **Multiple births are more likely to be born preterm than singletons. In Rhode Island between 2009 and 2013, 56.4% of multiple births were preterm, compared with 9.0% of singleton births.[15]**

◆ **The rate of preterm births among teen girls under age 20 between 2009 and 2013 in Rhode Island was 12.3%, higher than the state's overall preterm birth rate (10.7%).[16]**

◆ **Among women with private health insurance coverage in Rhode Island between 2009 and 2013, 9.6% of births were preterm, compared with 11.7% of those with public insurance coverage (RIte Care or Medicaid) and 21.4% of births to women with no health insurance.[17]**

Table 19. **Preterm Births, Rhode Island, 2009-2013**

CITY/TOWN	# BIRTHS	# PRETERM BIRTHS	% PRETERM BIRTHS
Barrington	497	38	NA
Bristol	812	80	9.9%
Burrillville	655	54	8.2%
Central Falls	1,654	186	11.2%
Charlestown	269	30	NA
Coventry	1,444	145	10.0%
Cranston	3,915	437	11.2%
Cumberland	1,586	134	8.4%
East Greenwich	524	56	10.7%
East Providence	2,536	242	9.5%
Exeter	257	12	NA
Foster	146	18	NA
Glocester	365	38	NA
Hopkinton	357	32	NA
Jamestown	120	10	NA
Johnston	1,318	126	9.6%
Lincoln	904	89	9.8%
Little Compton	84	12	NA
Middletown	845	69	8.2%
Narragansett	405	41	NA
New Shoreham	55	5	NA
Newport	1,366	154	11.3%
North Kingstown	992	57	5.7%
North Providence	1,533	155	10.1%
North Smithfield	433	47	NA
Pawtucket	5,020	604	12.0%
Portsmouth	593	45	7.6%
Providence	13,131	1,663	12.7%
Richmond	365	32	NA
Scituate	310	24	NA
Smithfield	615	53	8.6%
South Kingstown	947	83	8.8%
Tiverton	572	48	8.4%
Warren	470	58	NA
Warwick	3,888	383	9.9%
West Greenwich	240	25	NA
West Warwick	1,843	177	9.6%
Westerly	1,030	94	9.1%
Woonsocket	3,056	365	11.9%
Unknown	*17*	*3*	*NA*
Four Core Cities	*22,861*	*2,818*	*12.3%*
Remainder Of State	*32,291*	*3,103*	*9.6%*
Rhode Island	*55,169*	*5,924*	*10.7%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013.

The denominator is the total number of live births to Rhode Island residents from 2009-2013.

NA: Percentages were not calculated for cities and towns and racial categories with fewer than 500 births, because percentages based on small denominators are statistically unreliable.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in numerators and denominators.

*The Rhode Island Birth Worksheet was changed in 2008 to allow for multiple race and Hispanic options for the first time, resulting in a decline in the number of women reported as White and an increase in women coded as "other."

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Low Birthweight Infants

DEFINITION

Low birthweight infants is the percentage of infants born weighing less than 2,500 grams (5 pounds, 8 ounces). The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

An infant's birthweight is a key indicator of newborn health. Infants born weighing less than 5 pounds, 8 ounces are at greater risk for physical and developmental problems than infants of normal weights Factors that influence infant birthweight include maternal smoking, poverty, periodontal health, level of educational attainment, violence, stress, prenatal nutrition, and environmental hazards.[1,2,3]

Low birthweight often is a result of a premature birth but also can occur after a full-term pregnancy. In 2013 in the U.S., 46.1% of all preterm infants (under 37 weeks gestation) were born at low birthweight, while 3.2% of full-term infants (37 to 41 weeks gestation) were born at low birthweight.[4]

Cigarette smoking during pregnancy is a leading cause of low birthweight, with smokers nearly twice as likely to deliver a low birthweight as women who do not smoke.[5,6] In Rhode Island, 8.1% of babies born between 2009 and 2013 had mothers who smoked during their pregnancy.[7]

Children born at low birthweight face greater risks of physical and developmental health problems and death than infants of normal birthweight. Children born at very low birthweight (less than 1,500 grams or 3 pounds, 4 ounces) are more than 100 times more likely to die within the first year of life than infants of normal birthweight. Those who survive are at significantly higher risk of severe problems, including physical and sensory difficulties, developmental delays, and cognitive impairments. Low birthweight babies are at greater risk for long-term cognitive problems and school difficulties, and are less likely to complete high school than their peers.[8,9,10]

In the U.S. in 2013, 8.0% of infants were born at low birthweight, which is a 14% increase from 7.0% in 1990. Rhode Island's low birthweight rate increased from 6.2% in 1990 to 6.9% in 2013, an 11% increase.[11,12] *The Healthy People 2020* national target is 7.8%.[13]

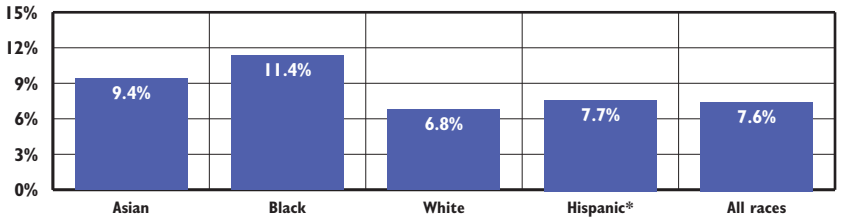
Low Birthweight Infants

	2003	2013
RI	8.5%	6.9%
US	7.9%	8.0%
National Rank*		*12th*
New England Rank**		*3rd*

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

Source: For 2013: Martin, J. A., et al. (2015). Births: Final data for 2013. *National Vital Statistics Reports, 64*(1), 1-65. For 2003: Martin, J. A., et al. (2005). Births: Final data for 2003. *National Vital Statistics Reports, 54*(2), 1-116.

Low Birthweight Infants by Race/Ethnicity, Rhode Island, 2009-2013



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013. Data for 2013 are provisional. *Hispanic infants can be of any race.

◆ **There are racial and ethnic disparities in rates of low birthweight.[14] In Rhode Island between 2009 and 2013, 11.4% of Black infants, 9.4% of Asian infants, and 7.7% of Hispanic* infants were born at low birthweight, compared to 6.8% of White infants.[15]**

◆ **Factors that persist throughout a woman's life, such as increased stress, insufficient health care, and/or lack of social supports, have been shown to increase the likelihood of delivering a low birthweight baby, particularly among Black women and other racial and ethnic minorities.[16,17]**

◆ **In both Rhode Island and the U.S., the rate of low birthweight infant births is higher for women under the age of 20 than for older women. Between 2009 and 2013 in Rhode Island, 9.0% of births to women under age 20 were low birthweight, compared to 7.5% for women age 20 and older.[18,19]**

◆ **Among women with private health insurance coverage in Rhode Island between 2009 and 2013, 6.8% of births were low birthweight, compared with 8.3% of those with public insurance (RIte Care or Medicaid) and 16.0% of births to women with no insurance.[20]**

◆ **Rhode Island women who deliver a low birthweight infant are more likely to report smoking while pregnant, delayed or no prenatal care, a depression diagnosis, and intimate partner violence than those with a normal weight baby, as well as health issues during their pregnancy such as high blood pressure, hypertension, preeclampsia, or toxemia.[21]**

◆ **Between 2009 and 2013 in Rhode Island, 1.6% of all live births were born at very low birthweight (less than 1,500 grams).[22]**

Table 20. **Low Birthweight Infants, Rhode Island, 2009-2013**

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	497	22	NA
Bristol	812	52	6.4%
Burrillville	655	44	6.7%
Central Falls	1,654	123	7.4%
Charlestown	269	14	NA
Coventry	1,444	101	7.0%
Cranston	3,915	330	8.4%
Cumberland	1,586	89	5.6%
East Greenwich	524	40	7.6%
East Providence	2,536	166	6.5%
Exeter	257	11	NA
Foster	146	15	NA
Glocester	365	24	NA
Hopkinton	357	20	NA
Jamestown	120	7	NA
Johnston	1,318	87	6.6%
Lincoln	904	65	7.2%
Little Compton	84	7	NA
Middletown	845	47	5.6%
Narragansett	405	25	NA
New Shoreham	55	3	NA
Newport	1,366	106	7.8%
North Kingstown	992	43	4.3%
North Providence	1,533	115	7.5%
North Smithfield	433	36	NA
Pawtucket	5,020	442	8.8%
Portsmouth	593	29	4.9%
Providence	13,131	1162	8.8%
Richmond	365	20	NA
Scituate	310	13	NA
Smithfield	615	37	6.0%
South Kingstown	947	61	6.4%
Tiverton	572	35	6.1%
Warren	470	39	NA
Warwick	3,888	267	6.9%
West Greenwich	240	17	NA
West Warwick	1,843	152	8.2%
Westerly	1,030	66	6.4%
Woonsocket	3,056	282	9.2%
Unknown	*17*	*1*	*NA*
Four Core Cities	*22,861*	*2,009*	*8.8%*
Remainder of State	*32,291*	*2,205*	*6.8%*
Rhode Island	*55,169*	*4,215*	*7.6%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013. Data for 2013 are provisional.

The denominator is the total number of live births to Rhode Island residents between 2009 and 2013.

NA: Percentages were not calculated for cities and towns with fewer than 500 births over the five year period, as percentages based on small denominators are statistically unreliable.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in numerators and denominators.

*The Birth Worksheet was changed in 2008 to allow for multiple race and Hispanic options for the first time, resulting in a decline in the number of women reported as White and an increase in women coded as "other."

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Infant Mortality

DEFINITION

Infant mortality is the number of deaths of 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

Infant mortality rates are associated with maternal health, quality of and access to medical care, socio-economic conditions, and public health practices.[1] Communities with high poverty and disadvantaged social conditions tend to have higher infant mortality rates than more advantaged communities.[2]

The five main causes of infant death in the U.S. – congenital malformations, low birthweight, maternal complications, Sudden Infant Death Syndrome (SIDS), and unintentional injuries – account for 57% of all infant deaths.[3] Congenital malformations are the leading cause of infant death in the U.S. for all groups, except for non-Hispanic black and Puerto Rican women, for whom low birthweight was the leading cause. These two ethnic groups also experienced high rates of infant deaths due to preterm-related causes. In both the U.S. and Rhode Island, Black women had more than twice the infant mortality rate of non-Hispanic white women.[4]

The U.S. infant mortality rate declined from 26.0 deaths per 1,000 live births in 1960 to 6.0 deaths per 1,000 live births in 2013, due to improvements in healthier behaviors, medical advances, and improved access to prenatal care.[5,6,7] Relative to other industrialized countries, the U.S. has made slower progress at reducing infant mortality due in part to a relatively high number of preterm births resulting in infant mortality.[8]

The overall infant mortality rate in Rhode Island between 2009 and 2013 was 6.6 deaths per 1,000 live births. The infant mortality rate was 8.3 per 1,000 live births in the four core cities, compared with 5.3 per 1,000 births in the remainder of the state. Also during that time, mothers with a high school degree or less had a higher infant mortality rate (6.4 per 1,000) than mothers with more advanced educational degrees (4.8 per 1,000 births).[9]

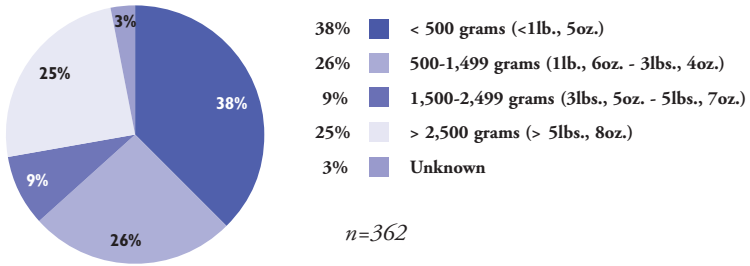
Infant Mortality Rate
(rate per 1,000 live births)

	2003	2013
RI	6.7	6.5
US	6.9	6.0
National Rank*		*31st*
New England Rank**		*5th*

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

Source: Population Reference Bureau calculations using CDC WONDER data, wonder.cdc.gov

Infant Mortality by Birthweight, Rhode Island, 2009-2013



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013. Data for births in 2013 are provisional. Totals may not sum to 100% due to rounding.

◆ **Between 2009 and 2013, 362 infants died in Rhode Island before their first birthday. Seventy-three percent of infants who died during this time period were low birthweight, 25% were born at normal weights, and 3% had unknown birthweights.[10]**

◆ **Of the 362 infant deaths between 2009 and 2013 in Rhode Island, 75% (270) occurred in the neonatal period (during the first 27 days of life).[11] Generally, infant deaths in the neonatal period are related to short gestation and low birthweight (less than 2,500 grams), malformations at birth, and/or conditions occurring in the perinatal period.[12]**

◆ **Between 2009 and 2013, 25% (92) of the 362 infant deaths in Rhode Island occurred in the post-neonatal period (between 28 days and one year after delivery).[13] Nationally, most of the progress in reducing the rate of infant mortality has resulted from improving outcomes during the post-neonatal period.[14]**

◆ **In Rhode Island between 2009 and 2013, the Black infant mortality rate was 11.2 deaths per 1,000 live births, the White infant mortality rate was 7.1 per 1,000 live births, and the Asian infant mortality rate was 1.5 per 1,000 live births. The Hispanic infant mortality rate was 5.8 per 1,000 live births, compared with 6.3 deaths per 1,000 live births among non-Hispanics in Rhode Island.[15]**

◆ **Preterm birth is the leading cause of infant death in Rhode Island.[16] Between 2009 and 2013, there were 5,924 preterm births (10.7% of all births).[17]**

Reducing Infant Mortality

◆ **Comprehensive state initiatives to reduce infant mortality should include the following seven broad strategies: improve health promotion efforts; ensure quality of care for all women and infants; improve maternal risk screening for all women of reproductive age; enhance service integration for women and infants; improve access to health care of women before, during, and after pregnancy; develop data systems to understand and inform efforts; and promote social equity.[18]**

◆ **Infant mortality is a result of a variety of factors and interventions to prevent infant mortality should occur at multiple levels, including individual education and counseling, ongoing evidence-based clinical interventions, long-lasting health promoting actions, creating health-promoting environments, and socioeconomic interventions to eliminate disparities.[19]**

Table 21. **Infant Mortality, Rhode Island, 2009-2013**

CITY/TOWN	# OF BIRTHS	# OF INFANT DEATHS	RATE PER 1,000 BIRTHS
Barrington	497	0	0
Bristol	812	*	NA
Burrillville	655	*	NA
Central Falls	1,654	8	4.8
Charlestown	269	*	NA
Coventry	1,444	8	5.5
Cranston	3,915	20	5.1
Cumberland	1,586	11	6.9
East Greenwich	524	5	9.5
East Providence	2,536	13	5.1
Exeter	257	0	0
Foster	146	*	NA
Glocester	365	*	NA
Hopkinton	357	0	0
Jamestown	120	0	0
Johnston	1,318	7	5.3
Lincoln	904	6	6.6
Little Compton	84	0	0
Middletown	845	*	NA
Narragansett	405	*	NA
New Shoreham	55	0	0
Newport	1,366	13	9.5
North Kingstown	992	*	NA
North Providence	1,533	10	6.5
North Smithfield	433	*	NA
Pawtucket	5,020	42	8.4
Portsmouth	593	*	NA
Providence	13,131	116	8.8
Richmond	365	*	NA
Scituate	310	*	NA
Smithfield	615	*	NA
South Kingstown	947	*	NA
Tiverton	572	*	NA
Warren	470	*	NA
Warwick	3,888	25	6.4
West Greenwich	240	*	NA
West Warwick	1,843	10	5.4
Westerly	1,030	*	NA
Woonsocket	3,056	24	7.9
Unknown	*17*	*NA*	*NA*
Four Core Cities	*22,861*	*190*	*8.3*
Remainder of State	*32,291*	*172*	*5.3*
Rhode Island	*55,169*	*362*	*6.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013. Data for births in 2013 are provisional.

The denominator is the total number of live births to residents between 2009 and 2013.

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

*Fewer than 5 infants are in this category. Actual numbers are not shown to protect confidentiality. These infant deaths are still counted in the four core cities, remainder of the state, and state totals.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in the numerators and denominators.

The birth worksheet was changed in 2008 to allow for multiple race and Hispanic options for the first time, resulting in a decline in the number of women reported as White and an increase in women coded as "other."

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(continued on page 176)

Breastfeeding

DEFINITION

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

SIGNIFICANCE

Breastfeeding is widely recognized as the ideal method of feeding and nurturing infants and a critical component in achieving optimal infant and child health, growth, and development.[1,2] National health experts recommend exclusive breastfeeding for six months after birth, continuous breastfeeding for at least 12 months after birth, and thereafter as long as mutually desired.[3]

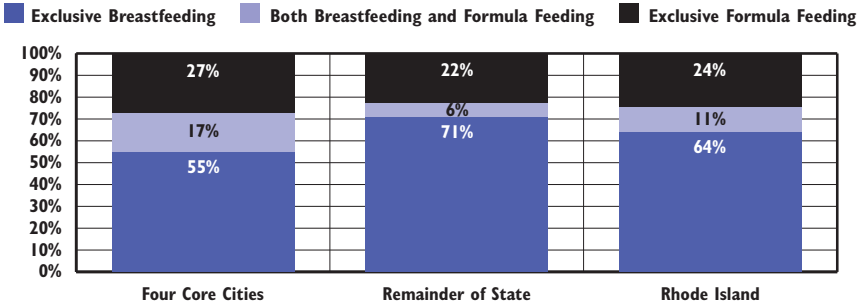
Breastfeeding decreases infant mortality and morbidity. Benefits for infants include optimal nutrition and reduced risk for Sudden Infant Death Syndrome as well as reduced risk for chronic conditions such as childhood obesity, type 1 and 2 diabetes, and childhood leukemia. Additionally, breastfeeding benefits mothers by creating a strong bond with infants and decreasing risk for postpartum depression, type 2 diabetes, and breast and ovarian cancer. Breastfeeding provides significant social and economic benefits, including reduced cost to the family, reduced health care costs, and reduced employee absenteeism.[4,5]

Breastfeeding can be effectively promoted by practices that take place before, during, and after labor and delivery. Hospital and other birth facility policies and practices influence success of breastfeeding. Access to professional lactation consultants, involvement in mother-to-mother lactation support networks, and birth facility support for breastfeeding all factor into protecting, supporting, and promoting breastfeeding. Rhode Island Hospitals rank among the best in the U.S. for breastfeeding support.[6,7] Without adequate support, women are more likely to stop breastfeeding earlier.[8]

Breastfeeding rates generally increase with maternal age, higher educational achievement, and higher income levels.[9] Mothers who have unintended pregnancies are less likely to breastfeed. In the U.S. between 2006-2010, 26% of babies from intended births were not breastfed at all, compared with 39% of babies from unintended births.[10]

Healthy People 2020 sets target breastfeeding rates of 81.9% of infants ever having been breastfed, 60.6% breastfeeding at six months of age, and 34.1% breastfeeding at one year.[11] Rhode Island reports 79.7% of infants ever having been breastfed, 47.0% at six months, and 22.2% at one year of age. Comparable national averages were 79.2% ever breastfed, 49.4% at six months, and 26.7% at one year.[12]

Breastfeeding and Formula Feeding, Rhode Island, 2009-2013



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Newborn Developmental Risk Screening Program, 2009-2013. Breastfeeding and formula feeding are defined as intended feeding method at hospital discharge. Totals may not sum to 100% because data on feeding methods were not available for all births.

◆ **Between 2009 and 2013, 64% of new mothers in Rhode Island indicated that they intended to exclusively breastfeed when discharged from the hospital. One in four new mothers (24%) intended to exclusively formula feed and 11% intended to use a combination of both breast and formula feeding.[13]**

◆ **More than three-quarters (83%) of new mothers in Rhode Island who were surveyed about three months after giving birth in 2011 reported having ever breastfed. Forty-five percent reported continued breastfeeding at the time of the survey.[14]**

◆ **Breastfeeding initiation has increased over the past decade in general and among all racial and ethnic population in the U.S. Non-Hispanic Black infants have the lowest prevalence of initiation as well as duration.[15,16] However, Rhode Island is one of only two states in which non-Hispanic Black mothers initiate breastfeeding at higher rates than non-Hispanic White mothers.[17]**

◆ **Rhode Island is one of 49 states with state legislation that provides mothers with the explicit right to breastfeed in public places. Rhode Island does not have legislation that mandates support for breastfeeding mothers who return to work, as do 16 states.[18]**

◆ **Rhode Island was the first state to eliminate the automatic distribution of free infant formula that is not medically necessary to postpartum women at hospital discharge, in 2011.[19]**

Table 22.

Breastfeeding, Rhode Island, 2009-2013

CITY/TOWN	NUMBER OF BIRTHS SCREENED	NUMBER BREAST AND FORMULA FEEDING	NUMBER EXCLUSIVELY BREASTFEEDING	PERCENT WITH ANY BREASTFEEDING	PERCENT EXCLUSIVELY BREASTFEEDING
Barrington	480	12	420	90%	88%
Bristol	767	42	564	79%	74%
Burrillville	593	20	420	74%	71%
Central Falls	1,625	376	830	74%	51%
Charlestown	261	6	211	83%	81%
Coventry	1,416	58	1,002	75%	71%
Cranston	3,854	357	2,553	76%	66%
Cumberland	1,433	91	1,034	79%	72%
East Greenwich	513	12	421	84%	82%
East Providence	2,466	186	1,659	75%	67%
Exeter	253	18	195	84%	77%
Foster	140	11	106	84%	76%
Glocester	351	11	267	79%	76%
Hopkinton	353	8	280	82%	79%
Jamestown	115	1	104	91%	90%
Johnston	1,302	82	845	71%	65%
Lincoln	867	44	617	76%	71%
Little Compton	64	2	50	81%	78%
Middletown	808	35	653	85%	81%
Narragansett	399	18	307	81%	77%
New Shoreham	54	7	45	96%	83%
Newport	1,297	95	918	78%	71%
North Kingstown	982	46	732	79%	75%
North Providence	1,494	93	1,020	74%	68%
North Smithfield	401	12	314	81%	78%
Pawtucket	4,769	712	2,738	72%	57%
Portsmouth	549	14	454	85%	83%
Providence	12,852	2,357	7,063	73%	55%
Richmond	349	15	289	87%	83%
Scituate	306	15	231	80%	75%
Smithfield	600	17	452	78%	75%
South Kingstown	939	59	733	84%	78%
Tiverton	370	14	283	80%	76%
Warren	443	17	322	77%	73%
Warwick	3,828	236	2,595	74%	68%
West Greenwich	238	10	176	78%	74%
West Warwick	1,804	117	1,104	68%	61%
Westerly	944	45	732	82%	78%
Woonsocket	2,848	317	1,516	64%	53%
Four Core Cities	*22,094*	*3,762*	*12,147*	*72%*	*55%*
Remainder of State	*31,033*	*1,826*	*22,108*	*77%*	*71%*
Rhode Island	*53,127*	*5,588*	*34,255*	*75%*	*64%*

Sources of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Newborn Developmental Risk Screening Program Database and Maternal and Child Health Database, 2009-2013.

Breastfeeding is defined as "breastfeeding as intended feeding method at hospital discharge." "Percent With Any Breastfeeding" includes infants fed breast milk in combination with formula and those exclusively breastfed.

The number of births screened may differ from the total number of births reported elsewhere in the Factbook as not all documented births received a screening. Births to Rhode Island women that occurred outside Rhode Island are not included.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in the numerators and denominators.

References

[1,3] American Academy of Pediatrics. (2012). Policy statement: Breastfeeding and the use of human milk. *Pediatrics, 129*(3), 827-841.

[2] *Executive summary: The Surgeon General's call to action to support breastfeeding.* (2011). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

[4,6] James, D. C. S. & Lessen, R. (2009). Position of the American Dietetic Association: Promoting and supporting breastfeeding. *Journal of the American Dietetic Association, 109*(11),1926-1942.

[5] *Breastfeeding.* (2014). Washington, DC: Child Trends.

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(continued on page 176)

Children with Lead Poisoning

DEFINITION

Children with lead poisoning is the percentage of three-year-old children with a confirmed elevated blood lead level (EBLL, ≥5 µg/dL) at any time prior to December 31, 2014.[1,2] These data are for children eligible to enter kindergarten in the fall of 2016 (i.e., children born between September 1, 2010 and August 31, 2011).

SIGNIFICANCE

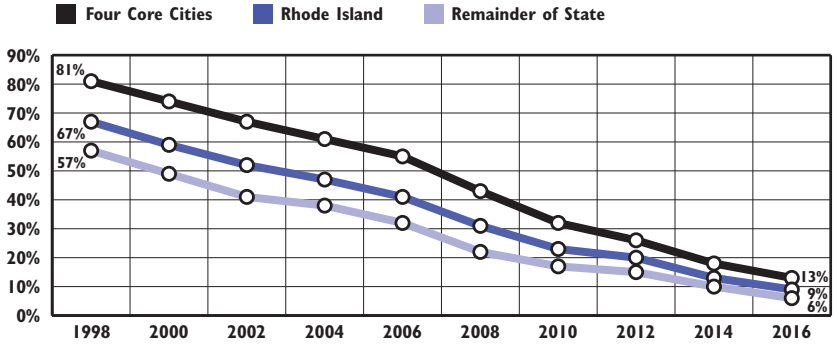
Lead poisoning is a preventable childhood disease. Infants, toddlers, and preschool-age children are most susceptible to the toxic effects of lead because they absorb lead more readily than adults and have inherent vulnerability due to developing central nervous systems.[3] Lead exposure, even at very low levels, can cause irreversible damage including reduced fetal and postnatal growth, decreased hearing, delayed puberty, poor muscle coordination, kidney damage, increased risk for behavioral problems, decreased cognitive abilities, and lower academic performance. Though rare, acute poisoning can result in severe illness and death.[4,5] The societal costs of childhood lead poisoning include the loss of future earnings due to decreased cognition, and increased medical and special education costs.[6,7]

The Centers for Disease Control and Prevention (CDC) has renewed its focus on primary prevention of lead exposure in response to research findings indicating there is no safe blood lead level in children. In an effort to better alert health officials and family members to the dangers of any lead exposure in children, in 2012 the CDC lowered the threshold for which a child is deemed to have an elevated blood lead level from 10 µg/dL to 5 µg/dL. This new lower reference value will result in more children being identified as having elevated blood lead levels, which will allow parents and health officials to take corrective actions sooner.[8,9]

Although the percentage of children with elevated blood lead levels are declining nationally and locally, low-income and minority children remain the most likely to be lead poisoned.[10,11,12] In Rhode Island, children living in the four core cities (where most poor and minority children reside) are at increased risk for lead exposure because the housing stock tends to be older.[13]

In 2014, 1,338 (5.2%) of the 25,855 Rhode Island children under age six who were screened had confirmed elevated blood lead levels of ≥5 µg/dL. Children living in the four core cities (7.5%) were more than twice as likely as children in the remainder of the state (3.3%) to have confirmed EBLLs ≥5 µg/dL.[14]

Children Entering Kindergarten with History of Elevated* Blood Lead Level Screening (≥5 µg/dL), Rhode Island, Four Core Cities, and Remainder of State, 1998-2016



Source: Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program, Children entering kindergarten between 1998 and 2016. *Elevated blood lead level of ≥5 µg/dL.

◆ **The number of children with elevated blood lead levels have been steadily declining in all areas of Rhode Island over the past decade and a half. Compared to the remainder of the state, children living in the four core cities are at an increased risk for lead exposure.[15]**

Lead Exposure and Academic Performance

◆ **Exposure to lead has been shown to negatively impact academic performance in early childhood. Rhode Island children with a history of lead exposure, even at low levels, have been shown to have decreased reading readiness at kindergarten entry and diminished reading and math proficiency in the third grade. The most significant declines in academic performance occurred among children with the highest blood level levels and those living in the four core cities. Children with lead exposure are also at increased risk for absenteeism, grade repetition, and special education services.[16,17,18]**

◆ **In an effort to better inform school administrators about the prevalence of lead exposure, the Rhode Island Department of Health and the Rhode Island Department of Education provide detailed reports to superintendents and heads of private schools on rates of lead exposure and immunization among students within their districts. Information regarding relevant regulations, associated risks, and parent communication were also included.[19,20]**

Significantly Lead Poisoned Children Under Age Six

◆ In Rhode Island, a child is considered to be "significantly lead poisoned" if she or he has a single venous blood test result of ≥20 µg/dL or two venous tests of 15-19 µg/dL that are 90-365 days apart. The number of children under age six who were significantly lead poisoned has decreased by 85% over the past nine years, from 212 in 2005 to 32 in 2014.[21,22]

◆ When a child is "significantly lead poisoned," an inspection of the child's home is offered. The Rhode Island Department of Health sends certified lead inspectors to determine whether lead hazards are present and, if hazards are found, it works with property owners to make the property lead-safe. In 2014, 38 environmental inspections were offered, of which 28 were performed, six were refused, three were not needed because the child moved, and one was pending.[23,24]

Table 23. **Lead Poisoning in Children Entering Kindergarten in the Fall of 2016, Rhode Island**

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	CONFIRMED WITH BLOOD LEAD LEVEL ≥5 µg/dL	
		NUMBER	PERCENT
Barrington	147	4	2.7%
Bristol	167	15	9.0%
Burrillville	122	12	9.8%
Central Falls	294	40	13.6%
Charlestown	48	2	4.2%
Coventry	289	10	3.5%
Cranston	722	43	6.0%
Cumberland	352	12	3.4%
East Greenwich	139	5	3.6%
East Providence	535	58	10.8%
Exeter	44	2	4.5%
Foster	27	1	3.7%
Glocester	68	3	4.4%
Hopkinton	62	7	11.3%
Jamestown	27	2	7.4%
Johnston	241	5	2.1%
Lincoln	161	7	4.3%
Little Compton	23	1	4.3%
Middletown	178	9	5.1%
Narragansett	68	0	0.0%
New Shoreham	11	1	9.1%
Newport	289	35	12.1%
North Kingstown	241	10	4.1%
North Providence	250	12	4.8%
North Smithfield	83	1	1.2%
Pawtucket	942	108	11.5%
Portsmouth	144	5	3.5%
Providence	2,750	382	13.9%
Richmond	40	7	17.5%
Scituate	76	3	3.9%
Smithfield	133	2	1.5%
South Kingstown	218	13	6.0%
Tiverton	135	7	5.2%
Warren	95	12	12.6%
Warwick	740	29	3.9%
West Greenwich	47	1	2.1%
West Warwick	331	19	5.7%
Westerly	183	10	5.5%
Woonsocket	537	40	7.4%
Four Core Cities	*4,523*	*570*	*12.6%*
Remainder of State	*6,436*	*365*	*5.7%*
Rhode Island	*10,959*	*935*	*8.5%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Healthy Homes and Childhood Lead Poisoning Prevention Program.

Data reported in this year's Factbook is not comparable to editions prior to 2012, due to a change in definition and data improvements within the Healthy Homes and Childhood Lead Poisoning Prevention Program.

Data for children entering kindergarten in the fall of 2016 reflect the number of Rhode Island children eligible to enter school in the fall of 2016 (i.e., born between 9/1/10 and 8/31/11).

Children confirmed positive for lead poisoning (blood lead level ≥5 µg/dL) are counted if they screened positive with a venous test and/or had a confirmed capillary test at any time in their lives prior to the end of December 2014. The Rhode Island Healthy Homes and Childhood Lead Poisoning Prevention Program recommends that children under age six with a capillary blood lead level of ≥5 µg/dL receive a confirmatory venous test.

The denominator for percent confirmed is the number of children entering kindergarten in the fall of 2016 who were tested for lead poisoning. Data include both venous and confirmed capillary tests.

Of the 952 children entering kindergarten in 2016 who had an initial blood lead screen of ≥5 µg/dL, 9 (1%) did not receive a confirmatory second test. Their lead poisoning status is unknown.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in numerators and denominators.

See Methodology Section for more information.

References

[1,8] Centers for Disease Control and Prevention. (2014). *Lead: What do parents need to know to protect their children?* Retrieved February 26, 2015, from www.cdc.gov

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(continued on page 176)

Children with Asthma

DEFINITION

Children with asthma is the rate of hospitalizations for asthma where asthma was the primary diagnosis 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 respiratory disease that causes reversible episodes of coughing, wheezing, shortness of breath, and chest tightness, which can be life threatening. Attacks can be triggered by respiratory infections, cigarette smoke, air pollutants, allergic reactions, stress, and exposure to cold air or sudden temperature change. While the exact cause of asthma is unknown, various genetic, environmental, birth, and health status factors have been linked to an increased risk for asthma.[1,2,3]

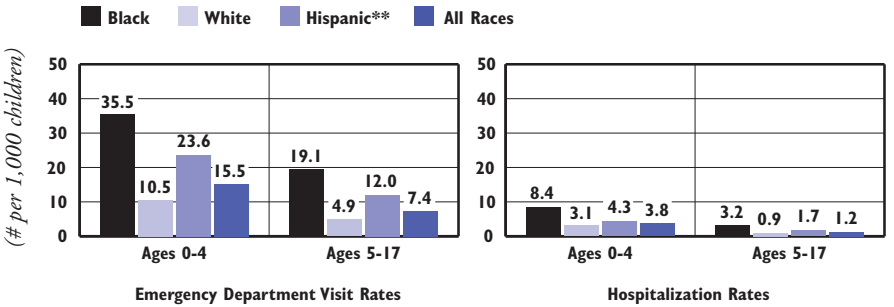
Nationally, asthma is the most common chronic condition among children.[4] In 2012, nearly one in ten (9.3%) U.S. children had asthma, with the highest rates among Black and Native American/Alaska Native children, boys, children living in poverty, and children with fair or poor health.[5] Racial and ethnic differences in asthma prevalence are believed to be correlated with poverty, exposure to indoor and outdoor air pollution, stress, acute exposure to violence, lack of access to preventive medical care, and genetic factors.[6,7] Childhood asthma in the U.S. increased between 2002 and 2012, from 8.3% to 9.3%.[8,9]

Compared with adults, children have higher rates for asthma primary care and emergency department visits, similar hospitalization rates, and lower death rates.[10] Asthma remains the third-ranked cause of hospitalization for children under age 15, and one of the leading causes of school absenteeism.[11]

Proper asthma management requires continued assessment and monitoring, patient education, environmental control, and appropriate medication. Health care providers should work with the patient and family to create an asthma action plan, which provides instruction on how to use medications properly and avoid asthma triggers. An asthma action plan, if adhered to and supported by enhanced care and community based interventions, can improve health outcomes and reduce costly asthma hospitalizations.[12,13,14,15,16]

In Rhode Island in 2013, the average charge for an asthma emergency department visit for a child was $1,608 and $10,278 for a child asthma hospitalization.[17]

Asthma* Emergency Department and Hospitalization Rates, by Age and Race/Ethnicity, Rhode Island Children, 2009-2013



Source: Rhode Island Department of Health, Hospital Discharge Database, 2009-2013; U.S. Census Bureau, Census 2010.
*Rates are for primary diagnosis of asthma. **Hispanic children can be of any race.

◆ **In Rhode Island between 2009 and 2013, non-Hispanic Black children, Hispanic children, and children under age five were more likely to visit the emergency department or be hospitalized as a result of asthma. During that time period, children of all ages were more likely to visit the emergency department for asthma than to be hospitalized for asthma.[18]**

◆ **In Rhode Island between 2009 and 2013, boys under age 18 had higher asthma emergency department (11.5 per 1,000 boys) and hospitalization (2.3 per 1,000 boys) rates than girls under age 18 (7.4 and 1.4 per 1,000 girls respectively).[19]**

◆ **Between 2009 and 2013, 15% (1,607) of all asthma emergency department visits for children under age 18 resulted in a hospitalization.[20]**

◆ **Between the 2009-2010 and 2012-2013 school years in Rhode Island, 37% (6,744) of children with asthma were chronically absent in at least one of the school years. Chronic absenteeism is defined as missing 10% or more days of school.[21]**

Table 24.

Asthma Emergency Department Visits and Hospitalizations for Children Under Age 18, Rhode Island, 2009-2013

CITY/TOWN	ESTIMATED ANNUAL # OF CHILDREN UNDER AGE 18**	# OF CHILD EMERGENCY DEPT. VISITS WITH PRIMARY ASTHMA DIAGNOSIS	RATE OF CHILD EMERGENCY DEPT. VISITS WITH PRIMARY ASTHMA DIAGNOSIS, PER 1,000 CHILDREN	# OF CHILD HOSPITALIZATIONS WITH PRIMARY ASTHMA DIAGNOSIS	RATE OF CHILD HOSPITALIZATIONS WITH PRIMARY ASTHMA DIAGNOSIS, PER 1,000 CHILDREN
Barrington	4,597	99	4.3	35	1.5
Bristol	3,623	84	4.6	23	1.3
Burrillville	3,576	82	4.6	24	1.3
Central Falls	5,644	381	13.5	63	2.2
Charlestown	1,506	48	6.4	7	0.9
Coventry	7,770	173	4.5	49	1.3
Cranston	16,414	730	8.9	169	2.1
Cumberland	7,535	160	4.2	42	1.1
East Greenwich	3,436	45	2.6	10	0.6
East Providence	9,177	401	8.7	133	2.9
Exeter	1,334	26	3.9	6	0.9
Foster	986	23	4.7	5	1.0
Glocester	2,098	23	2.2	9	0.9
Hopkinton	1,845	62	6.7	13	1.4
Jamestown	1,043	18	3.5	*	NA
Johnston	5,480	213	7.8	58	2.1
Lincoln	4,751	148	6.2	37	1.6
Little Compton	654	7	2.1	0	0.0
Middletown	3,652	140	7.7	23	1.3
Narragansett	2,269	47	4.1	*	NA
New Shoreham	163	*	NA	0	0.0
Newport	4,083	268	13.1	21	1.0
North Kingstown	6,322	167	5.3	41	1.3
North Providence	5,514	243	8.8	56	2.0
North Smithfield	2,456	48	3.9	14	1.1
Pawtucket	16,575	978	11.8	178	2.1
Portsmouth	3,996	92	4.6	18	0.9
Providence	41,634	3,817	18.3	685	3.3
Richmond	1,849	31	3.4	8	0.9
Scituate	2,272	54	4.8	18	1.6
Smithfield	3,625	57	3.1	23	1.3
South Kingstown	5,416	125	4.6	17	0.6
Tiverton	2,998	31	2.1	12	0.8
Warren	1,940	61	6.3	15	1.5
Warwick	15,825	520	6.6	110	1.4
West Greenwich	1,477	27	3.7	6	0.8
West Warwick	5,746	298	10.4	48	1.7
Westerly	4,787	206	8.6	27	1.1
Woonsocket	9,888	702	14.2	84	1.7
Four Core Cities	*73,741*	*5,878*	*15.9*	*1,010*	*2.7*
Remainder of State	*150,215*	*4,758*	*6.3*	*1,084*	*1.4*
Rhode Island	*223,956*	*10,636*	*9.5*	*2,094*	*1.9*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Database, 2009-2013.

The Centers for Disease Control and Prevention requests that states report asthma hospitalization data only where asthma is the primary diagnosis. Due to this change, data in this indicator are not comparable to data included in Factbooks prior to 2010.

*Between 1 and 4 children are in this category. These children are still counted in district totals and in the four core cities, remainder of the state, and state totals.

**The denominator used to compute the 2009-2013 rate of hospitalizations is the number of children according to the 2010 U.S. Census, multiplied by five. Census data for rates by age, race, and ethnicity and were provided by the Rhode Island Department of Health.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in numerators and denominators.

References

[1,4] *Asthma.* (2014). Washington, DC: Child Trends.

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(continued on page 177)

Housing and Health

DEFINITION

Housing and health is the percentage of children under age 18 who live in low-income families that reside in older housing, defined as housing built before 1980. Low-income families are those with incomes less than 200% of the federal poverty level.

SIGNIFICANCE

Safe, affordable, and stable housing maintains the health and well-being of families and children, supporting mental and emotional health as well physical safety. Healthy housing protects families from weather, environmental hazards, and injury and provides a safe place for children to eat, sleep, play, and grow.[1,2]

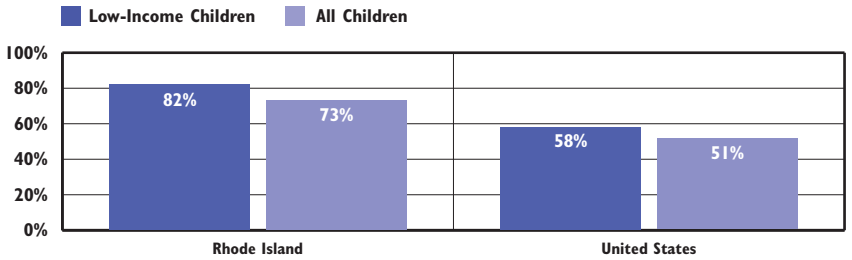
Unhealthy housing can cause or intensify many health conditions.[3] Children living in homes built before 1978, when lead paint was banned from interior use in the U.S., are at risk for lead poisoning.[4] Studies have connected poor quality construction, inadequate housing maintenance, and toxic building materials to respiratory illnesses, asthma, unintentional injuries, and lead poisoning.[5]

Adopting a comprehensive "healthy homes" approach that addresses multiple housing deficiencies simultaneously can help prevent housing-related injuries and illnesses, reduce health costs and improve children's quality of life. Because the causes of many health conditions related to the home environment are interconnected, it can be cost-effective to address multiple hazards simultaneously. For example, sealing cracks in a home's foundation can address multiple asthma triggers by keeping water and pests from entering the house. Similarly, addressing a roof leak and any related deteriorating lead paint simultaneously is the most effective way to remove lead and mold growth hazards.[6,7,8]

The quality and stability of children's homes can have long-term effects on children. Lack of adequate and affordable housing puts safe, healthy, well-maintained homes out of reach for many families. Families may be forced to move frequently in search of better, more affordable housing, or to raise their children in overcrowded and unsafe environments that can interfere with their growth, development, and academic performance. Overcrowded housing is associated with mental health concerns, stress, sleep problems, injury, and exposure to disease, while multiple moves are associated with behavioral and mental health concerns and academic difficulties.[9]

Low-income children also are more likely to be hurt in falls due to unsafe environments, including aging and deteriorating housing, compared to higher-income children.[10,11]

Children Living in Older Housing*, 2011-2013, Rhode Island and the United States



Source: Population Reference Bureau analysis of 2011-2013 American Community Survey (ACS) Public Use Microsample (PUMS) data. *Older housing is defined here as housing built before 1980. The ACS reports data on the year a housing structure was built by decade, so this is the best available approximation for housing built before 1978 (when lead paint was banned from interior use in the U.S.).

◆ **In both Rhode Island and the nation as a whole, children in low-income families are more likely to live in older housing than children in general. Between 2011 and 2013, 82% of low-income children in Rhode Island lived in older housing, compared to 58% of low-income children in the U.S. Of all 50 states, Rhode Island continues to have the highest percentage of low-income children living in older housing.[12]**

◆ **Rhode Island children were more likely to live in older housing (73%) than children in the nation as a whole (51%). Rhode Island continues to have the second highest percentage of children living in older housing in the nation after New York.[13]**

◆ **Rhode Island's older housing stock poses health risks for children because lead paint was commonly used in the interior and exterior of homes before 1978. Exposure to lead is associated with numerous health risks. Despite consistent lead poisoning declines, children living in the four core cities have disproportionately higher rates of lead poisoning than children living in the remainder of the state.[14,15,16]**

◆ **Because affordable housing is in short supply, many low-income families pay more for housing than they can afford. Low-income families who are forced to spend more than they can afford on housing frequently face difficult choices about where to spend their remaining income, and may not have enough money left in their budget to pay for nutritious food, health insurance, and health care.[17]**

Key Principles of Healthy Housing

The National Center for Healthy Housing has developed seven key principles of healthy housing. According to these principles, a healthy home is: dry, clean, pest-free, safe, contaminant-free, ventilated, and maintained.

◆ ***Dry:*** **Damp houses provide a welcoming environment for mites, roaches, rodents and molds, all of which are associated with asthma.**

◆ ***Clean:*** **Clean homes are less likely to harbor household pests and reduce children's exposure to contaminants.**

◆ ***Pest-free:*** **Mice and cockroaches can trigger asthma in some children. The pesticides used to rid homes of household pests can also exacerbate health problems.**

◆ ***Safe:*** **A majority of injuries to children occur in the home. Falls are the most frequent cause of residential injuries to children, followed by injuries from objects in the home, burns and poisonings.**

◆ ***Contaminant-free:*** **Many chemicals found in the home pose risks to children's health, including lead, radon, asbestos, pesticides, carbon monoxide, volatile organic compounds, and second-hand tobacco smoke.**

◆ ***Ventilated:*** **Having a well-ventilated home improves respiratory health.**

◆ ***Maintained:*** **Homes that are poorly maintained may have excessive moisture, pest problems or deteriorating lead paint, all of which pose health risks to children.**

Source: National Center for Healthy Housing. (n.d.). *Seven principles of healthy homes.* Retrieved January 22, 2015, from www.nchh.org

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(continued on page 177)

Health Problems Associated With Housing

Lead Poisoning

◆ **Children living in homes built before 1978, when lead paint was banned from interior use in the United States, are at risk for lead poisoning. Even at low levels, lead exposure during early childhood can negatively affect a child's health and development and cause learning disabilities, loss of IQ, and reduced attention span.[18,19]**

◆ **One in twelve (8.5%) Rhode Island children due to start kindergarten in the fall of 2016 has had a confirmed blood lead level of ≥5 µg/dL, indicating exposure to an environmental lead hazard.[20] Children living in the four core cities are at an increased risk for lead exposure in part because the housing stock tends to be older and less well-maintained.[21] The prevalence of childhood lead poisoning has steadily decreased over the past decade.[22]**

Asthma

◆ **The presence of dust mites, cockroaches, mold, pet dander and rodents all can trigger or exacerbate respiratory problems, including asthma.[23] Asthma is the most common chronic condition in children, the third leading cause of hospitalization for children under age 15, and a leading cause of school absences in the U.S.[24]**

◆ **Between 2009 and 2013, there were 2,094 hospitalizations of children in Rhode Island for which the primary diagnosis was asthma. Asthma hospitalization rates in Rhode Island were highest for Black and Hispanic children.[25,26] Low-income and minority children are more likely to live in the four core cities, where the housing stock tends to be older and children may be exposed to more asthma triggers.[27,28]**

Unintentional Injuries

◆ **Falls are the leading cause of non-fatal unintentional injuries among children under age 18 in the U.S. Residential hazards associated with falls among children include a lack of safety devices, such as safety gates and window guards; structural problems, such as uneven floors; and insufficient lighting in stairways and other areas.[29,30,31]**

◆ **In 2013, housing-related falls resulted in 4,685 emergency room visits by Rhode Island children. Half (50%) of these visits were for children under age six.[32]**

Adolescent Obesity

DEFINITION

Adolescent obesity is the percentage of high school students who report having a body mass index (BMI) at or above the 95th percentile for gender and age. Adolescents with a BMI at or above the 95th percentile are considered to be obese. Children and youth with a BMI between the 85th and 95th percentiles are considered to be overweight or at risk for obesity.[1]

SIGNIFICANCE

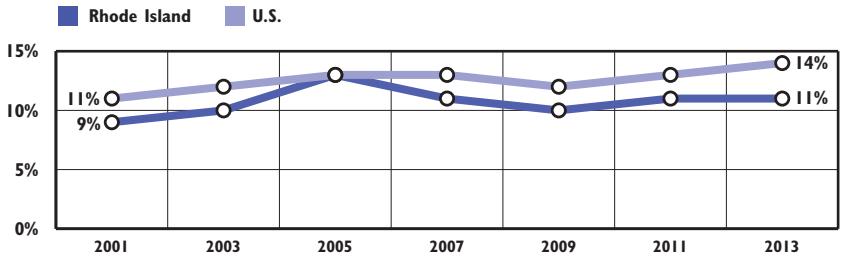
Children and adolescents who are overweight or obese are at immediate and/or long-term risk of many health problems, including type 2 diabetes, cardiovascular disease, asthma, joint pain, sleep apnea, and other acute and chronic health problems. Over time, these conditions may contribute to shorter lifespans. They may also experience social and psychological problems, including depression, bullying, and social marginalization.[2,3,4,5] Obese children and youth are also more likely to repeat a grade and be absent from school than their peers.[6]

Over the past four decades, the prevalence of childhood obesity in America has more than doubled, and today nearly one in three children ages 2-19 is obese (17%) or overweight (15%).[7] No single factor is driving the increased prevalence of childhood obesity; rather it is the result of complex interactions among many factors, including excess calorie consumption, genes, metabolism, behavior, environment, and culture.[8,9] Low consumption of fruits and vegetables, high consumption of sugar-sweetened beverages and energy dense foods, low levels of physical activity, and high levels of sedentary "screen time" are all associated with obesity.[10]

The health risks of being overweight and obese can be long-lasting.[11,12] Studies have shown that overweight kindergartners are four times as likely as their healthy-weight peers to become obese by the eighth grade, that two-thirds of obese fifth graders remain obese in the tenth grade, and that teenagers who are obese have a greater than 70% risk of being obese as an adult.[13,14,15] Prevention and intervention for at risk, overweight, and obese children should occur early and at all ages.[16]

Reducing overweight and obesity will require a comprehensive, multi-system approach. Policy strategies to reduce obesity include improving access to nutritional and affordable foods and beverages, ensuring healthy food in schools, increasing options for physical activity before, during, and after school, and improving access to safe and walkable neighborhoods and recreational areas.[17,18,19]

Obesity Among High School Students, Rhode Island and United States, 2001-2013



Source: *Youth Risk Behavior Survey,* Rhode Island and National, 2001-2013. BMI calculated using self-reported student response.

◆ **Rhode Island's overall high school obesity and overweight prevalence has not significantly changed (improved or worsened) since 2001. In Rhode Island in 2013, 11% of high school students reported being obese and 16% reported being overweight.[20] Among 42 ranked states in 2013, Rhode Island high school students ranked well (7th best) for the prevalence of obesity among adolescents, but not as well (37th best) for the prevalence of overweight.[21,22]**

Nutrition and Eating Habits

◆ **The total number of calories a child and adolescent needs varies depending on age, gender, height, weight and level of physical activity, as well as their need to lose, maintain, or gain weight. Yet, many children and adolescents consume diets with too many calories and not enough nutrients.[23]**

◆ **Among Rhode Island high school students in 2013, 17% reported consuming one or more cans of soda daily (down from 25% in 2007) and 80% reported eating less than five servings of fruits/vegetables (up from 68% in 2001).[24]**

◆ **In Rhode Island, strengthened nutritional standards for food and beverages sold or distributed in schools have resulted in declines in the availability of unhealthy food and drinks. Between 2006 and 2014 among Rhode Island middle and high schools, the availability of soda or fruit drinks that are not 100% juice (down 82%), chocolate candy (down 81%), sport drinks (down 80%), salty snacks not low in fat (down 76%), candy (down 75%), and 2% or whole milk (down 59%) declined, as did the number of schools allowing the sales of snack foods and beverages in general (down 25%).[25,26,27]**

Sedentary Behavior and Physical Activity, Rhode Island Middle School and High School Students by Gender, 2013

	MIDDLE SCHOOL			HIGH SCHOOL		
	MALE	FEMALE	ALL STUDENTS	MALE	FEMALE	ALL STUDENTS
3 or More Hours of TV on School Days	30%	31%	31%	28%	26%	27%
3 or More Hours of Computer* Time/Video Games on School Days	39%	37%	38%	40%	38%	39%
3 or Fewer Days of Physical Activity** Weekly	34%	43%	38%	38%	50%	44%
2 or Fewer days of Physical Education Weekly	59%	57%	58%	37%	33%	35%

Source: *2013 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis. *Non-school related. **Defined as at least 60 minutes per day.

◆ Technological advances have increased children's overall "screen time, contributing to sedentary lifestyles and increasing risk for obesity.[28,29] In Rhode Island in 2013, nearly a third of middle and high school students reported either spending three or more hours a day on watching TV or playing video games/using a computer for non-school related use on school days, while nearly 40% reported being physically active three or fewer days a week. Middle school students reported attending fewer day of Physical Education (PE) than their high school peers.[30]

◆ The American Academy of Pediatrics recommends that children and adolescents limit their total entertainment screen time to less than two hours per day and be physically active for at least 60 minutes per day.[31,32]

◆ Research has shown that physical activity, including school-based, can help improve academic achievement.[33] In Rhode Island, students are required to receive an average of 100 minutes per week of health and PE instruction.[34] Nationally, the weekly recommended amount of PE is 150 minutes in elementary school and 225 minutes in middle school and high school.[35]

Obesity in Young Children in Rhode Island

Children Enrolled in Head Start

◆ Head Start is a federally-funded comprehensive early childhood program for low-income preschool children and their families.[36] In Rhode Island during the 2013-2014 school year, 2,381 children ages three to five were enrolled in a Head Start program. Of those enrolled, 20% were obese (481), and 20% were overweight (468).[37] Comparable national data show that 16% of children enrolled in Head Start were obese and 13% were overweight during that time.[38]

Children Participating in WIC

◆ The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federally funded preventive program that provides eligible participants with nutritious food, nutrition education, and access to health care and social services.[39] In Rhode Island in 2014, 14,401 children ages two to four were enrolled in WIC, with 17% being obese (2,442).[40]

◆ Since 2011, there has been a 15% decline in the number of Rhode Island children ages two to four participating in WIC who are obese. This decline is partially attributed to new federally-mandated food standards as well as availability and use of nutrition education and assessments.[41]

◆ WIC also tracks the number of children under age five who are at risk for being obese, which is defined as either being overweight themselves (i.e. are age two and older with a BMI between the 85th and 95th percentile) or having a biological parent who is obese (i.e., have a BMI over 30). In 2014, 21% of infants (1,511) and 25% of children ages one to four (5,337) enrolled in WIC in Rhode Island were deemed at risk for being obese.[42]

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(continued on page 177)

Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 19 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 threaten the development of teen parents as well as their children. Teen mothers, particularly younger teen mothers, have difficulty finishing high school and continuing on to college. A recent study found that 38% of mothers who give birth before age 18 had a high school diploma by age 22, compared with 89% of young women who had not given birth as a teen. Less than 2% of teen mothers who give birth before age 18 finish college by age 30.[1]

Two-thirds of families headed by teen mothers live in poverty. About one-quarter of teen mothers have a second child within 24 months of the first baby, creating even greater challenges for the mothers to finish school, find and keep a job, and escape poverty.[2] Teen girls in foster care are almost twice as likely as their peers to get pregnant by age 19.[3]

Children of teen parents are at increased risk for low birthweight and preterm delivery and are more likely to experience child maltreatment and enter foster care.[4,5] They score lower on measures of school readiness and on standardized tests, are more likely to repeat a grade, and are less likely to complete high school compared with children of older mothers. Sons of teen mothers are twice as likely to spend time in prison and daughters of teen mothers are three times more likely to become teen mothers themselves.[6,7]

Despite improvements in recent years, the U.S. teen birth rate remains higher than many other developed countries.[8] After peaking in 1991, the U.S. teen birth rate reached a second consecutive historic low in 2013, with decreases among all racial and ethnic backgrounds. Rhode Island's teen birth rate mirrors national trends, peaking in 1993 and reaching a historic low in 2013.[9,10] Nationally and in Rhode Island, fewer teens are having sex and those that are sexually active are more likely to use contraception.[11,12]

In 2013 in Rhode Island, 664 babies were born to mothers under age 20, accounting for 6% of all babies born.[13]

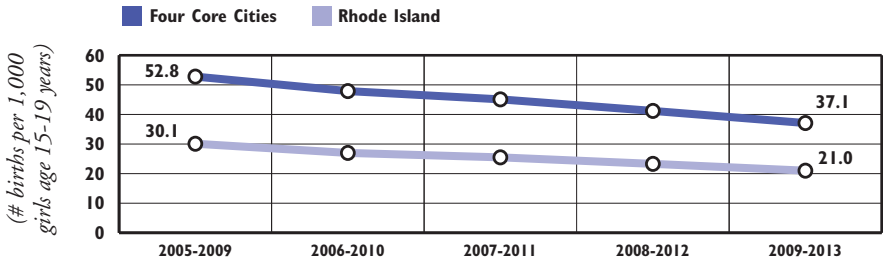
Teen Birth Rates
(rate per 1,000 girls ages 15-19)

	1991	2013
RI	44.7	17.7
US	61.8	26.5
National Rank*		*8th*
New England Rank**		*6th*

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

Sources: For 2013: Martin, J. A., et al. (2015). Births: Final data for 2013. *NVSR, 64*(1). For 1991: Ventura, S. J., et al. (2014). National and state patterns of teen births in the United States. *NVSR, 63*(4).

Teen Birth Rates, Rhode Island, Five Year Averages, 2005-2013



Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2005-2013. Data for 2013 are provisional.

◆ **The five-year average teen birth rate in Rhode Island declined 30% between 2005-2009, and 2009-2013, from 30.1 births per 1,000 teen girls to 21.0. The teen birth rate in the four core cities (Central Falls, Pawtucket, Providence, and Woonsocket) also declined by 30% during that time.[14]**

◆ **In 2013, the birth rate for U.S. teens (26.5 births per 1,000 teen girls) and Rhode Island teens (17.7 births per 1,000 teen girls) were the lowest ever recorded.[15,16]**

◆ **In Rhode Island between 2007 and 2012, the birth rate for Hispanic teens fell by 35% and the birth rate for Black teens fell by 46%. However, birth rates for both Hispanic and Black teens in Rhode Island continue to be much higher than for White and Asian teens.[17]**

Repeat Births to Teens, Rhode Island, 2009-2013

AGE	TOTAL NUMBER OF BIRTHS	NUMBER OF REPEAT BIRTHS	PERCENT REPEAT BIRTHS
15-17	1,286	88	6.8%
18-19	2,901	589	20.3%
Total	*4,187*	*677*	*16.2%*

Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2009-2013. Data for 2013 are provisional.

◆ **Nationally, 17% of all births to teens ages 15-19 in 2013 were repeat births. Since 1991, repeat teen births have declined 23% nationwide.[18] To continue to reduce repeat teen births, it is important to connect pregnant and parenting teens with evidence-based home visiting programs that address a broad range of needs and routinely offer effective postpartum contraception.[19]**

Table 25.

Births to Teens, Ages 15-19, Rhode Island, 2009-2013

CITY/TOWN	NUMBER OF BIRTHS TO GIRLS AGES 15-17	BIRTH RATE PER 1,000 GIRLS AGES 15-17	NUMBER OF BIRTHS TO GIRLS AGES 18-19	BIRTH RATE PER 1,000 GIRLS AGES 18-19	NUMBER OF BIRTHS TO GIRLS AGES 15-19	BIRTH RATE PER 1,000 GIRLS AGES 15-19
Barrington	2	0.9	6	9.0	8	2.7
Bristol	11	7.1	22	5.4	33	5.9
Burrillville	8	4.9	26	34.2	34	14.1
Central Falls	82	37.3	186	128.3	268	73.4
Charlestown	5	6.9	14	NA	19	16.6
Coventry	16	4.2	50	26.3	66	11.5
Cranston	59	7.6	144	29.1	203	16.0
Cumberland	13	3.6	36	21.6	49	9.2
East Greenwich	0	0.0	13	22.6	13	5.4
East Providence	38	9.1	102	40.8	140	21.0
Exeter	5	5.7	11	20.8	16	11.4
Foster	0	0.0	4	NA	4	5.2
Glocester	3	2.7	9	14.9	12	7.0
Hopkinton	5	6.2	14	NA	19	15.6
Jamestown	0	0.0	2	NA	2	2.8
Johnston	14	5.5	48	31.9	62	15.3
Lincoln	8	3.4	24	21.1	32	9.2
Little Compton	0	0.0	1	NA	1	NA
Middletown	9	5.7	27	42.9	36	16.2
Narragansett	3	2.4	5	3.8	8	3.1
New Shoreham	0	0.0	2	NA	2	NA
Newport	31	18.1	76	22.2	107	20.8
North Kingstown	7	2.1	33	29.6	40	9.0
North Providence	23	8.1	53	33.7	76	17.2
North Smithfield	7	5.4	6	10.8	13	7.0
Pawtucket	143	20.0	294	65.0	437	37.5
Portsmouth	6	3.1	7	6.5	13	4.3
Providence	535	29.3	1,036	32.1	1,571	31.1
Richmond	3	3.8	9	NA	12	11.2
Scituate	1	0.8	7	NA	8	4.6
Smithfield	3	1.6	13	4.0	16	3.1
South Kingstown	6	2.1	28	2.5	34	2.4
Tiverton	5	3.6	11	14.5	16	7.4
Warren	4	4.8	20	38.8	24	17.7
Warwick	47	6.4	111	29.0	158	14.2
West Greenwich	1	1.3	7	NA	8	7.2
West Warwick	44	19.9	114	69.1	158	40.9
Westerly	15	6.9	51	56.7	66	21.5
Woonsocket	124	32.6	278	111.2	402	63.8
Unknown	*0*	*NA*	*1*	*NA*	*1*	*NA*
Four Core Cities	*884*	*28.2*	*1,794*	*44.0*	*2,678*	*37.1*
Remainder of State	*402*	*5.6*	*1,106*	*20.0*	*1,508*	*11.9*
Rhode Island	*1,286*	*12.4*	*2,901*	*30.2*	*4,187*	*21.0*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, 2009-2013. Data for 2013 are provisional. The denominators are the number of girls in each age group according to Census 2010 Summary File 1, multiplied by five to compute rates over five years.

In the 2012 Factbook, the denominators for the city/town table were updated with population data from Census 2010. Factbooks prior to 2012 used population data from Census 2000. Changes in rates are affected by the updated population data. Factbooks published before 2007 reported only births to girls ages 15 to 17. The definition of teen childbearing was expanded to include teens ages 15 to 19 to align with reports from the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics.

NA: Rates were not calculated for cities and towns with fewer than 100 teen girls in the age category, as rates with small denominators are statistically unreliable.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Caution should be used with small numbers in numerators and denominators.

References

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(continued on page 178)

Alcohol, Drug, and Tobacco Use by Teens

DEFINITION

Alcohol, drug, and tobacco use by teens is the percentage of middle school and high school students who, on the *SurveyWorks!* student survey, report having used alcohol, illegal drugs, or cigarettes.

SIGNIFICANCE

The use and/or abuse of substances such as alcohol, tobacco, and other drugs by youth poses health and safety risks to them, their families, their schools, and their communities.[1,2,3] Rhode Island ranks among the states with the highest percentages of adolescents reporting use of alcohol and many types of illicit drugs.[4]

Key risk periods for alcohol, tobacco, and other drug abuse occur during major life transitions, including the shifts to middle school and high school, when young people experience new academic, social, and emotional challenges.[5] Adolescents are especially vulnerable to developing substance abuse disorders because their brains are still developing; the prefrontal cortex, responsible for decision making and risk assessment, is not mature until the mid-20s.[6]

Pathways for becoming a substance user involve the relationship between risk and protective factors, which vary in their effect on different people. Risk factors are associated with increased drug use and include early aggressive behavior, lack of parental supervision, peer substance abuse, and poverty. Protective factors lessen the risk of drug use, and include a strong parent-child bond, healthy school environment, academic competence, and a strong neighborhood attachment.[7,8] For over three decades, Hispanic and Black high school seniors in the U.S. have generally had lower rates of substance use than their White peers.[9]

Effective early family and school interventions strengthen protective factors and reduce risk factors to help prevent substance use among young people.[10] If implemented nationwide, effective school-based substance abuse prevention programs are estimated to save $18 in related costs for every $1 invested.[11] Adolescent substance use should be identified and addressed and abuse should be treated as soon as possible.[12]

In Rhode Island in 2012-2013, 3% of youth ages 12-17 needed but did not receive specialty treatment for their alcohol use problem, which is the 22nd highest rate among all states. Four percent of Rhode Island youth ages 12-17 also did not receive any specialty treatment for their illicit drug use. Rhode Island has the fifth highest percentage among all states on this measure.[13]

Substance Use and Related Behaviors, Rhode Island Middle School and High School Students, 2013

	6TH GRADE	8TH GRADE	9TH GRADE	12TH GRADE
Ever had a drink of alcohol in their life	11%	32%	NA	NA
Ever rode in vehicle driven by someone who had been drinking alcohol	13%	26%	NA	NA
Ever used marijuana in their life	3%	15%	26%	56%
Ever taken a prescription drug without a doctor's prescription	3%	7%	9%	21%
Ever used any form of cocaine	2%	2%	4%	7%

Source: *2013 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis. NA = Question not asked.

◆ **Fewer Rhode Island high school students reported current substance use in 2013 than in 1997 (binge drinking fell from 32% to 15%, alcohol consumption declined from 52% to 31%, and marijuana use decreased from 29% to 24%). In 2013, Rhode Island ranked eighth, 16th, and 34th best among states on these respective measures.[14,15]**

Tobacco Use Among Rhode Island Youth

◆ **Current cigarette smoking among U.S. high school students has reached record low levels.[16,17,18] In 2013, 8% of Rhode Island high school students reported smoking cigarettes in the past 30 days, which is the second lowest rate in the nation. Half (52%) of Rhode Island high school students who reported current cigarette use in 2013 also reported trying to quit smoking in the past year.[19,20]**

◆ **Use of cigars and smokeless tobacco products is becoming more common among high school youth.[21] In 2013 in Rhode Island, 7% of high school students reported using smokeless tobacco (fifth best in the U.S.) and 9% reported smoking cigars (fourth best in the U.S.) in the previous month.[22,23]**

◆ **Experimentation with and current use of e-cigarettes has risen sharply among U.S. adolescents. E-cigarette use is associated with increased intention to smoke cigarettes. In 2014, Rhode Island became one of 40 states to prohibit the sale of e-cigarettes to minors.[24,25]**

Table 26. **Alcohol, Marijuana, Prescription Drug, and Cigarette Use by Student Grade Level, Rhode Island, 2013-2014**

SCHOOL DISTRICT	ALCOHOL USE (CURRENT)		MARIJUANA USE (EVER)		PRESCRIPTION DRUG USE (EVER)		CIGARETTE USE (CURRENT)	
	MIDDLE SCHOOL	HIGH SCHOOL	MIDDLE SCHOOL	HIGH SCHOOL	MIDDLE SCHOOL	HIGH SCHOOL	MIDDLE SCHOOL	HIGH SCHOOL
Barrington	3%	26%	2%	31%	3%	11%	2%	12%
Bristol Warren	6%	29%	7%	40%	5%	20%	5%	13%
Burrillville	6%	29%	9%	35%	4%	10%	5%	11%
Central Falls	9%	27%	9%	30%	7%	7%	4%	6%
Chariho	3%	26%	3%	33%	3%	12%	1%	13%
Coventry	4%	23%	4%	34%	2%	13%	2%	13%
Cranston	5%	28%	6%	39%	3%	14%	2%	10%
Cumberland	3%	28%	4%	36%	2%	13%	2%	11%
East Greenwich	2%	30%	2%	27%	2%	10%	1%	6%
East Providence	6%	30%	8%	42%	4%	14%	2%	10%
Exeter-West Greenwich	6%	13%	6%	16%	3%	6%	4%	6%
Foster-Glocester	3%	23%	4%	30%	2%	13%	1%	11%
Jamestown	5%	NA	*	NA	*	NA	*	NA
Johnston	5%	33%	7%	40%	3%	17%	4%	15%
Lincoln	2%	29%	4%	33%	2%	10%	*	7%
Little Compton	NA	NA	NA	NA	NA	NA	NA	NA
Middletown	4%	28%	5%	36%	5%	12%	2%	6%
Narragansett	6%	32%	7%	38%	4%	13%	3%	9%
New Shoreham	*	*	*	27%	*	*	*	*
Newport	7%	32%	12%	48%	3%	16%	2%	10%
North Kingstown	2%	20%	2%	28%	2%	11%	1%	5%
North Providence	6%	28%	8%	42%	4%	11%	3%	11%
North Smithfield	2%	22%	3%	24%	2%	7%	*	7%
Pawtucket	9%	24%	10%	37%	3%	10%	2%	6%
Portsmouth	5%	27%	5%	32%	3%	11%	1%	9%
Providence	11%	24%	10%	31%	5%	9%	3%	5%
Scituate	5%	23%	5%	22%	3%	9%	2%	10%
Smithfield	2%	23%	2%	32%	2%	13%	1%	8%
South Kingstown	5%	24%	8%	29%	3%	11%	2%	8%
Tiverton	6%	27%	8%	40%	3%	13%	2%	12%
Warwick	5%	23%	6%	34%	3%	13%	3%	12%
West Warwick	5%	16%	7%	30%	3%	9%	4%	7%
Westerly	4%	21%	6%	31%	3%	10%	1%	8%
Woonsocket	6%	25%	9%	39%	3%	11%	2%	9%
Four Core Cities	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Remainder of State	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Rhode Island	*6%*	*26%*	*7%*	*34%*	*3%*	*12%*	*2%*	*9%*

Sources of Data for Table/Methodology

Data are from the *SurveyWorks!* student survey tool that was administered during the 2013-2014 school year.

Due to adoption of a new survey tool by the Rhode Island Department of Elementary Education, Alcohol, Drug, and Cigarette Use by Teens in this Factbook can only be compared with Factbooks since 2011.

Data reported as "current" use are for students who answered yes that they ever "have drunk beer, wine or other alcohol (other than for religious ceremonies)" and that they "have drunk alcohol between one and 30 days in the past month" and for those who answered yes that they "have ever smoked a cigarette, even one or two puffs" and that they "have smoked a cigarette in the past 30 days."

Data reported as "ever" use are for students who answered yes that they "have tried marijuana (pot, grass, hash)" and those who answered yes that they "have tried prescription drugs (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's permission." Data on the use of any illicit drugs are not available in the *SurveyWorks!* high school student survey.

NA indicates that the school district does not serve students at that grade level or that no data are available.

*Sample sizes of less than 10 students and instances in which fewer than five students gave a particular response are suppressed. These students are still counted in district totals and in state totals.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

See Methodology section for additional information about *SurveyWorks!*

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Safety

The Star

by Jane Taylor

Twinkle, twinkle, little star
How I wonder what you are!
Up above the world so high,
Like a diamond in the sky.

When the blazing sun is gone,
When he nothing shines upon,
Then you show your little light,
Twinkle, twinkle, all the night.

Then the traveller in the dark,
Thanks you for your tiny spark,
He could not see which way to go,
If you did not twinkle so.

In the dark blue sky you keep,
And often through my curtains peep,
For you never shut your eye,
Till the sun is in the sky.

As your bright and tiny spark,
Lights the traveller in the dark—
Though I know not what you are,
Twinkle, twinkle, little star.

Child Deaths

DEFINITION

Child deaths is the number of deaths from all causes among children ages one 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 health of children, maternal health, access to health care, the dangers to which children are exposed in the community, access to and use of safety devices and practices (such as bicycle helmets and smoke alarms) and the level of adult supervision children receive. Recent declines in the U.S. child death rate are due to increased parental education about the effective use of safety products (such as seat belts and car seats), child safety laws (such as requiring residential smoke detectors and window guards), and better product safety labeling.[1,2]

Nationally, child injuries and deaths disproportionately affect poor children, children under age five, males, and minorities.[3,4] Among children ages one to 14, Native American and Black children have the highest rate of injury deaths and overall child deaths.[5,6]

In Rhode Island between 2009 and 2013, there were 98 deaths of children ages one to 14 (a rate of 11.7 per 100,000 children). Thirty-six (37%) of these children lived in the four core cities and 62 (63%) lived in the remainder of the state. Of the 98 deaths, 64 (65%) were due to disease, 16 (16%) were due to unintentional injuries, 12 (12%) were due to intentional injuries (six homicides and six suicides), and 6 (6%) were due to unknown causes.[7,8] Unintentional injury mortality has declined over the past two decades, but remains the leading cause of death for children ages one to 14 in Rhode Island and in the U.S., after disease.[9,10,11]

Nationally, the leading causes of child injury deaths are motor vehicle accidents and drowning.[12] Child injury deaths can be reduced by raising awareness about injury prevention strategies and the importance of using safety products (such as seat belts), enforcing laws that promote safety (such as speed limits and the mandatory use of child passenger restraints), and through continued environmental and product design improvements (such as flame-resistant sleepwear and safety surfacing on playgrounds).[13]

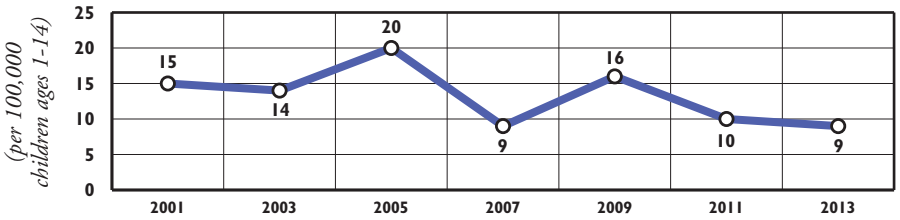
Child Death Rate
(per 100,000 Children Ages 1-14)

	2003	2013
RI	14	9
US	21	16
National Rank*		*1st*
New England Rank**		*1st*

**1st is best; 47th is worst*
***1st is best; 5th is worst*

Source: Centers for Disease Control and Prevention, CDC WONDER, wonder.cdc.gov

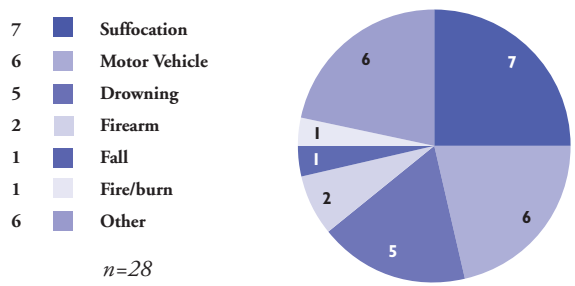
Child Death Rate per 100,000 Children Ages One to 14, Rhode Island, 2001-2013



Source: The Centers for Disease Control and Prevention, CDC WONDER, wonder.cdc.gov. Caution should be used with small numbers in numerators and denominators.

◆ **In 2013, Rhode Island's child death rate for children ages one to 14 was 9 per 100,000 children. This was a decrease from 14 deaths per 100,000 children in 2012, which resulted in Rhode Island's national rank rising from sixth to best in the nation.[14]**

Child Deaths Due to Injury, by Cause, Rhode Island, 2009-2013



Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2009-2013.

◆ **Between 2009 and 2013, 28 Rhode Island children ages one to 14 died as a result of injury. Suffocation, motor vehicle crashes, and drowning were the leading causes of child deaths due to injury in Rhode Island during this time period.[15]**

References

[1] *Infant, child, and teen mortality.* (2015). Washington, DC: Child Trends.

[2] Shore, R. & Shore, B. (2009). *KIDS COUNT indicator brief: Reducing the child death rate.* Baltimore, MD: The Annie E. Casey Foundation.

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Teen Deaths

DEFINITION

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

SIGNIFICANCE

Adolescents' health and safety can be threatened by a variety of risk behaviors, including alcohol, drug abuse, and violence. Teens' emotional health, including self-esteem and mental health, further impacts their safety. Nationally, the most prevalent causes of teen deaths are motor vehicle collisions, homicides, and suicides, all of which are preventable.[1,2,3,4,5]

Factors that protect against teen deaths include parent involvement, access to mental health services designed for adolescents, state policies regulating teens' driving, prevention of teen drinking, and reduced access to guns. School, community, and therapeutic programs can reduce risk behaviors and support positive and healthy youth development.[6,7,8]

Between 2009 and 2013, there were 113 deaths of teens ages 15 to 19 in Rhode Island, a rate of 29.2 per 100,000 teens.[9,10] Thirty-nine (35%) of these teens lived in the four core cities and 74 (65%) lived in the remainder of the state.[11]

Of the teen deaths between 2009 and 2013, 38 (34%) were due to unintentional injuries, 33 (29%) were due to intentional injuries, 27 (24%) were due to disease, 12 (11%) were due to unintentional overdose, and three (3%) were of unknown causes. Of the intentional injuries, 18 were suicides and 15 were homicides.[12]

According to the *2013 Rhode Island Youth Risk Behavior Survey*, 14% of Rhode Island high school students reported attempting suicide one or more times during the past 12 months, an increase of 40% since 1997 (10%).[13] Of the 18 youth ages 15 to 19 who died from suicide between 2009 and 2013 in Rhode Island, 16 were male and two were female.[14] Mental health problems, such as depression and bipolar disorder, as well as substance abuse are associated with an increased risk of suicide among youth.[15]

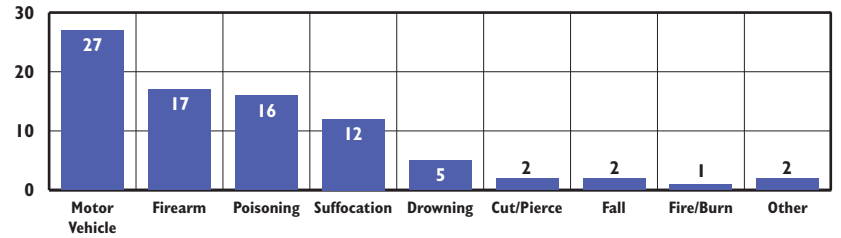
Teen Death Rate
(per 100,000 Youth Ages 15-19)

	2003	2013
RI	65	34
US	66	45
National Rank*		*6th*
New England Rank**		*3rd*

**1st is best; 49th is worst*
***1st is best; 5th is worst*

Source: Centers for Disease Control and Prevention, CDC WONDER, wonder.cdc.gov

Injury Deaths by Cause, Teens Ages 15 to 19, Rhode Island, 2009-2013



n=84

Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2009-2013. Data from 2013 are provisional. This chart and the first bullet below report deaths of teens residing in Rhode Island. Data reported in the second, third, and fourth bullets below reflect teen motor vehicle deaths that occurred in Rhode Island, regardless of residence.

◆ **Between 2009 and 2013 in Rhode Island, 60% of the 84 teen deaths caused by injury were unintentional. Nearly one-third (32%) of all injury deaths involved motor vehicles.[16]**

◆ **Among the 30 teens ages 15 to 19 killed in Rhode Island motor vehicle crashes between 2009 and 2013, 13 were driving, 15 were passengers in vehicles driven by others, one was a pedestrian, and one was a bicyclist.[17]**

◆ **Seven (54%) of the teen drivers who died in motor vehicle crashes in Rhode Island between 2009 and 2013 had been drinking and two teen fatalities occurred with adult drivers who had been drinking.[18]**

◆ **Sixty-nine percent (18) of teen drivers and passengers killed in an automobile accident in Rhode Island between 2009 and 2013 were not wearing a seatbelt.[19]**

◆ **According to the *2013 Rhode Island Youth Risk Behavior Survey*, 20% of Rhode Island high school students reported that during the month before the survey they rode in a vehicle driven by someone who had been drinking, and 6% reported that they never or rarely wore a seatbelt while riding in a car driven by someone else.[20]**

References

[1,6] Shore, R. and Shore, B. (2009). *KIDS COUNT indicator brief: Reducing the teen death rate.* Baltimore, MD: The Annie E. Casey Foundation.

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Youth Violence

DEFINITION

Youth violence is the number of arrests of youths under age 18 in Rhode Island for assault and weapons offenses and the percentage of high school students who report experiencing violence at school. These two measures of youth violence are used to account for violence that leads to arrest as well as some of the violence experienced by youth that may not come to the attention of the police.

SIGNIFICANCE

Youth violence refers to a variety of harmful behaviors that youth can experience as victims, witnesses, or offenders and that can cause emotional harm, injury, or death. Violence can impact the well-being of individuals, families, schools, and communities and can generate high social and economic costs.[1,2]

Effective youth violence prevention aims to reduce factors that place youth at risk for violent behavior and promote factors that protect youth at risk for perpetrating violence.[3] Efforts to prevent youth violence should begin in early childhood and continue through adolescence and address a wide range of individual, family, and community factors. Effective violence prevention strategies include strengthening youth's capacity to choose nonviolence, promoting supportive relationships between youth and adults, and improving economic conditions and safety in communities.[4]

Adolescents engage in risk-taking behaviors and are victims of violence at higher rates than young children or adults.[5] Youth at risk for committing violent acts often live in high-poverty neighborhoods with limited economic opportunities. They are more likely to have histories of substance use, association with delinquent peers, academic failure, poor family functioning, and be victims of child maltreatment.[6,7,8]

Nationally in 2013, one-quarter (25%) of students in grades nine through 12 reported being in a physical fight during the previous year, one in five (20%) reported being bullied on school property during the previous year, and more than one in six (18%) reported carrying a weapon during the previous month.[9]

The number of juveniles arrested for violent crimes in the U.S. reached a 30-year low in 2010, with juveniles making up 14% of all serious violent crime arrests. The Rhode Island juvenile arrest rate for serious violent crimes was 198 per 100,000 youth ages 10 to 17, compared to the U.S. rate of 225 per 100,000 youth ages 10 to 17.[10] In 2013 in Rhode Island, there were 566 juvenile arrests for assault offenses and 119 juvenile arrests for weapons offenses.[11] In 2014, violent crimes made up 4% (213) of the 4,904 juvenile offenses referred to Rhode Island Family Court.[12]

Violent Behavior and Victimization, Rhode Island Public High School Students, 2013

	FEMALES	MALES	TOTAL
Been bullied on school property during the past 12 months	21%	16%	18%
Carried a weapon on school property at least once in the past 30 days	2%	7%	5%
Did not go to school on one or more of the past 30 days because they felt they would be unsafe at school or on their way to or from school	7%	7%	7%
Were in a physical fight at least once in the past 12 months	14%	23%	19%
Were physically hurt on purpose by someone they were dating or going out with during the past 12 months	9%	7%	8%
Were ever physically forced to have sexual intercourse when they did not want to	10%	7%	9%

Source: *2013 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Center for Health Data and Analysis.

◆ **Violence in schools affects individual victims and disrupts the functioning of entire schools and communities.[13] In Rhode Island in 2013, 7% of high school students reported not going to school due to safety concerns and 18% had been bullied at school in the past year.[14]**

◆ **Lesbian, gay, bisexual, and transgender youth, youth with disabilities, and youth with low grades in Rhode Island are more likely than their peers to report experiencing violence, including being part of a physical fight and being the victim of dating violence.[15,16,17]**

◆ **Cyberbullying is bullying that takes place through computers, cell phones, and other electronic devices.[18] In 2013 in Rhode Island, 10% of middle school students reported having embarrassing pictures or rumors spread about them on the internet or through text message, and 12% were harassed or bullied on a social networking site.[19]**

Gun Violence Among Youth

◆ **Guns are the leading instrument of fatal teen violence and are used in 88% of teen homicides and 42% of teen suicides in the U.S.[20] In Rhode Island between 2009 and 2013, there were 146 Emergency Department visits for gunshot injuries, 65 hospitalizations, and 17 deaths of youth ages 15 to 19 attributed to firearms.[21]**

Table 27.

Youth Violence, Rhode Island

CITY/TOWN	COMMUNITY CONTEXT: VIOLENT CRIME OFFENSES (ALL AGES) 2013	COMMUNITY CONTEXT: TOTAL POPULATION AGES 11-17 2010	VIOLENCE IN HIGH SCHOOLS, 2014: % OF STUDENTS SAW ANOTHER STUDENT BRING A WEAPON TO SCHOOL IN PAST YEAR	VIOLENCE IN HIGH SCHOOLS, 2014: % OF STUDENTS IN A PHYSICAL FIGHT AT SCHOOL IN PAST YEAR	JUVENILE ARRESTS FOR VIOLENCE, 2013: # FOR ASSAULT OFFENSES	JUVENILE ARRESTS FOR VIOLENCE, 2013: # FOR WEAPONS OFFENSES	JUVENILE ARRESTS FOR VIOLENCE, 2013: TOTAL # FOR ASSAULT AND WEAPONS OFFENSES
Barrington	3	2,186	14%	6%	4	3	7
Bristol	11	1,545	12%	11%	3	0	3
Burrillville	20	1,526	10%	8%	2	0	2
Central Falls	131	2,089	12%	11%	20	1	21
Charlestown	8	659	23%	9%	0	0	0
Coventry	31	3,509	23%	8%	20	3	23
Cranston	151	6,984	16%	10%	11	0	11
Cumberland	36	3,271	21%	8%	6	0	6
East Greenwich	6	1,671	13%	5%	0	0	0
East Providence	60	3,730	18%	8%	19	3	22
Exeter	NA	673	11%	7%	NA	NA	NA
Foster	3	467	20%	10%	3	0	3
Glocester	3	1,000	20%	10%	2	0	2
Hopkinton	5	826	23%	9%	1	0	1
Jamestown	1	528	14%	8%	0	0	0
Johnston	26	2,376	24%	11%	20	3	23
Lincoln	22	2,189	12%	7%	8	0	8
Little Compton	0	284	11%	7%	0	0	0
Middletown	14	1,504	12%	9%	6	1	7
Narragansett	11	1,052	21%	6%	5	0	5
New Shoreham	3	64	NA	NA	0	0	0
Newport	111	1,484	24%	10%	18	2	20
North Kingstown	25	2,917	14%	8%	9	2	11
North Providence	47	2,303	17%	7%	24	2	26
North Smithfield	14	1,132	10%	6%	1	0	1
Pawtucket	279	6,268	15%	10%	69	9	78
Portsmouth	9	1,881	11%	7%	8	0	8
Providence	1,115	16,024	18%	10%	182	51	233
Richmond	5	759	23%	9%	5	0	5
Scituate	3	1,143	13%	8%	0	0	0
Smithfield	16	1,729	10%	8%	15	1	16
South Kingstown	21	2,498	16%	9%	16	0	16
Tiverton	21	1,318	13%	12%	6	1	7
Warren	12	777	12%	11%	2	0	2
Warwick	93	6,781	14%	10%	25	2	27
West Greenwich	7	678	11%	7%	1	0	1
West Warwick	54	2,139	13%	9%	19	1	20
Westerly	24	2,003	13%	7%	5	2	7
Woonsocket	241	3,649	22%	12%	28	4	32
State Police/Other	*NA*	*NA*	*NA*	*NA*	*4*	*2*	*6*
Four Core Cities	*1,766*	*28,030*	*NA*	*NA*	*299*	*65*	*364*
Remainder of State	*876*	*65,586*	*NA*	*NA*	*264*	*26*	*290*
Rhode Island	*2,642*	*93,616*	*16%*	*9%*	*567*	*93*	*660*

Note to Table

Due to a change in the *SurveyWorks!* question format, the weapons data in Violence in High Schools cannot be compared to Factbooks since 2014. In earlier years, the *SurveyWorks!* survey asked students if they had brought a weapon to school in the past year; since then, students are asked if they had seen another student with a weapon at school in the past year.

Sources of Data for Table/Methodology

Total violent crime offense data are from U.S. Department of Justice, Federal Bureau of Investigation. (2014). *Crime in the United States 2013: Rhode Island offenses known to law enforcement.* Retrieved February 18, 2015, from www.fbi.gov

Total population ages 11-17 data are from U.S. Census Bureau, Census 2010.

High school students experiencing violence at school data are from *SurveyWorks!* student survey, Rhode Island Department of Education, 2014. Percentages reflect students answering yes to the question of whether "they saw a student with a weapon like a gun, knife, or club at this school" and "they were in a physical fight at school" in the 12 months prior to the survey. *SurveyWorks!* data for communities that belong to regional districts reflect the district's overall survey results. Students from Little Compton attend high school in Portsmouth and students from Jamestown attend high school in North Kingstown.

Juvenile arrests for assault and weapons offenses data are from Mongeau, T. & Tocco, G. (2014). *2013 juvenile detention data.* Providence, RI: Rhode Island Department of Public Safety, Grant Administration Office. A complete list of assault and weapons offenses can be found in the Methodology Section of this Factbook.

NA indicates that the data are not available. Exeter arrest numbers are included in the State Police totals.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

[1,7] Centers for Disease Control and Prevention. (2012). *Understanding youth violence: Fact sheet.* Retrieved February 18, 2015, from www.cdc.gov

[2,4,6,9] David-Ferdon, C. and Simon, T. R. (2014). *Preventing youth violence: Opportunities for action.* Atlanta, GA: Centers for Disease Control and Prevention.

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Gun Violence

DEFINITION

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

SIGNIFICANCE

Children and youth can experience gun violence as victims of firearm assaults, self-inflicted firearm injuries, or accidental shootings.[1] Gun violence also can impact children and youth when someone they know is the victim or perpetrator of a shooting. Exposure to violence at home, in schools, and in the community can lead to lasting psychological and emotional damage (such as increased fear, anxiety, and depression, attachment problems, and conduct disorders), as well as cognitive and attention difficulties, and involvement in the child welfare and juvenile justice systems.[2,3,4]

In the U.S. during 2012, 62% of the 2,694 firearm deaths of children and youth under age 20 in the United States were the result of homicide, 32% were the result of suicide, 4% were the result of unintentional injuries, 1% was the result of shootings with an undetermined intent, and 1% was the result of a legal intervention (e.g., law enforcement shooting).[5]

While the number of children and youth killed by guns has decreased since peaking in the early 1990s, firearms remain one of the leading causes of deaths for youth ages 15 to 19 in the United States.[6,7] Of the 2,694 U.S. children and youth under age 20 killed by firearms during 2012, 85% (2,283) were ages 15 to 19. Children under age 15 have the lowest rates of firearm-related deaths of any age group.[8]

Nationally, males ages 15 to 19 are nearly eight times more likely to die from a firearm-related incident than females of the same age. Among teens in the U.S., the rate of firearm deaths for Black males (53.0 per 100,000) was more than three times the rate of Hispanic males (15.4 per 100,000) and five times the rate of White males (10.6 per 100,000) in 2012.[9]

Preventing access to guns is the most reliable measure to prevent firearm-related injuries and death in children and youth. The presence and availability of a gun is strongly associated with adolescent suicide risk. Possessing a gun also increases a person's risk for being shot in an assault. Keeping guns unloaded and locked, as well as storing and locking ammunition separately, reduces the risk of gun-related injury and death by suicide or homicide.[10,11]

Gun-Related Emergency Department (ED) Visits, Hospitalizations, and Deaths Among Children and Youth, Rhode Island, 2009-2013

AGE	# OF ED VISITS	# OF HOSPITALIZATIONS	# OF DEATHS
1 to 14	52	8	2
15 to 17	71	25	5
18 to 19	75	40	12
TOTAL	*198*	*73*	*19*

Source: Rhode Island Department of Health, Center for Health Data and Analysis, 2009-2013.

◆ **Between 2009 and 2013 in Rhode Island, 17% (19) of the 112 injury deaths of children and youth under age 20 were the result of firearms. Of these, 63% (12) were among youth ages 18 to 19, 26% (5) were among youth ages 15 to 17, and 11% (2) were among children ages 14 or younger. Between 2009 and 2013 in Rhode Island, there were three youth between ages 15 and 19 who committed suicide using a firearm.[12]**

◆ **In Rhode Island between 2009 and 2013, there were 198 emergency department visits and 73 hospitalizations of children and youth for gun-related injuries.[13]**

Weapon Carrying Among Rhode Island Public High School Students, 2013

	FEMALES	MALES	TOTAL
Carried a gun at least once in the past 30 days	2%	9%	6%
Carried a weapon on school property at least once in the past 30 days	2%	7%	5%

Source: *2013 Rhode Island Youth Risk Behavior Survey,* Rhode Island Department of Health, Office of Health Statistics.

◆ **In Rhode Island, male students report higher rates of weapon carrying on school property and gun carrying than females. Rhode Island rates are consistent with national figures.[14,15,16]**

References

[1] Murphy, S. L., Xu, J. Q. & Kochanek, K. D. (2013). Deaths: Final data for 2010. *National Vital Statistics Reports, 61*(4). Retrieved January 19, 2015, from www.cdc.gov

[2] Finkelhor, D., Turner, H., Ormrod, R., Hamby, S. & Kracke, K. (2009). *Children's exposure to violence: A comprehensive national survey.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

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Homeless and Runaway Youth

DEFINITION

Homeless and runaway youth is the number of youth in Rhode Island who accessed emergency shelter services without their families or who were absent without leave (AWOL) from state care placements (including youth in child welfare and juvenile justice community placements).

SIGNIFICANCE

There are three primary causes of homelessness among youth – family conflict, residential instability resulting from foster care and institutional placements, and economic problems. Many youth run away due to physical and sexual abuse, strained family relationships, substance abuse by a family member, and/or parental neglect.[1,2]

Youth may become homeless when they run away from or are discharged from the foster care system. In U.S. shelters, more than one in five homeless youth comes directly from foster care and more than one in four were in foster care in the previous year.[3] Homeless youth with foster care histories often become homeless at an earlier age and remain homeless longer than their peers.[4] While there are estimated to be nearly 1.7 million U.S. youth experiencing homelessness annually, less than 5% of federal spending on homeless programs is for homeless children and youth.[5,6]

Youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) are overrepresented in the homeless youth population, some of whom report being forced out of their homes by parents who disapprove of their sexual orientation or gender identity.[7,8,] LGBTQ homeless youth experience greater levels of violence and physical and sexual exploitation while on the streets and in shelters than their heterosexual peers.[9,10]

It is often difficult for homeless youth to obtain the food, clothing, and shelter they need. Many turn to prostitution, theft, and/or selling drugs to provide for their basic needs. Consequently, homeless youth face an increased risk of arrests and are more likely to become pregnant and/or contract sexually transmitted infections.[11,12]

Homeless youth often are disconnected from education, employment, medical, and mental health care.[13,14] They can have difficulty enrolling in school and are more likely than their peers to be suspended, expelled, repeat grades, and drop out.[15,16,17] Homeless youth experience higher rates of mortality and depression, post-traumatic stress disorder, substance abuse, and other mental health problems than youth with stable housing.[18,19] Homeless youth also have trouble accessing physical and mental health services because they may be asked for a permanent address, health insurance information, or parental permission for treatment.[20,21]

Homeless Youth in Rhode Island

- **There is one emergency shelter in Rhode Island tailored to the needs of unaccompanied and runaway homeless youth. This shelter became a federal Family and Youth Services Bureau grantee beginning October 1, 2014.[22]**

- **During the 2013-2014 school year, Rhode Island public school personnel identified 24 unaccompanied homeless youth.[23]**

- **An estimated 97 single youth ages 18 to 20 and 266 young adults ages 21 to 24 received emergency shelter services though the adult emergency shelter system in Rhode Island in 2014, compared to 50 18 to 20 year-olds and 179 21 to 24 year-olds in 2013.[24,25]**

- **In 2013, the National Runaway Switchboard handled 104 crisis-related calls regarding youth ages 21 and under who were homeless, runaways, or at risk of homelessness in Rhode Island. Nationally, 60% of callers to the Switchboard were youth and the remainder were friends, family, probation officers, and other adults.[26]**

- **On December 31, 2014, there were 52 youth in the care of the Rhode Island Department of Children, Youth and Families between the ages of 13 and 20 who were classified as unauthorized absences/runaways (AWOL), 26 of whom were male and 26 of whom were female. These youth were AWOL from either foster care or juvenile justice placements.[27]**

- **There were an additional 158 youth ages 13 to 17 who received emergency shelter services with their families in Rhode Island in 2014.[28] These youth are vulnerable to being separated from their families due to shelter or child welfare policies.[29]**

References

[1,4,10,11,13,17,29] National Conference of State Legislatures. (2013). *Homeless and runaway youth.* Retrieved March 9, 2015, from www.ncsl.org

[2,3] National Coalition for the Homeless. (2008). *Homeless youth.* Retrieved March 5, 2015, from www.nationalhomeless.org

[5,8] *LGBTQ youth national policy statement - LGBTQ youth homelessness.* (2012). Washington, DC: National Alliance to End Homelessness.

[6,9] Quintana, N. S., Rosenthal, J. & Krehely, J. (2010). *On the streets: The federal response to gay and transgender homeless youth.* Washington, DC: Center for American Progress.

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Youth Referred to Family Court

DEFINITION

Youth referred to Family Court is the percentage of youth ages 10 to 17 referred to Rhode Island Family Court for wayward or delinquent offenses.

SIGNIFICANCE

Risk factors for juvenile delinquency and involvement in the juvenile justice system include association with other delinquent youth, cognitive impairments, academic and learning difficulties, poor parenting, child maltreatment, and high levels of community disorganization and violence.[1]

The Rhode Island Family Court has jurisdiction over children and youth under age 18 referred for wayward and delinquent offenses. When a police or school department refers a youth to Family Court, a petition is submitted, accompanied by an incident report, detailing the alleged violation of law.[2] During 2014 in Rhode Island, 2,713 youth (3% of Rhode Island youth between the ages of 10 and 17) were referred to Family Court for 4,904 wayward and delinquent offenses, down from 2,926 youth and 4,964 offenses in 2013, and continuing a downward trend over the last five years. Of the juvenile offenses in 2014, 213 (4%) involved violent offenses (54% of which occurred in the four core cities). An additional 702 probation violations also came before the Family Court in 2014.[3,4,5]

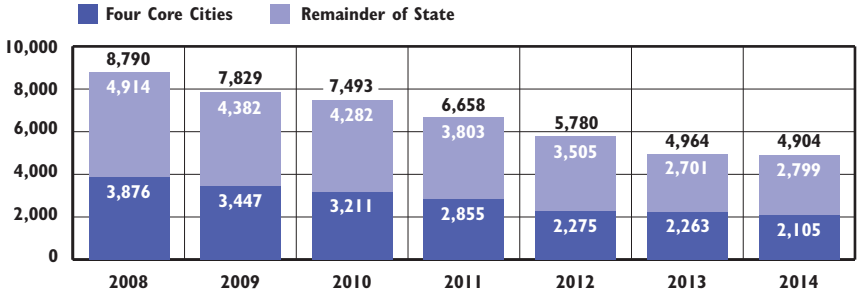
Youth in the four core cities are more likely to be referred for wayward or delinquent offenses; however, the majority of youth referred to Family Court lives in the remainder of the state. In 2014 in Rhode Island, 23% of juvenile offenses referred to Family Court were committed by youth from Providence, 20% were committed by youth from the other three core cities and 57% were committed by youth living in the remainder of the state.[6,7]

Assessing the risk of re-arrest and intervention needs of each youth is necessary for providing appropriate supports to prevent recidivism.[8] Seventeen percent of youth referred to the Family Court in 2014 had been referred once before and 23% had been referred at least twice before.[9]

Research shows that an over-reliance on incarceration of youth is not cost-effective and leads to worse public safety outcomes and higher recidivism rates than the use of community-based alternatives to incarceration.[10,11]

Key components of successful community-based programs to prevent juvenile recidivism are the provision of family therapy and an acknowledgment of the critical role families, homes, and communities play in resolving delinquency. Successful programs also work with youths' strengths and provide a wide range of services and resources tailored to the needs of youth and their families.[12]

Juvenile Wayward/Delinquent Offenses Referred to Rhode Island Family Court, 2008-2014



◆ **The number of children and youth referred to Family Court for wayward and delinquent offenses declined 48% between 2008 and 2014, from 5,242 to 2,713. During the same period, the number of juvenile offenses declined by 44%, from 8,790 to 4,904.**

◆ **In 2014, offenses referred to the Family Court involved 69% males and 31% females. Forty-eight percent of offenses involved White youth, 22% Black youth, 16% Hispanic youth, 1% Asian youth, and 13% involved youth of some other race or an unknown race.**

◆ **In 2014, 8% of offenses referred to Family Court involved youth ages 12 or younger, 42% youth ages 13 to 15, 49% youth ages 16 to 17, and 1% of unknown age.**

BY TYPE OF OFFENSE

23%	Status Offenses*	3%	Alcohol and Drug Offenses
23%	Property Crimes	4%	Violent Crimes
21%	Disorderly Conduct	4%	Motor Vehicle Offenses
11%	Simple Assault	4%	Weapons Offenses
		7%	Other**

n=4,904

**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, computer crimes and possession of a manipulative device for automobiles, etc. Probation violations, contempt of court, and other violations of court orders are not included in the offenses above.*

Source: Rhode Island Family Court, *2008-2014 Juvenile Offense Reports.* Percentages may not sum to 100% due to rounding.

Alternatives to Incarceration for Juvenile Offenders in Rhode Island

◆ Juvenile courts have a wide range of options for handling juvenile offenders, including restitution, community service, revocation of driving privileges, counseling, substance abuse treatment, and probation.[13] In 2014 in Rhode Island, 20% of all cases referred to Family Court were diverted instead of proceeding to a formal court hearing.[14]

◆ The Rhode Island Family Court administers several alternatives to traditional court hearings, including the Truancy Court and the Juvenile Drug Court. In 2014, 1,192 youth were referred to the Truancy Court by schools. In 2014, 86 youth who committed drug offenses or had highlighted drug issues were diverted to the Juvenile Drug Court pre-adjudication.[15] Youth referred to the Drug Court undergo a six- to twelve-month program that includes intensive court supervision, drug treatment, and educational and employment services.[16]

◆ In 2013, there were 34 Juvenile Hearing Boards in Rhode Island. Five communities did not have Juvenile Hearing Boards (Central Falls, Little Compton, North Providence, Richmond, and South Kingstown). Comprised of volunteer community members, these Boards permit the diversion of youth accused of status offenses or misdemeanors. Sanction options in this process include but are not limited to community service, restitution, and counseling. Rhode Island Juvenile Hearing Boards reported hearing 404 cases in 2013 (the most recent year for which data are available).[17,18]

Lesbian, Gay, Bisexual, and Transgender Youth in Juvenile Courts

◆ Many lesbian, gay, bisexual, and transgender (LGBT) youth experience family rejection, conflicts at home, and bullying and harassment in school due to their gender identity or sexual orientation. These factors increase LGBT youth's risk of family court involvement for status offenses (like running away), survival crimes (like shoplifting and prostitution), truancy related to safety issues at school, and assault charges related to self defense. Training and resources for adults working in the juvenile justice system about the specific family, social, and developmental challenges faced by LGBT youth can help support positive outcomes for these youth.[19]

Juveniles Tried as Adults

◆ Youth tried and punished in the adult court system are more likely to re-offend and to commit future violent crimes than youth who commit similar crimes but who are in juvenile systems. Adolescents in the adult criminal justice system are at risk for sexual and physical victimization and disruptions in their development, including identity formation and relationship skills.[20,21]

◆ Behavioral research shows that most youth offenders will stop breaking the law as part of normal development and that adolescents are less able than adults to weigh risks and consequences and resist peer pressure. Research also shows that judgment and decision-making skills do not fully develop until the mid-twenties.[22,23]

◆ When a juvenile has committed a heinous and/or premeditated felony offense or has a history of felony offenses, the Rhode Island Attorney General may request that the Family Court Judge voluntarily waive jurisdiction so that the juvenile may be tried as an adult in Superior Court. Waiver of jurisdiction is mandatory for juveniles who are 17 years old and who are charged with murder, first degree sexual assault, or assault with intent to commit murder.[24]

◆ In 2014, the Attorney General's Office filed 19 (17 discretionary and two mandatory) motions to waive jurisdiction to try juveniles as adults. Eight youth were waived voluntarily, three were waived after a hearing, three waiver motions were dismissed, and five were pending before the Family Court at the end of 2014. One additional waiver motion was filed during 2013 was decided in 2014 (this youth was waived after a hearing).[25]

◆ A juvenile in Rhode Island also may be "certified," allowing the family court to sentence the juvenile beyond age 19 if there is otherwise an insufficient period of time in which to accomplish rehabilitation. There were five certifications in 2014 (four resulted in a certification and one was pending at the end of 2014).[26] While the child is a minor, the sentence is served at the Training School. The youth can be transferred to an adult facility upon reaching age 19, if the court deems it appropriate.[27]

References

[1] Shader, Michael. (n.d.). *Risk factors for delinquency: An overview.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention. Retrieved February 4, 2014, from www.ncjrs.gov

[2] Rhode Island Family Court. (n.d.). *About the Family Court.* Retrieved February 25, 2013, from www.courts.ri.gov

(continued on page 180)

Youth at the Training School

DEFINITION

Youth at the Training School is the number of youth age 18 or under who were in the care or custody of the Rhode Island Training School at any time during the calendar year, including youth in community placements while in the care or custody of the Training School.

SIGNIFICANCE

The juvenile justice system is responsible for ensuring community safety by promoting the positive development of youth in its care while recognizing that children have different developmental needs than adults.[1]

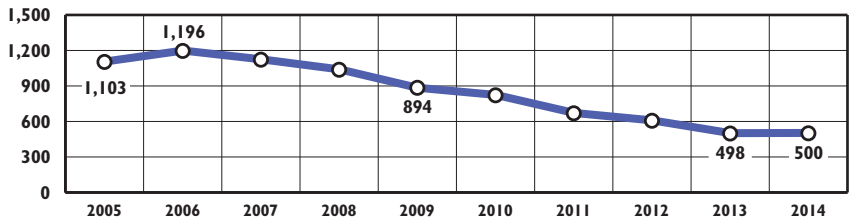
During adolescence, the brain's executive functions (including the ability to regulate emotions, control impulses, and weigh benefits and risk) have not fully developed and judgment and decision-making skills continue to grow into the mid-twenties.[2] Compared to adults, adolescents often show poor self-control, are easily influenced by peers, and less likely to think through the consequences of their actions. Most youth involved in delinquency in adolescence will cease engaging in law-breaking behavior when they become adults as part of the normal maturation process.[3]

Juvenile justice systems have a range of options for monitoring and rehabilitating youth in addition to incarceration, including probation, restorative justice programs, and evidence-based treatment programs such as Functional Family Therapy, Multi-Systemic Therapy, and Multi-Dimensional Treatment Foster Care. Alternatives to incarceration have been shown to be more effective in preventing recidivism and more cost-effective than incarceration. The most successful programs involve family in treatment and promote healthy development at the individual, family, school, and peer levels.[4,5,6]

The Rhode Island Department of Children, Youth and Families (DCYF) operates the Rhode Island Training School, the state's secure facility for adjudicated youth and youth in detention awaiting trial. A total of 500 youth (85% male and 15% female) were in the care or custody of the Training School at some point during 2014, up slightly from 498 in 2013. On December 31, 2014, there were 163 youth in the care or custody of the Training School, 97 of whom were physically at the Training School.[7]

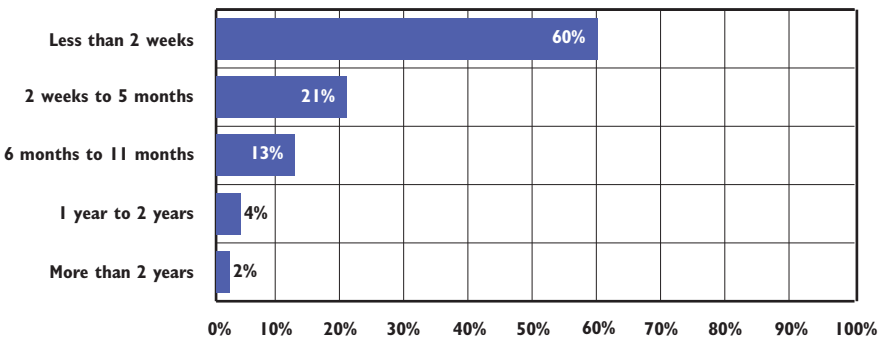
In 2008, the Rhode Island General Assembly instituted a cap on the number of detained and adjudicated youth at the Training School. On any given day, the limit is 148 boys and 12 girls.[8]

Youth in the Care and Custody of the Rhode Island Training School, 2005-2014



◆ **Between 2005 and 2014, the annual total number of youth in the care and custody of the Training School declined from 1,103 to 500. Some of this decline is due to the cap that was placed on the population at the Training School in July 2008 of 148 boys and 12 girls on any given day. The population further declined by 44% between 2009 and 2013 but leveled off during 2014.**

Discharges From the Rhode Island Training School, by Length of Time in Custody, 2014



n=622

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2005-2014. Total discharges (622) are higher than the total number of youth who passed through the Training School (500) due to some youth being discharged from the Training School more than once in 2014.

Youth at the Training School

Youth at the Training School by Age

◆ During 2014, the average age for youth at the Training School was 15.9 years. During 2014, there were two children age 10 or under held at the Training School, six children ages 11-12, 70 youth ages 13-14, 242 youth ages 15-16, and 205 youth ages 17-18.[9]

◆ Rhode Island is one of 15 states that has no statutory minimum age for holding children in secure confinement and no minimum age of delinquency jurisdiction.[10]

Promoting Rehabilitation and Preventing Recidivism

◆ Nationally and in Rhode Island, youth crime, including violent crime, has fallen sharply since 1995.[11] In 2010, the rate at which states hold youth in secure confinement reached a 35-year low, with almost every state reducing the number and percentage of youth held in secure facilities.[12]

◆ The Rhode Island Training School is an important resource for the rehabilitation of youth who commit serious offenses and who pose a danger to the community. However, a growing body of research shows that incarceration of youth does not reduce and can even increase criminal behavior, as well as increase recidivism among youth with less-serious offense histories. Research also suggests that increasing the length of time a youth is held in secure confinement has no impact on future offending and that sentencing youth to long stays in correctional facilities is an ineffective rehabilitation strategy.[13,14]

◆ Jurisdictions throughout the country have used objective admissions screening tools to limit the use of secure detention to serious offenders. The Rhode Island General Assembly passed a law in 2008 mandating the use of a screening tool for Rhode Island youth being considered for secure detention.[15,16]

◆ Of the 500 youth who were in the care or custody of the Training School at some point during 2014, 22% (108) were admitted at least twice in 2014, and 5% (23) were admitted to the Training School three or more times.[17]

Probation for Rhode Island Youth

◆ The Juvenile Probation division at DCYF works to rehabilitate youth in the community to ensure public safety and full compliance with court orders and conditions of probation. Adolescents are placed on probation by the Family Court either as an alternative to incarceration at the Training School or as the final part of their sentence after being incarcerated at the Training School.[18]

◆ On January 2, 2015, there were 578 youth on the DCYF probation caseload (506 males, 71 females, and one youth of unknown gender). Three percent (18) of youth on probation were ages 12 to 13, 21% (119) were ages 14 to 15, 56% (323) were ages 16 to 17, and 20% (118) were age 18 or older.[19]

◆ Almost half (47%) of youth on probation on January 2, 2015 were White, 21% were Black, 1% were Asian or Pacific Islander, 1% were American Indian, 7% were multiracial, and 21% were of undetermined race. Twenty-nine percent of youth were identified as Hispanic. Hispanic youth may be of any race.[20]

Juvenile Detention Alternatives Initiative (JDAI)

◆ The Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI) works in jurisdictions across the U.S. to strengthen juvenile justice systems by promoting policies and practices to reduce inappropriate and unnecessary use of secure detention, reduce racial and ethnic disparities, and improve public safety. JDAI promotes the vision that youth involved in the juvenile justice system are best served using proven, family-focused interventions, and creating opportunities for positive youth development. For youth who are not a threat to public safety, JDAI promotes the use of high-quality community-based programs that provide supervision, accountability, and therapeutic services while avoiding some of the negative outcomes associated with incarceration.

◆ In 2009, Rhode Island juvenile justice stakeholders joined in partnership with the Annie E. Casey Foundation to become a statewide JDAI site. The Rhode Island initiative has used JDAI's strategies to focus on reducing unnecessary and inappropriate use of secure confinement and enhancing community-based alternatives to detention.[21]

Youth at the Training School

Disproportionate Minority Contact in Juvenile Justice Systems

◆ Minority youth, especially Black youth, are disproportionately represented at every stage of the juvenile justice system. Youth of color are more likely to be arrested, formally charged in court, placed in secure detention, and receive harsher treatment than White youth.[22] The federal *Juvenile Justice and Delinquency Prevention Act (JJDPA)* requires states to collect data and implement strategies to reduce disproportionate minority contact with the juvenile justice system.[23]

Disproportionate Minority Contact in Rhode Island

	% OF TOTAL CHILD POPULATION, 2010	% OF YOUTH IN THE CARE AND CUSTODY OF RHODE ISLAND TRAINING SCHOOL, 2014
White	64%	34%
Hispanic	21%	34%
Black	6%	20%
Asian	3%	1%
Multi-Racial	5%	9%
Other*	2%	2%
Unknown	NA	1%
n=	*223,956*	*500*

◆ Youth of color are disproportionately more likely than White youth to be detained or sentenced to the Training School. During 2014, Black youth made up 20% of youth at the Training School, while making up 6% of the child population.

** Other includes American Indian and Alaska Native, Native Hawaiian and other Pacific Islander, and Some other race.*

Sources: Child Population data by race are from the U.S. Census Bureau, 2010 Census. Youth at the Training School data are from the Rhode Island Department of Children, Youth and Families (DCYF). Percentages may not sum to 100% due to rounding.

Girls in the Juvenile Justice System

◆ Girls in the juvenile justice system enter with different personal and offense histories and needs than their male peers. Girls are more likely than boys to be detained for non-serious offenses and many have experienced traumatic events, including physical and sexual abuse. Effective programs for girls in the juvenile justice system promote healing from trauma and abuse, address mental and physical health issues, and meet the needs of pregnant and parenting girls.[24]

Risk Factors for Rhode Island Youth at the Training School

History of Child Abuse and Neglect

◆ Twenty-eight (6%) of the 500 youth in the care or custody of the Training School during 2014 had at some point in their childhood been victims of documented child abuse or neglect.[25]

◆ Nationally, youth in child welfare systems are 2.5 times more likely to enter the juvenile justice system if they are placed in group homes instead of foster care homes.[26]

Behavioral Health Needs

◆ In 2014, 165 youth (144 males and 21 females) received mental health services at the Training School for psychiatric diagnoses other than conduct disorders and substance abuse disorders. During 2014, 120 residents (108 males and 12 females) received substance abuse treatment services at the Training School. Of these, 67 (all males) received residential substance abuse treatment.[27]

Educational Attainment

◆ While the average age of youth at the Training School in 2014 was 15.9, students' math skills were on average at the sixth grade level and their reading levels were on average at the seventh grade level at entry to the Training School.

◆ Of the youth in seventh through twelfth grade who received educational services at the Training School during 2014, 40% received special education services and had Individualized Education Plans (IEPs).

◆ During 2014, 46 youth graduated from high school while serving a sentence at the Training School (40 earned a GED and six graduated with a high school diploma). An additional 102 youth received post-secondary education services at the Training School in 2014.[28]

Teen Pregnancy and Parenting

◆ Nationally, 20% of youth in custody report having a child or expecting a child. The percentage of youth in custody who report they already have children (15% of boys and 9% of girls) is much higher than the general population (2% of boys and 6% of girls).[29]

Youth in Detention in Rhode Island

◆ In Rhode Island, the term "detention" is used to describe the temporary custody of a juvenile, who is accused of a wayward or delinquent offense, at the Training School pending the adjudication of his or her case. The legal reasons for pre-trial detention include cases where a youth poses a threat to public safety or is at risk for not attending his or her next court hearing.[30,31]

◆ In 2014, there were 622 admissions to detention at the Training School, up from from 597 in 2013. Of these, 27% resulted in stays of two days or less, 33% resulted in stays of three days to two weeks, and 41% resulted in stays of more than two weeks.[32]

Table 28. **Youth in the Care or Custody of the Rhode Island Island Training School, 2014**

CITY/TOWN	TOTAL POPULATION AGES 13-18	# OF ADJUDICATED YOUTH AT THE RITS	TOTAL # OF YOUTH AT THE RITS
Barrington	1,802	1	2
Bristol	1,780	0	2
Burrillville	1,319	2	6
Central Falls	1,859	3	17
Charlestown	554	0	1
Coventry	3,010	8	16
Cranston	6,184	12	25
Cumberland	2,746	5	7
East Greenwich	1,362	1	1
East Providence	3,243	7	20
Exeter	642	0	0
Foster	430	0	1
Glocester	878	0	0
Hopkinton	693	0	2
Jamestown	436	0	0
Johnston	2,025	2	6
Lincoln	1,851	1	5
Little Compton	228	0	0
Middletown	1,229	1	10
Narragansett	948	0	2
New Shoreham	50	0	0
Newport	1,604	3	21
North Kingstown	2,407	1	3
North Providence	2,027	3	10
North Smithfield	970	1	4
Pawtucket	5,514	26	53
Portsmouth	1,596	0	3
Providence	16,515	89	160
Richmond	637	1	1
Scituate	963	2	2
Smithfield	1,856	1	5
South Kingstown	3,540	2	4
Tiverton	1,115	2	2
Warren	675	1	4
Warwick	5,883	9	23
West Greenwich	568	0	1
West Warwick	1,891	7	18
Westerly	1,705	0	7
Woonsocket	3,112	21	38
Out-of-State	*NA*	*9*	*19*
Four Core Cities	*27,000*	*139*	*268*
Remainder of State	*58,847*	*73*	*214*
Rhode Island	*85,847*	*212*	*482*

Source of Data for Table/Methodology

Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2014 and the U.S. Census Bureau, Census 2010.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Youth included in the adjudicated column may or may not have been in detention at the Training School prior to adjudication.

Total number of youth includes adjudicated and detained youth who were in the care or custody of the Rhode Island Training School during Calendar Year 2014 (including youth from out of state, those with unknown addresses, and those in temporary community placements). Youth with out-of-state and unknown addresses are not included in the Rhode Island, four core cities, or remainder of state totals.

There is no statutory lower age limit for sentencing, however adjudicated children under age 13 typically do not serve sentences at the Training School.

An "out-of-state" designation is given to youth whose parent(s) have an address on file that is outside of Rhode Island or to a youth who lives in another state, but commits a crime in Rhode Island and is sentenced to serve time at the Training School. They are not included in the Rhode Island total.

References

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[6,13] *No place for kids: The case for reducing juvenile incarceration.* (2011). Baltimore, MD: The Annie E. Casey Foundation.

(continued on page 180)

Children of Incarcerated Parents

DEFINITION

Children of incarcerated parents is the number of children with parents serving sentences at the Rhode Island Department of Corrections per 1,000 children under age 18. The data are reported by the place of the parent's last residence before entering prison and do not include Rhode Island children who have parents incarcerated at other locations.

SIGNIFICANCE

Approximately 1.7 million children in the U.S. have a parent incarcerated in state or federal prison, and a quarter of minor children with a parent in prison are under age five.[1]

Having an incarcerated parent can negatively impact the quality of a child's attachment to their parent, which can lead to developmental regression, withdrawal, aggression, and other reactive behaviors.[2] Parental incarceration can affect a child's emotional and behavioral development. Children of incarcerated parents are more likely to suffer from depression or anxiety, have an eating or sleeping disorder, and be expelled or suspended from school. They also are more likely to engage in delinquent behavior and to be arrested and incarcerated as juveniles.[3]

Nationally, most children of incarcerated parents live with their other parent (84%), a grandparent (15%), and/or other relatives (6%).[4] Relative caregivers often experience significant economic hardship. They may be unaware that they are eligible for services, may be worried about stigma, or may have concerns about accessing services through the child welfare system (i.e., a formal kinship care arrangement).[5]

Children of incarcerated parents are more likely than other children to be involved with the child welfare system.[6] In the U.S. in 2009, more than 14,000 children entered foster care at least in part due to the incarceration of a parent.[7] These children often represent complex cases for child welfare agencies that involve balancing parental rights with the safety and well-being of the child.[8]

Programs and policies targeted at the unique needs of incarcerated pregnant women and mothers can improve outcomes for them and their families.[9] Keeping siblings together, providing family counseling and access to mental health care, mentoring, peer support services, and prison transition supports can alleviate the worst effects of parents' imprisonment on their children and improve the family reunification process.[10]

Of the 1,829 Rhode Island parents incarcerated on October 10, 2014 (including those awaiting trial), 45% were White, 30% were Black, 22% were Hispanic, and 3% were of another or unknown race. Sixty-two percent of incarcerated parents with a known in-state residence identified one of the four core cities as their last place of residence.[11]

Parents at the Rhode Island Adult Correctional Institute, October 10, 2014

	INMATES SURVEYED*	# REPORTING CHILDREN	% REPORTING CHILDREN	# OF CHILDREN REPORTED
Awaiting Trial	764	431	56%	914
Serving a Sentence	2,495	1,398	56%	3,006
TOTAL	*3,259*	*1,829*	*56%*	*3,920*

Source: Rhode Island Department of Corrections, October 10, 2014. **Does not include inmates who were missing responses to the question on number of children, inmates on home confinement, or those from another state's jurisdiction.*

◆ **Of the 3,259 Rhode Island inmates awaiting trial or serving a sentence who were surveyed as of October 10, 2014 and answered the question on number of children, 1,829 inmates reported having 3,920 children. Thirty-eight percent of sentenced mothers had one to five year sentences and 29% of sentenced fathers were serving a sentence of more than ten years.[12]**

◆ **Of the 71 sentenced mothers on October 10, 2014, 46% were serving a sentence for a nonviolent offense, 34% for a violent offense, 15% for a drug-related offense, and 3% for breaking and entering. Of the 1,327 sentenced fathers, 44% were serving sentences for a violent offense, 21% for a nonviolent offense, 14% for a sex-related offense, 12% for a drug-related offense, and 9% for breaking and entering.[13]**

◆ **Forty-three percent of incarcerated parents awaiting trial or serving a sentence on October 10, 2014 had less than a high school degree education, 45% had a high school diploma or a GED, and 12% had at least some college education.[14]**

◆ **A supportive family, education, job training, stable housing, employment assistance, health services, and substance abuse treatment are critical to the parents' successful transition to the community after incarceration and also support the well-being of their children.[15,16]**

◆ **High-quality prison-based parenting programs can benefit incarcerated parents and their children. Parents participating in these programs have demonstrated improved relationships with their children and increased knowledge of child development and behavior management techniques. Children have shown signs of improved relationships with their incarcerated mother, diminished feelings of sadness and anger, fewer behavioral problems at school, and better grades.[17]**

Table 29.

Children of Incarcerated Parents, Rhode Island, October 10, 2014

CITY/TOWN	# OF INCARCERATED PARENTS	# OF CHILDREN REPORTED*	2010 TOTAL POPULATION UNDER AGE 18	RATE PER 1,000 CHILDREN
Barrington	0	0	4,597	0.0
Bristol	8	15	3,623	4.1
Burrillville	10	23	3,576	6.4
Central Falls	51	92	5,644	16.3
Charlestown	2	2	1,506	1.3
Coventry	29	56	7,770	7.2
Cranston	69	120	16,414	7.3
Cumberland	16	43	7,535	5.7
East Greenwich	4	11	3,436	3.2
East Providence	24	54	9,177	5.9
Exeter	3	4	1,334	3.0
Foster	2	4	986	4.1
Glocester	4	5	2,098	2.4
Hopkinton	5	9	1,845	4.9
Jamestown	1	2	1,043	1.9
Johnston	27	65	5,480	11.9
Lincoln	4	7	4,751	1.5
Little Compton	0	0	654	0.0
Middletown	8	17	3,652	4.7
Narragansett	6	12	2,269	5.3
New Shoreham	0	0	163	0.0
Newport	22	57	4,083	14.0
North Kingstown	11	28	6,322	4.4
North Providence	28	51	5,514	9.2
North Smithfield	7	13	2,456	5.3
Pawtucket	134	281	16,575	17.0
Portsmouth	4	5	3,996	1.3
Providence	475	1,070	41,634	25.7
Richmond	4	9	1,849	4.9
Scituate	4	10	2,272	4.4
Smithfield	11	20	3,625	5.5
South Kingstown	13	31	5,416	5.7
Tiverton	9	17	2,998	5.7
Warren	9	20	1,940	10.3
Warwick	74	136	15,825	8.6
West Greenwich	3	8	1,477	5.4
West Warwick	46	84	5,746	14.6
Westerly	10	17	4,787	3.6
Woonsocket	104	240	9,888	24.3
Unknown Residence	*95*	*210*	*NA*	*NA*
*Out-of-State Residence***	*62*	*158*	*NA*	*NA*
Four Core Cities	*764*	*1,683*	*73,741*	*22.8*
Remainder of State	*477*	*955*	*150,215*	*6.4*
Rhode Island	*1,241*	*2,638*	*223,956*	*11.8*

Source of Data for Table/Methodology

Rhode Island Department of Corrections, October 10, 2014. Offenders who were on Home Confinement and the awaiting trial population are excluded from this table.

U.S. Census Bureau, Census 2010.

In the 2007-2014 Factbooks, data are reported as of September 30th, while previous Factbooks reported data as of December 31st. Since the 2006 Factbook, the Children of Incarcerated Parents rate has been based on both the sentenced and awaiting trial populations.

*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 includes inmates who are under jurisdiction in Rhode Island, but report an out-of-state address. Inmates who were from another state's jurisdiction, but serving time in Rhode Island, are not included in the Rhode Island, four core cities, or remainder of state rates.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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Children Witnessing Domestic Violence

DEFINITION

Children witnessing domestic violence is the percentage of reported domestic violence incidents resulting in an arrest in which children under age 18 were present in the home. The data are based on police reports of domestic violence. 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

An estimated 10 million U.S. children are exposed to domestic violence each year. Rates of partner violence are higher among couples with children than those without children.[1,2] In Rhode Island in 2013, police reports indicate that children were present at 40% of domestic violence incidents resulting in arrests.[3]

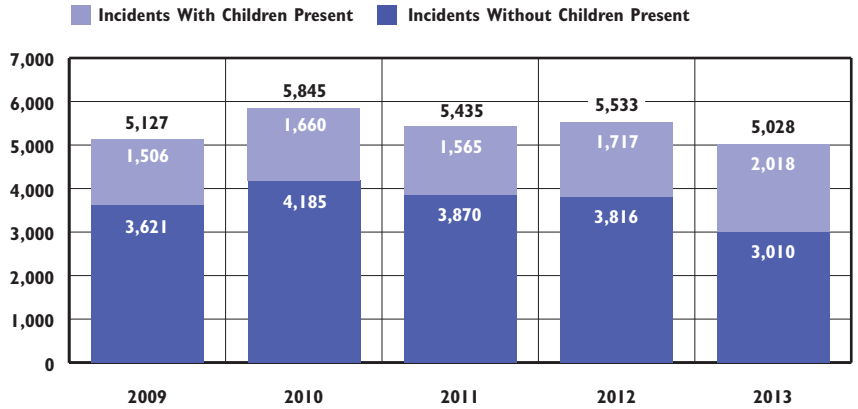
Children can be exposed to domestic violence in a number of ways. They may witness it directly (by seeing or hearing violent incidents in their homes or families), have their lives disrupted by moving or being separated from a parent, and/or may be used by the batterer to manipulate or gain control over the victim.[4] Children who are exposed to domestic violence are more likely to be victims of child abuse and neglect than those who are not.[5]

Exposure to domestic violence is distressing to children and can lead to mental health problems, including post-traumatic stress, depression, and anxiety, in childhood and later in life.[6] Children who witness domestic violence are more likely to experience physical, emotional, health and learning challenges. They are more prone to have concentration and memory problems, and to have difficulty with school performance than children who do not witness domestic violence.[7,8]

While many children who have witnessed domestic violence show resilience, exposure to violence may impair a child's capacity for partnering and parenting later in life.[9] There is a strong association between witnessing domestic violence as a child and becoming a perpetrator of domestic violence as an adult.[10]

Incidents of domestic violence are historically under-reported. Nationally, it is estimated that 41% of family violence incidents are not reported to police.[11] Similarly, Rhode Island data may under-represent the number of domestic violence incidents witnessed by children because not all incidents are reported and children may be unwilling to admit that they witnessed the incident.[12]

Domestic Violence Incidents Resulting in Arrest, Rhode Island, 2009-2013



Source: Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit, 2009-2013. Includes domestic violence reports resulting from an arrest by local police and Rhode Island State Police.

◆ **In Rhode Island in 2013, there were 5,028 domestic violence incidents that resulted in arrests, down 9% from 5,533 incidents in 2012. Children were reported present in 40% (2,018) of incidents in 2013.[13] Rhode Island police officers document children's exposure to violence on reporting forms by noting the number and ages of minor children living in the home, how many were present during the incident, how many saw the incident and how many heard it.[14]**

◆ **Rhode Island police reported that children saw the domestic violence incident in 1,091 arrests and children heard the incident in 1,193 arrests during 2013. These incidents were not mutually exclusive and more than one child may have witnessed the incident.[15]**

◆ **Rhode Island's statewide network of six domestic violence shelters and advocacy programs provides services to victims, including shelter, transitional housing, advocacy, individual and group counseling, and education.[16] During 2014, the network provided services to 8,876 individuals, including 466 children. In 2014, 275 children and 273 adults spent a total of 21,644 nights in domestic violence shelters. Fifty-three children and 44 adults lived in domestic violence transitional housing (longer-term private apartments for victims of domestic violence) during 2014.[17]**

Support for Children Witnessing Domestic Violence

◆ With the help of caring adults, children who have witnessed domestic violence can develop resilience and thrive. Effective therapeutic interventions often focus on supporting parents, and can include increasing parenting skills, assisting parents in addressing mental health issues, and supporting parents' efforts to live in safe environments. Other strategies include connecting children to adult mentors, identifying and nurturing areas of strength, and encouraging children to contribute to their families or communities in a positive way.[18]

◆ Rhode Island children often witness domestic violence before or during custody and visitation exchanges.[19] Rhode Island is not among the 24 states with legislation that requires Family Court to provide for the safety of a child and non-offending parent during visitation with an abusive parent.[20]

Table 30. **Children Present During Domestic Violence Incidents Resulting in Arrests, Rhode Island, 2013**

CITY/TOWN	TOTAL # OF REPORTS	TOTAL # OF INCIDENTS WITH CHILDREN PRESENT	% WITH CHILDREN PRESENT
Barrington	18	10	56%
Bristol	65	17	26%
Burrillville	44	15	34%
Central Falls	159	66	42%
Charlestown	18	7	39%
Coventry	152	68	45%
Cranston	280	141	50%
Cumberland	103	42	41%
East Greenwich	25	4	16%
East Providence	238	96	40%
Exeter*	NA	NA	NA
Foster	13	6	46%
Glocester	19	6	32%
Hopkinton	24	13	54%
Jamestown	3	2	67%
Johnston	109	48	44%
Lincoln	65	19	29%
Little Compton	8	2	25%
Middletown	88	26	30%
Narragansett	60	20	33%
New Shoreham	4	1	25%
Newport	128	26	20%
North Kingstown	83	31	37%
North Providence	211	74	35%
North Smithfield	62	27	44%
Pawtucket	572	180	31%
Portsmouth	68	18	26%
Providence	846	444	52%
Richmond	24	10	42%
Scituate	24	10	42%
Smithfield	74	20	27%
South Kingstown	84	36	43%
Tiverton	61	16	26%
Warren	68	26	38%
Warwick	348	141	41%
West Greenwich	15	7	47%
West Warwick	285	107	38%
Westerly	108	41	38%
Woonsocket	407	162	40%
Rhode Island State Police	*65*	*33*	*51%*
Four Core Cities	*1,984*	*852*	*43%*
Remainder of State	*3,044*	*1,166*	*38%*
Rhode Island	*5,028*	*2,018*	*40%*

Source of Data for Table/Methodology

The number of domestic violence incident reports in which an arrest was made and the number of incidents in which children were present are based on the Domestic Violence and Sexual Assault/Child Molestation Reporting Forms sent by Rhode Island law enforcement to the Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit between January 1, 2013 and December 31, 2013.

The data are only the incidents during which an arrest was made in which children were present, and do not represent the total number of children who experienced domestic violence in their homes. More than one child may have been present at an incident.

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

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

[1] Gilbert, A., Bauer, N., Carroll, A. & Downs, S. (2013). Child exposure to parental violence and psychological distress associated with delayed milestones. *Pediatrics, 132*(6), e1577-e1583.

[2] Berger, A., Wildsmith, E., Manlove, J. & Steward-Streng, N. R. (2012). *Relationship violence among young adult couples.* Washington, DC: Child Trends.

[3,12,13,15] Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit. Based on data from Domestic Violence and Sexual Assault/Child Molestation Reporting Forms, 2009-2013.

[4] Stop Violence Against Women. (2010). *Effects of domestic violence on children.* Retrieved January 29, 2015, from www.stopvaw.org

[5] Hamby, S., Finkelhor, D., Turner, H. & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse and Neglect, 34*(2010), 734-741.

[6] Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). *Children's exposure to intimate partner violence and other family violence.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

(continued on page 180)

Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total unduplicated number of victims of child abuse and neglect per 1,000 children. Child abuse includes physical, sexual and emotional abuse. Child neglect includes emotional, educational, physical and medical neglect, as well as a failure to provide for basic needs.

SIGNIFICANCE

Children need love, affection, and nurturing from their parents or caregivers for healthy physical and emotional development. Experiencing child abuse or neglect can have lifelong consequences for a child's health, well-being, and relationships with others. Parents or caregivers are at increased risk for maltreatment if they are overwhelmed by multiple risk factors such as poverty, divorce, substance abuse, or mental health problems.[1] The immediate effects of child abuse and neglect include isolation, fear, injury and even death. Children who have been maltreated are at increased risk for delinquency, substance abuse, mental health problems, teen pregnancy, impaired cognition, and low academic achievement in adolescence.[2,3]

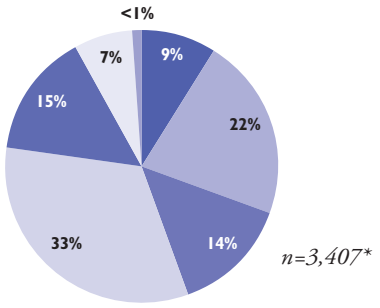
Responding to reports of child abuse and neglect and ensuring child safety are important functions of child protection systems. Maintaining the capacity to focus on prevention is equally critical and more cost-effective. In Rhode Island, if an investigation does not reveal maltreatment but family stressors and risk factors are identified, Child Protective Services (CPS) refers families to community-based support services to reduce the risk of future involvement with the Department of Children, Youth and Families (DCYF). When maltreatment has occurred, a determination may be made that it is safe for the children to remain at home when families are willing to work with community providers. In both of these cases, DCYF makes referrals to regional Family Care Community Partnerships (FCCP) agencies. They work with the family to identify appropriate services and resources, including natural supports (persons and resources that families can access independent from formal services).[4]

In 2014 in Rhode Island, there were 2,413 indicated investigations of child abuse and neglect involving 3,407 children. The child abuse and neglect rate per 1,000 children under age 18 was over two times higher in the four core cities (22.8 victims per 1,000 children) compared to the remainder of the state (10.5 victims per 1,000 children). Almost half (45%) of the victims of child abuse and neglect in 2014 were young children under age six and almost one-third (32%) were age three and younger.[5]

Child Abuse and Neglect, Rhode Island, 2014

By Age of Victim*

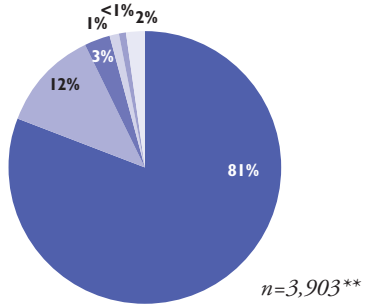
9% (320)	Under Age 1
22% (757)	Ages 1 to 3
14% (460)	Ages 4 to 5
33% (1,123)	Ages 6 to 11
15% (503)	Ages 12 to 15
7% (243)	Ages 16 and Older
<1% (1)	Unknown



n=3,407*

By Type of Neglect/Abuse**

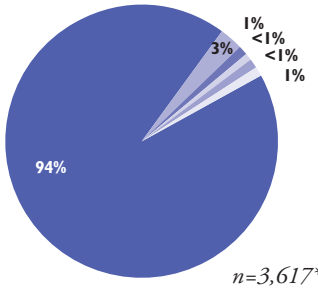
81% (3,176)	Neglect
12% (453)	Physical Abuse
3% (127)	Sexual Abuse
1% (49)	Medical Neglect
<1% (15)	Emotional Abuse
2% (83)	Other



n=3,903**

By Relationship of Perpetrator to Victims***

94% (3,402)	Parents
3% (105)	Relatives/Household Members
1% (32)	Foster Parents
<1% (17)	Child Care Providers
<1% (14)	Residential Facility Staff
1% (47)	Other or Unknown



n=3,617***

Source: Rhode Island DCYF, Rhode Island Children's Information System (RICHIST), 2014. Percentages may not sum to 100% due to rounding.

Notes on Pie Charts

**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. Under Rhode Island law, Child Protective Services can only investigate alleged perpetrators who are legally defined as caretakers to the victim(s), except in situations of child sexual abuse by another child.*

DCYF Child Protective Services (CPS) Hotline Calls for Reports of Abuse and/or Neglect, Investigations,* and Indicated Investigations, Rhode Island, 2005-2014

YEAR	TOTAL # UNDUPLICATED CHILD MALTREATMENT REPORTS	% AND # OF REPORTS WITH COMPLETED INVESTIGATIONS	# OF INDICATED INVESTIGATIONS
2005	13,144	55% (7,188)	2,260
2006	14,957	59% (8,841)	2,862
2007	13,542	54% (7,363)	2,396
2008	12,204	51% (6,214)	1,913
2009	12,189	52% (6,362)	2,075
2010	13,069	53% (6,956)	2,392
2011	13,382	49% (6,520)	2,225
2012	13,540	50% (6,784)	2,266
2013	13,905	50% (6,975)	2,294
2014	14,735	51% (7,573)	2,413

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2005-2014.

**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).*

◆ **In 2014, Rhode Island experienced more child maltreatment reports, completed investigations, and indicated investigations than any year since 2006. Between 2013 and 2014, unduplicated child maltreatment reports increased by 6%, the number of completed investigations increased by 9%, and the number of indicated investigations increased by 5%. In 2014, there were 2,413 indicated investigations based on child maltreatment investigations, 32% of all completed investigations.[6] An indicated investigation is one in which there is a preponderance of evidence that child abuse and/or neglect occurred.[7]**

◆ **Of the 14,735 maltreatment reports in 2014, 5,820 were classified as "information/referrals" (formerly "early warnings").[8] Information/referrals are reports made to the CPS Hotline that contain a concern about the well-being of a child but do not meet the criteria for an investigation. Criteria for investigation include that the victim is a minor, the alleged perpetrator is a legal caretaker or is living in the home, there is reasonable cause to believe that abuse or neglect circumstances exist, and there is a specific incident or pattern of incidents suggesting that harm can be identified. When essential criteria for investigation are not present, the report may lead to a referral to other services or to the information being passed on to a DCYF case-worker (depending on whether the family is active with DCYF).[9,10]**

Emergency Department Visits, Hospitalizations, and Deaths Due to Child Abuse and/or Neglect, Rhode Island, 2009-2013

YEAR	# OF EMERGENCY DEPARTMENT VISITS	# OF HOSPITALIZATIONS	# OF DEATHS**
2009	193	26	6
2010	161	31	0
2011	159	38	2
2012	153	25	1
2013	133	34	3
TOTAL	*799*	*154*	*12*

Source: Rhode Island Department of Health, 2009-2013. Data for 2012 and 2013 are provisional.

***Due to a change in data source, data for child deaths due to child abuse and/or neglect are only comparable with Factbooks since 2013.*

◆ **Between 2009 and 2013, there were 799 emergency department visits, 154 hospitalizations, and 12 deaths of Rhode Island children under age 18 due to child abuse and/or neglect.[11] Nationally, 70% of child maltreatment deaths involved neglect and 44% involved physical abuse (because a victim may have suffered more than one type of maltreatment, these categories are not mutually exclusive).[12]**

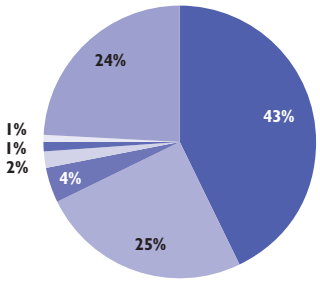
Child Abuse and Neglect in Rhode Island Communities

◆ **Many parents at risk of child abuse and neglect lack essential parenting skills and are struggling with a combination of social and economic issues. These families can benefit from programs that enhance social supports, parental resilience, and knowledge of parenting and child development.[13] In addition, providing access to child care, early childhood learning programs, and evidence-based home visiting programs (such as the Nurse-Family Partnership) to families with multiple risk factors can prevent the occurrence and recurrence of child abuse and neglect.[14,15,16]**

◆ **In 2014, Rhode Island had 14.5 child victims of abuse and neglect per 1,000 children. With a rate of 38.6 victims per 1,000 children, Central Falls had the highest rate of child victims of abuse and neglect in the state. Other cities and towns with rates higher than 20 victims per 1,000 children were Woonsocket (37.6), Newport (30.4), Warren (24.7), Pawtucket (23.3), and West Warwick (20.5).[17]**

Child Abuse and Neglect

Indicated Allegations of Child Neglect, by Nature of Neglect, Rhode Island, 2014



43% (1,805)	Lack of Supervision
25% (1,052)	Exposure to Domestic Violence
4% (147)	Inadequate Food, Clothing or Shelter
2% (74)	Neglect Resulting in Physical Injuries/Death
1% (61)	Medical Neglect
1% (45)	Specific Other Small Categories
24% (1,006)	Unspecified "Other"

*n=4,190**

◆ **The importance of adequate capacity, affordability, and quality of child care, preschool, other early childhood programs and quality after-school opportunities is highlighted by the fact that of the 4,190 indicated allegations (confirmed claims) of neglect to children under age 18 in Rhode Island in 2014, 43% involved lack of supervision.**

◆ **The second largest category of neglect (25%) is "exposure to domestic violence." These are instances where the neglect is related to the child witnessing domestic violence in the home.**

◆ **The "specific other small categories" include: drug and alcohol abuse (15), emotional neglect (9), excessive/inappropriate discipline (6), educational neglect (6), abandonment (4), failure to thrive (4), and tying/close confinement (1).**

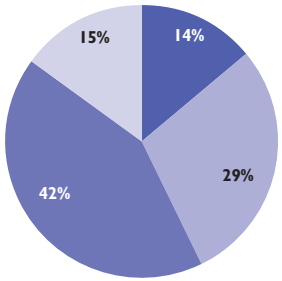
**The total refers to indicated allegations of neglect. Some children were victims of neglect more than once. Multiple allegations may be involved in each indicated investigation. Numbers do not include indicated allegations of institutional neglect.*

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2014.

Child Sexual Abuse, by Gender and Age of Victim, Rhode Island, 2014

Girls

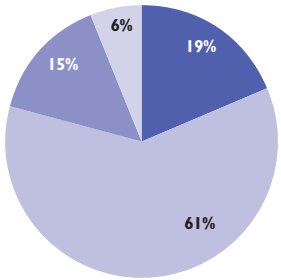
14% (15)	Age 5 and Under
29% (31)	Ages 6 to 11
42% (44)	Ages 12 to 15
15% (16)	Ages 16 and Older



n=106

Boys

19% (10)	Age 5 and Under
61% (33)	Ages 6 to 11
15% (8)	Ages 12 to 15
6% (3)	Ages 16 and Older



n=54

Source: Rhode Island Department of Children, Youth and Families, RICHIST, 2014. Percentages may not sum to 100% due to rounding.

◆ **In Rhode Island in 2014, there were 160 indicated allegations (confirmed claims) of child sexual abuse. Some children were victims of sexual abuse more than once. The victim was a female in 66% (106) of the 160 indicated allegations of sexual abuse. Forty-three percent of the female victims were known to be under age 12 while 80% of the male victims were under age 12.[18]**

◆ **The perpetrator is a relative or person known to the victim in the majority of cases of child sexual abuse. Sexual abuse by family members is more common than sexual abuse by strangers.[19]**

Table 31. **Indicated Investigations of Child Abuse and Neglect, Rhode Island, 2014**

CITY/TOWN	# OF CHILDREN UNDER AGE 18	# OF INDICATED INVESTIGATIONS OF CHILD ABUSE/NEGLECT	INDICATED INVESTIGATIONS PER 1,000 CHILDREN	# OF VICTIMS OF CHILD ABUSE/NEGLECT	VICTIMS PER 1,000 CHILDREN
Barrington	4,597	9	2.0	12	2.6
Bristol	3,623	38	10.5	36	9.9
Burrillville	3,576	39	10.9	48	13.4
Central Falls	5,644	137	24.3	218	38.6
Charlestown	1,506	19	12.6	19	12.6
Coventry	7,770	53	6.8	81	10.4
Cranston	16,414	130	7.9	145	8.8
Cumberland	7,535	32	4.2	62	8.2
East Greenwich	3,436	8	2.3	18	5.2
East Providence	9,177	89	9.7	111	12.1
Exeter	1,334	2	1.5	4	3.0
Foster	986	6	6.1	9	9.1
Glocester	2,098	23	11.0	15	7.1
Hopkinton	1,845	11	6.0	16	8.7
Jamestown	1,043	1	1.0	3	2.9
Johnston	5,480	45	8.2	43	7.8
Lincoln	4,751	14	2.9	36	7.6
Little Compton	654	0	0.0	1	1.5
Middletown	3,652	34	9.3	30	8.2
Narragansett	2,269	13	5.7	26	11.5
New Shoreham	163	0	0.0	0	0.0
Newport	4,083	72	17.6	124	30.4
North Kingstown	6,322	47	7.4	59	9.3
North Providence	5,514	55	10.0	86	15.6
North Smithfield	2,456	29	11.8	31	12.6
Pawtucket	16,575	259	15.6	387	23.3
Portsmouth	3,996	12	3.0	19	4.8
Providence	41,634	581	14.0	704	16.9
Richmond	1,849	7	3.8	11	5.9
Scituate	2,272	16	7.0	20	8.8
Smithfield	3,625	22	6.1	18	5.0
South Kingstown	5,416	21	3.9	38	7.0
Tiverton	2,998	14	4.7	37	12.3
Warren	1,940	48	24.7	48	24.7
Warwick	15,825	105	6.6	154	9.7
West Greenwich	1,477	6	4.1	4	2.7
West Warwick	5,746	81	14.1	118	20.5
Westerly	4,787	57	11.9	89	18.6
Woonsocket	9,888	279	28.2	372	37.6
Unknown	*0*	*0*	*NA*	*4*	*NA*
Four Core Cities	*73,741*	*1,256*	*17.0*	*1,681*	*22.8*
Remainder of State	*150,215*	*1,158*	*7.7*	*1,571*	*10.5*
Rhode Island	*223,956*	*2,414*	*10.8*	*3,256*	*14.5*

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), Calendar Year 2014.

Victims of child abuse/neglect are unduplicated counts of victims with substantiated allegations of child abuse and/or neglect. More than one victim can be involved in an investigation.

An indicated investigation is an investigated report of child abuse and/or neglect for which a preponderance of 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 includes fewer indicated investigations than the chart with reports/investigations and indicated cases.

Data cannot be compared to Factbooks prior to 2009. The denominator is the number of children under age 18 according to the U.S. Census 2010 and the numerator is an unduplicated count of child victims. Previous Factbooks used children under age 21 as the denominator and the indicated investigations as the numerator to calculate the rate of indicated investigations per 1,000 children.

In 2008, Rhode Island lowered the eligibility age for entry into DCYF services to under age 18, although some children remain eligible for services after their 18th birthday.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

[1,13,14] U.S. Department of Health and Human Services, Administration for Children and Families. *Making meaningful connections: 2014 prevention resource guide.* (2014). Washington, DC: Government Printing Office.

[2] *Long-term consequences of child abuse and neglect.* (2013). Washington, DC: U.S. Department of Health and Human Services, Children's Bureau, Child Welfare Information Gateway.

(continued on page 181)

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 permanency. Out-of-home placements include foster care homes, group homes, shelter care, residential facilities, and medical facilities. Permanency can be achieved through reunification with the family, adoption, or guardianship.

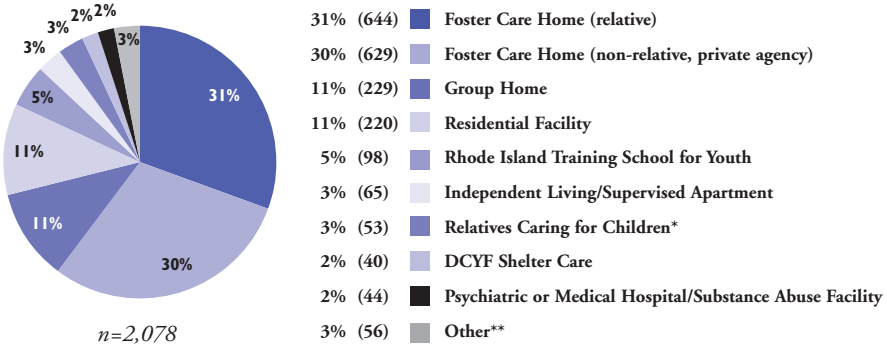
SIGNIFICANCE

Children need stability, permanency, and safety for healthy development. Removal from the home may be necessary for the child's safety and well-being; however, critical connections and a sense of permanency may be lost when a child is placed out-of-home.[1] Permanency planning efforts should begin as soon as a child enters the child welfare system so that a permanent living situation can be achieved as quickly as possible.[2] The federal *Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections Act)* promotes permanency through supports for relative guardianship and incentives for adoption.[3]

Rhode Island children in out-of-home care often experience multiple placements, lose contact with family members, and may have overlooked educational, physical, and mental health needs.[4] Children in out-of-home care suffer more frequent and more serious medical, developmental, and mental health problems than their peers.[5,6] Long-term stays in care can cause emotional, behavioral, or educational problems that can negatively impact children's long-term well-being and success.[7] Children in foster care are more likely than their peers to change schools, be suspended, qualify for special education, repeat a grade and drop out of school.[8] Appropriate supports and services can help youth in care maximize their potential and ensure that they are prepared for higher education and work.[9]

Children of color are overrepresented at all decision points in the child welfare system, including reporting, investigation, substantiation, placement, and exit from care. Minority children in child welfare systems experience significantly worse outcomes, have more placement changes, receive fewer supports, stay in the child welfare system longer, are less likely to be adopted or reunited with their families, have fewer contacts with caseworkers, less access to mental health and substance abuse services and are placed in detention or correctional facilities at higher rates than White children.[10]

Children in Out-of-Home Placement, Rhode Island, December 31, 2014



**Relatives caring for children are classified as an out-of-home placement by DCYF, despite the fact that these relatives did not receive monetary payments from DCYF to care for the children and the children were never removed and never needed to be removed from the relatives' homes. In these cases, the relative caring for the child initiated contact with DCYF to receive assistance from the agency. **The placement category "Other" includes: runaway youth in DCYF care or those with unauthorized absences (52), pre-adoptive homes (3), and minors with mother in shelter/group home/residential facility (1).*

◆ **As of December 31, 2014, there were 2,078 children under age 21 in the care of DCYF who were in out-of-home placements, the second straight annual increase.**

◆ **The total caseload of DCYF on December 31, 2014 was 7,078, including 2,380 children living in their homes under DCYF supervision and 2,541 children living in adoption settings. This total caseload shows a second consecutive annual increase after years of decline, increasing from 7,004 in 2013.**

◆ **The total DCYF caseload also includes 55 children in out-of-state placements/other agency custody; 14 children receiving respite care services; two youth in a prison other than the Rhode Island Training School; and three children in other placement.**

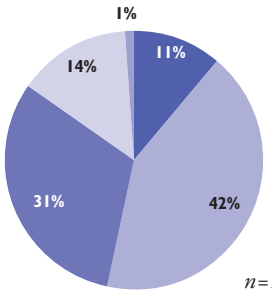
◆ **On December 31, 2014, there were 65 youth in an independent living arrangement or supervised apartment setting, a decline of 68% from 203 youth in 2006. The number of youth in these arrangements has declined steadily since 2007, when the maximum age at which youth can remain in foster care in Rhode Island was lowered from age 21 to age 18.**

Source: RI Department of Children, Youth and Families, RICHIST, 2006-2014.

Children and Youth in Out-of-Home Placement by Type of Setting and Age, Rhode Island*

In Foster Care Homes

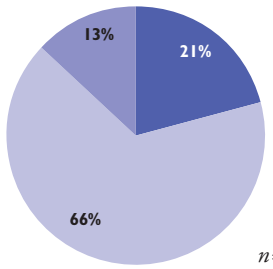
11% (141)	Under Age 1
42% (540)	Ages 1 to 5
31% (401)	Ages 6 to 13
14% (179)	Ages 14 to 17
1% (19)	Ages 18 and Over



n=1,280

In Group Homes and Residential Facilities**

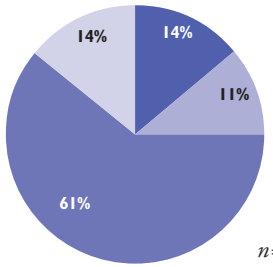
0% (0)	Under Age 1
0% (0)	Ages 1 to 5
21% (93)	Ages 6 to 13
66% (298)	Ages 14 to 17
13% (59)	Ages 18 and Over



n=450

In Medical Facilities***

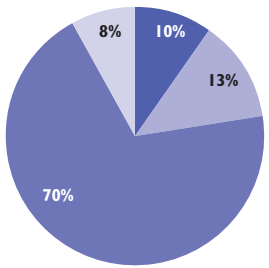
14% (6)	Under Age 1
0% (0)	Ages 1 to 5
11% (5)	Ages 6 to 13
61% (27)	Ages 14 to 17
14% (6)	Ages 18 and Over



n=44

In Shelter Care

0% (0)	Under Age 1
10% (4)	Ages 1 to 5
13% (5)	Ages 6 to 13
70% (28)	Ages 14 to 17
8% (3)	Ages 18 and Over



n=40

**Pie charts show data for a single point-in-time (Foster Care Homes-January 2, 2015; Group Homes and Residential Facilities, Medical Facilities, and Shelter Care-December 31, 2014.)*

***Residential facilities do not include psychiatric hospitals, medical hospitals, or the Rhode Island Training School.*

****Medical facilities data includes medical hospitals (9), psychiatric hospitals (32), and substance abuse treatment facilities (3).*

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), January 2015. Percentages may not sum to 100% due to rounding. Data do not match chart on previous page due to different report dates.

Safety, Permanency, and Well-Being

Fostering Connections

◆ The federal *Fostering Connections Act* promotes kinship care and family connections by requiring states to notify relatives when a child is placed in foster care and providing funding for states offering kinship guardianship assistance payments.[11] Rhode Island's guardianship assistance program defines kin broadly and includes any adult who has a close and caring relationship with the child, including godparents, caretakers, close family friends, neighbors, and clergy.[12]

Placement Stability

◆ In Federal Fiscal Year (FFY) 2014, 12.4% of the 1,534 children who had been in out-of-home care for less than one year had experienced three or more placements, up from 11.7% in FFY 2013. Three or more placements were experienced by 25.1% of the 730 children who were in care between 12 and 24 months, down from 31.9% in FFY 2013. Fifty-nine percent of the 749 children who had been in care for 24 months or more experienced three or more placements.[13]

Recurrence of Abuse and Neglect

◆ Of the 1,711 Rhode Island children who were victims of abuse or neglect during FFY 2014 (whether or not they were removed from the home), 8.8% experienced one or more recurrences of abuse or neglect within six months, up from 8.2% in FFY 2013. The national standard is 6.1% or fewer.[14]

Shelter Care

◆ The number of children in shelter care (facilities providing emergency care to eight children or less for no more than 90 days each) decreased from 49 on December 31, 2013 to 40 on December 31, 2014. Four of these Rhode Island children in shelter care were under age six; five were ages six to 13; and 31 were age 14 and older.[15]

References

[1,7] Williams-Mbengue, N. (2008). *Moving children out of foster care - The legislative role in finding permanent homes for children.* Permanency: A key concept for children in foster care. Washington, DC: National Conference of State Legislatures.

[2] U.S. Department of Health and Human Services, Administration for Children and Families. 1998. *Program instruction: Adoption and Safe Families Act of 1997.* Retrieved January 19, 2015, from www.acf.hhs.gov

(continued on page 181)

Permanency for Children in DCYF Care

DEFINITION

Permanency for children in DCYF care is the percentage of children in out-of-home care who transition to a permanent living arrangement through reunification, adoption, or guardianship. Data are for all children who were in out-of-home placement with the Rhode Island Department of Children, Youth and Families (DCYF) during the Federal Fiscal Year.

SIGNIFICANCE

The uncertainty of multiple, prolonged, or unstable out-of-home placements can negatively affect children's emotional well-being, which has an impact on behavior, academic achievement, and the formation of secure relationships.[1,2] Particular attention must be paid to populations of children for whom permanency may be more difficult to achieve, including older children, minority children, sibling groups, and children with mental, emotional, or behavioral health needs.[3,4,5] Planning for permanency requires a mix of family-centered and legal strategies designed to ensure that children and youth have safe, stable, and lifelong connections with caring adults.[6,7,8]

Reunification with parents is the most common permanency outcome for children who have been in foster care.[9] When reunification is not possible, child welfare agencies focus on placing children in another permanent family through adoption or guardianship.[10] Federal law requires states to notify relatives when a child is placed in foster care, provides funding for states offering kinship guardianship assistance payments, provides incentive payments for adoptions of older children and children with special needs, and requires that states inform families considering adopting a child in foster care about the availability of the federal adoption tax credit.[11,12,13]

Youth who age out of foster care experience high rates of economic hardship (inability to pay rent, utilities, etc.), low educational attainment, homelessness, unemployment, and poor physical and mental health. They are more likely to enter the criminal justice system, become teen parents, and enroll in public assistance programs.[14]

Part of permanency planning for all children and youth in care includes providing services that prepare them for adulthood. Child welfare agencies can develop systems that ensure children and youth achieve positive outcomes in the areas of independent living, employment skills, financial literacy, and self-advocacy.[15] The federal *Fostering Connections Act of 2008* and *Strengthening Families Act of 2014* provide a wide range of strategies and incentives to states for supporting children and youth while in foster care as well as permanency.[16,17]

Exits from Foster Care*, Rhode Island, FFY 2014

	ALL EXITS	WITH DISABILITY	OVER AGE 12 AT ENTRY
Adoption	18%	19%	1%
Guardianship	8%	5%	5%
Reunification	55%	45%	56%
Aged Out	14%	NA**	29%
Other	4%	31%	10%
Total Number	*1,091*	*364*	*458*

Source: *Safety, permanency, and well-being in Rhode Island: Child welfare outcomes annual report for FY 2014.* (2015). New Haven, CT: Prepared by the Consultation Center, Yale University School of Medicine for the Data Analytic Center of the Rhode Island Department of Children, Youth and Families. Percentages may not sum to 100% due to rounding.

*Foster Care refers to all out-of-home placements, consistent with language used in federal reports.
**Children with a disability who age out are included in the "other" category.

◆ **In Federal Fiscal Year (FFY) 2014, 1,091 children in out-of-home placement in Rhode Island exited foster care. Of the children who exited, 82% exited to permanency (adoption, guardianship, or reunification). Children who were over age 12 when they entered foster care were more likely to age out of care without achieving permanency.[18]**

◆ **In FFY 2014, 13.7% of children in Rhode Island who entered out-of-home placement re-entered care within 12 months of a prior episode, above the national standard of 8.6%.[19]**

Reunification, FFY 2014

◆ **The percentage of children in the Rhode Island child welfare system who were reunified with their family of origin in less than 12 months from the time of removal from the home decreased from 77.8% in FFY 2013 to 72.8% in FFY 2014. The national standard is 76.2% of reunifications occurring within 12 months of the child's removal.[20]**

◆ **In FFY 2014, three-quarters (77.0%) of child maltreatment cases in Rhode Island involved neglect.[21] Poverty, parental substance abuse, and mental health problems are leading contributors to neglect. Achieving timely and successful reunification requires access to substance abuse and mental health treatment, as well as interventions designed to improve the economic status of families.[22]**

Subsidized Guardianship, FFY 2014

◆ The federal *Fostering Connections Act* provides funding for states offering kinship guardianship assistance payments. Rhode Island's guardianship assistance program defines kin broadly as any adult who has a close and caring relationship with the child, including godparents, caretakers, close family friends, neighbors, and clergy.[23] Rates of children exiting foster care to guardianship in Rhode Island decreased from 9.9% in FFY 2013 to 8.1% in FFY 2014.[24]

Adoptions of Children in DCYF Care, 2014

◆ During Calendar Year 2014, 212 children in the care of DCYF were adopted in Rhode Island. Of these children, 64% were White, 20% were multiracial, 15% were Black, <1% was American Indian, and 1% was of unknown race. Twenty-eight percent of children adopted in 2014 were Hispanic (belonging to any race category).[25]

◆ Of the 212 children adopted, 67% were under age six, 27% were ages six to 13, and 5% were age 14 or older.[26]

Rhode Island Children Waiting to be Adopted, September 30, 2014

◆ On September 30, 2014, there were 205 Rhode Island children in the care of DCYF who were waiting to be adopted. Of these, none was under age one, 32% were ages one to five, 25% were ages six to 10, 31% were ages 11 to 15, 11% were ages 16 and older, and 1% was of unknown age.[27]

◆ Of all waiting children, 41% were White, non-Hispanic, 28% were Hispanic (of any race), 15% were Black, non-Hispanic, 14% were Two or more races, 1% was Asian, none were Native American, and 1% was of unknown race/ethnicity.[28]

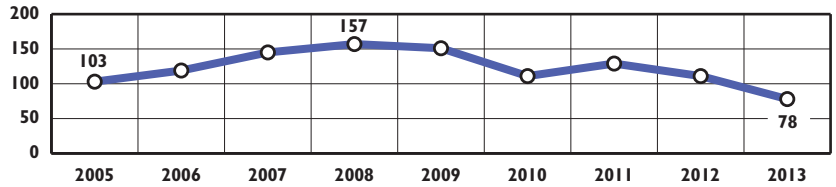
◆ Of the 205 children waiting to be adopted, 48% were children of parents whose parental rights had been legally terminated.[29]

◆ In FFY 2014, 42% of children in the Rhode Island child welfare system were adopted within 24 months from the time of removal from their home, up from 34% in FFY 2013. Rhode Island exceeded the national standard of 32% of adoptions occurring within 24 months of the child's removal in FFY 2014.[30]

Youth Aging Out of Foster Care

◆ Youth who exit foster care to adulthood never having gained permanency through adoption, guardianship, or reunification are considered to have "aged out" of foster care. As of July 1, 2007, youth in Rhode Island age out of the foster care system at age 18, a change from age 21 in previous years. Youth with serious emotional disturbances, autism, or a functional developmental disability continue to have their cases managed by DCYF and remain legally entitled to services through age 21.[31]

Rhode Island Youth Aging Out of Foster Care, FFYs 2005-2013



Source: *Safety, permanency, and well-being in Rhode Island: Child welfare outcomes annual reports for FY 2005-2013.* New Haven, CT: Prepared by the Consultation Center, Yale University School of Medicine for the Data Analytic Center of the Rhode Island Department of Children, Youth and Families.

◆ The number of Rhode Island youth who exited foster care never having gained permanency through reunification, adoption, or guardianship was 152 during FFY 2014. This is not comparable to previous FFYs due to a change in methodology used by DCYF to report 18-21 year olds.[32]

◆ Beginning January 1, 2014, the federal *Affordable Care Act (ACA)* allows youth who have aged out of foster care to have Medicaid coverage until age 26, regardless of their income. This provides former foster youth the same access to health coverage as other young adults, who are allowed to remain on their parents' commercial health coverage until age 26.[33]

◆ If states extend foster care to age 21, an option that the *Fostering Connections Act* encourages, the potential benefits in terms of increased educational attainment, reduced reliance on public assistance, and increased earnings will more than offset the costs to states.[34]

References

[1] Pecora, P. J. (2010). Why should child welfare focus on promoting placement stability? In *CW360° Promoting Placement Stability*, 4-5.

[2,3] Walsh, W. A. & Mattingly, M. J. (2011). *Long-term foster care – Different needs, different outcomes.* Durham, NH: University of New Hampshire, Carsey Institute.

(continued on page 181)

Education

I Continue to Dream

by Langston Hughes

I take my dreams and make of them a bronze vase
and a round fountain with a beautiful statue in its center.
And a song with a broken heart and I ask you:
Do you understand my dreams?
Sometimes you say you do,
And sometimes you say you don't.
Either way it doesn't matter.
I continue to dream.

Children Enrolled in Early Intervention

DEFINITION

Children enrolled in Early Intervention is the number and percentage of children under age three who have an active Individual Family Service Plan through a Rhode Island Early Intervention provider.

SIGNIFICANCE

During the first few years of life, children develop the basic brain architecture that serves as a foundation for all future development and learning. Early and effective intervention for vulnerable young children yields improved long-term outcomes.[1]

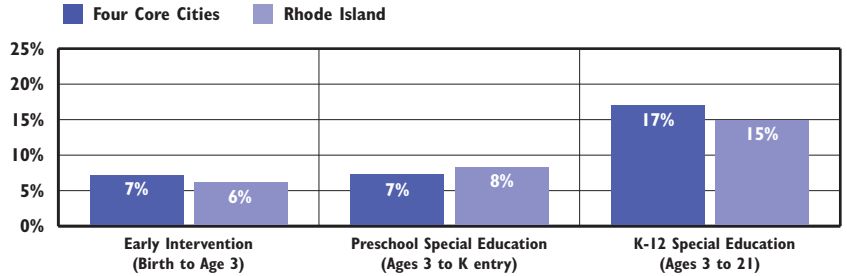
In 1986, Congress established Early Intervention (EI) services for infants and toddlers under the *Individuals with Disabilities Education Act (IDEA). Part C of IDEA* requires states to identify and provide appropriate EI services to children under age three who are developmentally delayed or have a diagnosed condition that is associated with a developmental delay. States may also choose to serve children who are at risk of experiencing a delay if early intervention services are not provided.[2]

In Rhode Island, children are eligible for EI if they have a diagnosed medical disorder bearing relatively well-known expectancy for developmental delay (single established condition) or if they have a developmental delay in one or more areas of development (cognitive, physical, communication, social-emotional, and adaptive). Until November 2013, children were also eligible under a "multiple established conditions" category.[3] Current eligibility criteria allow children with significant circumstances (including significant trauma/losses, history of abuse/neglect, family lacking basic resources, parental substance abuse, significant parental health/mental health issues, or intellectual disability of caretaker) to qualify through informed clinical opinion if the circumstances impact child or family functioning.[4]

Approximately 15% of U.S. children ages three to 17 have developmental disabilities, with higher prevalence among children from low-income families and among boys. The percentage of children recognized with developmental disabilities has been increasing in recent years due to increased survival rates among preterm infants and children with birth defects/genetic disorders and improved awareness and diagnosis of many conditions.[5]

The American Academy of Pediatrics recommends that physicians incorporate the use of a standardized developmental screening tool into the 9-, 18-, and 30-month well-child visits in order to improve detection of developmental delays and ensure that children who could benefit from services receive timely interventions.[6]

Percentage of Children Receiving Special Education Services by Grade Span, Rhode Island, June 2014



Source: Rhode Island KIDS COUNT calculations using Rhode Island Executive Office of Health and Human Services, June 30, 2014 Early Intervention enrollment, Census 2010, Summary File 1, Rhode Island Department of Education, June 30, 2014 Special Education Census, population of children ages 3-5 from KIDS NET, and Resident Average Daily Membership.

◆ **As of June 30, 2014 there were 2,184 infants and toddlers receiving Early Intervention (EI) services, 6% of the population under age three. Seventeen percent were under age one, 32% were age one, and 51% were age two. Of these, 80% were eligible under the developmental delay category, 17% were eligible under the single established condition category, and 3% were eligible under the multiple established conditions category.**[7]

◆ **In Calendar Year 2014 in Rhode Island, 4,339 children received EI services, a 4% increase from 2013.**[8,9] **In 2014, 1,047 children were discharged from EI upon reaching age three. Of these, 65% were found eligible and 20% were found not eligible for preschool special education. Eleven percent were in the process of eligibility determination and 4% left the program.**[10]

◆ **Because maltreated infants and toddlers are six times more likely to have a developmental delay, federal legislation requires states to refer children under age three who have been substantiated victims of child abuse or neglect to EI for an eligibility assessment.**[11,12] **In 2014 in Rhode Island, there were 831 infants and toddlers under age three who were maltreated. Of these, 62% were referred to EI for an eligibility assessment, 23% were referred to First Connections for screening, 4% were already enrolled in EI, and 11% were not referred due to case closure or family consent refusal. Of the 514 substantiated victims referred to EI in 2014, 57% were found eligible, 22% were found not eligible, 13% were not evaluated/did not complete a service plan, and 8% were in the determination process.**[13,14]

Table 32. **Infants and Toddlers Enrolled in Early Intervention (EI) by Eligibility Type, Rhode Island, 2014**

		CALENDAR YEAR 2014 ENROLLMENT		JUNE 30, 2014 ENROLLMENT				
CITY/TOWN	# OF CHILDREN UNDER AGE 3	# OF CHILDREN ENROLLED IN EI	% OF CHILDREN ENROLLED IN EI	SINGLE ESTABLISHED CONDITION	DEVELOP-MENTAL DELAY	MULTIPLE ESTABLISHED CONDITIONS	# OF CHILDREN ENROLLED IN EI	% OF CHILDREN ENROLLED IN EI
Barrington	366	37	10%	1	22	0	23	6%
Bristol	507	72	14%	12	28	1	41	8%
Burrillville	460	55	12%	1	29	0	30	7%
Central Falls	1,028	153	15%	9	57	1	67	7%
Charlestown	186	25	13%	4	6	0	10	5%
Coventry	940	125	13%	5	56	2	63	7%
Cranston	2,318	266	11%	28	101	5	134	6%
Cumberland	970	115	12%	5	53	0	58	6%
East Greenwich	299	40	13%	6	12	0	18	6%
East Providence	1,560	189	12%	21	70	3	94	6%
Exeter	166	16	10%	0	7	0	7	4%
Foster	113	11	10%	0	5	0	5	4%
Glocester	247	21	9%	5	9	0	14	6%
Hopkinton	258	24	9%	1	9	0	10	4%
Jamestown	85	14	16%	0	7	0	7	8%
Johnston	816	99	12%	4	42	2	48	6%
Lincoln	587	76	13%	9	32	1	42	7%
Little Compton	68	4	6%	0	0	0	0	0%
Middletown	502	81	16%	5	33	1	39	8%
Narragansett	271	20	7%	0	11	1	12	4%
New Shoreham	21	2	10%	0	0	0	0	0%
Newport	820	96	12%	6	34	1	41	5%
North Kingstown	728	88	12%	8	37	3	48	7%
North Providence	851	117	14%	10	53	1	64	8%
North Smithfield	290	63	22%	4	29	0	33	11%
Pawtucket	2,959	353	12%	47	140	8	195	7%
Portsmouth	429	45	10%	3	15	1	19	4%
Providence	7,609	1,098	14%	88	425	12	525	7%
Richmond	235	10	4%	2	2	1	5	2%
Scituate	193	35	18%	3	12	1	16	8%
Smithfield	402	40	10%	2	19	0	21	5%
South Kingstown	640	84	13%	4	32	1	37	6%
Tiverton	398	41	10%	2	16	1	19	5%
Warren	296	29	10%	4	12	0	16	5%
Warwick	2,322	289	12%	24	125	6	155	7%
West Greenwich	178	20	11%	2	7	2	11	6%
West Warwick	1,044	148	14%	10	62	4	76	7%
Westerly	726	85	12%	10	34	2	46	6%
Woonsocket	1,900	253	13%	17	115	3	135	7%
Four Core Cities	*13,496*	*1,857*	*14%*	*161*	*737*	*24*	*922*	*7%*
Remainder of State	*20,292*	*2,482*	*12%*	*201*	*1,021*	*40*	*1,262*	*6%*
Rhode Island	*33,788*	*4,339*	*13%*	*362*	*1,758*	*64*	*2,184*	*6%*

Source of Data for Table/Methodology

Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, Early Intervention enrollment, Calendar Year 2014 and June 30, 2014 enrollment (point-in-time). Note: Children eligible under the Multiple Established Conditions category enrolled before November 2013. The Multiple Established Conditions eligibility category was eliminated in November 2013.

The denominator is the number of children under age three, according to Census 2010, Summary File 1.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

[1,2,11] Gebhard, B. (2009). *Early experiences matter: A guide to improved policies for infants and toddlers.* Washington, DC: Zero to Three.

[3] *Early Intervention certification standards.* (2005). Cranston, RI: State of Rhode Island, Department of Human Services, Center for Child and Family Health.

[4] *Rhode Island Early Intervention policies and procedures: Eligibility determination.* (2013). Cranston, RI: Rhode Island Executive Office of Health and Human Services.

[5] Boyle, C. A., et al. (2011). Trends in the prevalence of developmental disabilities in U.S. Children, 1997-2008. *Pediatrics, 127*(6), 1034-1042.

[6] Council on Children with Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children with Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *Pediatrics, 118*(1), 405-420.

[7,8,10,14] Rhode Island Executive Office of Health and Human Services, 2014.

[9] Rhode Island Executive Office of Health and Human Services, 2013.

(continued on page 182)

Children Enrolled in Early Head Start

DEFINITION

Children enrolled in Early Head Start is the number and percentage of children enrolled in a Rhode Island Early Head Start program.

SIGNIFICANCE

Established in 1994, Early Head Start is a comprehensive early childhood program serving low-income children birth to age three, pregnant women and their families. Early Head Start programs serve children in families with incomes below 130% of the federal poverty level ($26,117 for a family of three in 2015). Children in families with incomes below the federal poverty line have priority enrollment.[1,2,3] The federally-funded Early Head Start program is designed to address the comprehensive needs of low-income infants and toddlers and pregnant women by providing high-quality early education, nutrition and mental health services, medical and dental referrals, and fostering the development of healthy family relationships.[4]

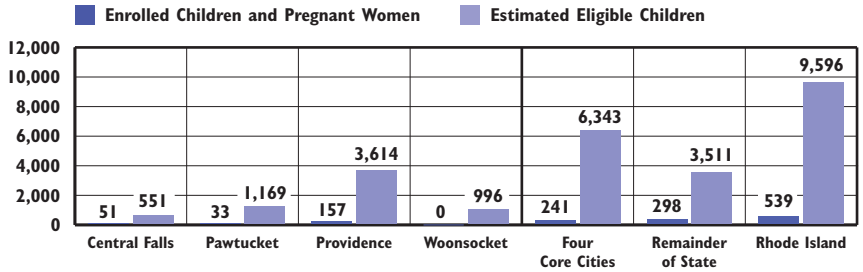
Pregnant women enrolled in Early Head Start are assessed for risks to a successful pregnancy. Individualized plans are developed to support prenatal health, promote healthy behaviors and prepare for the baby's arrival.[5] After the baby is born, families participate by enrolling in either a center-based or a home-based program. Home-based programs use weekly home visits to support child development and twice monthly group meetings. Children in center-based models attend a center-based early care and education program and families receive at least two home visits per year. Some Early Head Start programs provide a combination of home-based and center-based services for families.[6]

In Rhode Island in 2014, there were 529 federally-funded Early Head Start slots. Of these, 31% were center-based and 69% were home-based.[7] There are eight more Early Head Start slots in Rhode Island than in 2013.[8]

Early Head Start has been shown to produce significant cognitive, language, and social-emotional gains in participating children and more positive interactions with their parents. Early Head Start parents provide more emotional support and more opportunities for language and learning to their children, and are more likely to pursue education and job-training activities and to be employed.[9,10] Children who enroll in preschool after Early Head Start have better outcomes in early reading skills.[11]

As of October 2014, 527 infants and toddlers and 12 pregnant women were receiving Early Head Start services in Rhode Island, 6% of the estimated eligible population.[12]

Access to Early Head Start for Low-Income Children and Pregnant Women, Rhode Island, 2014



Source: Rhode Island Early Head Start program enrollment data compiled by Rhode Island KIDS COUNT, October 2014. Estimated eligible children is the number of children under age three according to Census 2010 multiplied by the % of children under age six living in families with incomes below 125% of the federal poverty level (FPL) according to the Population Reference Bureau's analysis of U.S. Census 2009-2013 American Community Survey, 5-year estimates. Estimates for children living in families between 125% and 129% FPL are not available.

◆ **In 2014 in Rhode Island, federal funding enabled 241 children and pregnant women to participate in Early Head Start from three of the four core cities (4% of the estimated income-eligible population) and 298 children and pregnant women from the remainder of the state (8% of the estimated income-eligible population). The estimated percentage of the eligible population enrolled in Early Head Start for each core city is: Central Falls – 9%, Pawtucket – 3%, Providence – 4%, and Woonsocket – 0%.[13]**

◆ **As of October 2014, there were 203 eligible children and pregnant women on agency waiting lists for Early Head Start Services in Rhode Island. There are no Early Head Start services available for families in Woonsocket, Cumberland, Lincoln or any towns in Washington County.[14] A new federal Early Head Start-Child Care Partnership grant, awarded in 2015, will create 100 new Early Head Start slots in Rhode Island.[15]**

◆ **As of October 2014 in Rhode Island, 18% of the children enrolled in Early Head Start had a developmental delay or disability and were receiving Early Intervention services.[16] Early Head Start programs are required to prioritize enrollment for children with special needs and to screen all enrolled children to identify developmental delays and disabilities.[17]**

◆ **As of October 2014 in Rhode Island, 25% of children enrolled in Early Head Start were also participating in the Child Care Assistance Program.[18] Center-based Early Head Start programs are open 6 hours per day but do not cover the entire day for many working parents.[19]**

Table 33. **Children Ages Birth to 3 and Pregnant Women Enrolled in Early Head Start, Rhode Island, 2014**

CITY/TOWN	ALL CHILDREN UNDER AGE 3	# OF PREGNANT WOMEN ENROLLED IN EARLY HEAD START	# OF CHILDREN ENROLLED IN EARLY HEAD START	ESTIMATED % OF ALL CHILDREN ENROLLED IN EARLY HEAD START
Barrington	366	0	0	0%
Bristol	507	0	3	1%
Burrillville	460	2	15	3%
Central Falls	1,028	1	50	5%
Charlestown	186	0	0	0%
Coventry	940	0	11	1%
Cranston	2,318	1	19	1%
Cumberland	970	0	0	0%
East Greenwich	299	0	1	0%
East Providence	1,560	0	28	2%
Exeter	166	0	0	0%
Foster	113	0	0	0%
Glocester	247	0	2	1%
Hopkinton	258	0	0	0%
Jamestown	85	0	0	0%
Johnston	816	0	15	2%
Lincoln	587	0	0	0%
Little Compton	68	0	1	1%
Middletown	502	0	12	2%
Narragansett	271	0	0	0%
New Shoreham	21	0	0	0%
Newport	820	3	50	6%
North Kingstown	728	0	0	0%
North Providence	851	1	19	2%
North Smithfield	290	0	2	1%
Pawtucket	2,959	1	32	1%
Portsmouth	429	0	2	0%
Providence	7,609	1	156	2%
Richmond	235	0	0	0%
Scituate	193	0	1	1%
Smithfield	402	0	1	0%
South Kingstown	640	0	0	0%
Tiverton	398	0	2	1%
Warren	296	0	8	3%
Warwick	2,322	0	43	2%
West Greenwich	178	0	2	1%
West Warwick	1,044	2	52	5%
Westerly	726	0	0	0%
Woonsocket	1,900	0	0	0%
Four Core Cities	*13,496*	*3*	*238*	*2%*
Remainder of State	*20,292*	*9*	*289*	*1%*
Rhode Island	*33,788*	*12*	*527*	*2%*

Source of Data for Table/Methodology

Rhode Island Early Head Start Programs, children enrolled as of October 2014.

Children enrolled are listed by residence of child, not location of the Head Start program.

The estimated number of children under age three in each community is from Census 2010, Summary File 1. It is no longer possible to estimate the number of children eligible for Early Head Start for each city and town in Rhode Island because family income data are no longer collected in the decennial census. Family income estimates from the American Community Survey are available for most cities and towns, but estimates for many smaller towns in Rhode Island have large margins of error or are suppressed.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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[8] Rhode Island Early Head Start program reports to Rhode Island KIDS COUNT, October 2013.

(continued on page 182)

Licensed Capacity of Early Learning Programs

DEFINITION

Licensed capacity of early learning programs is the number of child care and early learning programs and slots licensed by the Rhode Island Department of Children, Youth and Families for children under age six. Licensed centers include child care programs, preschools, nursery schools, and center-based Head Start and Early Head Start programs.

SIGNIFICANCE

Research indicates that high-quality child care and early learning programs for infants, toddlers and preschoolers can have long-lasting positive effects on how children learn and develop.[1]

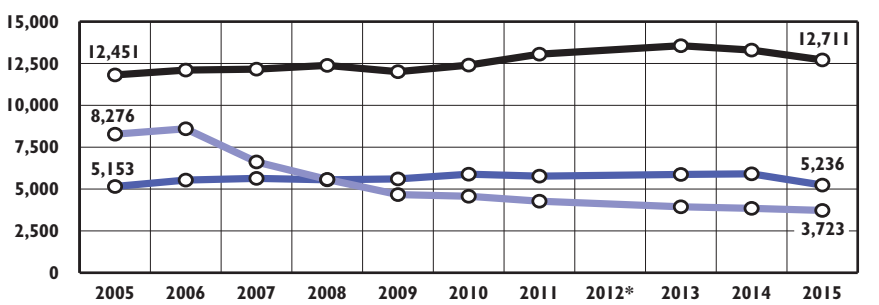
Early and on-going enrollment in child care and early learning programs is common in the United States. Across the U.S., 42% of infants under the age of one and 73% of preschoolers between ages three and five regularly participate in a non-parental early care and education arrangement. Participation in early care and education varies by family income, with 63% of children ages birth to five living in households at or above the poverty line enrolled in child care or early learning programs versus 49% of those in households below the poverty line. Enrollment in center-based programs increases as children get older, with 28% of infants under age one participating in a center-based program while 78% of preschoolers (children ages three to five) are enrolled in a center. Children with disabilities can have great difficulty accessing child care and early learning programs despite a federal law requiring that community-based child care and preschool settings include children with disabilities.[2]

Access to stable, affordable, quality child care is a basic need for many working families and is critical for Rhode Island's economy. When parents have difficulty finding and keeping child care, they are more likely to be absent from work and to leave their jobs.[3] Between 2011 and 2013, 72% of Rhode Island children under age six had all parents in the workforce, higher than the U.S. rate of 65%.[4]

The availability of high-quality child care and early learning programs depends on the stability of a skilled teaching workforce. However, there are significant systemic workforce challenges including low compensation, inadequate professional development opportunities, and high turnover.[5] In addition, high-quality early care and education programs require well-designed, safe buildings that meet the needs of young children.[6]

Rhode Island's $50 million Race to the Top-Early Learning Challenge grant, awarded in December 2011, is designed to increase the quality of early learning programs and strengthen the workforce statewide, with a focus on programs and staff serving low-income and disadvantaged children.[7]

Early Learning Program Capacity, Rhode Island, 2005-2015



Source: Options for Working Parents, slots in licensed child care centers and certified family child care homes, 2005-2006. Rhode Island Department of Children, Youth and Families, slots in licensed child care centers and family child care homes, 2007-2015.*In the 2013 Factbook, data was collected as of January 2013, instead of December 2012.

◆ **In January 2015, there were 673 fewer slots for infants and toddlers (children under age three), an 11% reduction, and 589 fewer slots for preschoolers (children ages three to five), a 4% reduction, in licensed child care centers in Rhode Island than in the previous year.[8]**

◆ **In January 2015, there were 124 fewer slots in licensed family child care homes than in the previous year. The number of family child care slots is down 57% from a peak high of 8,601 in 2006 to 3,723 in 2015.[9]**

Quality Child Care for Infants and Toddlers

◆ **Infants and toddlers benefit from low child-to-provider ratios and small group sizes where they can form nurturing, responsive and continuous relationships with adults. Specific infant-toddler training along with regular on-site coaching and monitoring helps providers meet key health and safety standards particular to babies and learn how to provide sensitive and enriching care in a group setting.[10]**

Licensed Capacity of Early Learning Programs

Table 34.

Capacity of Licensed Early Learning Programs, Rhode Island, January 2015

CITY/TOWN	# OF LICENSED CENTERS	# OF CENTER SLOTS FOR CHILDREN < AGE 3	# OF CENTER SLOTS FOR CHILDREN AGES 3-5	# OF LICENSED FAMILY CHILD CARE HOMES	# OF LICENSED FAMILY CHILD CARE HOME SLOTS*	TOTAL LICENSED EARLY LEARNING PROGRAM SLOTS
Barrington	9	129	362	5	32	523
Bristol	5	68	102	4	21	191
Burrillville	3	19	89	2	14	122
Central Falls	4	78	199	21	136	413
Charlestown	4	14	72	2	14	100
Coventry	6	104	211	5	34	349
Cranston	29	424	1,168	49	335	1,927
Cumberland	7	126	315	8	68	509
East Greenwich	11	281	608	0	0	889
East Providence	15	136	497	8	56	689
Exeter	2	31	38	1	8	77
Foster	1	17	25	0	0	42
Glocester	3	47	82	0	0	129
Hopkinton	3	5	60	2	16	81
Jamestown	1	31	33	1	8	72
Johnston	18	303	452	9	59	814
Lincoln	4	57	204	4	26	287
Little Compton	1	0	18	0	0	18
Middletown	9	143	419	5	37	599
Narragansett	2	12	56	0	0	68
New Shoreham	1	13	26	0	0	39
Newport	4	60	183	4	34	277
North Kingstown	9	183	415	3	22	620
North Providence	9	150	260	10	66	476
North Smithfield	1	30	91	3	32	153
Pawtucket	17	223	736	40	253	1,212
Portsmouth	5	53	174	1	6	233
Providence	47	795	1,865	323	2,129	4,789
Richmond	0	0	0	4	35	35
Scituate	1	11	16	5	40	67
Smithfield	10	341	676	0	0	1,017
South Kingstown	11	193	347	6	46	586
Tiverton	3	24	113	1	8	145
Warren	5	60	210	2	16	286
Warwick	28	695	1,443	11	79	2,217
West Greenwich	2	6	48	0	0	54
West Warwick	5	158	329	4	28	515
Westerly	7	99	280	2	13	392
Woonsocket	9	117	489	7	52	658
Four Core Cities	*77*	*1,213*	*3,289*	*391*	*2,570*	*7,072*
Remainder of State	*234*	*4,023*	*9,422*	*161*	*1,153*	*14,598*
Rhode Island	*311*	*5,236*	*12,711*	*552*	*3,723*	*21,670*

Source of Data for Table/Methodology

Rhode Island Department of Children, Youth and Families, number of licensed child care center slots and programs for children under age six and number of licensed family child care homes and slots, January 2015. Only full-day and morning slots are counted for center-based care.

Licensed centers include child care programs, preschools, nursery schools, and center-based Head Start and Early Head Start programs.

*Family child care slots are for children ages birth to 12 years old.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

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Children Receiving Child Care Subsidies

DEFINITION

Children receiving child care subsidies is the number of children receiving child care that is either fully or partially paid for with a child care subsidy from the Rhode Island Department of Human Services. Child care subsidies can be used for care in a child care center, family child care home, or by 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. Yet the high cost of child care puts quality care out of reach for many low-income families. State child care subsidy programs help low-income, working families enroll their children in licensed child care programs.[1]

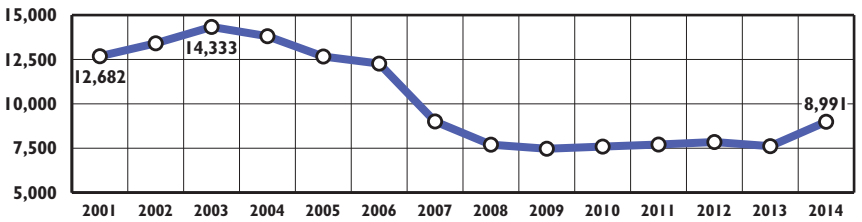
In Rhode Island, the average cost of full-time child care for an infant in a child care center consumes 49% of the median single-mother family income and 13% of the median two-parent family income. The average annual cost of child care for two children (an infant and a preschooler) in Rhode Island is more than twice the state's median annual rent.[2] Using the federal affordability guideline that families should spend no more than 10% of their gross income on child care, a Rhode Island family would need to earn approximately $95,000 annually to afford the average yearly cost for a three-year-old at a licensed center ($9,587).[3,4]

Child care subsidies increase the likelihood that low-income parents are able to work, reduce the likelihood that parents who previously received cash assistance payments do so again, and increase the range of affordable child care options. Families who use child care subsidies have higher rates of parental employment, more stable employment, and more income than poor families who do not use them.[5,6]

In 1996, Rhode Island established an entitlement to child care assistance for families with incomes up to 185% of the federal poverty level (FPL) as a key component of welfare reform. In 1998, legislation expanded eligibility for families with incomes up to 225% FPL, and adjusted rates paid to child care providers biennially in order to improve access to high-quality child care.[7] In 2007, eligibility for child care subsidies was reduced to 180% FPL ($36,162 for a family of three in 2015).[8,9] In 2008, the requirement to adjust rates biennially was eliminated.[10]

Nationally, many families lose access to child care subsidies after a short period of time and then return to the subsidy program. Access and continuity of care can be improved by simplifying application and renewal processes, and expanding eligibility periods.[11,12]

Child Care Subsidies, Rhode Island, 2001-2014



Source: Rhode Island Department of Human Services, December 2001-December 2014.

◆ **In December 2014, there were 8,991 child care subsidies in Rhode Island, an increase of 18% from 7,616 in December 2013, but down 37% from the 2003 peak.[13]**

◆ **In 2014 in Rhode Island, 76% of child care subsidies were for care in a licensed child care center, 23% were for care by a licensed family child care home or group family child care home, and 1% were for care by a non-licensed relative, friend, or neighbor.[14]**

◆ **As of January 2015, 77% of licensed early childhood centers, 95% of licensed school-age centers, and 84% of licensed family child care homes in Rhode Island accepted Child Care Assistance Program payments.[15]**

◆ **In December 2014, 82% of all child care subsidies in Rhode Island were used by low-income working families not receiving cash assistance and 10% were used by families enrolled in the Rhode Island Works Program who were engaged in employment activities. Another 9% of child care subsidies were used for children in the care of the Rhode Island Department of Children, Youth and Families.[16]**

Average Annual Cost for Full-Time Child Care, Rhode Island, 2013

PROGRAM TYPE	COST PER CHILD
Child Care Center (infant care)	$12,097
Child Care Center (preschool care)	$9,587
Family Child Care Home (preschool care)	$8,715
School-Age Center-Based Program (child age 6-12)	$6,786

Source: Rhode Island KIDS COUNT analysis of average weekly rates from Bodah, M. M. (2013). *Statewide survey of child care rates in Rhode Island.* Kingston, RI: University of Rhode Island.

Children Receiving Child Care Subsidies

Table 35.

Child Care Subsidies, Rhode Island, December 2014

CITY/TOWN	SUBSIDY USE BY CHILD RESIDENCE: ENROLLED IN RI WORKS	SUBSIDY USE BY CHILD RESIDENCE: NOT ENROLLED IN RI WORKS	SUBSIDY USE BY CHILD RESIDENCE: TOTAL CHILD CARE SUBSIDIES	SUBSIDY USE BY PROGRAM LOCATION: UNDER AGE 3	SUBSIDY USE BY PROGRAM LOCATION: AGES 3-5	SUBSIDY USE BY PROGRAM LOCATION: AGES 6-12	SUBSIDY USE BY PROGRAM LOCATION: TOTAL CHILD CARE SUBSIDIES
Barrington	1	15	16	9	8	7	24
Bristol	6	62	68	13	16	18	47
Burrillville	1	38	39	3	7	20	30
Central Falls	42	325	367	86	120	149	355
Charlestown	1	7	8	3	1	4	8
Coventry	13	119	132	34	63	64	161
Cranston	52	438	490	160	226	220	606
Cumberland	7	80	87	17	29	28	74
East Greenwich	2	8	10	24	23	16	63
East Providence	23	265	288	64	160	160	384
Exeter	3	11	14	5	6	2	13
Foster	1	7	8	4	8	2	14
Glocester	0	11	11	9	9	0	18
Hopkinton	0	18	18	5	1	1	7
Jamestown	1	2	3	4	2	1	7
Johnston	17	157	174	95	100	89	284
Lincoln	6	95	101	33	42	77	152
Little Compton	0	0	0	0	0	0	0
Middletown	1	52	53	20	41	7	68
Narragansett	0	32	32	0	1	8	9
New Shoreham	0	1	1	0	1	0	1
Newport	20	211	231	57	107	83	247
North Kingstown	16	146	162	54	74	47	175
North Providence	22	173	195	43	54	67	164
North Smithfield	5	31	36	19	30	15	64
Pawtucket	104	876	980	201	349	424	974
Portsmouth	1	23	24	12	14	11	37
Providence	396	2,882	3,278	754	1,033	1,471	3,258
Richmond	3	15	18	0	3	3	6
Scituate	1	22	23	2	3	4	9
Smithfield	7	27	34	50	63	35	148
South Kingstown	11	45	56	18	32	24	74
Tiverton	3	30	33	4	9	7	20
Warren	5	55	60	25	36	26	87
Warwick	8	306	314	135	220	150	505
West Greenwich	0	8	8	1	4	0	5
West Warwick	11	227	238	58	76	62	196
Westerly	3	70	73	32	36	31	99
Woonsocket	80	522	602	94	187	284	565
DCYF	*NA*	*NA*	*775*	*NA*	*NA*	*NA*	*NA*
Out-Of-State	*0*	*0*	*0*	*12*	*20*	*1*	*33*
Four Core Cities	*622*	*4,605*	*5,227*	*1,135*	*1,689*	*2,328*	*5,152*
Remainder of State	*251*	*2,807*	*3,058*	*1,012*	*1,505*	*1,289*	*3,806*
Rhode Island	*873*	*7,412*	*9,060*	*2,159*	*3,214*	*3,618*	*8,991*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, InRhodes Database, December 2014.

RI Works is Rhode Island's cash assistance program (formerly known as the Family Independence Program).

DCYF is the number of children in the care of the Department of Children, Youth and Families who are receiving child care subsidies.

Out-of-State is Rhode Island resident children who attend child care located outside of Rhode Island; they are included in the total count for Rhode Island.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

NA=Not applicable

Subsidy data by age of child are reported by the location of the program. Total subsidy use numbers by child residence and total subsidy use numbers by program location do not match because children may be enrolled in more than one program and the InRhodes database is a live system and reports run on different days can have slight variation.

The average annual cost for full-time child care was determined by multiplying the average weekly tuition rate by 52 weeks (for infants and preschoolers). For school-age children, the annual cost was determined by multiplying the average weekly tuition for before and after school care by 39 weeks and adding three weeks of average school vacation tuition and 10 weeks of average summer vacation tuition.

References

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(continued on page 182)

Early Learning Programs Participating in BrightStars

DEFINITION

Early learning programs participating in BrightStars is the percentage of licensed early learning centers and family child care homes in Rhode Island that are participating in BrightStars, Rhode Island's Quality Rating and Improvement System for child care and early learning programs.

SIGNIFICANCE

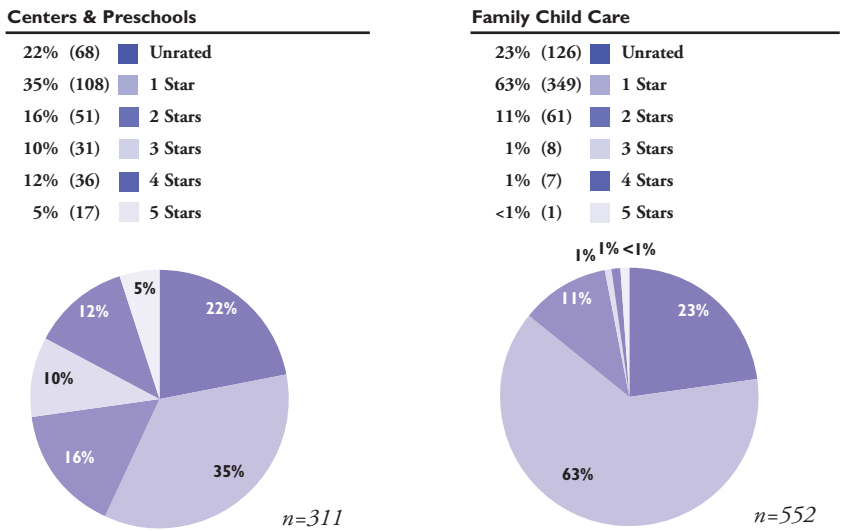
Research on early care and education reveals a strong relationship between program quality and children's developing skills and well-being. Children who attend high-quality programs score higher on tests of language and cognitive skills and demonstrate stronger social and emotional development than children who attend low-quality programs.[1,2,3] Programs across the U.S. and in Rhode Island vary markedly in quality and can range from rich learning experiences to mediocre, custodial care.[4,5,6]

High-quality early care and education is characterized by smaller numbers of children in a classroom or group, fewer children per adult, skilled staff, a language-rich environment with stimulating curricula, warm, nurturing and dependable relationships between staff and children, and a safe environment.[7] The development and retention of a highly qualified and appropriately compensated workforce for early childhood programs is critical to improve program quality.[8]

Quality Rating and Improvement Systems (QRIS) are becoming an increasingly common strategy used by states to measure, improve and incentivize program quality. QRIS incorporate five components: (1) quality standards with incremental steps for programs, (2) a process to assess program quality, (3) strategies to support quality improvement, (4) financial incentives for programs, and (5) a system to share program quality information with parents and the public. Studies have shown that, over time, state QRIS can improve the quality of care available.[9,10] Many states provide financial incentives to encourage and support achievement of quality standards. Incentives include offering tiered child care subsidy payments with higher rates for higher quality care and providing program improvement grants.[11]

Launched in 2009, BrightStars conducts program quality assessments using research based standards for licensed centers (including child care, preschool and Head Start), family child care homes, and public schools. Programs participating in BrightStars receive a star rating and develop a quality improvement plan across six quality domains.[12] As of October 2014, all programs serving children participating in the Child Care Assistance Program are required to have a BrightStars rating.[13]

Quality Ratings of Licensed Early Learning Programs Participating in BrightStars, Rhode Island, January 2015



Source: Rhode Island Association for the Education of Young Children, January 2015.

◆ **As of January 2015, there were 669 licensed early care and education programs with an active BrightStars quality rating, more than three times as many as were rated in January 2014. Seventeen percent of licensed early learning centers had met the benchmarks for a high-quality rating of four or five stars, while 1% of family child care homes had received a high-quality rating of four or five stars.[14]**

◆ **As of January 2015, there were 21 public schools with a BrightStars quality rating (40% of the 53 public schools serving preschoolers). Five (9%) had a high-quality rating of four or five stars.[15]**

◆ **The Rhode Island Department of Education awards Comprehensive Early Childhood Education approval to preschool classrooms that meet state-defined quality benchmarks. As of January 2015, there were 24 preschool classrooms in 16 licensed centers and zero public school classrooms that met approval standards.[16]**

◆ **Rhode Island's four-year, $50 million Race to the Top-Early Learning Challenge grant is focused on increasing participation in BrightStars and providing intensive support to programs to meet high-quality benchmarks.[17]**

Early Learning Programs Participating in BrightStars

Table 36.

Licensed Early Learning Programs Participating in the BrightStars Quality Rating and Improvement System, Rhode Island, January 2015

	CHILD CARE CENTERS AND PRESCHOOLS					FAMILY CHILD CARE HOMES				
CITY/TOWN	LICENSED PROGRAMS	PROGRAMS WITH A QUALITY RATING	PROGRAMS WITH A HIGH-QUALITY RATING	% IN BRIGHTSTARS	% WITH HIGH-QUALITY RATING	LICENSED PROGRAMS	PROGRAMS WITH A QUALITY RATING	PROGRAMS WITH A HIGH-QUALITY RATING	% IN BRIGHTSTARS	% WITH HIGH-QUALITY RATING
Barrington	9	5	1	56%	11%	5	0	0	0%	0%
Bristol	5	5	0	100%	0%	4	2	0	50%	0%
Burrillville	3	2	1	67%	33%	2	1	0	50%	0%
Central Falls	4	3	2	75%	50%	21	20	0	95%	0%
Charlestown	4	3	1	75%	25%	2	1	0	50%	0%
Coventry	6	5	1	83%	17%	5	1	0	20%	0%
Cranston	29	19	2	66%	7%	49	40	0	82%	0%
Cumberland	7	5	2	71%	29%	8	3	1	38%	13%
East Greenwich	11	9	2	82%	18%	0	NA	NA	NA	NA
East Providence	15	12	3	80%	20%	8	6	0	75%	0%
Exeter	2	2	0	100%	0%	1	1	1	100%	100%
Foster	1	1	0	100%	0%	0	NA	NA	NA	NA
Glocester	3	3	0	100%	0%	0	NA	NA	NA	NA
Hopkinton	3	1	0	33%	0%	2	1	1	50%	50%
Jamestown	1	1	0	100%	0%	1	0	0	0%	0%
Johnston	18	17	1	94%	6%	9	6	0	67%	0%
Lincoln	4	4	1	100%	25%	4	2	0	50%	0%
Little Compton	1	0	0	0%	0%	0	NA	NA	NA	NA
Middletown	9	6	1	67%	11%	5	0	0	0%	0%
Narragansett	2	0	0	0%	0%	0	NA	NA	NA	NA
New Shoreham	1	1	1	100%	100%	0	NA	NA	NA	NA
Newport	4	2	1	50%	25%	4	2	0	50%	0%
North Kingstown	9	9	2	100%	22%	3	2	0	67%	0%
North Providence	9	8	1	89%	11%	10	3	0	30%	0%
North Smithfield	1	1	0	100%	0%	3	2	2	67%	67%
Pawtucket	17	14	1	82%	6%	40	34	0	85%	0%
Portsmouth	5	3	0	60%	0%	1	0	0	0%	0%
Providence	47	39	14	83%	30%	323	277	3	86%	1%
Richmond	0	NA	NA	NA	NA	4	1	0	25%	0%
Scituate	1	1	0	100%	0%	5	2	0	40%	0%
Smithfield	10	8	1	80%	10%	0	NA	NA	NA	NA
South Kingstown	11	8	3	73%	27%	6	4	0	67%	0%
Tiverton	3	2	0	67%	0%	1	1	0	100%	0%
Warren	5	2	0	40%	0%	2	0	0	0%	0%
Warwick	28	22	5	79%	18%	11	4	0	36%	0%
West Greenwich	2	2	0	100%	0%	0	NA	NA	NA	NA
West Warwick	5	5	1	100%	20%	4	2	0	50%	0%
Westerly	7	5	0	71%	0%	2	2	0	100%	0%
Woonsocket	9	8	5	89%	56%	7	6	0	86%	0%
Four Core Cities	*77*	*64*	*22*	*83%*	*29%*	*391*	*337*	*3*	*86%*	*1%*
Remainder of State	*234*	*179*	*31*	*76%*	*13%*	*161*	*89*	*5*	*55%*	*3%*
Rhode Island	*311*	*243*	*53*	*78%*	*17%*	*552*	*426*	*8*	*77%*	*1%*

Source of Data for Table/Methodology

Data on the number of licensed early learning programs and family child care homes are from the Rhode Island Department of Children, Youth and Families, January 2015. Data on BrightStars quality ratings is from the Rhode Island Association for the Education of Young Children, January 2015.

High-quality rating means a BrightStars rating of four or five stars.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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(continued on page 182)

Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the number and percentage of children enrolled in a Rhode Island Head Start preschool program.

SIGNIFICANCE

Head Start is a federally-funded comprehensive early childhood program for low-income preschool children and their families. It is designed to address a wide variety of needs during the two years before kindergarten so that low-income children can begin school on a more equal footing with their economically advantaged peers.[1] Head Start programs deliver early education, medical and dental screenings and referrals, nutrition services, mental health services, family engagement activities, and social service referrals for the whole family.[2]

Family income is strongly correlated with children's cognitive, language, and literacy skills at school entry. Before kindergarten entry, children in the highest socio-economic group have cognitive test scores that are 60% higher than the average scores of children in the lowest socio-economic group. Children in families with incomes below the federal poverty threshold are typically 18 months behind their peers at age four.[3]

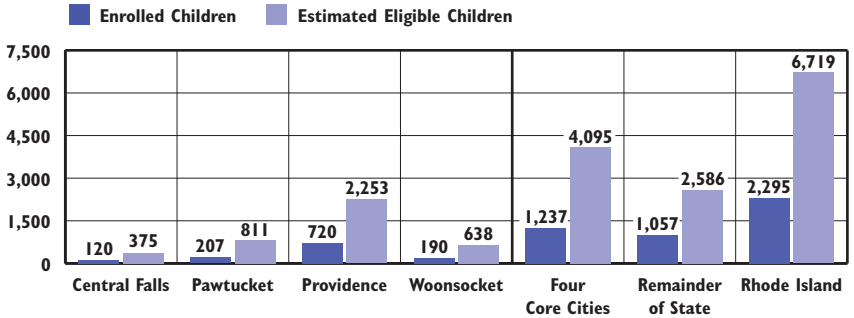
On average, Head Start centers are higher quality than most other early care and education programs available to low-income parents.[4] Head Start also has been found to be more effective than many other early learning programs.[5] Children who participate in Head Start show improvements in language and literacy skills.[6,7]

Lasting impacts for children who participate in Head Start have been found in reduced grade retention and special education placement and increased high school graduation rates.[8] However, a recent study found that improved language and literacy skills were no longer discernible by the end of third grade, perhaps due to the fact that children in the study attended elementary schools with higher levels of poverty than schools nationwide.[9]

For the 2014-2015 school year there were 2,284 Head Start slots in Rhode Island, with 2,154 federally-funded slots and 130 state-funded slots.[10] This is 143 fewer federally-funded slots than in 2012-2013.

As of October 2014, there were 2,295 children enrolled in Head Start and 532 eligible children on the waiting list. Rhode Island Head Start providers served 275 preschool children with developmental delays or disabilities, 12% of all children enrolled. Twelve percent of children enrolled in Rhode Island Head Start programs were also participating in the Child Care Assistance Program.[12] Head Start funding is not sufficient to provide a full-day or full-year program.[13]

Access to Head Start for Low-Income Children, Rhode Island, 2014

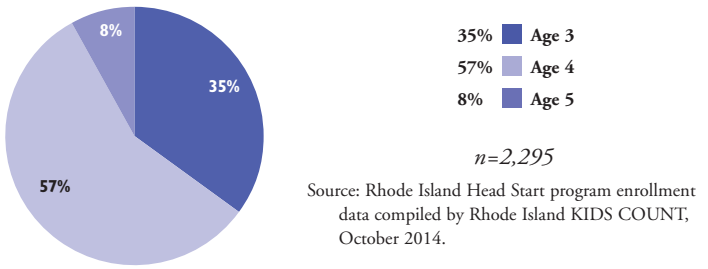


Source: Rhode Island Head Start program enrollment data compiled by Rhode Island KIDS COUNT, October 2014. Estimated eligible children is the number of children ages three and four according to Census 2010 multiplied by the % of children under age six living in families with incomes below 125% of the federal poverty level (FPL) according to the Population Reference Bureau's analysis of U.S. Census 2009-2013 American Community Survey, five-year estimates. Estimates for children living in families between 125% and 129% FPL are not available.

◆ **Head Start is not funded at a level to serve all eligible children and all Rhode Island Head Start programs maintain active waiting lists of eligible children. In October 2014, Rhode Island Head Start programs served 2,295 children, 34% of the estimated 6,719 income-eligible three- and four-year old children and 10% of all children ages three and four.[14]**

◆ **In the four core cities, 30% of the estimated eligible children were enrolled in Head Start, compared with 41% in the remainder of the state. The estimated percentage of eligible children enrolled in Head Start for each core city is: Central Falls – 32%, Pawtucket – 26%, Providence – 32%, and Woonsocket – 30%.[15]**

Children Enrolled in Head Start by Age, Rhode Island, 2014



n=2,295

Source: Rhode Island Head Start program enrollment data compiled by Rhode Island KIDS COUNT, October 2014.

Table 37.

Children Enrolled in Head Start, Rhode Island, 2014

CITY/TOWN	# OF CHILDREN AGES 3 & 4	# OF CHILDREN ENROLLED IN HEAD START	ESTIMATED % OF CHILDREN ENROLLED IN HEAD START
Barrington	369	2	1%
Bristol	401	25	6%
Burrillville	321	17	5%
Central Falls	699	120	17%
Charlestown	153	9	6%
Coventry	734	55	7%
Cranston	1,684	182	11%
Cumberland	810	0	0%
East Greenwich	277	6	2%
East Providence	982	108	11%
Exeter	105	5	5%
Foster	99	0	0%
Glocester	191	1	1%
Hopkinton	167	7	4%
Jamestown	102	0	0%
Johnston	528	47	9%
Lincoln	412	0	0%
Little Compton	49	1	2%
Middletown	431	43	10%
Narragansett	210	6	3%
New Shoreham	15	0	0%
Newport	514	79	15%
North Kingstown	593	27	5%
North Providence	575	58	10%
North Smithfield	218	2	1%
Pawtucket	2,053	207	10%
Portsmouth	359	9	3%
Providence	4,743	720	15%
Richmond	190	2	1%
Scituate	197	1	1%
Smithfield	343	7	2%
South Kingstown	504	15	3%
Tiverton	287	17	6%
Warren	240	26	11%
Warwick	1,579	118	7%
West Greenwich	115	1	1%
West Warwick	703	110	16%
Westerly	490	71	14%
Woonsocket	1,218	190	16%
Homeless	*NA*	*1*	*NA*
Four Core Cities	*8,713*	*1,237*	*14%*
Remainder of State	*14,947*	*1,057*	*7%*
Rhode Island	*23,660*	*2,295*	*10%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, all children enrolled (ages three to five) as of October 2014. Children enrolled are listed by residence of child, not location of the Head Start program.

The estimated number of children ages three and four in each community is from Census 2010, Summary File 1. It is no longer possible to estimate the number of children eligible for Head Start for each city and town in Rhode Island because family income data is no longer collected in the decennial census. Family income estimates from the American Community Survey are available for most cities and towns, but estimates for many smaller towns in Rhode Island have large margins of error or are suppressed.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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(continued on page 182)

Children Enrolled in State Pre-K

DEFINITION

Children enrolled in State Pre-K is the number and percentage of children enrolled in the State Pre-Kindergarten (Pre-K) program managed by the Rhode Island Department of Education. The State Pre-K program is operated by child care programs, Head Start programs, and public schools.

SIGNIFICANCE

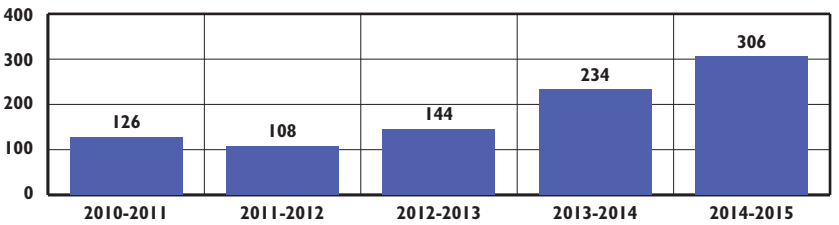
State-funded Pre-K programs for children ages three and four are available in 40 states, with 28% of four-year-olds and 4% of three-year-olds enrolled nationwide. Eight states and the District of Columbia have more than half of their four-year-olds enrolled in State Pre-K.[1] States have increased investments in Pre-K, recognizing that children who attend high-quality preschool make substantive developmental, academic, language, and social gains that can persist well into later school years, and are less likely to be retained a grade or enrolled in special education.[2,3,4] In states without large public Pre-K programs, children from high-income and highly educated families are much more likely to be enrolled in preschool than children from low- to moderate-income families.[5]

High-quality preschool programs have shown strong economic returns, with benefits to children and the public far exceeding the original investment. Small class sizes, low child-teacher ratios, and teachers who are well-educated, emotionally supportive, and use curricula effectively produce the biggest gains among children.[6,7,8]

In 2008, the General Assembly passed *The Rhode Island Prekindergarten Education Act*, acknowledging the need to adequately prepare all children to succeed in school by providing access to publicly-funded, high-quality Pre-K and requiring the Rhode Island Department of Education to plan for the development of a State Pre-K program that meets high-quality standards, builds on the existing early childhood education infrastructure, and serves children ages three and four.[9] Rhode Island began offering the State Pre-K program for four-year-olds in the 2009-2010 school year. The state's program is one of only four in the U.S. to meet all recommended quality benchmarks.[10] Rhode Island's State Pre-K program has been found to improve children's language and literacy skills and close the achievement gap between low-income children and their more affluent peers by three-quarters.[11]

Currently, there are 306 children enrolled in State Pre-K (3% of four-year-olds in the state), placing Rhode Island near the bottom of the 40 states in terms of ranking for access to State Pre-K.[12,13] Expansion of the State Pre-K program is included in the state's education funding formula, with a $1 million increase in funding planned each year for 10 years.[14,15]

Rhode Island State Pre-K Funded Slots, 2010-2011 through 2014-2015



Sources: National Institute for Early Education Research, *The State of Preschool 2010, 2011, 2012, 2013*. Rhode Island Department of Education, State Pre-K programs 2013-2014 and 2014-15.

◆ **As of the 2014-2015 school year, there are 17 State Pre-K classrooms in Rhode Island with a total of 306 children enrolled. Thirty-two percent of children enrolled in State Pre-K speak a language other than English at home and 11% have a developmental delay or disability.[16]**

◆ **Of the 17 State Pre-K classrooms, eight are operated by a child care center/preschool, eight are operated by a Head Start agency, and one is operated by a public school district.[17]**

◆ **State Pre-K funds are targeted to communities with a high proportion of low-income families, using the percentage of children participating in the local school district's free and reduced-price lunch program as a guideline.[18]**

◆ **Children are selected to participate in State Pre-K through a lottery, with children from families at or below 185% of the federal poverty level (FPL) prioritized for enrollment based on the proportion of low-income children in the local school district.[19] In the 2014-15 school year, 67% of children enrolled in State Pre-K are at or below 185% FPL, while 33% are above.[20]**

State Pre-K and the Early Learning System

◆ **State Pre-K is an important part of a strong state early learning system that starts at birth and continues through third grade, including nurturing, language rich environments in child care, Head Start, full-day kindergarten, and the early elementary grades.[21] Head Start programs collaborate with State Pre-K in many states to serve more children in high-quality early childhood education programs.[22]**

Table 38.

Children Enrolled in State Pre-K, Rhode Island, 2014-2015

CITY/TOWN	% LOW-INCOME STUDENTS	# OF CHILDREN AGE 4	# OF CHILDREN ENROLLED IN STATE PRE-K	% OF CHILDREN ENROLLED IN STATE PRE-K
Barrington	4%	199	0	0%
Bristol	36%	206	0	0%
Burrillville	36%	173	0	0%
Central Falls	79%	345	18	5%
Charlestown	21%	81	0	0%
Coventry	34%	366	0	0%
Cranston	42%	862	18	2%
Cumberland	25%	426	0	0%
East Greenwich	6%	158	0	0%
East Providence	50%	469	0	0%
Exeter	14%	55	0	0%
Foster	23%	53	0	0%
Glocester	16%	106	0	0%
Hopkinton	21%	87	0	0%
Jamestown	12%	50	0	0%
Johnston	37%	278	0	0%
Lincoln	27%	211	0	0%
Little Compton	13%	28	0	0%
Middletown	28%	226	0	0%
Narragansett	21%	117	0	0%
New Shoreham	17%	7	0	0%
Newport	62%	232	36	16%
North Kingstown	22%	318	0	0%
North Providence	49%	282	0	0%
North Smithfield	17%	108	0	0%
Pawtucket	73%	1,006	18	2%
Portsmouth	15%	196	0	0%
Providence	80%	2,382	90	4%
Richmond	21%	102	0	0%
Scituate	20%	94	0	0%
Smithfield	16%	169	0	0%
South Kingstown	19%	273	0	0%
Tiverton	29%	143	0	0%
Warren	36%	127	0	0%
Warwick	34%	850	54	6%
West Greenwich	14%	53	0	0%
West Warwick	49%	354	36	10%
Westerly	40%	244	0	0%
Woonsocket	72%	584	36	6%
Four Core Cities	*77%*	*4,317*	*162*	*4%*
Remainder of State	*31%*	*7,703*	*144*	*2%*
Rhode Island	*47%*	*12,020*	*306*	*3%*

Source of Data for Table/Methodology

The number children enrolled in State Pre-K and percentage of low-income students (eligible for free and reduced price lunch) is from the Rhode Island Department of Education, October 2014. The number of four-year-olds is from Census 2010, Summary File 1.

% of low-income students is the percentage of students enrolled in free and reduced price lunch. Data for regional school districts (Chariho, Bristol Warren, Exeter-West Greenwich) is not separated by community.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

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(continued on page 182)

Children Receiving Preschool Special Education Services

DEFINITION

Children receiving preschool special education services is the percentage of children ages three to five who have an Individualized Education Program (IEP) and are receiving special education services in Rhode Island.

SIGNIFICANCE

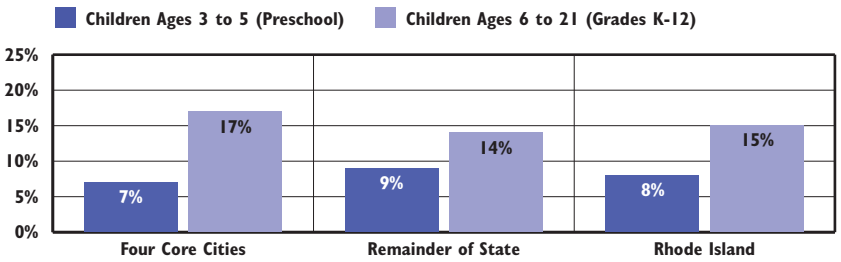
Preschool special education is an important component of the early care and education system, providing access to early learning opportunities for hundreds of thousands of preschool-age children across the U.S.[1] The federal *Individuals with Disabilities Education Act (IDEA)* specifies that, beginning at age three, children are eligible for special education through their local school district if they have a specific disability or a developmental delay in one or more of the following areas: physical, cognitive, communication, social/emotional, or adaptive.[2] Children under age three are eligible for special education services through Early Intervention providers.[3]

Developmental delays are identified when a child does not reach developmental milestones at the same time as other children his or her age. Some young children with developmental delays are eventually diagnosed with a disability while others catch up to their peers when therapy or intervention is provided.[4,5]

In Rhode Island, children are eligible for special education services under the "developmental delay" category up to age eight.[6] As of June 2014, 39% of children in preschool special education in Rhode Island qualified under the developmental delay category, 50% had an identified speech/language disability, 6% were diagnosed with autism, and 5% had another diagnosed disability.[7]

Under *IDEA*, states are required to identify, locate and evaluate all children ages birth to 21 with disabilities in the state.[8] Early childhood developmental screening is often the first step in identifying children who may have a disability or developmental delay and could benefit from intervention. Regular screening during the early stages of life, followed by evaluation and diagnostic assessment for children who appear to have special needs, helps children gain early access to needed services in order to prevent the occurrence of more severe problems.[9] In Rhode Island, school districts work to screen every child ages three through five every year through the Child Outreach screening program. Screenings are conducted in the child's dominant language.[10] In the 2013-2014 school year in Rhode Island, districts completed developmental screenings for 48% of three-year-olds, 62% of four-year-olds, and 63% of five-year-olds.[11]

Special Education Participation, Four Core Cities and Rhode Island, June 2014



Source: Rhode Island Department of Education, June 2014 Special Education Census. Denominator for children ages three to five is the number of children ages three to five residing in each district during the 2013-2014 school year from the Rhode Island Department of Health's KIDSNET database shared with RIDE. Denominator for children ages six to 21 is the resident average daily membership (RADM) from RIDE.

◆ **Approximately 15% of children ages three to 17 have a disability. Children in low-income families are more likely to have a developmental disability than children in higher-income families.[12]**

◆ **In June 2014 there were 2,786 children enrolled ages three to five receiving preschool special education services, 8% of all preschool-age children in the state. Children in the four core cities are less likely to be receiving preschool special education services (7%) than children in the remainder of the state (9%). Thirty percent of the students receiving preschool special education services were eligible for free or reduced price lunch, less than the state's overall rate of 47%.[13]**

◆ **In June 2014 in Rhode Island, 43% of preschool-age children received special education services within an inclusive early childhood classroom along with their typically developing peers, while 20% were enrolled in a separate special education class, school or residential facility. Another 10% were enrolled in a regular early childhood classroom but did not receive their special education services in that class and 27% were not enrolled in an early childhood classroom, receiving services at home or through "walk-in" visits to a service provider.[14]**

◆ **In June 2014, children in the four core cities were less likely to receive preschool special education services in an inclusive early childhood setting (36%) than children in the remainder of the state (47%).[15] Inclusion in high-quality early learning programs benefits children with and without disabilities.[16]**

Children Receiving Preschool Special Education Services

Table 39. **Children Ages 3 to 5 Receiving Special Education Services, Rhode Island, 2014**

SCHOOL DISTRICT	# OF CHILDREN AGES 3-5	DEVELOPMENTAL SCREENING RATES			PRESCHOOL SPECIAL EDUCATION BY SETTING			
		% 3-YEAR-OLDS SCREENED	% 4-YEAR-OLDS SCREENED	% 5-YEAR-OLDS SCREENED	INCLUSIVE EARLY CHILDHOOD CLASS	OTHER	TOTAL ENROLLED	% ENROLLED
Barrington	293	130%	134%	58%	45	*	51	17%
Bristol Warren	797	51%	56%	23%	32	28	60	8%
Burrillville	400	92%	89%	87%	32	17	49	12%
Central Falls	1,005	51%	55%	70%	43	54	97	10%
Chariho	621	76%	71%	54%	20	45	65	10%
Coventry	855	78%	84%	90%	72	30	102	12%
Cranston	2,350	36%	54%	41%	42	100	142	6%
Cumberland	962	71%	82%	58%	47	38	85	9%
East Greenwich	305	36%	76%	32%	*	34	41	13%
East Providence	1,563	26%	40%	76%	25	113	138	9%
Exeter-West Greenwich	310	95%	74%	55%	14	14	28	9%
Foster	82	90%	111%	84%	*	*	10	12%
Glocester	222	90%	111%	84%	12	14	26	12%
Jamestown	72	66%	189%	171%	12	*	14	19%
Johnston	758	59%	89%	38%	22	55	77	10%
Lincoln	538	93%	93%	45%	68	19	87	16%
Little Compton	61	43%	67%	125%	*	0	*	3%
Middletown	519	48%	78%	97%	33	13	46	9%
Narragansett	244	90%	63%	37%	21	*	27	11%
New Shoreham	32	100%	36%	0%	*	0	*	16%
Newport	811	35%	57%	67%	51	22	73	9%
North Kingstown	589	95%	77%	62%	22	39	61	10%
North Providence	904	44%	55%	29%	44	40	84	9%
North Smithfield	272	92%	122%	87%	17	12	29	11%
Pawtucket	3,075	31%	51%	24%	37	171	208	7%
Portsmouth	360	51%	92%	108%	19	15	34	9%
Providence	8,071	37%	51%	82%	209	252	461	6%
Scituate	171	90%	111%	84%	*	13	19	11%
Smithfield	370	89%	95%	41%	26	19	45	12%
South Kingstown	572	89%	111%	49%	30	27	57	10%
Tiverton	355	52%	47%	73%	14	21	35	10%
Warwick	2,343	36%	47%	62%	36	105	141	6%
West Warwick	1,140	62%	72%	73%	14	94	108	9%
Westerly	637	94%	97%	33%	40	15	55	9%
Woonsocket	1,864	23%	46%	75%	65	146	211	11%
Charter Schools	*NA*	*NA*	*NA*	*NA*	*	*	*	*NA*
RI School for the Deaf	*NA*	*NA*	*NA*	*NA*	*0*	*	*	*NA*
Four Core Cities	*14,015*	*34%*	*51%*	*67%*	*354*	*623*	*977*	*7%*
Remainder of State	*19,508*	*58%*	*70%*	*59%*	*837*	*959*	*1,796*	*9%*
Rhode Island	*33,523*	*48%*	*62%*	*63%*	*1,199*	*1,587*	*2,786*	*8%*

Sources of Data for Table/Methodology

Rhode Island Department of Education (RIDE), June 2014 Special Education Census.

*Fewer than 10 students are in this category. Actual numbers are not shown to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

The denominator is the number of children ages three to five residing in each district during the 2013-2014 school year from the Rhode Island Department of Health's KIDSNET database shared with RIDE.

2013-2014 Child Outreach screening data is from the Office of Student, Community, and Academic Supports, Rhode Island Department of Education. Screening rates sometimes exceed 100% because population estimates may be inaccurate and/or districts may screen out-of-district children. Screening rates for five year old children may be low because many have entered kindergarten and do not receive screening through Child Outreach.

Foster, Glocester, and Scituate school districts collaborate to conduct Child Outreach screenings. Separate rates are not available for each of these districts so the same combined rate is used for all three districts.

Inclusive early childhood class means children receive the majority of their special education services in a general early childhood education class at a public school, Head Start program, or a community-based child care program or preschool. Data include children who are district-placed and who are parentally-placed.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

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(continued on page 183)

Public School Enrollment and Demographics

DEFINITION

Public school enrollment and demographics is the total number of students enrolled in Rhode Island public schools on October 1.

SIGNIFICANCE

Education is a lifetime process that begins at birth and continues throughout a child's life into adulthood. Racial, ethnic and income gaps in educational attainment have been well-documented throughout the country. Research has shown that there are three clusters of factors that have an impact on student achievement: school factors, factors related to connections between home and school and factors that exist before and beyond school (including health, nutrition, and non-school academic supports).[1]

On October 1, 2014, there were 141,959 students enrolled in Rhode Island public schools in preschool through grade 12, a decrease of 9% from 156,498 on October 1, 2004.

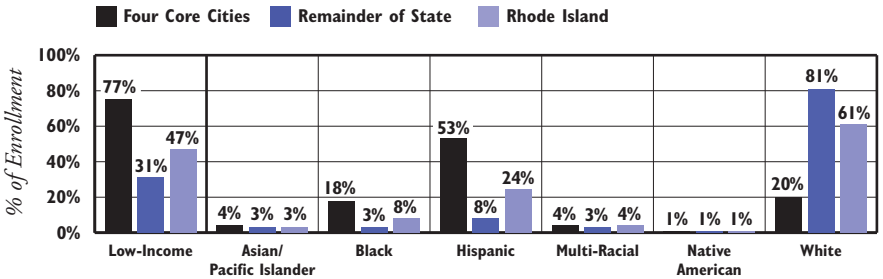
Of the 141,959 Rhode Island public school students in October 2014, 29% (41,642) were attending schools in the four core cities (communities with the highest child poverty rates, 66% (92,932) were attending schools in the remaining districts, and the remaining 7,385 attended charter schools, state-operated schools, or the Urban Collaborative Accelerated Project (UCAP). There were an additional 19,809 Rhode Island students attending private and parochial schools (including out-of-state schools) and 1,527 students were home-schooled.[2]

In October 2014, there were 64,140 students in grades K-5, 32,558 in grades 6-8, and 42,892 in grades 9-12. There were 2,369 children enrolled in preschool in Rhode Island public schools.[3] The Rhode Island State Pre-K program serves 306 children in 2014-2015, including 18 in a public school classroom and the remainder in community-based centers.[4]

In October 2014, 61% of Rhode Island public school students were non-Hispanic White, 24% were Hispanic, 8% were Black, 3% were Asian/Pacific Islander, 4% were Multi-Racial, and 1% were Native American. In October 2014, 47% of students in Rhode Island were low-income (students who were eligible for the free or reduced-price lunch program).[5]

Rhode Island schools are also diverse in terms of students with disabilities and students who are English Language Learners. During the 2013-2014 school year, 15% of Rhode Island public school students were receiving special education services and 7% were receiving English as a Second Language (ESL) or bilingual education services.[6]

Rhode Island Public School Enrollment by Low-Income Status, Race and Ethnicity, October 1, 2014



Source: Rhode Island Department of Education, October 1, 2014.

◆ **In October 2014, 20% of students enrolled in the four core cities were White, compared with 81% in the remainder of the state, and 77% of students enrolled in the four core cities were low-income compared with 31% in the remainder of the state.[7]**

Projecting School Enrollment

◆ **Nationally, projections indicate there will be a 7% increase in public school enrollment from Fall 2008 to Fall 2020. While increases are expected for the Midwest, South, and West, a decrease is expected for the Northeast.[8]**

◆ **Enrollment has fallen in many of Rhode Island's urban ring and suburban school districts due to a decrease in the number of school-age children living in these communities and an increase in the number of children from these communities attending charter schools, career and technical schools, and private schools.[9]**

◆ **With falling enrollment, more districts may consider closing or consolidating schools, regionalization, or reconfiguring schools (e.g., by putting fifth graders in middle schools). Districts that are considering closing schools should be mindful of future needs, including potential expansion to full-day kindergarten and future enrollment increases. Regionalization may help address declines in enrollment and reduce costs, allowing for more electives and Advanced Placement (AP) courses, providing opportunities to better serve students with special needs, driving more dollars into the classroom, and encouraging stronger academic performance.[10]**

Table 40. **Rhode Island Public School Enrollment by Grade and Demographic Groups, October 1, 2014**

	ENROLLMENT BY GRADE LEVEL*				ENROLLMENT BY DEMOGRAPHIC GROUPS							
SCHOOL DISTRICT	PRE-SCHOOL	ELEMEN-TARY	MIDDLE	HIGH	% LOW-INCOME	% ASIAN PACIFIC ISLANDER	% BLACK	% HISPANIC**	% NATIVE AMERICAN	% MULTI-RACIAL	% WHITE	TOTAL ENROLL-MENT
Barrington	22	1,372	823	1,071	4%	5%	1%	2%	<1%	3%	89%	3,288
Bristol Warren	48	1,583	779	948	36%	1%	2%	5%	1%	3%	88%	3,358
Burrillville	50	996	628	734	36%	1%	1%	3%	<1%	2%	93%	2,408
Central Falls	90	1,408	432	753	79%	1%	12%	74%	<1%	4%	9%	2,683
Chariho	69	1,318	753	1,165	21%	1%	1%	3%	2%	2%	92%	3,305
Coventry	112	2,028	1,150	1,564	34%	1%	1%	3%	<1%	2%	93%	4,854
Cranston	54	4,624	2,555	3,224	42%	7%	5%	24%	<1%	4%	60%	10,457
Cumberland	81	2,024	1,130	1,308	25%	3%	3%	9%	<1%	3%	83%	4,543
East Greenwich	34	1,033	621	724	6%	6%	1%	5%	<1%	3%	86%	2,412
East Providence	107	2,473	1,141	1,559	50%	6%	8%	2%	1%	6%	76%	5,280
Exeter-West Greenwich	43	640	422	540	14%	1%	<1%	3%	0%	<1%	94%	1,645
Foster	0	284	0	0	23%	0%	0%	1%	0%	2%	97%	284
Foster-Glocester	0	0	470	651	19%	1%	1%	<1%	0%	1%	97%	1,121
Glocester	3	526	0	0	16%	1%	<1%	0%	<1%	2%	97%	529
Jamestown	26	324	147	3	12%	2%	1%	2%	<1%	2%	93%	500
Johnston	68	1,443	747	858	37%	3%	4%	15%	<1%	1%	77%	3,116
Lincoln	82	1,294	782	926	27%	2%	3%	6%	<1%	1%	89%	3,084
Little Compton	0	148	100	0	13%	2%	1%	1%	0%	1%	96%	248
Middletown	23	1,061	530	671	28%	4%	6%	11%	<1%	7%	71%	2,285
Narragansett	53	559	301	427	21%	2%	2%	2%	2%	3%	89%	1,340
New Shoreham	0	43	39	36	17%	3%	0%	11%	0%	2%	85%	118
Newport	44	1,006	435	587	62%	2%	17%	24%	2%	11%	44%	2,072
North Kingstown	89	1,598	965	1,436	22%	2%	1%	4%	1%	2%	90%	4,088
North Providence	91	1,625	839	1,005	49%	3%	9%	19%	<1%	3%	65%	3,560
North Smithfield	37	757	446	535	17%	2%	1%	6%	<1%	3%	88%	1,775
Pawtucket	132	4,790	2,019	2,116	73%	1%	26%	31%	1%	6%	34%	9,057
Portsmouth	32	988	598	945	15%	1%	2%	4%	<1%	2%	91%	2,563
Providence	321	11,691	5,382	6,513	80%	5%	17%	64%	1%	3%	9%	23,907
Scituate	11	577	364	467	20%	1%	<1%	1%	0%	<1%	97%	1,419
Smithfield	48	1,022	585	717	16%	2%	1%	5%	<1%	3%	89%	2,372
South Kingstown	110	1,384	774	1,053	19%	2%	2%	5%	3%	4%	85%	3,321
Tiverton	54	810	435	572	29%	1%	1%	<1%	<1%	1%	96%	1,871
Warwick	215	4,016	2,190	2,856	34%	3%	2%	8%	<1%	3%	83%	9,277
West Warwick	60	1,620	763	974	49%	2%	5%	12%	1%	2%	78%	3,417
Westerly	90	1,323	659	950	40%	3%	1%	7%	2%	5%	82%	3,022
Woonsocket	56	3,012	1,323	1,604	72%	6%	10%	31%	1%	5%	48%	5,995
Charter Schools	*12*	*2,715*	*1,092*	*1,626*	*65%*	*2%*	*14%*	*53%*	*1%*	*4%*	*27%*	*5,445*
State-Operated Schools	*2*	*25*	*12*	*1,762*	*64%*	*3%*	*14%*	*41%*	*1%*	*6%*	*35%*	*1,801*
UCAP	*0*	*0*	*127*	*12*	*73%*	*1%*	*17%*	*71%*	*1%*	*6%*	*3%*	*139*
Four Core Cities	*599*	*20,901*	*9,156*	*10,986*	*77%*	*4%*	*18%*	*53%*	*1%*	*4%*	*20%*	*41,642*
Remainder of State	*1,756*	*40,499*	*22,171*	*28,506*	*31%*	*3%*	*3%*	*8%*	*1%*	*3%*	*81%*	*92,932*
Rhode Island	*2,369*	*64,140*	*32,558*	*42,892*	*47%*	*3%*	*8%*	*24%*	*1%*	*4%*	*61%*	*141,959*

Source of Data for Table/Methodology

Rhode Island Department of Education, Public School Enrollment in preschool through grade 12 as of October 1, 2014.

*Preschool includes students enrolled in half-day or full-day preschool through the public school district (primarily preschool special education classrooms). The Rhode Island State Pre-K program serves 306 children in 2014-2015, including 18 in a public school classroom and the remainder in community-based centers.

*Elementary includes students in kindergarten through 5th grade, middle includes 6th through 8th grades, and high includes 9th through 12th grades.

**Hispanic students can be of any race.

Children are counted as low-income if they are eligible for a Free or Reduced-Price Lunch Program.

State-operated schools include: Metropolitan Regional Career and Technical Center, William M. Davies Jr. Career & Technical High School, DCYF and the Rhode Island School for the Deaf.

Charter Schools include: Achievement First Rhode Island, Beacon Charter High School for the Arts, Blackstone Academy, Blackstone Valley Prep Mayoral Academy, The Compass School, Paul Cuffee Charter School, The Greene School, Highlander Charter School, Hope Academy, International Charter School, Kingston Hill Academy, The Learning Community, Rhode Island Nurses Institute Middle College, Segue Institute for Learning, Sheila C. "Skip" Nowell Leadership Academy, South Side Elementary Charter School, Trinity Academy for the Performing Arts, and The Village Green Virtual Public Charter School.

UCAP is the Urban Collaborative Accelerated Program.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Students enrolled in state-operated schools, charter schools and UCAP are not counted in totals for the four core cities or for the remainder of the state, but they are included in the Rhode Island state totals.

References

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(continued on page 183)

Children Enrolled in Full-Day Kindergarten

DEFINITION

Children enrolled in full-day kindergarten is the percentage of public school children enrolled in full-day kindergarten programs on October 1. Children enrolled in private kindergarten programs or in half-day kindergarten programs that offer after-school child care are not included.

SIGNIFICANCE

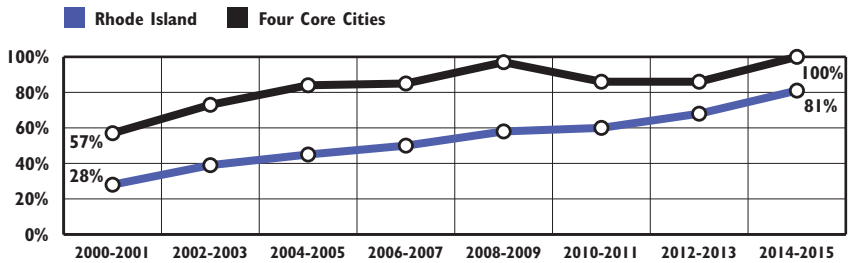
Children benefit academically from participating in full-day kindergarten. Children in full-day kindergarten make significant gains in early reading, math, and social skills when compared with children in half-day kindergarten. Full-day kindergarten can reduce grade retention and remediation rates. One study found that participation in full-day, high-quality kindergarten can close the achievement gap between the highest and lowest performing students by nearly one-third in reading and one-fourth in math.[1,2] Full-day kindergarten benefits all students, but it has a particularly strong impact for disadvantaged children.[3]

With an estimated 75% of four-year-olds in the U.S. enrolled in some type of preschool program, kindergarten no longer serves as the entry-point to formal, full-day school for most young children.[4] The majority of parents favor full-day kindergarten as it provides continuity for children who are accustomed to full-day preschool experiences and it reduces the number of transitions and disruptions their child experiences each day.[5] Also, teachers in full-day kindergarten programs have more time to provide meaningful learning opportunities that encourage cognitive, physical, and social-emotional development.[6,7]

Nationally, enrollment in full-day kindergarten has been increasing steadily over the past 30 years. In 1979, 25% of U.S. kindergartners were in full-day programs, compared with 77% in 2013.[8,9] As the number of children enrolled in preschool and full-day kindergarten has grown, expectations of kindergarten teachers have changed. The majority of kindergarten teachers in the U.S. now believe that academic instruction in literacy and math should begin in preschool and children entering kindergarten should know their alphabet and have strong social and self-regulation skills (e.g., ability to follow directions, share, and take turns).[10] Enrollment in high-quality kindergarten is associated with immediate academic gains and long-term improved outcomes, including attending college, owning a house, and earning more as an adult.[11]

In the 2014-2015 school year, 81% of the Rhode Island children who attended public kindergarten were in a full-day program, with 100% of students in the four core cities and 68% of students in the remainder of the state attending full-day kindergarten.[12]

Children in Full-Day Public Kindergarten Programs, Rhode Island, 2000-2001 through 2014-2015 School Years



Source: Rhode Island Department of Education, kindergarten enrollment October 1, 2000-October 1, 2014.

◆ **In the 2014-2015 school year, 81% of Rhode Island kindergartners statewide and 100% of kindergartners in the four core cities were in full-day kindergarten. As of the 2014-2015 school year, 28 of the 35 elementary school districts and all of the public charter elementary schools in Rhode Island offer universal access to full-day kindergarten programs.[13]**

◆ **Five school districts are operating universal full-day kindergarten for the first time in the 2014-2015 school year (Barrington, Exeter-West Greenwich, Glocester, Scituate, and Smithfield). Woonsocket also has restored full-day kindergarten.[14] Each of these districts received start-up or planning grant funding to support the transition to full-day kindergarten available through the state *Full-Day Kindergarten Accessibility Act* passed in 2012.[15]**

◆ **As of the 2014-2015 school year, there are only seven districts in Rhode Island that do not offer full-day kindergarten for all students: Coventry, Cranston, East Greenwich, Johnston, North Kingstown, Tiverton, and Warwick. East Greenwich, North Kingstown, and Warwick offer limited enrollment in full-day kindergarten classrooms.[16]**

Academic Progress in Full-Day Kindergarten

◆ **Nationally, 68% of full-day kindergarten classes spend more than one hour per day on reading instruction, compared to 37% of half-day classes. Full-day kindergarten classes are more likely than half-day classes to spend time every day on math, social studies, and science.[17] Children in full-day kindergarten classes make greater academic gains in both reading and mathematics compared to those in half-day classes.[18]**

Children Enrolled in Full-Day Kindergarten

Table 41. **Children Enrolled in Full-Day Kindergarten Programs, Rhode Island, 2013-2014 and 2014-2015**

SCHOOL DISTRICT	2013-2014 SCHOOL YEAR			2014-2015 SCHOOL YEAR		
	TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL-DAY K	% OF CHILDREN IN FULL-DAY K	TOTAL CHILDREN IN K PROGRAMS	CHILDREN IN FULL-DAY K	% OF CHILDREN IN FULL-DAY K
Barrington	161	0	0%	170	170	100%
Bristol Warren	279	279	100%	253	253	100%
Burrillville	157	157	100%	145	145	100%
Central Falls	237	237	100%	222	222	100%
Chariho	469	469	100%	188	188	100%
Coventry	279	0	0%	292	1	< 1%
Cranston	677	0	0%	598	3	< 1%
Cumberland	277	277	100%	317	317	100%
East Greenwich	121	25	21%	140	34	24%
East Providence	437	437	100%	386	386	100%
Exeter-West Greenwich	91	0	0%	101	101	100%
Foster	44	44	100%	31	31	100%
Glocester	72	0	0%	82	82	100%
Jamestown	43	43	100%	46	46	100%
Johnston	204	0	0%	231	4	2%
Lincoln	219	219	100%	191	191	100%
Little Compton	23	23	100%	22	22	100%
Middletown	144	144	100%	174	174	100%
Narragansett	79	79	100%	75	75	100%
New Shoreham	7	7	100%	8	8	100%
Newport	172	172	100%	195	195	100%
North Kingstown	211	63	30%	205	64	31%
North Providence	259	259	100%	249	249	100%
North Smithfield	106	106	100%	112	112	100%
Pawtucket	800	800	100%	764	764	100%
Portsmouth	153	153	100%	148	148	100%
Providence	2,035	2,035	100%	1,838	1,838	100%
Scituate	147	0	0%	69	69	100%
Smithfield	130	11	8%	120	120	100%
South Kingstown	200	200	100%	203	203	100%
Tiverton	115	0	0%	108	0	0%
Warwick	607	66	11%	581	162	28%
West Warwick	295	295	100%	295	295	100%
Westerly	220	220	100%	217	217	100%
Woonsocket	512	17	3%	523	523	100%
Charter Schools	*504*	*504*	*100%*	*583*	*583*	*100%*
State-Operated Schools	*4*	*4*	*100%*	*3*	*3*	*100%*
Four Core Cities	*3,584*	*3,089*	*86%*	*3,347*	*3,347*	*100%*
Remainder of State	*6,398*	*3,748*	*59%*	*5,952*	*4,065*	*68%*
Rhode Island	*10,490*	*7,345*	*70%*	*9,885*	*7,998*	*81%*

Source of Data for Table/Methodology

Rhode Island Department of Education, October 1, 2013 and October 1, 2014.

Note: Some districts that do not operate full-day kindergarten classrooms may report children who are enrolled in full-day kindergarten due to their special needs.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Charter schools included in this indicator are Achievement First Rhode Island, Blackstone Valley Prep Mayoral Academy, Highlander Charter School, International Charter School, Kingston Hill Academy, Paul Cuffee Charter School, Southside Elementary Charter School, The Compass School, The Hope Academy, and The Learning Community. The state-operated school is the Rhode Island School for the Deaf.

References

[1,5,6] Kauerz, K. (2010). *PreK-3rd: Putting full-day kindergarten in the middle.* Washington, DC: Foundation for Child Development.

[2,7] Strategies for Children. (2013). *Investing in full-day kindergarten is essential.* Retrieved January 9, 2015, from www.strategiesforchildren.org

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[4] Barnett, W. S., Carolan, M. E., Fitzgerald, J. & Squires, J. H. (2011). *The state of preschool 2011: State preschool yearbook.* New Brunswick, NJ: Rutgers University, National Institute for Early Education Research.

[8] Kauerz, K. (2005). *Full-day kindergarten: A study of state policies in the United States.* Denver, CO: Education Commission of the States.

[9] U.S. Census Bureau, Current Population Survey, 2013. Table 3: Nursery and primary school enrollment of people 3 to 6 years old, by control of school, attendance status, age, race, Hispanic origin, mother's labor force status and education, and family income: October 2013.

(continued on page 183)

Out-of-School Time

DEFINITION

Out-of-school time is the number of children participating in organized after-school programs. This indicator presents data on the number of licensed after-school child care programs and slots for children ages six and older as well as available data on children served by after-school programs that do not require state licensing.

SIGNIFICANCE

Organized programs for school-age children offered during the hours and days when school is not in session have become increasingly popular over the past 50 years. Growth has been driven by the expansion of mothers' labor force participation, concerns over negative consequences associated with children being home alone, passage of the 1990 *Child Care Development and Block Grant Act* which provided the first major funding stream for school-age child care, and federal funding for 21st Century Community Learning Centers which began in 1998. Over time, policymakers have increasingly recognized that out-of-school time programs can contribute significantly to children's development and learning.[1]

High-quality, organized after-school and summer programs promote academic and social skills, provide opportunities for children and youth to develop positive relationships with peers and adult mentors, increase children's safety and reduce the likelihood that youth engage in inappropriate activities. Children who participate in organized after-school programs and extra-curricular activities benefit socially, emotionally and academically. Children who are from low-income families and those in need of social and academic supports are most likely to benefit.[2,3]

In most communities there are not enough high-quality, affordable after-school and summer programs to serve all the children who could benefit from them. Resources are needed both to improve the quality of current programs and to expand access.[4] In Rhode Island, the Providence After School Alliance and the Rhode Island After School Plus Alliance act as intermediaries to address access issues and support program quality improvement through the use of the Rhode Island Program Quality Assessment (RIPQA) tool.[5]

Between 2011 and 2013, 77% of Rhode Island children ages six to 17 had all parents in the workforce, higher than the U.S. rate of 71%.[6] Nationally, 56% of children ages five to 14 with employed mothers stay with a relative during the hours when they are not in school, while 19% regularly participate in enrichment activities, 7% each are in a child care center or in home-based child care, and 14% regularly stay at home by themselves.[7]

Students Served by 21st Century Community Learning Centers by Grade Span, Rhode Island, 2013-2014

SCHOOL DISTRICT	GRADES PK-5	GRADES 6-8	GRADES 9-12	TOTAL
Central Falls	544	272	248	1,064
Cranston	221	23	0	244
Newport	725	245	303	1,273
North Kingstown	276	503	20	799
Pawtucket	1,300	458	475	2,233
Providence	796	1,950	1,461	4,207
West Warwick	161	151	0	312
Woonsocket	525	423	949	1,897
Charter Schools	*548*	*309*	*2*	*859*
State-Operated Schools	*0*	*0*	*363*	*363*
UCAP	*0*	*183*	*27*	*210*
Four Core Cities	*3,165*	*3,103*	*3,133*	*9,401*
Remainder of State	*1,383*	*922*	*323*	*2,628*
Rhode Island	*5,096*	*4,517*	*3,848*	*13,461*

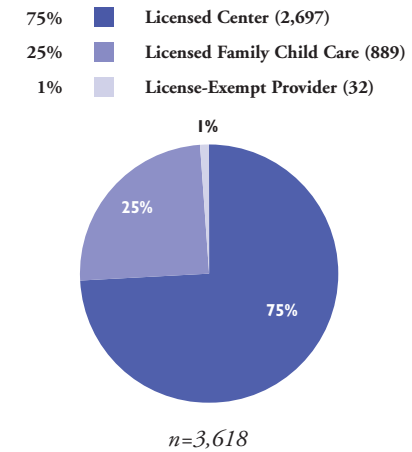
Source: RI Department of Education, Office of Student, Community and Academic Supports, Summer 2013 and 2013-2014 school year. Students participating in summer programs are reported in the grade level they are entering in the fall. Data are not unduplicated as students can be served by more than one grantee and in more than one community. Charter schools are: Highlander Charter School, Paul Cuffee Charter School, and The Learning Community. State-operated schools are: Metropolitan Regional Career and Technical Center and the Rhode Island Training School. UCAP is the Urban Collaborative Accelerated Program.

Expanded Learning Opportunities

◆ **Expanded learning opportunities provide safe, structured learning environments for school-age children beyond the traditional school day and include after-school and summer learning programs. They can be delivered by schools and community-based organizations. High-quality expanded learning programs offer a variety of content-rich programming that engages students and builds both academic and non-academic skills.[8]**

◆ **The federal 21st Century Community Learning Centers initiative provides funding for after-school and summer enrichment programs serving students attending high-poverty, low-performing schools.[9] During the summer of 2013 and the 2013-2014 school year, 21st Century programs in Rhode Island served 13,461 students from 51 schools, including students in pre-kindergarten through grade 12.[10] Students attending 21st Century programs in Rhode Island have fewer unexcused absences and disciplinary incidents than their peers.[11]**

School-Age Child Care Subsidies by Type of Setting, Rhode Island, 2014



n=3,618

Source: Rhode Island Department of Human Services, InRhodes Database, December 2014. Totals may not sum to 100% due to rounding.

◆ **In January 2015, there were 11,385 school-age child care slots in 202 licensed centers (104 were operated as part of a licensed early childhood center and 98 were operated under an independent license, serving only school-age children).[12]**

◆ **In January 2015 in Rhode Island, there were 83 independent school-age child care programs participating in BrightStars, Rhode Island's Quality Rating and Improvement System (85% of licensed independent school-age child care programs). Seven programs had a high-quality rating of four or five stars.[13]**

Table 42. **Licensed School-Age Child Care for Children Ages Six to 12 Rhode Island, January 2015**

CITY/TOWN	NUMBER OF CHILDREN AGES 6 TO 12	NUMBER OF LICENSED PROGRAMS: OPERATED AS PART OF AN EARLY CHILDHOOD CENTER	NUMBER OF LICENSED PROGRAMS: OPERATED INDEPENDENTLY	TOTAL NUMBER OF SLOTS
Barrington	2,038	3	1	200
Bristol	1,421	1	3	156
Burrillville	1,456	1	2	213
Central Falls	2,045	2	0	159
Charlestown	616	0	1	60
Coventry	3,142	4	4	332
Cranston	6,331	10	5	627
Cumberland	2,976	0	6	433
East Greenwich	1,482	3	1	143
East Providence	3,395	5	7	497
Exeter	480	2	1	74
Foster	369	1	0	18
Glocester	809	1	1	55
Hopkinton	741	0	1	52
Jamestown	429	0	0	0
Johnston	2,119	7	0	133
Lincoln	1,900	1	6	441
Little Compton	299	0	1	26
Middletown	1,442	2	1	232
Narragansett	856	0	1	60
New Shoreham	73	0	0	0
Newport	1,399	2	2	205
North Kingstown	2,581	6	2	250
North Providence	2,073	2	3	262
North Smithfield	1,002	1	1	172
Pawtucket	6,015	8	4	685
Portsmouth	1,622	2	0	74
Providence	15,342	17	21	3,295
Richmond	777	0	2	88
Scituate	935	1	0	26
Smithfield	1,445	6	1	347
South Kingstown	2,199	0	1	50
Tiverton	1,201	1	1	111
Warren	770	1	1	98
Warwick	6,195	7	5	726
West Greenwich	624	0	0	0
West Warwick	2,155	3	4	405
Westerly	1,850	1	1	116
Woonsocket	3,653	3	7	564
Four Core Cities	*27,055*	*30*	*32*	*4,703*
Remainder of State	*59,202*	*74*	*66*	*6,682*
Rhode Island	*86,257*	*104*	*98*	*11,385*

Source of Data for Table/Methodology

Number of children ages six to 12 years is from the U.S. Census Bureau, Census 2010 Summary File 1.

Rhode Island Department of Children, Youth and Families. Number of licensed school-age child care programs and slots for children ages six to 12 as of January 2015. These numbers do not include licensed family child care home slots, informal child care arrangements, or community programs for youth ages six and older that do not require licensing by the state. Licensed school-age child care programs also provide services to five year-old children who are enrolled in kindergarten.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

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(continued on page 183)

English Language Learners

DEFINITION

English Language Learners is the percentage of all public school children (preschool through grade 12) who are receiving English as a Second Language services or bilingual education services in Rhode Island public schools.

SIGNIFICANCE

English Language Learner (ELL) students are the fastest growing student population in the U.S.[1] Nationally and in Rhode Island, there are large achievement gaps between ELL and non-ELL students, with ELL students having lower rates of math and reading achievement than non-ELL students.[2] Many children of immigrants face challenges to succeeding in school, including poverty, limited access to health care, and low parental education levels, that may contribute to these achievement gaps.[3]

ELL students enter school without the English skills necessary for full participation in and access to the education system. They face diverse challenges based on their home language, immigration status, academic background, and socioeconomic status.[4,5] Successful ELL programs strategically use ongoing assessments of student progress, have highly qualified teachers trained to teach ELL students, address students' learning, language, and cultural needs.[6,7,8]

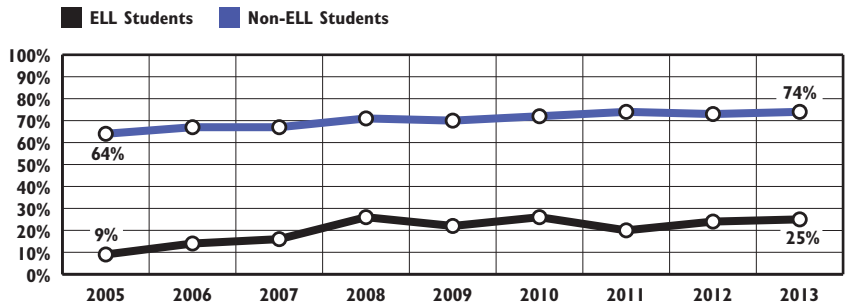
Additionally, ELL students and children in immigrant families are more likely to attend schools that are under-resourced, urban, large, serve high proportions of minority students, and located in high-poverty communities.[9,10] In the 2013-2014 school year in Rhode Island, ELL students were 7% of total students (10,233). Of these, 88% were enrolled in free or reduced-price lunch programs and 76% lived in the four core cities.[11]

Children of immigrants believe that school prepares them to get ahead and most hope to go to college. Schools that foster relationships and offer personalized instruction by effective teachers can help ELL students succeed.[12,13]

In the 2013-2014 school year, ELL students in Rhode Island public schools spoke 85 different languages. The majority (77%) spoke Spanish, 7% spoke Asian languages, 6% spoke Creole or Patois, 3% spoke Portuguese, 1% spoke African languages, and 6% spoke other or multiple languages.[14]

Bilingual education in early grades can significantly improve English reading proficiency.[15] During the 2013-2014 school year, 14% percent of ELL students were enrolled in a bilingual program and 86% were enrolled in an English as a Second Language (ESL) program. Bilingual programs are offered in the Central Falls and Providence school districts and at the International Charter School.[16]

Fourth-Grade Reading Proficiency, English Language Learner Students and Non-ELL Students, 2005-2013



Source: Rhode Island Department of Education, *New England Common Assessment Program (NECAP)*, October 2005-2013.

◆ **In October 2013, 25% of fourth-grade ELL students scored at or above proficiency in reading on the *New England Common Assessment Program (NECAP)*, compared to 9% in 2005.[17]**

◆ **While the achievement gap in fourth-grade reading has been reduced from 55% in 2005 to 49% in 2013, ELL students are consistently performing lower than their non-ELL peers.[18]**

Early English Language Learning

◆ **As of September 1, 2014, there were 4,817 children under age five born to a mother who did not speak English in Rhode Island.[19] In the 2013-2014 school year, 49% of all ELL students in Rhode Island were in grades preschool to grade three.[20]**

◆ **For young children growing up in homes where English is not the first language, the quality, type, and amount of early childhood education can help boost English language development and kindergarten readiness of ELL students.[21] A consistent approach to language development, common curriculum, and aligned assessment from preschool to third grade can help young ELL students gain English skills and reading proficiency and set the stage for future academic success.[22]**

Table 43.

English Language Learner Students, Rhode Island, 2013-2014

SCHOOL DISTRICT	TOTAL # OF STUDENTS	NUMBER OF ENGLISH LANGUAGE LEARNER STUDENTS				% OF TOTAL DISTRICT
		ELEMENTARY (GRADES PRE-K-5)	MIDDLE (GRADES 6-8)	HIGH (GRADES 9-12)	TOTAL # OF ELL STUDENTS	
Barrington	3,237	38	*	*	44	1%
Bristol Warren	3,395	77	17	*	96	3%
Burrillville	2,379	0	*	*	*	<1%
Central Falls	2,692	399	114	228	741	28%
Chariho	3,383	*	*	*	10	<1%
Coventry	4,769	*	*	*	14	<1%
Cranston	10,177	397	118	81	596	6%
Cumberland	4,490	67	19	*	95	2%
East Greenwich	2,360	*	*	*	10	<1%
East Providence	5,265	140	31	26	197	4%
Exeter-West Greenwich	1,582	*	*	*	13	1%
Foster	284	0	NA	NA	0	0%
Foster-Glocester	1,148	NA	0	0	0	0%
Glocester	499	0	NA	NA	0	0%
Jamestown	492	*	*	0	*	1%
Johnston	2,991	77	12	*	98	3%
Lincoln	3,095	17	*	*	24	1%
Little Compton	257	0	0	0	0	0%
Middletown	2,267	46	20	16	82	4%
Narragansett	1,366	*	0	*	*	<1%
New Shoreham	117	*	*	*	10	9%
Newport	1,994	56	15	32	103	5%
North Kingstown	3,948	39	*	13	59	1%
North Providence	3,459	55	11	13	79	2%
North Smithfield	1,724	*	0	*	*	<1%
Pawtucket	8,750	638	174	252	1,064	12%
Portsmouth	2,628	*	*	*	*	<1%
Providence	23,799	3,448	921	1,087	5,456	23%
Scituate	1,403	0	0	0	0	0%
Smithfield	2,343	10	*	0	11	<1%
South Kingstown	3,333	29	0	*	31	1%
Tiverton	1,796	*	*	*	10	1%
Warwick	9,061	78	11	13	102	1%
West Warwick	3,348	56	*	12	77	2%
Westerly	3,010	33	*	*	48	2%
Woonsocket	5,649	286	106	95	487	9%
Charter Schools	*4,952*	*481*	*108*	*41*	*630*	*13%*
State-Operated Schools	*1,773*	*0*	*0*	*20*	*20*	*1%*
UCAP	*138*	*NA*	*0*	*0*	*0*	*0%*
Four Core Cities	*40,889*	*4,771*	*1,315*	*1,662*	*7,748*	*19%*
Remainder of State	*91,600*	*1,273*	*304*	*258*	*1,835*	*2%*
Rhode Island	*139,353*	*6,525*	*1,727*	*1,981*	*10,233*	*7%*

Sources of Data for Table/Methodology

Rhode Island Department Education, 2013-2014 school year. Total number of English Language Learner students 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 2013-2014 school year. Students who are not yet fully English proficient but have exited ESL or bilingual education programs to regular education are not included in these numbers.

*Fewer than 10 students are in this category. Actual numbers are not shown to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

NA indicates that the school district does not serve students at that grade level or that no data are available.

Due to a change in methodology, the percentage of English Language Learner students by district cannot be compared with percentages before the 2004 Factbook. The "% of Total District" is based on the total number of English Language Learners divided by the "Total # of Students," which is the average daily membership in the districts of instruction. The charter schools that reported ELL students are Achievement First Rhode Island, Blackstone Academy, Blackstone Valley Prep, Paul Cuffee Charter School, Highlander Charter School, International Charter School, The Learning Community, Segue Institute for Learning, Sheila C. "Skip" Nowell Leadership Academy, and Trinity Academy for the Performing Arts. State-operated schools with ELL students are William M. Davies Career & Technical High School and DCYF Schools. UCAP is the Urban Collaborative Accelerated Program.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

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(continued on page 183)

K-12 Students Receiving Special Education Services

DEFINITION

K-12 students receiving special education services is the percentage of students ages six to 21 who received special education services in Rhode Island public schools or who were placed in private special education programs by their district of residence.

SIGNIFICANCE

Effective and appropriate special education and related services are important resources for improving long-term outcomes for children and youth with special needs. Students with disabilities are more likely than students without disabilities to have lower academic achievement and graduation rates, reduced participation in postsecondary education, and less economic success in adulthood.[1,2] Students with disabilities are more likely than their peers to report discrimination.[3]

The federal *Individuals with Disabilities Education Act (IDEA) Part B* mandates that local school districts identify and evaluate students ages three to 21 who have disabilities. Once found eligible for special education, a student must be provided with an Individualized Education Program (IEP) laying out goals and outlining steps for achieving the goals. Services described in the IEP must be provided to students in the least restrictive environment (to the extent appropriate, integrated into a regular-education setting).[4,5,6] Students with disabilities who do not require individualized instruction may have a 504 Plan that provides accommodations, supports, and auxiliary aides to allow the student to participate in the general curriculum.[7]

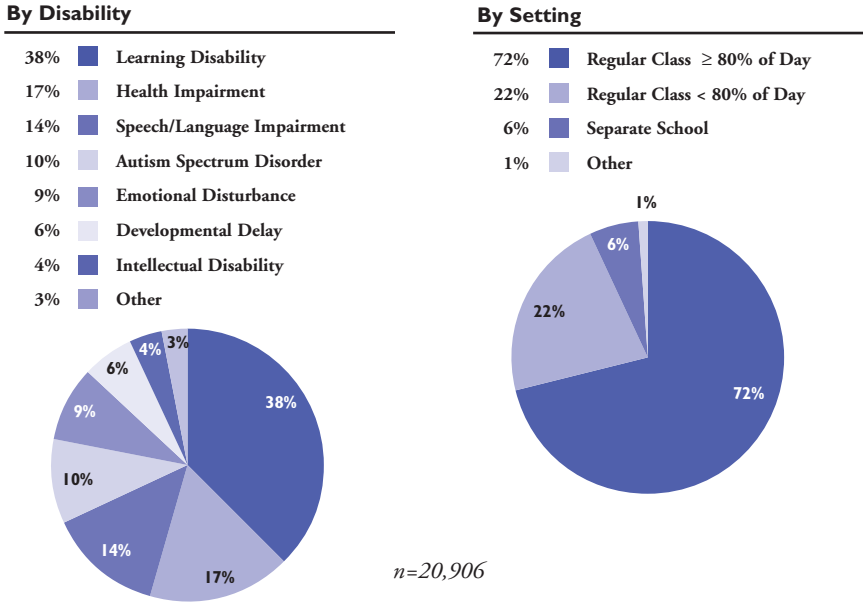
Approximately 15% of U.S. children ages three to 17 have a developmental disability. Children in low-income families are more likely to have a developmental disability than children in higher-income families.[8]

The federal *No Child Left Behind Act (NCLB)* requires states, districts, and schools to apply the same content and achievement standards to all students, including those with disabilities. Together with *IDEA, NCLB* promotes accountability for the achievement of students with disabilities.[9,10]

In 2013 in Rhode Island, 52% of students receiving special education services in fourth grade were substantially below proficient in reading, compared with 6% of regular education students.[11]

In Rhode Island, the four-year graduation rate for the Class of 2014 was 60% for students receiving special education services, compared to 87% for students not receiving these services. Some students receiving special education services may take additional time to graduate.[12]

Students Ages Six to 21 Receiving Special Education Services, Rhode Island, June 2014



Source: Rhode Island Department of Education, Office of Diverse Learners, Special Education Census, June 30, 2014.
Excludes parentally-placed students.

◆ **As of June 2014, there were 20,906 Rhode Island students ages six to 21 (15% of K-12 students) receiving special education services. Thirty-eight percent had a learning disability, 17% had a health impairment, 14% had a speech/language disorder, 10% had an autism spectrum disorder, 9% had an emotional disturbance, 6% had a developmental delay, 4% had an intellectual disability, and 3% had other disabilities.[13]**

◆ **During the 2013-2014 school year, 72% of special education students ages six to 21 were in a regular class for 80% of the day or more, 10% were in a regular class for 40% to 79% of the day, and 12% were in a regular class for less than 40% of the day. Six percent were in a separate school and 1% were in a residential facility, a correctional facility, were home-bound, or were hospitalized.[14] Two-thirds (68%) were boys, 59% were low-income (receiving free or reduced-price lunch), 41% identified as Hispanic or a racial/ethnic category other than White, and 8% were English Language Learners.[15]**

K-12 Students Receiving Special Education Services

Table 44.

Students Ages Six through 21 Receiving Special Education Services by Primary Disability, Rhode Island, 2014

SCHOOL DISTRICT	TOTAL # OF STUDENTS	AUTISM SPECTRUM DISORDER	DEVELOP-MENTAL DELAY	EMOTIONAL DISTURBANCE	HEALTH IMPAIRMENT	LEARNING DISABILITY	INTELLECTUAL DISABILITY	SPEECH/ LANGUAGE IMPAIRMENT	OTHER	TOTAL STUDENTS WITH DISABILITIES	% STUDENTS RECEIVING SPECIAL EDUCATION
Barrington	3,225	47	19	45	49	94	10	54	13	331	10%
Bristol Warren	3,370	59	22	18	36	116	25	87	15	378	11%
Burrillville	2,353	39	19	27	43	120	14	78	10	350	15%
Central Falls	2,616	22	22	38	92	292	26	54	18	564	22%
Chariho	3,344	49	22	11	49	120	16	36	20	323	10%
Coventry	4,705	46	46	49	94	289	25	33	24	606	13%
Cranston	10,145	172	82	122	306	499	41	87	23	1,332	13%
Cumberland	4,445	80	25	44	123	221	28	132	22	675	15%
East Greenwich	2,338	45	21	15	51	59	11	36	13	251	11%
East Providence	5,226	81	37	83	164	299	29	97	32	822	16%
Exeter-West Greenwich	1,562	30	*	12	34	53	11	52	*	206	13%
Foster	284	*	0	0	*	*	*	18	*	31	11%
Foster-Glocester	1,148	16	*	*	22	43	*	*	*	103	9%
Glocester	495	*	*	*	11	10	*	19	*	50	10%
Jamestown	475	13	*	*	18	21	*	17	*	77	16%
Johnston	2,965	57	39	33	125	320	15	40	16	645	22%
Lincoln	3,053	47	29	36	74	134	14	74	16	424	14%
Little Compton	257	*	*	*	*	25	*	*	*	45	18%
Middletown	2,255	36	*	45	66	131	18	47	17	365	16%
Narragansett	1,337	20	12	23	54	84	*	34	*	236	18%
New Shoreham	117	*	*	0	11	0	*	*	*	23	20%
Newport	1,973	28	16	36	30	139	19	56	*	331	17%
North Kingstown	3,902	47	46	36	51	139	18	85	10	432	11%
North Providence	3,408	51	64	38	107	189	12	83	18	562	16%
North Smithfield	1,703	23	12	16	54	84	10	55	*	258	15%
Pawtucket	8,670	123	88	101	174	551	59	168	22	1,286	15%
Portsmouth	2,606	41	10	44	86	137	*	30	12	366	14%
Providence	23,527	192	253	417	406	1,649	169	690	109	3,885	17%
Scituate	1,396	19	*	*	23	56	0	41	*	150	11%
Smithfield	2,313	28	16	19	34	90	12	20	*	226	10%
South Kingstown	3,274	55	25	36	92	94	15	52	24	393	12%
Tiverton	1,781	46	10	34	29	149	11	43	13	335	19%
Warwick	8,967	210	88	130	295	637	41	143	44	1,588	18%
West Warwick	3,299	81	50	83	76	186	24	35	11	546	17%
Westerly	2,928	46	30	42	97	132	18	47	22	434	15%
Woonsocket	5,614	131	73	91	259	350	78	156	38	1,176	21%
Charter Schools	*4,940*	*48*	*22*	*45*	*126*	*313*	*	*125*	*	*691*	*14%*
State-Operated Schools	*1,769*	*	*0*	*54*	*103*	*112*	*	*	*59*	*340*	*19%*
UCAP	*138*	*	*0*	*0*	*	*22*	*0*	*0*	*0*	*25*	*18%*
Department of Corrections	*NA*	*0*	*0*	*	*	*29*	*0*	*0*	*0*	*45*	*NA*
Four Core Cities	*40,427*	*468*	*436*	*647*	*931*	*2,842*	*332*	*1,068*	*187*	*6,911*	*17%*
Remainder of State	*90,648*	*1,526*	*758*	*1,090*	*2,316*	*4,617*	*461*	*1,643*	*429*	*12,894*	*14%*
Rhode Island	*137,922*	*2,052*	*1,216*	*1,845*	*3,485*	*7,989*	*797*	*2,838*	*684*	*20,906*	*15%*

Source of Data for Table/Methodology

Rhode Island Department of Education (RIDE), Office for Diverse Learners, Special Education Census June 30, 2014. The denominator (number of students) is the "resident average daily membership" (RADM) for grades K-12 in the 2013-2014 school year provided by RIDE.

Due to changes in methodology, *K-12 Students Receiving Special Education Services* in this Factbook cannot be compared with prior Factbooks. Data about preschool students receiving special education services can be found in the *Children Receiving Preschool Special Education Services* indicator.

*Fewer than 10 students are in this category. Actual numbers are not shown to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

NA indicates that the school district does not serve students at that grade level or that no data are available.

Totals of students and percentages of students receiving special education may not sum due to rounding.

The category "other" includes students who are blind/visually impaired, deaf, deaf/blind, hearing impaired, multi-handicapped, orthopedically impaired, and who have traumatic brain injury.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Independent charter schools reported for this indicator are Achievement First Rhode Island, Beacon Charter High School for the Arts, Blackstone Academy, Blackstone Valley Prep, The Compass School, Paul Cuffee Charter School, The Greene School, Highlander Charter School, International Charter School, Kingston Hill Academy, The Learning Community, Rhode Island Nurses Institute Middle College Charter School, Segue Institute for Learning, Sheila C. "Skip" Nowell Leadership Academy, Trinity Academy for the Performing Arts, and Village Green Virtual Charter School

State-operated schools are William M. Davies Career & Technical High School, DCYF Schools, Metropolitan Regional Career and Technical Center and Rhode Island School for the Deaf.

UCAP is the Urban Collaborative Accelerated Program.

References are on page 183.

Student Mobility

DEFINITION

Student mobility is the number of students who enrolled in school after September 30 or withdrew from school before June 1 divided by the total enrollment for that school district.

SIGNIFICANCE

Student mobility is associated with lower academic performance, social and psychological difficulties, lower levels of school engagement and increased risk of dropping out of high school.[1] Changing schools disrupts learning, can result in children missing critical conceptual knowledge and skills, and can cause social upheaval for children. Student mobility also can lead to less active parent involvement in their children's schools.[2,3]

Students who change schools frequently are more likely to have lower math and reading skills, are more likely to repeat a grade, are more likely to be suspended and are less likely to graduate from high school than their non-mobile peers.[4,5]

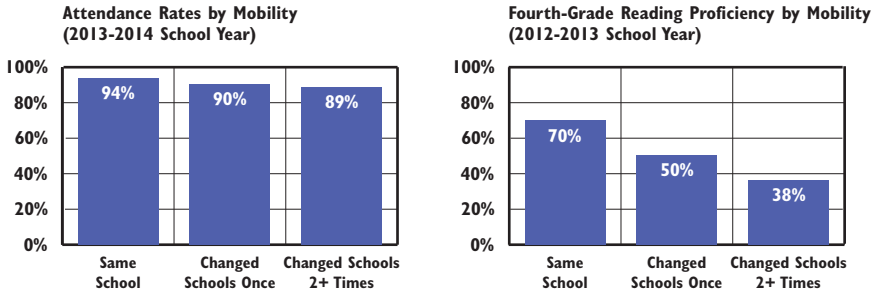
Low-income and minority children are more likely to be mobile than higher-income and White students. School mobility has a greater negative impact on the academic achievement of low-income students than it does on higher-income students. Students receiving special education services also are likely to be negatively impacted by changing schools.[6]

High mobility rates in schools can negatively impact all students because teachers must slow curriculum progress, repeat lessons and adjust to changing classroom dynamics and student needs. Within-year moves are particularly disruptive for students, teachers and schools.[7,8]

Families may move their children to a different school because they are dissatisfied with the school, concerned about their child's safety or because they are moving due to changes in family circumstances.[9] Changes in family circumstances can be either positive or negative factors including eviction or foreclosure, divorce or marriage, job loss or job changes, death in the family, or a desire to improve quality of life. Mobile students in low-income and Black families are more likely to change schools due to family reasons than mobile students in higher-income and White families.[10,11]

Between 2011 and 2013 in Rhode Island, 11% of children ages five to 17 changed residence at least once during the previous year, 83% of whom moved within Rhode Island and 17% of whom moved from another state or abroad.[12] Nationally and in Rhode Island, people with incomes below the poverty line are more likely to move than higher-income residents. Between 2011 and 2013, 25% of Rhode Islanders living below the poverty line moved, compared with 10% of higher-income residents.[13]

School Mobility and Education Outcomes in Rhode Island



Source: Rhode Island Department of Education, 2012-2013 and 2013-2014 school years.

◆ **Rhode Island students who change schools mid-year are absent more often than students who do not change schools. Rhode Island students who did not change schools had a 94% attendance rate, compared with 90% for those who changed schools once and 89% for those who changed schools two or more times during the 2013-2014 school year.[14]**

◆ **Children who change schools mid-year also perform worse on standardized tests than children who have not experienced school mobility. During the 2012-2013 school year in Rhode Island, 70% of fourth-grade children who did not experience mobility were proficient in reading on the state assessments, compared with 50% of students who moved once and 38% of students who moved two or more times.[15] Rhode Island students who change schools mid-year are suspended more often than students who do not change schools.[16]**

◆ **High school students in urban districts in Rhode Island are more likely than those in non-urban districts to be mobile, regardless of race, ethnicity, or income.[17]**

◆ **School districts with high mobility rates can reduce the negative impacts of mobility on students by providing immediate and comprehensive screening of entering students to ensure that students are properly placed and providing professional development for teachers on working effectively with students who transfer into their classrooms during the school year. Districts also can identify those districts where students most frequently transfer to and from and align their curricula, programs, and policies to reduce disruption of learning.[18]**

Student Mobility and Stability Rates

- Mobility rates are calculated by adding all children who enrolled after September 30 to all those who withdrew before June 1 and dividing the total by the total enrollment for that school district.[19]

- Stability rates measure the number of children who attended the same school the entire school year in a school district. The stability rate is calculated by dividing the number of children enrolled the whole year at the same school in the school district by total enrollment for that school district.[20]

- Total enrollment for each district is cumulative over the course of the school year.[21]

- The overall Rhode Island student mobility rate was 13% in the 2013-2014 school year. The four core cities had a higher mobility rate (21%) than districts in the remainder of the state (10%).[22]

- One study showed that the average length of time between enrollments for mobile students in Rhode Island during the 2007-2008 school year was 10 days.[23]

Table 45. **Student Mobility and Stability Rates by District, Rhode Island, 2013-2014 School Year**

SCHOOL DISTRICT	CUMULATIVE ENROLLMENT FOR 2013-2014	# ENROLLED THE WHOLE YEAR	# ENROLLED AFTER SEPT. 30	# EXITED BEFORE JUNE 1	STABILITY RATE	MOBILITY RATE
Barrington	3,393	3,297	46	52	97%	3%
Bristol Warren	3,599	3,305	132	180	92%	9%
Burrillville	2,554	2,305	135	149	90%	11%
Central Falls	3,149	2,417	413	389	77%	25%
Chariho	3,625	3,262	169	213	90%	11%
Coventry	5,208	4,825	170	241	93%	8%
Cranston	11,217	10,069	561	650	90%	11%
Cumberland	4,773	4,390	186	215	92%	8%
East Greenwich	2,477	2,376	63	39	96%	4%
East Providence	5,645	5,036	287	353	89%	11%
Exeter-West Greenwich	1,728	1,589	71	76	92%	9%
Foster	298	270	16	12	91%	9%
Foster-Glocester	1,188	1,117	38	35	94%	6%
Glocester	560	517	22	21	92%	8%
Jamestown	529	487	22	20	92%	8%
Johnston	3,330	2,975	159	217	89%	11%
Lincoln	3,290	3,050	113	139	93%	8%
Little Compton	265	252	*	*	95%	5%
Middletown	2,484	2,100	199	216	85%	17%
Narragansett	1,447	1,348	49	57	93%	7%
New Shoreham	126	110	12	*	87%	13%
Newport	2,252	1,848	232	207	82%	19%
North Kingstown	4,273	3,930	188	178	92%	9%
North Providence	3,753	3,330	229	231	89%	12%
North Smithfield	1,831	1,700	91	62	93%	8%
Pawtucket	10,024	8,313	851	973	83%	18%
Portsmouth	2,786	2,530	126	149	91%	10%
Providence	27,170	21,934	2,427	3,192	81%	21%
Scituate	1,482	1,415	30	38	95%	5%
Smithfield	2,533	2,339	113	97	92%	8%
South Kingstown	3,581	3,277	150	178	92%	9%
Tiverton	1,963	1,808	55	104	92%	8%
Warwick	10,009	8,983	507	582	90%	11%
West Warwick	3,755	3,158	244	405	84%	17%
Westerly	3,181	2,878	154	171	90%	10%
Woonsocket	6,710	5,389	630	813	80%	22%
Charter Schools	*5,156*	*4,827*	*126*	*213*	*94%*	*7%*
State-Operated Schools	*2,104*	*1,620*	*282*	*313*	*77%*	*28%*
UCAP	*155*	*127*	*14*	*17*	*82%*	*20%*
Four Core Cities	*47,053*	*38,053*	*4,321*	*5,367*	*81%*	*21%*
Remainder of State	*99,135*	*89,876*	*4,574*	*5,299*	*91%*	*10%*
Rhode Island	*153,603*	*134,503*	*9,317*	*11,209*	*88%*	*13%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2013-2014 school year.

*Fewer than 10 students are in this category. Actual numbers are not shown to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

Charter Schools include: Achievement First Rhode Island, Beacon Charter High School for the Arts, Blackstone Academy, Blackstone Valley Prep, The Compass School, Paul Cuffee Charter School, The Greene School, Highlander Charter School, International Charter School, Kingston Hill Academy, The Learning Community, Rhode Island Nurses Institute Middle College Charter School, Segue Institute for Learning, Sheila C. "Skip" Nowell Leadership Academy, Trinity Academy, and the Village Green Virtual Public Charter School. State-operated schools include DCYF Schools, Metropolitan Regional Career and Technical Center, William M. Davies Career & Technical High School and the Rhode Island School for the Deaf. UCAP is the Urban Collaborative Accelerated Program.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

References

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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 on the *New England Common Assessment Program (NECAP)* test.

SIGNIFICANCE

Educators and researchers have long recognized the importance of achieving reading proficiency by the end of third grade, when children begin to shift from learning to read to reading to learn. Students who do not read proficiently by then struggle in later grades and are four times more likely to drop out of high school than their proficient peers.[1]

Literacy begins long before children encounter formal school instruction in writing and reading. Supportive, literacy-rich home learning environments (including reading and telling stories to children) and parents who invest in early cognitive development activities contribute to advanced literacy development, reading achievement, and success in school.[2,3]

High-quality preschool and Pre-K programs can boost language and literacy skills, and have the greatest impact on children living in or near poverty.[4] Programs targeting the development of social-emotional and behavioral skills improve children's school readiness and academic achievement. Children who participate in high-quality Pre-K programs score higher on future reading and math assessments, are more likely to become proficient readers in the primary grades, and have higher graduation rates.[5,6]

Students that have difficulty reading beyond third grade often need intensive interventions in order to read proficiently. While interventions implemented before third grade have high rates of success, interventions after third grade are much less effective. Once they fall behind, most children never catch up to their peers.[7,8]

Literacy development in the elementary grades can be enhanced through the prioritization of literacy development, early warning systems that identify students who are falling behind and provide intervention services as early as possible, individualized teaching strategies and materials designed to meet diverse student needs, high-quality teacher training, and parent involvement.[9]

4th-Grade *NAEP* Reading Proficiency

	2003	2013
RI	29%	38%
US	30%	34%
National Rank*		*13th*
New England Rank**		*5th*

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

Source: The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org.

The *National Assessment of Educational Progress (NAEP)* measures proficiency nationally and across states every other year.

Fourth-Grade *NECAP* Reading Proficiency Rates, by Student Subgroups, 2005 and 2013

	2005	2013
English Language Learners	19%	25%
Non-English Language Learners	64%	74%
Students With Disabilities	26%	21%
Students Without Disabilities	68%	78%
Low-Income Students	40%	58%
Higher-Income Students	74%	83%
ALL STUDENTS	*60%*	*71%*

Source: Rhode Island Department of Education, *New England Common Assessment Program (NECAP)*, October 2005 and October 2013. Low-income status is determined by eligibility for the free or reduced-price lunch program.

◆ **In October 2013, 71% of Rhode Island fourth graders scored at or above proficiency for reading on the *New England Common Assessment Program (NECAP)*, up from 60% in 2005.[10]**

◆ **In Rhode Island between 2005 and 2013, the percentage of higher-income fourth graders achieving at or above the proficient level on the *NECAP* was consistently higher than that of low-income fourth graders. In 2013, 58% of low-income fourth graders scored at or above the proficient level, compared with 83% of higher-income fourth graders.[11]**

Statewide Assessments of Reading and English Language Arts

◆ **The *New England Common Assessment Program (NECAP)* has been Rhode Island's statewide assessment system since 2005. Starting in the 2014-2015 school year, Rhode Island is using a new statewide assessment, the *Partnership for Assessment of Readiness for College and Careers (PARCC).*[12]**

◆ **The *PARCC* is aligned to the *Common Core State Standards* in English language arts/literacy and will assess students' ability to read and comprehend complex texts, use different sources to compare and synthesize ideas, and write effectively.[13]**

Table 46.

Fourth-Grade Reading Proficiency, Rhode Island, 2005-2013

SCHOOL DISTRICT	% AT OF ABOVE THE PROFICIENCY LEVEL								
	2005	2006	2007	2008	2009	2010	2011	2012	2013
Barrington	89%	91%	91%	90%	92%	91%	90%	90%	88%
Bristol Warren	69%	73%	79%	78%	74%	77%	74%	73%	68%
Burrillville	63%	73%	72%	72%	61%	74%	73%	75%	70%
Central Falls	40%	46%	45%	48%	52%	58%	45%	42%	44%
Chariho	73%	80%	80%	73%	85%	86%	93%	88%	92%
Coventry	68%	76%	73%	75%	80%	80%	86%	80%	78%
Cranston	71%	71%	72%	80%	75%	72%	73%	73%	79%
Cumberland	74%	70%	70%	75%	71%	75%	85%	81%	85%
East Greenwich	86%	78%	82%	85%	85%	91%	92%	83%	87%
East Providence	59%	63%	58%	73%	64%	61%	65%	62%	62%
Exeter-West Greenwich	74%	65%	71%	75%	77%	77%	82%	83%	89%
Foster	68%	69%	69%	86%	78%	75%	82%	79%	94%
Glocester	77%	65%	76%	77%	82%	76%	73%	76%	90%
Jamestown	83%	81%	82%	80%	77%	82%	88%	80%	79%
Johnston	58%	68%	65%	66%	71%	66%	69%	71%	76%
Lincoln	72%	76%	78%	77%	76%	81%	79%	76%	81%
Little Compton	73%	76%	79%	76%	79%	76%	88%	81%	87%
Middletown	68%	63%	73%	70%	67%	71%	77%	75%	78%
Narragansett	81%	84%	71%	86%	77%	87%	91%	89%	86%
New Shoreham	100%	78%	90%	91%	NA	82%	92%	83%	90%
Newport	46%	54%	50%	53%	53%	66%	58%	64%	61%
North Kingstown	79%	81%	78%	75%	79%	80%	83%	83%	83%
North Providence	64%	71%	69%	73%	69%	67%	72%	74%	70%
North Smithfield	77%	77%	83%	85%	88%	83%	83%	83%	77%
Pawtucket	48%	48%	55%	58%	56%	61%	60%	60%	62%
Portsmouth	75%	77%	80%	75%	80%	78%	87%	86%	78%
Providence	31%	39%	36%	47%	44%	47%	46%	45%	52%
Scituate	72%	77%	75%	79%	86%	79%	82%	86%	82%
Smithfield	79%	78%	81%	84%	83%	85%	89%	84%	88%
South Kingstown	76%	74%	75%	75%	81%	83%	90%	83%	82%
Tiverton	77%	64%	74%	74%	75%	75%	83%	88%	87%
Warwick	71%	72%	75%	75%	76%	73%	77%	78%	78%
West Warwick	55%	59%	58%	69%	60%	67%	74%	72%	71%
Westerly	69%	74%	78%	70%	75%	78%	82%	87%	77%
Woonsocket	46%	50%	50%	53%	54%	59%	59%	56%	53%
Charter Schools	*43%*	*55%*	*58%*	*64%*	*58%*	*67%*	*70%*	*69%*	*71%*
Four Core Cities	*37%*	*43%*	*43%*	*50%*	*48%*	*52%*	*51%*	*50%*	*54%*
Remainder of State	*71%*	*72%*	*73%*	*76%*	*75%*	*76%*	*75%*	*78%*	*79%*
Rhode Island	*60%*	*63%*	*64%*	*68%*	*67%*	*69%*	*71%*	*69%*	*71%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education, *New England Common Assessment Program (NECAP)*, October 2005 to October 2013.

Due to the adoption of a new assessment tool by RIDE, Fourth-Grade Reading Skills cannot be compared with Factbooks prior to 2007, when the *NECAP* data were first presented.

% at or above the proficiency level are the fourth-grade students who received proficient or proficient with distinction scores on the reading section of the *NECAP*. Only students who actually took the test are counted in the denominator for the district and school proficiency rates. All enrolled students are eligible unless their Individualized Education Program (IEP) specifically exempts them or unless they are beginning English Language Learners.

2013 *NECAP* data for independent charter schools include The Compass School, The Paul Cuffee Charter School, Highlander Charter School, International Charter School, Kingston Hill Academy, and The Learning Community. Charter schools included in total differ by year, depending on the schools serving that grade level on the year of the test. Charter schools are not included in the core city and remainder of state calculations. NA indicates that no data are available.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

See Methodology Section for more information.

References

[1,8] Hernandez, D. J. (2012). *Double jeopardy: How third-grade reading skills and poverty influence high school graduation.* Baltimore, MD: The Annie E. Casey Foundation.

[2,6] Fiester, L. (2013). *Early warning confirmed: A research update on third-grade reading.* Baltimore, MD: The Annie E. Casey Foundation.

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Eighth-Grade Reading Skills

DEFINITION

Eighth-grade reading skills is the percentage of eighth-grade students who scored at or above the proficiency level for reading on the *New England Common Assessment Program (NECAP)* test.

SIGNIFICANCE

Strong reading skills are essential for a student's academic success in high school and college.[1] Reading skills also are a powerful indicator of a student's ability to contribute to, participate in, and succeed in the workforce and the community.[2] Literacy demands intensify dramatically in grades four through 12, as students are expected to comprehend, synthesize, and analyze increasingly complex texts across academic disciplines. Even after mastering basic literacy skills, adolescents need ongoing support and instruction to develop advanced literacy skills required to succeed in middle and high school, such as applying critical thinking skills and drawing conclusions based on evidence.[3]

Reading difficulties can persist over time with long-term consequences for youth. Adolescents who are poor readers are more likely to drop out of high school, to have lower wages, and to rely on public assistance than their peers with higher levels of literacy.[4] These problems are exacerbated for English Language Learners and low-income students, who are more likely to have low literacy skills.[5]

There has been limited progress in improving literacy skills among secondary students.[6] When literacy-specific instruction is used as remedial support for struggling adolescent students, the programs typically serve only a small proportion of students who need assistance.[7] These supplementary programs are generally insufficient for dealing with the pervasive low levels of adolescent literacy in many schools and communities.[8]

Intensive individualized instruction can help improve adolescent literacy among struggling readers.[9] Successful adolescent literacy programs include comprehensive professional development for teachers and principals in literacy instruction strategies, incorporating literacy instruction in content area classes, providing opportunities for student discussion, and using student assessments effectively.[10,11]

8th Grade *NAEP* Reading Proficiency

	2002	2013
RI	30%	36%
US	31%	34%
National Rank*		*21st*
New England Rank**		*6th*

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

Source: The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

The *National Assessment of Educational Progress (NAEP)* measures proficiency nationally and across states every other year.

Eighth-Grade *NECAP* Reading Proficiency Rates, by Student Subgroups, 2005 and 2013

	2005	2013
English Language Learners	6%	19%
Non-English Language Learners	58%	77%
Students With Disabilities	21%	32%
Students Without Disabilities	63%	81%
Low-Income Students	33%	61%
Higher-Income Students	67%	86%
ALL STUDENTS	*55%*	*74%*

Source: Rhode Island Department of Education, *New England Common Assessment Program (NECAP)*, October 2005 and October 2013. Low-income status is determined by eligibility for the free or reduced-price lunch program

◆ **In October 2013, 74% of Rhode Island eighth graders scored at or above proficiency in reading on the *New England Common Assessment Program (NECAP)*, up from 55% in 2005.[12]**

◆ **In Rhode Island between 2005 and 2013, the percentage of higher-income eighth graders achieving at or above the proficient level on the *NECAP* was consistently higher than that of low-income eighth graders. In 2013, 61% of low-income eighth graders scored at or above the proficient level, compared with 86% of higher-income eighth graders.[13]**

Statewide Assessments of Reading and English Language Arts

◆ **The *NECAP* has been Rhode Island's statewide assessment system since 2005. Starting in the 2014-2015 school year, Rhode Island is using a new statewide assessment, the *Partnership for Assessment of Readiness for College and Careers (PARCC)*.[14]**

◆ **The *PARCC* is aligned to the *Common Core State Standards* in English language arts/literacy and will assess students' ability to read and comprehend complex texts, use different sources to compare and synthesize ideas, and write effectively.[15]**

Table 47.

Eighth-Grade Reading Proficiency, Rhode Island, 2005 through 2013

SCHOOL DISTRICT	% AT OR ABOVE THE PROFICIENCY LEVEL								
	2005	2006	2007	2008	2009	2010	2011	2012	2013
Barrington	92%	91%	95%	94%	92%	94%	95%	92%	94%
Bristol Warren	63%	66%	77%	76%	78%	81%	88%	87%	84%
Burrillville	67%	59%	63%	64%	61%	73%	75%	83%	75%
Central Falls	27%	27%	35%	34%	43%	53%	51%	41%	39%
Chariho	58%	66%	79%	85%	84%	90%	93%	92%	94%
Coventry	66%	77%	77%	80%	80%	86%	88%	83%	83%
Cranston	57%	65%	65%	68%	78%	78%	84%	82%	83%
Cumberland	72%	65%	63%	71%	82%	82%	85%	84%	83%
East Greenwich	87%	85%	90%	86%	94%	91%	93%	95%	94%
East Providence	57%	52%	65%	65%	65%	79%	77%	80%	74%
Exeter-West Greenwich	72%	71%	75%	78%	80%	82%	93%	87%	86%
Foster-Glocester	57%	75%	78%	67%	82%	82%	90%	87%	87%
Jamestown	86%	85%	75%	87%	90%	93%	94%	94%	95%
Johnston	58%	62%	63%	66%	71%	74%	77%	74%	82%
Lincoln	74%	75%	71%	79%	83%	87%	90%	92%	86%
Little Compton	83%	93%	87%	75%	94%	87%	97%	93%	97%
Middletown	64%	63%	76%	80%	74%	79%	79%	80%	76%
Narragansett	81%	88%	70%	87%	88%	93%	88%	93%	86%
New Shoreham	NA	91%	NA	NA	100%	75%	NA	NA	NA
Newport	50%	46%	46%	69%	76%	68%	78%	85%	86%
North Kingstown	73%	81%	76%	73%	84%	87%	88%	87%	91%
North Providence	70%	64%	66%	66%	65%	78%	76%	82%	82%
North Smithfield	72%	71%	55%	58%	87%	89%	90%	92%	90%
Pawtucket	44%	40%	47%	52%	55%	62%	67%	62%	62%
Portsmouth	81%	78%	73%	80%	84%	90%	89%	87%	89%
Providence	25%	34%	37%	41%	45%	44%	52%	56%	49%
Scituate	89%	77%	87%	87%	91%	85%	91%	92%	89%
Smithfield	78%	79%	85%	81%	85%	92%	92%	92%	92%
South Kingstown	76%	81%	83%	82%	89%	87%	90%	90%	83%
Tiverton	67%	60%	51%	68%	75%	73%	87%	84%	73%
Warwick	59%	64%	65%	73%	76%	78%	84%	80%	75%
West Warwick	56%	59%	62%	59%	71%	79%	74%	73%	72%
Westerly	59%	73%	76%	77%	73%	84%	87%	84%	78%
Woonsocket	28%	31%	30%	43%	51%	60%	63%	56%	55%
Charter Schools	*55%*	*35%*	*49%*	*48%*	*62%*	*76%*	*71%*	*73%*	*69%*
UCAP	*6%*	*22%*	*36%*	*43%*	*48%*	*42%*	*66%*	*47%*	*46%*
Four Core Cities	*30%*	*34%*	*38%*	*43%*	*48%*	*52%*	*57%*	*57%*	*52%*
Remainder of State	*66%*	*69%*	*71%*	*74%*	*79%*	*83%*	*85%*	*85%*	*83%*
Rhode Island	*55%*	*58%*	*61%*	*65%*	*70%*	*74%*	*77%*	*77%*	*74%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education (RIDE), *New England Common Assessment Program (NECAP)*, October 2005 through October 2013.

Eighth-Grade Reading Skills cannot be compared with Factbooks prior to 2007, when the *NECAP* data were first presented.

% at or above the proficiency level are the eighth-grade students who received proficient or proficient with distinction scores on the reading section of the *NECAP*. Only students who actually took the test are counted in the denominator for the school or district proficiency rate. All enrolled students are eligible unless their IEP specifically exempts them or unless they are beginning ELLs.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

2013 *NECAP* eighth-grade reading data for independent charter schools include: Blackstone Valley Prep Mayoral Academy, The Compass School, Paul Cuffee Charter School, Highlander Charter School, The Learning Community, Segue Institute for Learning, and Trinity Academy for the Performing Arts. Charter schools included in totals differ by year, depending on the schools serving that grade level on the year of the test. UCAP is the Urban Collaborative Accelerated Program. Four core cities and remainder of state calculations do not include charter schools or UCAP.

NA indicates that the number of students is too small to report or no data is available.

See Methodology Section for more information.

References

[1,6,10] *Adolescent readers in middle school.* (2013). New York, NY: Generation Ready.

[2,4] Salinger, T. (2011). *Addressing the "crisis" in adolescent literacy.* Washington, DC: U.S. Department of Education, Office of Elementary and Secondary Education, Smaller Learning Communities Program.

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Math Skills

DEFINITION

Math skills is the percentage of fourth-, eighth-, and eleventh-grade students who scored at or above the proficiency level for math on the *New England Common Assessment Program (NECAP)* test.

SIGNIFICANCE

Math skills are critical for students to understand and use. Students must rely on mathematics to perform everyday activities, advance their education, and navigate today's technological world. Strong math skills predict higher college attendance and success rates, and increase students' employability.[1,2] Improving education in the STEM disciplines (science, technology, engineering, and math) can spur national innovation and competitiveness and ensure that we have qualified workers for our growing STEM industries.[3]

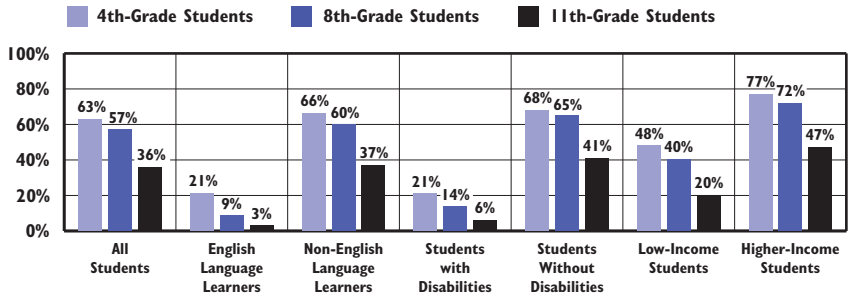
State, national, and international assessments show that U.S. students fare well when asked to perform straightforward computational procedures, but tend to have a limited understanding of basic mathematical concepts needed to solve simple problems. Performance in mathematics, while generally low, has been improving over the past decade.[4,5,6]

Family risk factors such as poverty and low parental education levels are associated with low student achievement in mathematics. Disparities in math achievement related to race and family income persist in the U.S.[7] Opportunities for high-quality math instruction are especially important for low-income children. Low-income children demonstrate lower levels of math skills before entering school and the gaps continue and even widen throughout their time in school.[8]

Achieving math proficiency for all students requires that improvements be made in curriculum, instructional materials, assessments, classroom practice, teacher preparation, and professional development.[9,10] Early warning and intervention systems that identify students struggling with math can provide personalized and timely academic support.[11]

The *National Assessment of Educational Progress (NAEP)* measures proficiency in math and other subjects nationally and across states every other year.[12] In 2013, 83% of Rhode Island and U.S. fourth graders performed at or above the Basic level in math on the *NAEP*, and 74% of Rhode Island and U.S. eighth graders performed at or above the Basic level in math on the *NAEP*.[13,14] Unlike in the previous two testing periods, the performance of Rhode Island fourth and eighth graders did not improve between the 2011 and 2013 *NAEP* math tests.[15,16,17]

4th-Grade, 8th-Grade & 11th-Grade Math Proficiency Levels by Student Subgroup, Rhode Island Public Schools, October 2013



Source: Rhode Island Department of Education, *New England Common Assessment Program (NECAP)*, October 2013.
Low-income status is determined by eligibility for the free or reduced-price lunch program.

◆ **As students progress in school, math proficiency drops. In October 2013, 63% of Rhode Island fourth graders scored at or above the proficient level on the *NECAP*, compared to 57% of eighth graders, and 36% of eleventh graders.[18]**

◆ **Nationally and in Rhode Island, there are math achievement gaps between subgroups of students. Across all tested grade levels, English Language Learners and students with disabilities were the least proficient in math in Rhode Island in 2013.[19,20]**

Statewide Assessments of Math

◆ **The *New England Common Assessment Program (NECAP)* has been Rhode Island's statewide assessment system since 2005. Starting in the 2014-2015 school year, Rhode Island is using a new statewide assessment, the *Partnership for Assessment of Readiness for College and Careers (PARCC)*.[21]**

◆ **The *PARCC* is aligned to the *Common Core State Standards* in mathematics and will assess students' ability to demonstrate mathematical reasoning and apply mathematical concepts to solve complex, real-world problems.[22]**

Table 48. **Fourth-, Eighth-, and Eleventh-Grade Math Proficiency, Rhode Island, 2005 and 2013**

SCHOOL DISTRICT	FOURTH GRADE		EIGHTH GRADE		ELEVENTH GRADE	
	% OF STUDENTS WHO SCORED AT OR ABOVE PROFICIENCY, 2005	% OF STUDENTS WHO SCORED AT OR ABOVE PROFICIENCY, 2013	% OF STUDENTS WHO SCORED AT OR ABOVE PROFICIENCY, 2005	% OF STUDENTS WHO SCORED AT OR ABOVE PROFICIENCY, 2013	% OF STUDENTS WHO SCORED AT OR ABOVE PROFICIENCY, 2007*	% OF STUDENTS WHO SCORED AT OR ABOVE PROFICIENCY, 2013
Barrington	85%	79%	87%	90%	63%	78%
Bristol Warren	62%	66%	57%	68%	28%	41%
Burrillville	55%	57%	52%	55%	20%	41%
Central Falls	28%	42%	16%	14%	3%	13%
Chariho	66%	86%	55%	74%	29%	50%
Coventry	63%	72%	62%	62%	26%	36%
Cranston	55%	63%	41%	61%	18%	28%
Cumberland	58%	75%	56%	72%	20%	46%
East Greenwich	83%	85%	84%	85%	54%	70%
East Providence	59%	54%	46%	58%	14%	30%
Exeter-West Greenwich	68%	85%	64%	74%	30%	58%
Foster	66%	75%	NA	NA	NA	NA
Foster-Glocester	NA	NA	61%	74%	18%	53%
Glocester	62%	86%	NA	NA	NA	NA
Jamestown	65%	85%	77%	86%	NA	NA
Johnston	45%	67%	41%	63%	17%	23%
Lincoln	72%	79%	62%	69%	35%	52%
Little Compton	59%	87%	76%	86%	NA	NA
Middletown	68%	78%	70%	66%	33%	59%
Narragansett	66%	79%	75%	69%	36%	66%
New Shoreham	57%	90%	NA	NA	27%	64%
Newport	34%	50%	39%	55%	24%	24%
North Kingstown	71%	84%	61%	80%	43%	58%
North Providence	39%	63%	38%	42%	19%	38%
North Smithfield	80%	70%	66%	77%	29%	52%
Pawtucket	42%	50%	37%	37%	12%	18%
Portsmouth	67%	83%	72%	78%	37%	63%
Providence	25%	39%	20%	34%	10%	14%
Scituate	62%	81%	79%	80%	27%	55%
Smithfield	72%	82%	64%	74%	31%	47%
South Kingstown	71%	79%	72%	79%	42%	59%
Tiverton	75%	80%	62%	67%	29%	27%
Warwick	63%	66%	52%	61%	18%	33%
West Warwick	42%	61%	51%	48%	21%	31%
Westerly	56%	78%	47%	58%	28%	54%
Woonsocket	41%	50%	29%	33%	11%	20%
Charter Schools	*36%*	*69%*	*39%*	*59%*	*7%*	*20%*
State-Operated Schools	*NA*	*NA*	*NA*	*NA*	*6%*	*26%*
UCAP	*NA*	*NA*	*5%*	*18%*	*NA*	*NA*
Four Core Cities	*31%*	*43%*	*25%*	*34%*	*10%*	*16%*
Remainder of State	*62%*	*71%*	*57%*	*67%*	*27%*	*45%*
Rhode Island	*52%*	*63%*	*47%*	*57%*	*22%*	*36%*

Source of Data for Table/Methodology

Data are from the Rhode Island Department of Education, *New England Common Assessment Program (NECAP)*, October 2005 and October 2013.

Due to the adoption of a new assessment tool by the Rhode Island Department of Education in 2005, Math Skills in this Factbook cannot be compared with Factbooks prior to 2007, when the *NECAP* data were first presented.

*2007 is the first year that eleventh-grade students participated in the *NECAP*.

% at or above proficiency are students who received proficient or proficient with distinction scores on the math section of the *NECAP*. Only students who actually took the test are counted in denominator for the district's or school's proficiency rate. All enrolled students are eligible unless their Individualized Education Program (IEP) specifically exempts them or unless they are beginning English Language Learners.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

2013 *NECAP* data for independent charter schools include Beacon Charter School for the Arts, Blackstone Valley Prep Mayoral Academy, The Compass School, Paul Cuffee Charter School, The Greene School, Highlander Charter School, International Charter School, Kingston Hill Academy, The Learning Community, Segue Institute for Learning, Sheila C. "Skip" Nowell Leadership Academy, and Trinity Academy for the Performing Arts. State-operated schools include the William M. Davies Jr. Career & Technical High School and the Metropolitan Regional Career and Technical Center. DCYF Schools and the Rhode Island School for the Deaf are not included because the number of students is too small to report. Charter schools, state-operated schools, and the Urban Collaborative Accelerated Program (UCAP) are not included in the four core cities and remainder of state calculations.

NA indicates that the school district does not serve students at that grade level or that the number of students was too small to report.

References

[1,5,7] *Mathematics proficiency.* (2013). Washington, DC: Child Trends.

(continued on page 184)

Schools Identified for Intervention

DEFINITION

Schools identified for intervention is the percentage of Rhode Island public schools that are identified for intervention as classified by the Rhode Island Department of Education. Classification levels are: "Commended," "Leading," "Typical," "Warning," "Focus," and "Priority." Schools designated "Focus" or "Priority" are identified for intervention. Rhode Island's accountability system is designed to recognize outstanding performance and provide support to low-achieving schools and options for intervention to improve student achievement.

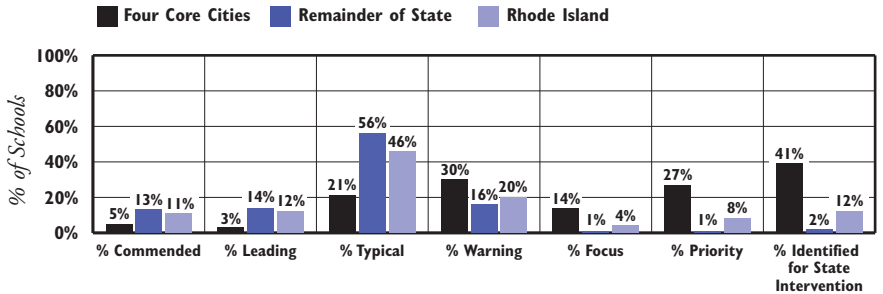
SIGNIFICANCE

Since its passage in 2001, the federal *No Child Left Behind Act (NCLB)* has focused on closing achievement gaps and improving public schools. In 2012, Rhode Island replaced this system of classifying schools, which was based on whether schools "Met Adequate Yearly Progress (AYP)," with a new accountability system, which identifies each school's strengths and weaknesses. By focusing on student subgroups, Rhode Island provides the support and interventions needed to help improve student achievement and close achievement gaps. As with the previous system, the new accountability system uses standardized test scores and graduation rates to measure school performance; however, there is now greater focus on schools' success in closing achievement gaps, progress toward 2017 goals, and the year-over-year growth or improvement of individual students.[1,2]

Strong state accountability systems are aligned with college and career-ready standards, make accountability determinations for all schools and districts, focus on student performance and growth, disaggregate data by student subgroup, report timely data that is accessible to a wide range of stakeholders, offer diagnostic reviews tied to the delivery of meaningful interventions, build district and school capacity for sustained improvement, target the lowest-achieving schools for interventions, and promote innovation, evaluation, and continuous improvement.[3]

Students who have attained proficiency in reading and math are more likely to graduate from high school, attend college, earn more and have more stable employment than students with lower test scores.[4,5] Districts can improve student performance by focusing on student achievement, improving curricula, using data to improve instruction and accountability, building structures to support staff, nurturing positive relationships within schools and communities, investing in instructional leadership, using coherent school-improvement strategies, strengthening professional development, and aligning district infrastructure.[6]

Rhode Island School Performance Classifications, 2013-2014 School Year



Source: Rhode Island Department of Education, 2013-2014 school year. Note: Percentages may not sum to 100% due to rounding. See Methodology Section for more detail on the definition of each school classification strategy.

◆ **In Rhode Island in 2014, 30 schools (11%) were classified as "Commended," 32 schools (12%) were classified as "Leading," 128 schools (46%) were classified as "Typical," 55 schools (20%) were classified as "Warning," 11 schools (4%) were classified as "Focus," and 21 schools (8%) schools were classified as "Priority."[7] Schools designated as "Priority" or "Focus" schools (12% of schools in Rhode Island in 2013) were identified for intervention, and 27 of these 32 schools were located in the four core cities.[8,9]**

Interventions Designed to Improve Schools

◆ **Rhode Island's transition from the *New England Common Assessment Program (NECAP)* to the *Partnership for Assessment of Readiness for College and Careers (PARCC)* assessments will require some changes to the assessment and classification system.[10]**

◆ **In Rhode Island, intervention in low-achieving schools has led to improvements in school climate and student achievement. The Rhode Island Department of Education works with districts and schools to design, implement, and monitor plans focused on improving instruction and student achievement that schools can sustain over time.[11]**

◆ **Once identified as a priority or focus school requiring intervention, the school and state begin a multi-year intervention plan that begins with diagnostic evaluation and the development of comprehensive strategies for intervention.[12]**

◆ **All public schools in Rhode Island, regardless of classification, are included in the accountability system and are expected to strive for continued improvement.[13]**

Table 49.

Schools Identified for Intervention, 2013-2014 School Year

SCHOOL DISTRICT	TOTAL # OF SCHOOLS	# COMMENDED	# LEADING	# TYPICAL	# WARNING	# FOCUS	# PRIORITY	# SUBJECT TO INTERVENTION	% SUBJECT TO INTERVENTION
Barrington	6	1	1	4	0	0	0	0	0%
Bristol Warren	6	2	0	3	1	0	0	0	0%
Burrillville	4	0	1	2	1	0	0	0	0%
Central Falls	4	0	0	0	1	1	2	3	75%
Chariho	6	2	2	2	0	0	0	0	0%
Coventry	7	0	0	2	5	0	0	0	0%
Cranston	23	2	5	12	3	1	0	1	4%
Cumberland	8	0	1	6	1	0	0	0	0%
East Greenwich	6	2	1	3	0	0	0	0	0%
East Providence	11	0	0	5	4	0	2	2	18%
Exeter-West Greenwich	3	1	1	1	0	0	0	0	0%
Foster	1	0	1	0	0	0	0	0	0%
Foster-Glocester	2	1	0	1	0	0	0	0	0%
Glocester	2	0	1	1	0	0	0	0	0%
Jamestown	2	0	0	2	0	0	0	0	0%
Johnston	6	0	0	6	0	0	0	0	0%
Lincoln	6	0	1	5	0	0	0	0	0%
Little Compton	1	0	1	0	0	0	0	0	0%
Middletown	5	1	1	3	0	0	0	0	0%
Narragansett	3	1	0	2	0	0	0	0	0%
New Shoreham	1	0	0	1	0	0	0	0	0%
Newport	2	0	0	1	1	0	0	0	0%
North Kingstown	8	1	3	4	0	0	0	0	0%
North Providence	9	1	1	5	2	0	0	0	0%
North Smithfield	4	1	0	3	0	0	0	0	0%
Pawtucket	16	2	0	7	5	0	2	2	13%
Portsmouth	4	1	0	2	1	0	0	0	0%
Providence	37	1	2	6	6	8	14	22	59%
Scituate	5	2	1	2	0	0	0	0	0%
Smithfield	6	2	2	2	0	0	0	0	0%
South Kingston	7	1	0	4	2	0	0	0	0%
Tiverton	5	1	1	3	0	0	0	0	0%
Warwick	22	0	1	17	4	0	0	0	0%
West Warwick	5	0	0	2	3	0	0	0	0%
Westerly	6	1	0	2	3	0	0	0	0%
Woonsocket	9	0	0	1	8	0	0	0	0%
Charter Schools	*14*	*3*	*3*	*4*	*3*	*1*	*0*	*1*	*7%*
State-Operated Schools	*4*	*0*	*1*	*1*	*1*	*0*	*1*	*1*	*25%*
UCAP	*1*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0%*
Four Core Cities	*66*	*3*	*2*	*14*	*20*	*9*	*18*	*27*	*41%*
Remainder of State	*192*	*24*	*28*	*108*	*31*	*1*	*2*	*3*	*2%*
Rhode Island	*277*	*30*	*32*	*128*	*55*	*11*	*21*	*32*	*12%*

Source of Data for Table/Methodology

All data are from the Rhode Island Department of Education, 2013-2014 school year. See the Methodology Section for more information.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Charter schools that are classified include Beacon Charter High School for the Arts, Blackstone Academy Charter School, Blackstone Valley Prep, The Compass School, Paul Cuffee Charter School, The Greene School, Highlander Charter School, International Charter School, Kingston Hill Academy, The Learning Community, Rhode Island Nurses Institute Middle College Charter School, Segue Institute for Learning, and Trinity Academy for the Performing Arts.

State-operated schools that are classified include the William M. Davies Jr. Career and Technical High School, DCYF, Metropolitan Regional Career & Technical Center, and the Rhode Island School for the Deaf. UCAP is the Urban Collaborative Accelerated Program.

A total of four schools were not classified because they did not have sufficient years of data or had new school designations.

See the Methodology Section for more information.

References

[1] Rhode Island Department of Education. (2012). *Rhode Island school and district accountability system ESEA flexibility under NCLB.* Retrieved November 9, 2012, from www.ride.ri.gov

[2] Rhode Island Department of Education. (2014). *RIDE releases 2014 school classifications: 30 schools honored as commended* [Press release]. Retrieved from www.ride.ri.gov

[3] Council of Chief State School Officers. (n.d.). *Roadmap for next-generation state accountability systems.* Retrieved January 6, 2015, from www.ccsso.org

[4] *Reading proficiency.* (2014). Washington, DC: Child Trends.

[5] *Mathematics proficiency.* (2013). Washington, DC: Child Trends.

(continued on page 184)

Chronic Early Absence

DEFINITION

Chronic early absence is the percentage of children in kindergarten through third grade (K-3) who were enrolled for at least 90 days and missed 18 days or more of school, including excused and unexcused absences (10% or more of the school year for a 180-day school year).

SIGNIFICANCE

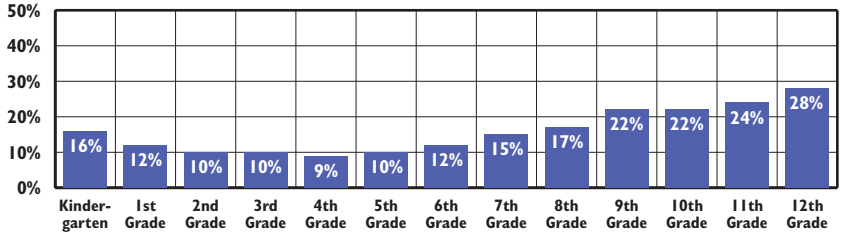
Students who are absent from school miss opportunities to learn and develop positive relationships within the school community. During the early elementary school years, children develop important skills and approaches to learning that are critical for ongoing school success. Through their experiences in K-3 classrooms, children build academic, social-emotional and study skills.[1,2] Children who are chronically absent in kindergarten show lower levels of achievement in math, reading, and general knowledge in first grade. Chronic absence in kindergarten appears to be especially detrimental for poor and Hispanic children.[3] In Rhode Island, children who are chronically absent in kindergarten have lower levels of achievement as far out as the seventh grade and are more than twice as likely to be retained.[4]

Chronic early absence affects one out of 10 children in the U.S. during their first two years of school.[5] Children from poor families are much more likely to have high rates of chronic absenteeism in the early grades than higher-income children. In the U.S., one in five (21%) poor kindergartners were chronically absent, compared to less than one in 10 (8%) of their higher-income peers.[6] Children who are homeless or formerly homeless experience poor educational outcomes related to school absenteeism and mobility.[7] Lack of access to preventive health care and chronic health issues, such as asthma, can result in increased absenteeism.[8]

Chronic early absence is most often a result of a combination of school, family, and community factors.[9] While illness is a leading factor in chronic early absence, poverty, teenage parenting, single parenting, low maternal education levels, unemployment, poor maternal health, public assistance enrollment, and household food insecurity all can affect school attendance. Rates of chronic absence rise significantly when three or more of these risk factors are present.[10,11]

Chronic absenteeism also can result from poor quality education, ambivalence about or alienation from school, and chaotic school environments, including high rates of teacher turnover, disruptive classrooms and/or bullying.[12] Unreliable or insufficient transportation, violence at and around school, multiple foster care placements, lack of clean or affordable clothes, and lack of safe and affordable housing are factors that can lead to chronic absence.[13]

Chronic Absence Rates in Rhode Island by Grade, 2013-2014 School Year



Source: Rhode Island Department of Education, 2013-2014 school year.

◆ **Chronic absence rates are high in kindergarten and then decline before increasing again in middle and high school. During the 2013-2014 school year, 16% of Rhode Island kindergarten students, 12% of first graders, 10% of second graders, and 10% of third graders were chronically absent (i.e., absent 18 days or more).[14]**

◆ **During the 2013-2014 school year, 12% of Rhode Island children in grades K-3 were chronically absent, and a quarter (26%) missed 12 or more days of school during the 2013-2014 school year.[15] Chronic absenteeism affects all students in a class because teachers may backtrack or slow the learning pace to review lessons for students who have missed school.[16]**

◆ **Averages for school-wide attendance can mask significant numbers of chronically absent individual students.[17] During the 2013-2014 school year, the average daily attendance rate for K-3 students in Rhode Island's four core cities was 93%, but 22% of students were chronically absent.[18]**

◆ **Most schools monitor average daily attendance or unexcused absences, but few actively track chronic absenteeism. Rhode Island is one of the few states that makes school-level data on chronic absence available on a state website.[19]**

◆ **Schools, districts, and the state can nurture a culture of attendance by raising awareness among school and community personnel about the problem of chronic absence, using positive messaging to encourage parents to send their children to school on time and every day in the early grades, providing frequent reports on student absenteeism and identifying and intervening with students with troubling absenteeism patterns.[20,21]**

Table 50. **Chronic Early Absence Rates, Grades K-3, Rhode Island, 2013-2014 School Year**

SCHOOL DISTRICT	K-3 STUDENTS ENROLLED LESS THAN 90 DAYS	K-3 STUDENTS ENROLLED 90 DAYS OR MORE	K-3 ATTENDANCE RATE	% OF K-3 STUDENTS ABSENT 0-5 DAYS	% OF K-3 STUDENTS ABSENT 6-11 DAYS	% OF K-3 STUDENTS ABSENT 12-17 DAYS	% OF K-3 STUDENTS ABSENT 18+ DAYS
Barrington	NA	891	96%	48%	38%	11%	3%
Bristol Warren	57	1,088	95%	39%	38%	14%	8%
Burrillville	37	661	95%	40%	36%	16%	8%
Central Falls	144	1,008	93%	27%	31%	19%	24%
Chariho	42	888	96%	44%	40%	11%	4%
Coventry	59	1,336	96%	50%	36%	9%	5%
Cranston	207	3,028	95%	42%	33%	15%	10%
Cumberland	64	1,319	97%	58%	32%	7%	3%
East Greenwich	16	646	96%	50%	36%	10%	3%
East Providence	107	1,699	95%	40%	32%	16%	12%
Exeter-West Greenwich	20	386	96%	48%	39%	9%	4%
Foster	NA	192	98%	80%	16%	4%	1%
Glocester	16	351	98%	74%	20%	5%	1%
Jamestown	NA	204	96%	41%	42%	13%	4%
Johnston	53	962	95%	36%	34%	17%	13%
Lincoln	40	848	96%	47%	34%	13%	6%
Little Compton	NA	91	92%	11%	34%	24%	31%
Middletown	61	697	96%	43%	38%	13%	7%
Narragansett	15	378	96%	47%	37%	9%	7%
New Shoreham	NA	27	94%	22%	48%	19%	11%
Newport	59	682	94%	35%	35%	17%	12%
North Kingstown	59	1,047	96%	50%	34%	10%	6%
North Providence	96	1,049	96%	49%	30%	13%	9%
North Smithfield	18	466	96%	48%	34%	13%	4%
Pawtucket	377	3,257	95%	41%	28%	17%	14%
Portsmouth	55	652	96%	50%	36%	10%	4%
Providence	1,124	7,971	93%	30%	29%	18%	23%
Scituate	10	363	94%	37%	32%	15%	17%
Smithfield	33	690	97%	52%	37%	9%	2%
South Kingstown	48	895	96%	44%	39%	11%	6%
Tiverton	31	542	96%	47%	34%	11%	8%
Warwick	165	2,623	96%	45%	35%	12%	7%
West Warwick	132	1,116	95%	45%	31%	14%	10%
Westerly	47	886	96%	40%	40%	12%	8%
Woonsocket	333	2,065	91%	23%	27%	20%	31%
Charter Schools	*23*	*1,783*	*97%*	*56%*	*30%*	*8%*	*6%*
Rhode Island School for the Deaf	*NA*	*12*	*88%*	*8%*	*17%*	*25%*	*50%*
Four Core Cities	*1,978*	*14,301*	*93%*	*32%*	*29%*	*18%*	*22%*
Remainder of State	*1,574*	*26,703*	*96%*	*46%*	*35%*	*12%*	*7%*
Rhode Island	*3,578*	*42,799*	*95%*	*41%*	*32%*	*14%*	*12%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2013-2014 school year.

Attendance rates are calculated by dividing the state-calculated "average days of attendance" by the "average days of membership."

Chronic absence rates are based on attendance patterns for students who were enrolled in a district for at least 90 days. A total of 3,578 Rhode Island students in grades K-3 were not included in this analysis because they were only enrolled for a short period. The Rhode Island Department of Education excludes these students so that chronic absence issues can be examined separate from student mobility issues. It is likely that more students were excluded from districts with higher student mobility rates.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Charter schools include Achievement First Rhode Island, Blackstone Valley Prep, The Compass School, the Paul Cuffee Charter School, Highlander Charter School, International Charter School, Kingston Hill Academy, and the Learning Community.

NA indicates that the number of students was too small to report or that data from the district were not available.

References

[1] Romero, M. & Lee, Y. (2008). *The influence of maternal and family risk on chronic absenteeism in early schooling.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[2,3,5,9,11,12,20] Chang, H. N. & Romero, M. (2008). *Present, engaged, and accounted for: The critical importance of addressing chronic absence in the early grades.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[4] RI DataHUB. (n.d.). *Chronic absenteeism among kindergarten students.* Retrieved February 4, 2015, from http://ridatahub.org

(continued on page 184)

Chronic Absence, Middle School and High School

DEFINITION

Chronic absence, middle school and high school is the percentage of children in middle and high school who were enrolled for at least 90 days and missed 18 days or more of school, including excused and unexcused absences (10% or more of the school year for a 180-day school year).

SIGNIFICANCE

Students who are frequently absent from school miss critical academic and social learning opportunities and are at risk of disengagement from school, academic failure, and dropping out.[1] Studies in large cities have shown strong relationships between chronic absence in middle and high school and the likelihood of dropping out.[2] Chronic absence in sixth grade is one of three early warning signs that a student is likely to drop out of high school, and by ninth grade, a student's attendance is a better predictor of dropout risk than eighth-grade achievement test scores.[3]

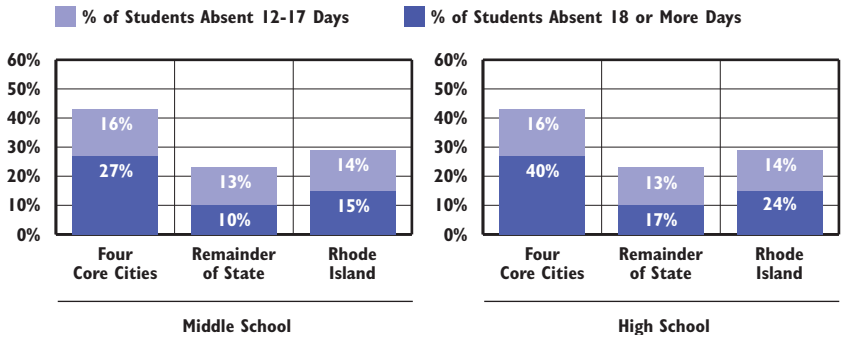
Family and economic factors connected to student absenteeism include poverty, lack of access to health care, unstable housing, child welfare or juvenile justice involvement, work or family responsibilities, and lack of affordable or reliable transportation. School factors contributing to chronic absence include school climate, discipline policies, and concerns about bullying and unsafe situations.[4,5,6]

Student-reported reasons for not attending school include repeated suspensions, disruptive learning environments, irrelevant or unchallenging courses, poor achievement, concerns for safety, difficulty with peer and adult relationships, conflicts between school and work, family responsibilities, and negative perceptions of school.[7,8]

The U.S. Department of Education and the Rhode Island Department of Education (RIDE) define truancy as ten or more unexcused absences in a school year.[9,10] During the 2013-2014 school year in Rhode Island, 22% of middle school students and 30% of high school students were considered truant by RIDE.[11] Truant students in Rhode Island may be referred to the Family Court's Truancy Calendar, a community and school-based intervention program.[12]

Almost one-third (30%) of Rhode Island's low-income middle and high school students were chronically absent in 2013-2014, compared with 11% of higher-income students. Middle and high school students receiving special education services (30%) were more likely than their peers not receiving these services (18%) to be chronically absent. More than two-thirds (69%) of absences by middle and high school students were unexcused absences.[13]

School Attendance in Rhode Island by Number of School Days Missed, Middle and High School, 2013-2014 School Year



Source: Rhode Island Department of Education, 2013-2014 school year.

◆ **The chronic absence rate among middle (27%) and high (40%) school students in the four core cities is more than twice as high as the rates among middle (10%) and high (17%) school students in the remainder of the state.[14]**

◆ **One of the most effective strategies for increasing student achievement, high school graduation rates, and college access and completion, and for closing achievement gaps between higher income and lower income students, would be to increase the number of low-income students who attend school regularly.[15]**

Reducing Chronic Absence

◆ **Schools and districts together with community agencies can improve student attendance by developing systems that provide frequent reports on student absenteeism and reasons for the absenteeism, problem solving to address reasons for absenteeism, building and sustaining relationships with students and their families, developing a community response that involves adults who interact with students outside of school, recognizing and rewarding good attendance, and committing to learning what works and expanding effective programs and halting efforts that are not working.[16]**

◆ **States can reduce chronic absence by raising awareness about the problem; producing chronic absence reports with data available by district, grade, and subgroup; requiring that district and school improvement plans include chronic absence data and strategies for improving; and allocating resources to address barriers to attendance.[17]**

Chronic Absence, Middle School and High School

Table 51.

Chronic Absence and Attendance Rates, Middle and High School, Rhode Island, 2013-2014 School Year

	MIDDLE SCHOOL					HIGH SCHOOL				
SCHOOL DISTRICT	# ENROLLED LESS THAN 90 DAYS	# ENROLLED 90 DAYS OR MORE	ATTENDANCE RATE	% ABSENT 12-17 DAYS	% ABSENT 18+ DAYS	# ENROLLED LESS THAN 90 DAYS	# ENROLLED 90 DAYS OR MORE	ATTENDANCE RATE	% ABSENT 12-17 DAYS	% ABSENT 18+ DAYS
Barrington	*	864	96%	9%	5%	13	1,040	95%	12%	7%
Bristol Warren	28	739	95%	17%	9%	68	997	93%	17%	18%
Burrillville	26	622	95%	17%	10%	55	691	93%	16%	16%
Central Falls	71	418	91%	17%	32%	136	749	88%	17%	40%
Chariho	41	749	96%	8%	5%	91	1,227	95%	13%	11%
Coventry	30	1,173	96%	10%	6%	96	1,591	95%	12%	13%
Cranston	96	2,517	95%	14%	14%	250	3,259	90%	16%	31%
Cumberland	32	1,077	96%	11%	6%	69	1,355	94%	15%	14%
East Greenwich	10	600	97%	8%	4%	14	731	96%	9%	9%
East Providence	65	1,174	94%	19%	16%	121	1,528	93%	11%	19%
Exeter-West Greenwich	19	403	96%	10%	4%	22	549	95%	11%	9%
Foster-Glocester	19	463	95%	17%	5%	23	683	97%	7%	4%
Jamestown	NA	160	95%	15%	13%	NA	NA	NA	NA	NA
Johnston	32	737	94%	16%	16%	96	898	92%	14%	24%
Lincoln	18	739	95%	13%	11%	39	999	93%	16%	19%
Little Compton	NA	97	92%	28%	30%	NA	NA	NA	NA	NA
Middletown	42	542	95%	15%	10%	57	690	95%	12%	9%
Narragansett	18	314	95%	13%	11%	19	432	94%	16%	14%
New Shoreham	NA	31	94%	26%	13%	NA	36	95%	11%	11%
Newport	52	434	94%	18%	14%	105	547	88%	16%	34%
North Kingstown	30	968	95%	11%	9%	64	1,398	95%	9%	11%
North Providence	45	763	94%	15%	18%	72	998	93%	15%	24%
North Smithfield	20	413	96%	11%	6%	43	528	96%	10%	6%
Pawtucket	167	1,922	93%	16%	21%	288	2,112	90%	16%	35%
Portsmouth	24	594	96%	11%	9%	46	980	96%	13%	8%
Providence	712	5,188	92%	16%	26%	1,087	6,431	87%	16%	41%
Scituate	*	376	95%	12%	11%	17	462	93%	18%	19%
Smithfield	29	575	96%	9%	5%	22	759	95%	12%	11%
South Kingstown	42	790	96%	11%	6%	68	1,062	94%	11%	12%
Tiverton	21	452	95%	15%	8%	19	561	95%	13%	12%
Warwick	114	2,223	95%	15%	11%	230	2,890	92%	15%	23%
West Warwick	78	751	94%	11%	13%	98	942	91%	11%	22%
Westerly	21	673	95%	15%	10%	55	940	95%	16%	12%
Woonsocket	127	1,267	90%	18%	36%	190	1,584	86%	17%	45%
Charter Schools	*29*	*1,073*	*97%*	*8%*	*4%*	*126*	*1,421*	*92%*	*15%*	*30%*
State-Operated Schools	*18*	*	*90%*	*0%*	*33%*	*327*	*1,717*	*92%*	*18%*	*26%*
UCAP	*16*	*121*	*88%*	*17%*	*46%*	*NA*	*14*	*89%*	*7%*	*36%*
Four Core Cities	*1,077*	*8,795*	*92%*	*16%*	*27%*	*1,701*	*10,876*	*87%*	*16%*	*40%*
Remainder of State	*993*	*22,134*	*95%*	*13%*	*10%*	*1,877*	*28,793*	*93%*	*13%*	*17%*
Rhode Island	*2,117*	*32,011*	*94%*	*14%*	*15%*	*4,031*	*42,807*	*92%*	*14%*	*24%*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2013-2014 school year.

Attendance rates are calculated by dividing the state-calculated "average days of attendance" by the "average days of membership."

Chronic absence rates are based on attendance patterns for students who were enrolled in a district for at least 90 days. A total of 2,117 Rhode Island middle school students and 4,031 high school students were not included in this analysis because they were only enrolled for a short period. The Rhode Island Department of Education excludes these students so that chronic absence issues can be examined separate from student mobility issues. It is likely that more students were excluded from districts with higher student mobility rates.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Little Compton students attend high school in Portsmouth and Jamestown students attend high school in North Kingstown.

Charter middle schools include Blackstone Valley Prep, The Compass School, Paul Cuffee Charter School, Highlander Charter School, The Learning Community, Segue Institute for Learning, and Trinity Academy for the Performing Arts. Charter high schools include Beacon Charter High School for the Arts, Blackstone Academy, Highlander Charter School, Paul Cuffee Charter School, The Greene School, Rhode Island Nurses Institute Middle College Charter School, Sheila C. "Skip" Nowell Leadership Academy, Trinity Academy for the Performing Arts, and the Village Green Virtual Public Charter School.

State-operated schools include The Rhode Island Training School operated by DCYF, Metropolitan Regional Career and Technical Center, Rhode Island School for the Deaf, and William M. Davies Jr. Career & Technical High School. UCAP is the Urban Collaborative Accelerated Program.

*Fewer than 10 students are in this category. Actual numbers are not shown to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

References are on page 185.

Suspensions

DEFINITION

Suspensions is the number of disciplinary actions per 100 students in pre-kindergarten through 12th grade in Rhode Island public schools. Students can receive more than one disciplinary action during the school year. Disciplinary actions include in-school suspensions, out-of-school suspensions, and removal to an Interim Alternative Educational Setting (IAES) by school personnel.

SIGNIFICANCE

Effective school disciplinary practices promote a safe and respectful school climate, support learning and address the causes of student misbehavior. Punitive disciplinary practices, including "zero tolerance" policies, are largely ineffective and even counterproductive.[1,2] Despite this evidence, out-of-school suspension is a widely used disciplinary technique, both nationally and in Rhode Island. Suspensions are used for minor offenses, such as attendance infractions, and for more serious offenses, such as weapon possession.[3,4]

Suspension usually does not deter students from misbehaving and may actually reinforce negative behavior patterns. Suspended students are more likely than their peers to experience academic failure, juvenile justice system involvement, disengagement from school, isolation from teachers and peers, and dropping out of school. In fact, being suspended even once in ninth grade is associated with a twofold increase in the likelihood of dropping out.[5,6]

Schools and districts can improve school climate and discipline by setting high expectations for student behavior, using tiered supports based on student needs, providing professional development focused on engaging instruction and promoting positive behavior, and developing and enforcing disciplinary policies that ensure the equitable, appropriate, and limited use of suspensions.[7]

During the 2013-2014 school year in Rhode Island, 30,790 disciplinary actions were attributed to 11,848 students. In Rhode Island during the 2013-2014 school year, 9% of the student population was suspended at least once. The total number of disciplinary actions is two and a half times the number of students disciplined because some students were disciplined multiple times.[8]

Of all disciplinary actions during the 2013-2014 school year, 10% (3,013) involved elementary school students (pre-kindergarten through 5th grade), 39% (11,911) involved middle school students (6th-8th grades), and 52% (15,866) involved high school students (9th-12th grades). Kindergartners received 197 disciplinary actions, including 184 out-of-school suspensions.[9]

Out-of-School Suspensions, Rhode Island Public Schools, 2013-2014

BY TYPE OF INFRACTION*	#	%
Insubordination/Disrespect	4,927	31%
Disorderly Conduct	3,290	21%
Fighting	2,233	14%
Assault of Student or Teacher	1,275	8%
Obscene/Abusive Language	1,169	7%
Harassment/Intimidation/Threat	1,030	7%

BY TYPE OF INFRACTION	#	%
Alcohol/Drug/Tobacco Offenses	718	5%
Arson/Larceny/Robbery/Vandalism	412	3%
Weapon Possession	206	1%
Communications/Electronic Devices	186	1%
Attendance Offenses	0	0%
Other Offenses	317	2%
Total	*15,763*	

**Harassment offenses include hazing and hate crimes. Assault offenses include sexual assault. Examples of other offenses include cheating/plagiarism, fire regulation violations, sexual misconduct, trespassing, forgery, as well as disciplinary actions where the infraction is missing or not specified.*

Source: Rhode Island Department of Education, 2013-2014 school year. Percentages may not sum to 100% due to rounding.

◆ **Since the 2008-2009 school year, the number of out-of-school suspensions in Rhode Island has decreased by 37%.[10] However, during the 2013-2014 school year, out-of-school suspensions still accounted for 51% of disciplinary actions.[11]**

◆ **More than one-half of out-of-school suspensions were for non-violent offenses, such as insubordination or disrespect (31%) and disorderly conduct (21%).[12]**

◆ **In 2012, the Rhode Island General Assembly passed a law that prohibits schools from using a student's absenteeism as the sole basis for an out-of-school suspension.[13] During the 2013-2014 school year, there were 3,697 disciplinary actions in Rhode Island public schools for attendance-related infractions, and all resulted in in-school suspensions.[14]**

Disparities in School Discipline

◆ **Minority and low-income students receive more school suspensions and disproportionately severe disciplinary actions compared with their White and higher-income peers.[15] In Rhode Island during the 2013-2014 school year, minority students made up 39% of the student population, but received 57% (17,572) of all disciplinary actions. Less than one-third (29%) of Rhode Island students were enrolled in the four core city districts, but students in these districts received 51% of the disciplinary actions.[16,17]**

◆ **While 15% of Rhode Island students received special education services in 2013-2014, they accounted for 30% of the disciplinary actions and 26% of students disciplined.[18,19]**

Table 52.

Disciplinary Actions, Rhode Island School Districts, 2013-2014

SCHOOL DISTRICT	TOTAL # OF STUDENTS ENROLLED	SUSPENDED IN-SCHOOL	SUSPENDED OUT-OF-SCHOOL	TOTAL DISCIPLINARY ACTIONS	ACTIONS PER 100 STUDENTS
Barrington	3,237	*	60	67	2
Bristol Warren	3,395	583	408	991	29
Burrillville	2,379	85	230	315	13
Central Falls	2,692	455	108	563	21
Chariho	3,383	441	292	733	22
Coventry	4,769	745	156	901	19
Cranston	10,177	1,435	1,437	2,884	28
Cumberland	4,490	90	449	539	12
East Greenwich	2,360	20	38	58	2
East Providence	5,265	0	701	701	13
Exeter-West Greenwich	1,582	15	129	144	9
Foster	284	0	0	0	0
Foster-Glocester	1,148	175	98	273	24
Glocester	499	*	0	*	<1
Jamestown	492	*	0	*	<1
Johnston	2,991	30	70	100	3
Lincoln	3,095	*	241	246	8
Little Compton	257	0	0	0	0
Middletown	2,267	373	128	501	22
Narragansett	1,366	176	125	301	22
New Shoreham	117	*	0	*	<1
Newport	1,994	74	399	473	24
North Kingstown	3,948	478	90	568	14
North Providence	3,459	759	597	1,356	39
North Smithfield	1,724	*	53	55	3
Pawtucket	8,750	12	905	917	10
Portsmouth	2,628	260	109	369	14
Providence	23,799	2,022	6,296	8,318	35
Scituate	1,403	46	*	53	4
Smithfield	2,343	55	99	154	7
South Kingstown	3,333	339	137	476	14
Tiverton	1,796	35	179	214	12
Warwick	9,061	480	763	1,243	14
West Warwick	3,348	173	235	412	12
Westerly	3,010	41	188	229	8
Woonsocket	5,649	5,076	687	5,763	102
Charter Schools	*4,952*	*187*	*277*	*464*	*9*
State-Operated Schools	*1,773*	*330*	*23*	*353*	*20*
UCAP	*138*	*0*	*49*	*50*	*36*
Four Core Cities	*40,889*	*7,565*	*7,996*	*15,561*	*38*
Remainder of State	*91,600*	*6,928*	*7,418*	*14,362*	*16*
Rhode Island	*139,353*	*15,010*	*15,763*	*30,790*	*22*

Source of Data for Table/Methodology

Rhode Island Department of Education, 2013-2014 school year.

The disciplinary actions rate per 100 students is the total disciplinary actions for the school district at all grade levels (Pre-K through 12th grade), multiplied by 100, and divided by the student enrollment ("average daily membership").

Schools and districts only report suspensions of one day or longer. If an incident involves more than one infraction, schools and districts are asked to code the incident as the most serious type of infraction (e.g., violent offenses involving weapons and offenses involving drugs and alcohol are considered more serious than other offenses). 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.

*Only 17 removals to an Interim Alternative Education Setting (IAES) by school personnel were reported because new guidance from the Rhode Island Department of Education defined in-school suspensions more broadly than in the past. These removals are counted in district, four core city, remainder of state, and Rhode Island totals.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Charter schools include: Achievement First Rhode Island, Beacon Charter High School for the Arts, Blackstone Academy, Blackstone Valley Prep, The Compass School, Paul Cuffee Charter School, The Greene School, Highlander Charter School, International Charter School, Kingston Hill Academy, The Learning Community, Rhode Island Nurses Institute Middle College Charter School, Segue Institute for Learning, Sheila C. "Skip" Nowell Leadership Academy, Trinity Academy for the Performing Arts, and The Village Green Virtual Public Charter School. State-operated schools include: William M. Davies Jr. Career & Technical High School, DCYF Schools, Metropolitan Regional Career and Technical Center, and Rhode Island School for the Deaf. UCAP is the Urban Collaborative Accelerated Program.

References

[1,3,5] Sundius, J. & Farneth, M. (2008). *Putting kids out of school: What's causing high suspension rates and why they are detrimental to students, schools, and communities.* Baltimore, MD: Open Society Institute – Baltimore.

(continued on page 185)

High School Graduation Rate

DEFINITION

High school graduation rate is the percentage of students who graduate from high school within four years of entering, calculated by dividing the number of students who graduate in four years or fewer by the total number of first-time entering ninth graders (adjusted for transfers in and transfers out during the four years).

SIGNIFICANCE

High school graduation is the minimum requisite for college and most employment. In Rhode Island, adults without high school diplomas (17.1%) are more likely to be unemployed than those with a high school diploma (11.7%).[1] Between 2011 and 2013 in Rhode Island, the median income of adults without high school diplomas or GEDs was $22,256, compared to $30,298 for adults with high school degrees, and $52,184 for adults with bachelor's degrees.[2] In 2013, 14% of Rhode Island children lived in households headed by a non-high school graduate, consistent with the national average.[3]

Children who attend high-quality preschool programs and read at grade level in elementary school are more likely to graduate from high school than their peers.[4] Early warning and intervention systems use early predictors of dropping out, such as poor attendance, behavior problems, and course failure in math and reading to identify students who are off-track; so personalized and timely academic supports can be put in place to help students get "on track" for graduation.[5]

Other strategies for improving graduation rates include reducing chronic absenteeism; creating eighth to ninth grade transition programs; supporting personalized learning and meaningful student connections with adults in the school; implementing rigorous, engaging and relevant curricula, including expanded learning opportunities; providing clear pathways from high school to college and career training; and offering dropout recovery programs.[6,7]

In order to graduate, Rhode Island students must complete at least 20 courses in core subject areas, two performance-based assessments, and starting with the Class of 2020, reach a minimum achievement level on the state assessment in content areas designated by the Board of Education.[8]

High School Graduation Rates

	2012-2013
RI	80%
US	81%
National Rank*	*34th*
New England Rank**	*6th*

**1st is best; 49th is worst*
***1st is best; 6th is worst*

Source: EDFacts. (2015). Consolidated state performance report, school years 2010-11, 2011-12, and 2012-13. Retrieved February 10, 2015, from www.ed.gov

Rhode Island Four-Year High School Graduation and Dropout Rates, by Student Subgroup, Class of 2014

	COHORT SIZE	DROPOUT RATE	% COMPLETED GED	% OF STUDENTS STILL IN SCHOOL	FOUR-YEAR GRADUATION RATE
Females	5,520	6%	2%	7%	84%
Males	5,813	9%	3%	10%	77%
English Language Learners	1,140	15%	2%	11%	72%
Students With Disabilities	2,491	16%	3%	21%	60%
Students Without Disabilities	8,842	6%	2%	5%	87%
Low-Income Students	6,286	12%	4%	13%	71%
Higher-Income Students	5,047	2%	1%	4%	93%
White	7,373	6%	2%	7%	85%
Asian	294	5%	2%	4%	88%
Black	980	12%	2%	14%	72%
Hispanic	2,372	13%	3%	13%	72%
Native American	54	28%	6%	9%	57%
ALL STUDENTS	*11,333*	*8%*	*2%*	*9%*	*81%*

Source: Rhode Island Department of Education, Class of 2014. Percentages may not sum to 100% due to rounding.

◆ **The Rhode Island four-year graduation rate for the Class of 2014 was 81%, up from 70% for the Class of 2007 (the first class for which the Rhode Island Department of Education (RIDE) began calculating graduation rates using a cohort formula).[9]**

◆ **Poverty is strongly linked to the likelihood of dropping out.[10] Students in Rhode Island's four core cities (14% drop out) are almost three times as likely to drop out of high school as students in the remainder of the state (5% drop out).[11]**

Rhode Island Five- and Six-Year High School Graduation Rates

◆ **Rhode Island calculates five- and six-year graduation rates to recognize the graduation accomplishment regardless of the time it takes. Of the 12,036 Rhode Island students who enrolled in ninth grade in 2008, 9,325 (77.5%) graduated in four years in 2012, 444 (3.7%) graduated in five years in 2013, and 87 (0.7%) graduated in six years in 2014.[12]**

◆ **Of the 444 students who graduated in five years in 2014, 43% were students with disabilities. Of the 87 students who graduated in six years in 2014, 70% were students with disabilities.[13]**

Table 53.

High School Graduation Rates, Rhode Island, Class of 2014

SCHOOL DISTRICT	# OF STUDENTS IN COHORT	FOUR-YEAR COHORT RATES: DROPOUT RATE	% COMPLETED GED	% STILL IN SCHOOL	FOUR-YEAR GRADUATION RATE
Barrington	269	1%	0%	5%	94%
Bristol Warren	275	6%	1%	7%	87%
Burrillville	180	16%	3%	7%	74%
Central Falls	210	13%	1%	15%	71%
Chariho	306	5%	1%	3%	92%
Coventry	432	7%	1%	8%	85%
Cranston	911	5%	3%	7%	85%
Cumberland	334	5%	2%	7%	87%
East Greenwich	183	1%	0%	3%	96%
East Providence	393	8%	6%	8%	77%
Exeter-West Greenwich	140	5%	3%	2%	90%
Foster-Glocester	193	3%	1%	2%	94%
Johnston	229	6%	3%	3%	88%
Lincoln	271	4%	2%	6%	89%
Middletown	176	2%	2%	11%	85%
Narragansett	125	5%	4%	5%	86%
Newport	141	18%	1%	12%	70%
North Kingstown	370	5%	2%	5%	87%
North Providence	261	1%	3%	8%	88%
North Smithfield	121	4%	2%	3%	90%
Pawtucket	569	9%	2%	9%	80%
Portsmouth	267	1%	<1%	3%	96%
Providence	1,797	14%	2%	14%	71%
Scituate	116	4%	1%	3%	91%
Smithfield	222	6%	0%	5%	88%
South Kingstown	260	5%	2%	2%	91%
Tiverton	136	3%	1%	5%	91%
Warwick	764	6%	5%	10%	79%
West Warwick	241	14%	2%	3%	81%
Westerly	213	1%	3%	10%	85%
Woonsocket	436	25%	6%	12%	58%
Beacon Charter High School for the Arts	*56*	*2%*	*2%*	*4%*	*93%*
Blackstone Academy	*41*	*5%*	*5%*	*7%*	*83%*
Paul Cuffee Charter School	*59*	*2%*	*0%*	*7%*	*92%*
Sheila C. "Skip" Nowell Leadership Academy	*60*	*28%*	*0%*	*52%*	*20%*
The Greene School	*38*	*0%*	*5%*	*8%*	*87%*
William M. Davies Jr. Career & Technical High School	*177*	*6%*	*2%*	*11%*	*81%*
DCYF Schools	*56*	*23%*	*43%*	*25%*	*9%*
Metropolitan Regional Career and Technical Center	*240*	*5%*	*1%*	*8%*	*87%*
Four Core Cities	*3,012*	*14%*	*3%*	*13%*	*71%*
Remainder of State	*7,537*	*5%*	*2%*	*6%*	*86%*
Rhode Island	*11,333*	*8%*	*2%*	*9%*	*81%*

Source of Data for Table/Methodology

Rhode Island Department of Education, Class of 2014.

The 2014 four-year cohort graduation rate is the number of students who graduate in four years or fewer divided by the total number of students in the cohort. The cohort is calculated as the number of first-time entering ninth graders in 2010-2011 adjusted for transfers in and transfers out during the course of the four years. The cohort dropout rate is calculated the same way as the graduation rate, but the numerator is the number of students who drop out or whose status is unknown at the end of four years. Separate rates are calculated for the percentage of students who are retained in high school and therefore are taking more than four years to graduate and for the percentage of students who received their GED within four years instead of graduating with a traditional diploma.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Students from Little Compton attend high school in Portsmouth, and students from Jamestown attend high school in North Kingstown. DCYF includes students attending DCYF alternative schools.

Rates are not reported for districts or schools with fewer than 10 students in the cohort or for Rhode Island Nurses Institute Middle College Charter School. There are 57 students in this cohort included in the four core cities, remainder of the state, and Rhode Island totals that come from districts and schools not reported.

Rhode Island Nurses Institute Middle College Charter High School is not reported because students complete their course of study in five years instead of four.

References

[1] U.S. Census Bureau, American Community Survey, 2011-2013. Table S2301.

[2] U.S. Census Bureau, American Community Survey, 2011-2013. Table B20004.

[3] KIDS COUNT Data Center. (2015). *Children by household head's educational attainment–2013.* Retrieved February 5, 2015, from datacenter.kidscount.org

(continued on page 185)

College Preparation and Access

DEFINITION

College preparation and access is the percentage of Rhode Island high school seniors who graduate and go on to college (i.e., enroll in a two-year or four-year college) immediately or within six months of graduation.

SIGNIFICANCE

By 2020, 71% of jobs in Rhode Island will require post-secondary education beyond high school.[1] Between 2011 and 2013 in Rhode Island, adults with high school diplomas were almost three times more likely to be unemployed as those with bachelor's degrees or higher.[2] During that same period, the median annual income for adults with high school diplomas was $30,298, compared to $52,184 for adults with bachelor's degrees.[3]

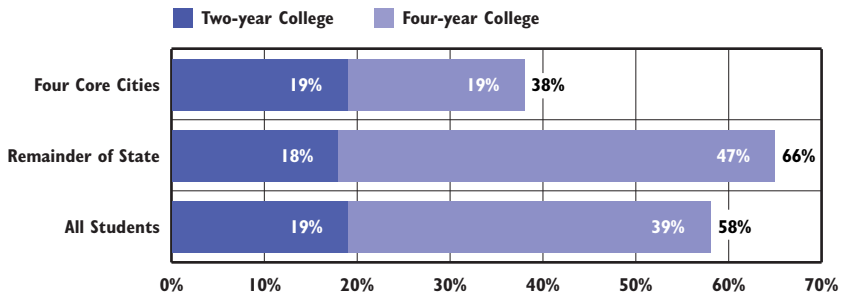
During the 2013-2014 school year, 87% of Rhode Island high school seniors reported planning to attend a two- or four-year college.[4] However, many students, and low-income students in particular, face barriers, including insufficient academic preparation, difficulty navigating the application and financial aid process, and the high cost of college.[5]

Many students arrive at college unprepared for the work. In 2014, 58% of Rhode Island public school seniors took the SATs. Average scores were 483 in critical reading, 484 in math, and 471 in writing.[6] Students with scores of 500 or better in each section are more likely to enroll in and succeed in college.[7] Students who participate in upper-level honors and Advanced Placement (AP) courses are likely to attend and succeed in college.[8] Among Rhode Island's 2013 high school graduates, 26% took at least one AP exam, compared with 33% nationally.[9]

Students need information, support, and encouragement to plan, prepare for, and attend college. Without support, low-income and first-generation college students are particularly likely to "undermatch" (enroll in a college for which they are academically overqualified) or not enroll at all.[10] Seniors who have completed a Free Application for Federal Student Aid (FAFSA) by May and been accepted to a four-year college are 50% more likely to enroll than students who have not completed their FAFSA.[11]

Many students who enroll in college do not complete their degree. Low-income students, minority students, and first-generation students are less likely to enroll in and complete college. Academic, financial, and social supports can increase college enrollment and completion rates, especially among these groups.[12,13,14]

Immediate College Enrollment by District Type and Type of College, Class of 2012, Rhode Island



Source: Rhode Island Department of Education, Class of 2012. Percentages may not sum exactly due to rounding.

◆ **Fifty-eight percent of Rhode Island students who graduated from high school in the Class of 2012 immediately enrolled in college. However, there are large gaps in college access between students who graduate from high schools in the four core cities and the remainder of the state. Among Rhode Island students who graduated from high school in 2012, 19% of students from the four core cities immediately enrolled in a four-year college, compared to 47% of students from the remainder of the state.[15]**

◆ **Low-income and first-generation college students are more likely to go to college when they attend high schools with strong college-going cultures, in which teachers encourage students to attend college, help them with the application process, and make sure that students are academically prepared. High schools that offer rigorous coursework, set high expectations for students, offer dual enrollment in college classes, and increase access to financial aid counseling can improve their students' enrollment and completion rates.[16,17,18]**

◆ **Improving college access and success will require improvements at all points in the early education to college education system, including increasing access to high-quality preschool, implementing research-driven dropout prevention programs, aligning the K-12 education system with college and career expectations, simplifying the college admission process, keeping college affordable, and providing student support programs that increase college completion rates.[19] State policies that reward colleges for meeting performance goals, transform remediation practices, encourage full-time college attendance, help students balance work and school, and support on-time graduation could further increase college completion rates.[20]**

Table 54.

College Preparation and Access, Rhode Island

SCHOOL DISTRICT	TOTAL 12TH GRADE ENROLLMENT OCT. 2014	% OF 11TH GRADERS PROFICIENT IN READING, 2013	% OF 11TH GRADERS PROFICIENT IN MATH, 2013	% OF 12TH GRADERS WHO PLANNED TO ATTEND COLLEGE, 2013	4-YEAR HIGH SCHOOL GRADUATION RATE, 2014	% OF 12TH GRADERS WHO FILLED OUT THE FAFSA, 2014	% OF 12TH GRADERS TAKING THE SATs, 2014
Barrington	299	97%	78%	93%	94%	58%	78%
Bristol Warren	226	95%	41%	85%	87%	66%	65%
Burrillville	190	86%	41%	84%	74%	38%	35%
Central Falls	226	53%	13%	89%	71%	34%	31%
Chariho	298	93%	50%	83%	92%	51%	54%
Coventry	399	93%	36%	87%	85%	56%	63%
Cranston	838	85%	28%	90%	85%	59%	55%
Cumberland	355	89%	46%	86%	87%	54%	61%
East Greenwich	202	95%	70%	96%	96%	55%	77%
East Providence	381	80%	30%	88%	77%	45%	45%
Exeter-West Greenwich	140	88%	58%	90%	90%	65%	79%
Foster-Glocester	161	90%	53%	85%	94%	78%	75%
Johnston	206	81%	23%	88%	88%	48%	56%
Lincoln	262	93%	52%	90%	89%	65%	68%
Middletown	173	90%	59%	91%	85%	55%	65%
Narragansett	125	96%	66%	NA	86%	52%	70%
New Shoreham	13	100%	64%	NA	NA	NA	46%
Newport	122	78%	24%	82%	70%	55%	55%
North Kingstown	360	93%	58%	88%	87%	66%	75%
North Providence	252	90%	38%	90%	88%	54%	46%
North Smithfield	143	96%	52%	85%	90%	43%	51%
Pawtucket	503	70%	18%	88%	80%	51%	57%
Portsmouth	233	93%	63%	92%	96%	71%	81%
Providence	1,435	61%	14%	88%	71%	66%	69%
Scituate	116	94%	55%	87%	91%	67%	67%
Smithfield	167	91%	47%	89%	88%	84%	97%
South Kingstown	261	88%	59%	90%	91%	59%	71%
Tiverton	133	88%	27%	80%	91%	54%	58%
Warwick	718	86%	33%	84%	79%	36%	48%
West Warwick	202	80%	31%	79%	81%	66%	61%
Westerly	271	91%	54%	83%	85%	44%	45%
Woonsocket	394	70%	20%	80%	58%	36%	33%
Beacon Charter High School for the Arts	*53*	*96%*	*24%*	*88%*	*93%*	*72%*	*68%*
Blackstone Academy	*39*	*90%*	*35%*	*NA*	*83%*	*79%*	*100%*
Paul Cuffee Charter School	*61*	*67%*	*12%*	*NA*	*NA*	*67%*	*95%*
The Greene School	*30*	*88%*	*44%*	*79%*	*87%*	*67%*	*77%*
RI Nurses Institute Middle College	*100*	*86%*	*23%*	*NA*	*NA*	*16%*	*47%*
Sheila C. "Skip" Nowell Leadership Academy	*32*	*31%*	*1%*	*NA*	*NA*	*NA*	*NA*
William M. Davies Jr. Career & Technical High School	*205*	*93%*	*35%*	*NA*	*81%*	*32%*	*24%*
DCYF Schools	*17*	*NA*	*NA*	*NA*	*9%*	*NA*	*NA*
Metropolitan Regional Career and Technical Center	*222*	*67%*	*16%*	*86%*	*87%*	*62%*	*10%*
RI School for the Deaf	*14*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Four Core Cities	*2,558*	*63%*	*16%*	*87%*	*71%*	*56%*	*58%*
Remainder of State	*7,247*	*89%*	*45%*	*87%*	*86%*	*51%*	*61%*
Rhode Island	*10,578*	*82%*	*36%*	*87%*	*81%*	*51%*	*58%*

Source of Data for Table/Methodology

12th grade enrollment data (October 1, 2014), 11th grade *New England Common Assessment Program (NECAP)* data, % of 12th graders taking the SATs, and high school graduation rates data are all from the Rhode Island Department of Education.

11th grade *NECAP* reading and math proficiency rates are the percentage of *NECAP* test-takers who scored at the "proficient" or "proficient with distinction" levels (levels three and four) on the October 2013 *NECAP*.

% of 12th graders who planned to attend college is from the 2013-2014 administration of *SurveyWorks!*, based on responses to the question, "What are you thinking about doing after finishing high school?" and includes students who responded that they planned to go to a community college, two-year college, or four-year college. See the Methodology Section for more information on *SurveyWorks!*

The high school graduation rate is the number of students who graduate in four years or fewer divided by the total number of students who started 9th grade in 2010-2011, adjusted for transfers in and transfers out.

% of 12th graders who filled out the FAFSA is from U.S. Department of Education, Federal Student Aid. (2014). *FAFSA completion by high school.* Retrieved March 2, 2015, from studentaid.ed.gov

% of 12th graders taking the SATs is the number of students who took the SATs in 2014 divided by the 12th grade enrollment. This number likely includes some 11th graders who took the SATs that year and may not be consistent with the percentage of graduating seniors who took the SATs as reported by the College Board and reported in other places in this indicator.

NA indicates that data are not available either because data were not collected or reported or because the number of students was too small to report.

Core cities are Central Falls, Pawtucket, Providence, and Woonsocket.

Students from Little Compton attend high school in Portsmouth and students from Jamestown attend high school in North Kingstown. DCYF includes students attending DCYF alternative schools.

References are on page 185.

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. Teens who are recent high school graduates and who are unemployed, and teens who have dropped out of high school and are jobless are included.

SIGNIFICANCE

School and work help teens acquire the skills, knowledge and supports they need to become productive adults.[1] Teens who drop out of school and do not become a part of the workforce are at risk of experiencing negative outcomes as they transition from adolescence to adulthood. Teens in low-income families, teens who drop out of school, teen parents, teens with a disability, teens in foster care and teens involved in the juvenile justice system are most at risk of being disconnected from both school and work.[2]

Disconnected youth are more likely to live in poverty, suffer from substance abuse and mental health problems, have low educational attainment, become teen parents, engage in violent activity, lack health insurance, experience difficulties maintaining employment, and earn low wages.[3,4,5]

Meaningful family support, adult mentoring, out-of-school programs, job training, safer schools and school-to-career programs lessen the likelihood of teens becoming disconnected from school and work.[6,7,8] Research shows that youth who are consistently connected to work and school have similar annual earnings regardless of whether they are Hispanic, White, or Black.[9]

Between 2011 and 2013, an estimated 4,095 (6%) youth ages 16 to 19 were not in school and not working in Rhode Island. Of the youth who were not in school and not working, 42% were females and 58% were males. Fifty-five percent of these youth were high school graduates and 45% had not graduated from high school.[10]

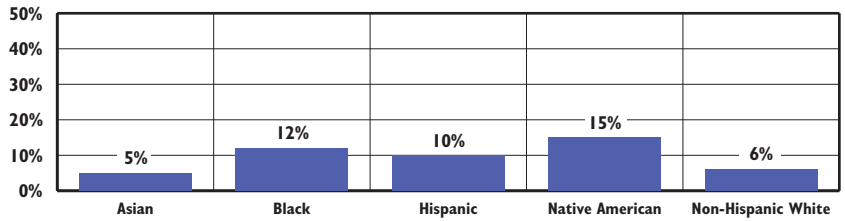
Teens Not in School and Not Working

	2013
RI	6%
US	8%
National Rank*	*11th*
New England Rank**	*5th*

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

Source: The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

Percentage of U.S. Youth Ages 16 to 19, Not in School and Not Working, by Race and Ethnicity, 2013



Source: The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org

◆ **Nationally and in Rhode Island, minority youth are more likely to be disconnected from school and work.[11,12] In 2013 among youth ages 16 to 19 in the U.S., 15% of Native American youth, 12% of Black youth, and 10% of Hispanic youth were not in school and not working, compared to 6% of non-Hispanic White youth and 5% of Asian youth.[13]**

◆ **The economic recession had a negative impact on the job market for youth and young adults. In 2011, youth employment in the U.S. reached its lowest level since World War II, with 26% of teens ages 16 to 19 employed.[14]**

Compulsory School Attendance

◆ **In 2011, Rhode Island raised its school attendance requirement from age 16 to 18. Rhode Island students over age 16 may obtain a waiver from the attendance requirement if they have an alternative learning plan for obtaining a diploma. Plans can include independent study, private instruction, community service, or online coursework and must be developed in consultation with the student, school guidance counselor, school principal, and at least one parent or guardian. Alternative learning plans must be approved by the district superintendent.[15]**

◆ **As of August 2013, 23 states have set compulsory attendance to age 18, 11 states required attendance to age 17, and the remaining 16 states required school attendance to age 16.[16]**

Connecting Youth to School and Work

◆ **Education has a positive impact on the likelihood of finding and maintaining employment. Between 2011 and 2013, the unemployment rate for Rhode Island adults ages 25 to 64 with a bachelor's degree or higher was 4%, compared with 17% for those with less than a high school diploma.[17]**

◆ **Successful strategies to connect youth to work and school must be comprehensive, including attention to community engagement in schools, early identification of youth at risk of dropping out of school, targeted workforce development programs, and multiple pathways to high school graduation and employment.[18,19,20]**

◆ **Programs and alternative schools that enable students to earn college credits while working towards their high school degrees can improve high school graduation rates and better prepare students for college completion and high-skill careers.[21]**

Youth Work Experience

◆ **Work experience during the teen years increases employability and wages into early adulthood and improves the likelihood that workers will receive formal training, including apprenticeship training, from their employers early in their careers.[22]**

◆ **Investment in summer work programs helps keep adolescents attached to constructive youth development activities and can help prevent youth violence.[23]**

◆ **Expanding work experience opportunities, internships, and job shadowing programs can help more youth in Rhode Island successfully transition into the workforce. These types of programs can help to motivate students, teach them critical skills, connect them with mentors and positive adult role models, as well as help them to make informed decisions about vocational training, colleges, and careers. Many internship programs allow youth to receive school credit and/or earn money, while gaining important workplace experience.[24,25]**

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Methodology

The *2015 Rhode Island Kids Count Factbook* examines 71 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.

◆ ***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. The New England Rank highlights Rhode Island's rank among the six New England states – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

◆ ***City/Town Tables:*** Data presented for each of Rhode Island's cities and towns, the state as a whole, and the four core cities.

◆ ***Four Core Cities Data:*** The core cities are the four Rhode Island communities with the highest percentages of children living below the poverty threshold according to the 2009-2013 American Community Survey conducted by the U.S. Census Bureau. They are Central Falls, Pawtucket, Providence, and Woonsocket. The core cities are different than in previous Factbooks that were identified based on the child poverty rates reported in Census 2000. In prior Factbooks, the six core cities were Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket. When core city trends are presented in this Factbook, they are based on the new definition of core cities for all years presented.

◆ ***Most Recent Available Data:*** The 2015 Factbook uses the most current, reliable data available for each indicator.

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 2009 and 2013. 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 Rhode Island 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. Caution should be used with small numbers in numerators and denominators.

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) is 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 source of data for the total number of children eligible for respective indicator (the denominator) is also noted within the Source of Data/Methodology section. Rates and percentages are 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.

In the indicator for child deaths and teen deaths, and other indicators in which the events are rare, city and town rates are not calculated, as small numbers make these rates statistically unreliable.

Census Data

There are four sources of U.S. Census Bureau data used in the Factbook: Census 2010, the Current Population Survey, Population Estimates, and the American Community Survey. In all city/town tables that require population statistics, data is from Census 2010 (as is stated in Source sections). Throughout the text portions of each indicator, all four sources are used and the relevant citations provide clarification on which source the data come from.

Starting with the *2012 Rhode Island Kids Count Factbook*, rates that use the child population as the denominator are based on Census 2010. Previous years are based on Census 2000. In instances where Census 2010 data is used in the denominator, caution should be taken when comparing new rates with those for past years, as actual population numbers may have changed. Indicators affected by this change include:

Children in Families Receiving Cash Assistance, Children with Asthma, Births to Teens, Children of Incarcerated Parents, Child Abuse and Neglect, Children Enrolled in Early Intervention, Children Enrolled in Early Head Start, and Children Enrolled in Head Start.

Whenever possible, Census data are updated using the most recent data from Census 2010; however, Census 2010 was a briefer survey than Census 2000 and did not include questions on employment and education status or on income, so indicators based on these measures use the most recent data from the American Community Survey.

Margins of Error for Median Family Income and Children in Poverty

The 2009-2013 Median Family Income and Child Poverty data are estimates based on the American Community Survey, a sample survey. The reliability of estimates varies by community. In general, estimates for small communities are not as reliable as estimates for larger communities. The Margin of Error is a measure of the reliability of the estimate and is provided by the U.S. Census Bureau. The Margin of Error means that there is 90 percent chance that the true value is no less than the estimate minus the Margin of Error and no more than the estimate plus the Margin of Error. Margins of Error are provided for all communities in the tables in this section.

Margins of Error, Median Family Income, Rhode Island, 2009-2013

CITY/TOWN	2009-2013 MEDIAN FAMILY INCOME FOR FAMILIES WITH CHILDREN UNDER AGE 18	MARGIN OF ERROR
Barrington	$131,656	$4,879
Bristol	$100,913	$15,527
Burrillville	$71,013	$14,691
Central Falls	$28,953	$5,256
Charlestown	$72,054	$17,588
Coventry	$83,156	$12,920
Cranston	$80,105	$3,439
Cumberland	$96,629	$12,740
East Greenwich	$167,539	$16,465
East Providence	$55,127	$6,737
Exeter	$120,441	$22,826
Foster	$79,728	$50,691
Glocester	$91,327	$9,265
Hopkinton	$85,071	$20,395
Jamestown	$137,734	$32,957
Johnston	$80,784	$7,043
Lincoln	$98,803	$10,723
Little Compton	$124,028	$39,136
Middletown	$84,038	$10,401
Narragansett	$103,654	$17,842
New Shoreham	$106,071	$46,806
Newport	$54,412	$11,507
North Kingstown	$107,165	$12,172
North Providence	$68,904	$5,838
North Smithfield	$97,353	$17,644
Pawtucket	$41,421	$3,358
Portsmouth	$101,250	$16,977
Providence	$33,154	$1,865
Richmond	$116,500	$18,490
Scituate	$87,083	$20,226
Smithfield	$92,596	$14,062
South Kingstown	$104,334	$11,652
Tiverton	$91,103	$14,556
Warren	$70,203	$7,856
Warwick	$79,162	$4,633
West Greenwich	$104,323	$12,195
West Warwick	$53,558	$12,906
Westerly	$64,375	$18,836
Woonsocket	$31,307	$3,280
Four Core Cities	*NA*	*NA*
Remainder of State	*NA*	*NA*
Rhode Island	*$67,904*	*$2,186*

Margins of Error, Children Living Below the Federal Poverty Threshold, Rhode Island, 2009-2013

CHILDREN UNDER AGE 18 LIVING BELOW POVERTY, 2009-2013			
#	MARGIN OF ERROR	%	MARGIN OF ERROR
53	61	1.2%	1.39%
167	100	4.8%	2.85%
372	200	11.7%	6.13%
2,334	400	41.1%	5.78%
273	220	18.3%	14.29%
866	305	11.6%	4.00%
2,189	446	13.9%	2.74%
480	213	6.4%	2.81%
207	166	6.5%	5.21%
1,592	424	16.7%	4.25%
80	78	6.6%	6.26%
66	64	7.9%	7.47%
82	71	4.6%	3.92%
50	75	3.6%	5.33%
103	89	10.6%	8.89%
642	257	11.7%	4.54%
232	136	5%	2.92%
37	51	5.7%	7.70%
666	189	16.8%	4.53%
127	81	5.6%	3.44%
21	35	23.1%	36.61%
533	204	14.5%	5.35%
683	275	11.1%	4.40%
630	242	12.1%	4.50%
163	105	7.1%	4.47%
4,550	624	28.9%	3.69%
250	148	7.4%	4.35%
16,049	1,234	39.7%	2.82%
134	165	7.3%	8.90%
174	117	8.6%	5.66%
66	83	1.8%	2.26%
247	159	4.9%	3.09%
133	83	4.4%	2.72%
230	106	11.1%	4.91%
1,260	256	8.4%	1.66%
74	84	5.1%	5.75%
1,309	392	22.4%	6.44%
901	374	18.9%	7.59%
4,222	597	42.8%	5.38%
27,155	*947*	*37.9%*	*1.21%*
15,092	*738*	*10.4%*	*0.50%*
42,247	*1,959*	*19.5%*	*0.89%*

Methodology

Methodology for Homeless Children

The number of homeless children identified by public schools is based on the federal *McKinney-Vento Act* definition of homelessness and includes children living in emergency and transitional shelters, as well as children doubling up in homes with relatives and friends and living in hotels and motels, cars, campsites, parks, and other public places. Schools report the number of children by grade and the child's primary nighttime residence (i.e., sheltered, doubled-up, unsheltered, or in a hotel/motel). The total number of students identified by school districts may be higher than the total for Rhode Island if students were identified as homeless by multiple school districts in which they were enrolled.

Methodology for Children with Lead Poisoning

In 2012, the Centers for Disease Control and Prevention (CDC) lowered the threshold for which a child is considered to have an elevated blood lead level from ≤10 µg/dL to ≤5 µg/dL.

This new threshold, also called a reference value, is based on the U.S. population of children age one through five who are in the highest 2.5% of children when tested for lead in their blood. The CDC will update the reference value every four years using the two most recent National Health and Nutrition Examination Surveys (NHANES). Because no safe blood lead level in children has been identified, the CDC also will no longer use the term "level of concern" when talking about those children whose blood lead level exceed the reference value and require case management. Instead, they will replace that term with the reference value and the date of the NHANES that was used to calculate the reference value. For more information on this policy change, see www.cdc.gov.

Rhode Island law requires providers to conduct at least two blood lead screening tests on all children by age three and to continue screening annually through age six. In October 2007, the Rhode Island Department of Health's Healthy Homes and Childhood Lead Poisoning Prevention Program made its screening guidelines consistent with the American Academy of Pediatrics, which recommends a blood lead screening test for every child at age one and two.

The guidelines (which were updated in 2012 to reflect the new CDC recommendations) indicate that if either of the blood lead tests done at ages one and two is ≥5 µg/dL, follow up and annual screening should continue until the age of six. For those children whose blood lead tests are ≤5 µg/dL, the pediatrician can use the Risk Assessment Questionnaire instead of a blood lead test until the age of six, which means that not all children receive an annual blood test after age two. For those children under age six who have not been screened at least twice prior to 36 months of age, it is recommended that a blood lead test be ordered. If the blood lead level is ≥5 µg/dL, the child should be screened annually.

Confirmed lead data at ≥5 µg/dL are based on venous tests and confirmed capillary tests only. The highest result (venous or capillary) is used. Complete confirmed lead poisoning trend data at the ≥5 µg/dL reference level are only available since 2012, when state blood lead screening protocols were updated to reflect the new lower CDC threshold. Prior to 2012, confirmed lead data at the ≥5 µg/dL reference value are available, but is incomplete and is limited to only those children who had a venous test. Children who had an initial capillary test and screened positive for lead between 5 µg/dL and 10 µg/dL were not required to have a confirmation test prior to 2012 as their blood lead level did not exceed the old reference value of ≥10 µg/dL.

Indicators Using *SurveyWorks!* Data

The following indicators use *SurveyWorks!* data: Alcohol, Drug and Tobacco Use by Teens; Youth Violence; and College Preparation and Access. *SurveyWorks!* is an on-line survey that is sponsored by the Rhode Island Department of Education. In 2009, *SurveyWorks!* replaced the School Accountability for Learning and Teaching (SALT) survey, although some questions were retained in order to provide trend data over time. The *SurveyWorks!* tool was administered in the 2013-2014 school year to students in grades 4-12, with the exception of students who were excused by their parents and students with Individualized Education Programs (IEPs) who were 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.

Methodology for Youth Violence

All law enforcement agencies in Rhode Island are required to maintain a record of the nature of detentions and characteristics of juveniles they arrest.

They submit this information to the Rhode Island Public Safety Grant Administration Office on a monthly basis, and the information is aggregated into a summary report submitted annually to the federal Office of Juvenile Justice and Delinquency Prevention. More information can be found at www.rijustice.ri.gov.

Assault offenses in this indicator include simple assault, robbery, assault, felony assault, assault with a dangerous weapon, domestic assault, assault on a police officer, threats, assault on a school teacher, strong-arm robbery, kidnapping, attempted murder, extortion, fighting,

intimidating witness, stalking, attempted robbery, cyber-stalking, carjacking, harassment, and murder.

Weapons offenses in this indicator include possession of an unspecified weapon, possession of a knife, possession of a firearm, possession of a weapon at school, possession of a bb gun, discharging a firearm, possession of ammunition, possession of a dangerous weapon, carrying a concealed weapon, and discharging a bb gun.

Methodology for Child Deaths due to Child Abuse and Neglect

Beginning with the 2013 Factbook, child deaths due to child abuse and neglect are reported using data provided by the Rhode Island Department of Health. Data from previous Factbooks are not comparable due to a change in data source.

State-Operated and Charter Schools

The state-operated schools and charter schools included in each table are listed in the Source/Methodology Section next to the table. Charter schools include only independently-run charter schools and not those affiliated with a district. The Academy for Career Exploration, the New England Laborers'/Cranston Public Schools Construction Career Academy, and Times2 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 (UCAP) is listed separately when data are available. Charter schools, state-operated schools, and UCAP are not included in core city and remainder of state calculations.

New England Common Assessment Program (NECAP)

The New England Common Assessment Program (NECAP) has been Rhode Island's statewide assessment system since 2005. Rhode Island began using the *NECAP* for elementary and middle school students in October 2005 and for high school students in October 2007. The tests were developed and administered in collaboration with New Hampshire, Vermont, and Maine through the *New England Common Assessment Program (NECAP)*, the first multi-state testing collaboration in the nation. The *NECAP* tested students in reading, writing and mathematics, and all test questions were directly related to specific state educational standards. Test results are available for the state, district and school levels on the Rhode Island Department of Education (RIDE) website. Results from the *NECAP* are not comparable with statewide assessment tests from years prior to 2005 for elementary and middle schools and 2007 for high schools.

Starting in the 2014-2015 school year, Rhode Island began using a new statewide assessment, the *Partnership for Assessment of Readiness for College and Careers (PARCC)*. PARCC data will be available in the 2016 Factbook.

Rhode Island totals may not be the same as the sum of the districts because results for districts with fewer than 20 students are not reported by RIDE. An asterisk is used when there are fewer than 10 students in a category to protect student confidentiality. These students are still counted in district totals and in the four core cities, remainder of the state, and state totals.

Methodology for Schools Identified for Intervention

Under Rhode Island's new accountability system, each school receives a Composite Index Score (CIS) ranging from 20 to 100 points. Accountability calculations are made for schools at each applicable level (i.e., elementary, middle, or high school). Scores are based on seven measures of performance: reading and math proficiency on the state assessment, progress toward target goals in reading and math proficiency, achievement gap-closing, distinction on reading and math assessments, year-over-year growth in reading and math performance (elementary and middle schools only), the graduation rate (high schools only), and improvement in math and reading state assessment scores (high schools only).

Many metrics are disaggregated into subgroups: a consolidated group of minority and economically disadvantaged students which includes African-American, Hispanic, Asian, Pacific Islander, and Native American students as well as students receiving free or reduced-price lunch and a consolidated program subgroup which includes special needs students with Individualized Education Plans (IEPs) and English Language Learner (ELL) students. Each subgroup is only measured if there are at least 20 students in that subgroup.

The individual scores for each metric are then added to arrive at the total score, the CIS. The cut score is the primary factor used to determine which of the six classifications schools are assigned to (e.g., Commended, Leading, Typical, Warning, Focus, and Priority), although other factors, such as the participation rate on state assessment tests and graduation rate target are also considered.

Limitations of the Data

In any data collection process there are always concerns about the accuracy and completeness of the data that are collected. All data used in Factbook 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 for these systems.

Methodology & References

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 2014 federal poverty threshold is $19,790 for a family of three with two children and $23,850 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 U.S. 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 for public programs. The figures are adjusted upward for larger family sizes.

The phrases "Federal Poverty Level" and "Federal Poverty Line" (often abbreviated FPL) are used interchangeably and can refer to either the poverty thresholds or the poverty guidelines.

Family Income Levels Based on the Federal Poverty Guidelines

2015 FEDERAL POVERTY GUIDELINES	ANNUAL INCOME FAMILY OF THREE	ANNUAL INCOME FAMILY OF FOUR
50%	$10,045	$12,125
100%	$20,090	$24,250
130%	$26,117	$31,525
175%	$35,158	$42,438
180%	$36,162	$43,650
185%	$37,167	$44,863
200%	$40,180	$48,500
225%	$45,203	$54,563
250%	$50,225	$60,625

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